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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Contents

Figures

Tables

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

per cent for histrionic personality disorder using DSM-III criteria and noted no sex difference for this diagnosis in those under the age of 45 years. However, for those over this age, the prevalence rate in women compared to men was over eight times higher (Nestadt *et al.*, 1990). In addition, 17 per cent of the women with histrionic personality disorder also suffered from depression, and a higher rate of suicide attempts and use of medical services compared to those without this personality disorder was noted. The prevalence rate of borderline personality disorder varies between 0.2 and 4.6 per 100 depending on the survey and whether point or lifetime prevalence is assessed (Weissman, 1990); in the UK, the prevalence is 0.7 per 100 (Coid *et al.*, 2006). In general, the diagnosis of borderline personality disorder is associated with being young, single and female, and with relatively high rates of alcohol and tobacco use, suicide attempts, and comorbid diagnosis of schizophrenia and phobias as well as other personality disorders (Zimmerman and Coryell, 1990). Individuals in this group have been found to be high users of mental health services, and are associated with poor marital relationships, work difficulties, alcohol related problems and psycho-sexual problems (Swartz *et al.*, 1990).

Cluster C – prevalence

Within Cluster C (avoidant, dependent, compulsive, passive aggressive), Reich *et al.* (1989) found no cases of avoidant personality disorder among relatives of control probands and Zimmerman and Coryell (1990) reported low rates of between 0.4 and 1.3 per 100 depending on which instrument was used at assessment. Dependent personality disorder is more prevalent, with rates of between 1.6 and 6.7 per cent reported, and lower rates when structured interviews are utilized (Weissman, 1993). Using the PDQ, Zimmerman and Coryell (1990) reported a prevalence rate of 4 per 100 for obsessive compulsive personality disorder and again a lower rate of 1.7 per 100 with a structured interview. Untypically of personality disorders, this disorder is more common among educated, married individuals (Nestadt *et al.*, 1991). Using the PDQ, Zimmermann and Coryell (1990) found a low rate of passive aggressive personality disorder (0.4 per 100), but when direct interview was used this rate rose to 3 per 100, which suggests that individuals with this type of disorder may under-report on self-report measures. In a UK community sample, obsessive compulsive personality disorder was more common than avoidant or dependent personality disorders (1.9 versus 0.8 and 0.1 per cent respectively) (Coid *et al.*, 2006).

Prevalence of personality disorders in psychiatric populations

When prevalence rates of personality disorder are investigated in psychiatric populations, it is clear that patients not only have more personality

disturbance and disorder but also suffer from clinical syndromes and disorders in addition to personality disorder. Studies have found variable rates depending on the sampling procedure, the diagnostic criteria, the assessment instruments and other factors such as admission policies and availability of services. Borderline, schizotypal and histrionic personality disorders are commonly found in samples of treated patients, many of whom may require admission to hospital, or intensive psychiatric care due to the level of severity of psychological and social impairment. In outpatient samples, dependent and passive aggressive personality disorders are also commonly found (Girolamo and Reich, 1993). With the introduction of diagnostic tools for personality disorder with DSM-III, these disorders are increasingly recognized and diagnosed. For example, in one large teaching hospital in the United States, the percentage of patients with a diagnosis of personality disorder rose from 19 to 49 per cent over two five-year periods before and after the introduction of DSM-III (Loranger, 1990).

Comorbidity

Feinstein (1970) introduced the term "comorbidity", defined as "any distinct additional clinical entity that has existed or that may occur during the clinical course of a patient who has the index disease under study" (p. 456). The term "comorbid" is restricted to diseases or disorders and, strictly speaking, does not apply to symptoms. There are several uses of the term in psychiatric research and practice (Maser and Cloninger, 1990). Clinical studies use the concept of comorbidity to describe the fact that more than one disorder can be diagnosed in the same individual, whereas in psychiatric epidemiological studies the term is used to indicate the relative risk of disorders, other than the index disorder, being present within an individual patient. One of the difficulties of working either clinically or as a researcher in the area of personality disorders is that comorbidity is extremely common, both with other personality disorders and with clinical syndromes and disorders (Tyrer *et al.*, 1997). Coid and his colleagues (Coid *et al.*, 2006) found that, after adjusting for socio-demographic factors such as age, gender and social class, Cluster B personality disorders (borderline, antisocial only) were associated with functional psychosis and affective and anxiety disorders, and Cluster C disorders (avoidant, dependent and obsessive compulsive) with affective and anxiety disorders and hazardous drinking, indicating clear associations between clusters of personality disorders and mental disorders.

This has several implications. It means that the clinician is likely to encounter considerable overlap between different personality disorders, with patients meeting criteria for several personality disorders or patients who have several seriously dysfunctional personality traits but who do not meet criteria for any one specific personality disorder. Some have suggested that the diagnostic categories themselves have low specificity, but it might also

suggest that personality disorder and dysfunction is an integral part of pathology experienced by patients attending psychiatric services.

Suicide and personality disorder

Suicidal behaviour is associated with patients who have more than one personality disorder, though it is not clear whether certain combinations of disorders carry a higher suicide risk than others (Oldham *et al.*, 1992). Both antisocial and borderline personality disorders are associated with suicidal attempts and completed suicide (Soloff *et al.*, 1994), with estimates of lifetime suicidal risk of around 5 per cent for antisocial personality disorder (Links *et al.*, 2003) and up to 9 per cent for borderline personality disorder (Paris *et al.*, 1987). Factors known to contribute to the risk of suicide, such as substance abuse, impulsivity, major depression, affective instability and interpersonal difficulties, are all found in individuals with antisocial and borderline personality disorder.

Can psychological treatment help?

There are an increasing number of psychological treatment approaches to personality disorder, many coming from cognitive therapy (Beck *et al.*, 2004; Layden *et al.*, 1993; Young *et al.*, 2003). Dialectical behaviour therapy (Linehan, 1993) was designed specifically for suicidal borderline personality disordered patients and was one of the first treatments to be manualized and systematically evaluated. Most other approaches have come from established forms of psychotherapy but have been modified for personality disordered patients. Psychodynamic therapies have been modified to accommodate patients with personality disorder as traditional approaches were not helpful (Dowson and Grounds, 1995) and more modern approaches allow the therapist to be more active and directive. Cognitive therapy has also been modified to fit with the problems of those with personality disorder, with Jeff Young (Young *et al.*, 2003) taking a more schema-focused approach than Beck *et al.* (2004).

Some of these treatments have been systematically evaluated in randomized controlled trials and found to be helpful in reducing problems associated with personality disorder, particularly borderline personality disorder. Most often the comparison has been made between the specialized treatment and the prevailing treatment at the time of the study and in the country where the study takes place. This latter type of treatment is often called "treatment as usual". Apart from studies using randomized controlled trial designs, evaluation of treatment effectiveness comes from single case studies and non-randomized clinical trials. From these latter studies, there is evidence that behaviour therapy, cognitive therapy and cognitive analytical therapy can be helpful in improving relationships and in reducing dysfunctional

behaviour (e.g. Turkat and Maisto, 1985; Ryle, 1997) including self-harm (Davidson and Tyrer, 1996; Evans *et al.*, 1999). In an open trial of cognitive therapy, patients with borderline personality disorder showed significant improvements after one year of cognitive therapy and this benefit continued to be maintained at 18-month follow-up (Brown *et al.*, 2004).

The strongest evidence for effectiveness of treatment comes from studies that use randomized controlled designs. The main therapies that have been evaluated using these more rigorous designs are cognitive behaviour therapy (Davidson *et al.*, 2006a), schema-focused therapy (Giesen-Bloo *et al.*, 2006), dialectical behaviour therapy (Linehan *et al.*, 1991, 1993, 1994; Verheul *et al.*, 2003; Koons *et al.*, 2001; Turner, 2000), psychodynamic oriented therapy (Munroe-Blum and Marziali, 1995) and psychodynamic informed partial hospitalization (Bateman and Fonagy, 1999, 2001). All of these therapeutic approaches reduced self-harm when compared with a control treatment for patients who had self-harmed before entering into the trial. In one of the DBT trials (Koons *et al.*, 2001) self-harm was not reduced. In this study, the sample may have been less extreme in their behaviour than the participants in Linehan's original study, as less than half of the patients reported self-harm at baseline.

Although the above findings may be cause for optimism, several methodological problems limit the findings and the generalisability of the majority of the above studies (Davidson *et al.*, 2006b). This is largely due to the fact that the numbers of patients involved in the studies are often small, with up to 42 per cent of patients withdrawing because of difficulties accepting randomization or because of likely non-compliance with study requirements. Following up patients after treatment has finished is important if we are to determine whether treatments work in the longer term. We need to know that the treatment is not just an effect of being seen by a therapist and that any gains made in treatment last after the treatment period has finished. Not all of the above studies followed up patients to see what happened to them after treatment ended. For example, only one of the DBT trials had followed up patients at the end of a finite amount of treatment to investigate the naturalistic outcome (Linehan *et al.*, 1994). In the study on partial hospitalization, Bateman and Fonagy (2001) reported on patients who continued to receive active treatment throughout the follow-up period, thereby blurring the definition of follow-up. In our study reported below we followed up all patients for one year after the CBT treatment period ended and so we have information on patients' problems and adjustment after treatment ends.

The type of cognitive behaviour therapy that is described in this clinician's guide has been evaluated on a randomized controlled design by our research team in 106 men and women who met diagnostic criteria for borderline personality disorder (Davidson *et al.*, 2006b). This three-centre study in the United Kingdom followed up patients and obtained data on 102 (96%) at two years after entry into the study. We offered CBT in addition to the patient's

usual treatment and compared this with usual treatment alone. All CBT therapy was given individually by trained and supervised CBT therapists working in the National Health Service. Those patients who were randomized to CBT were offered an average of 27 sessions over 12 months and attended on average 16 (range 0 to 35). We found that those who had CBT had significantly fewer suicidal acts over the two years, one year of therapy and one year of follow-up, compared with those who had treatment as usual. Those who had CBT also showed significantly less anxiety, and greater improvement in dysfunctional beliefs and in distress. All patients, regardless of which treatment they received, showed a gradual and sustained improvement in important outcomes such as in-patient hospitalization, suicidal behaviour and use of accident and emergency treatment facilities, and in symptoms and problems. The study showed that CBT can deliver clinically important changes in relatively few clinical sessions in real clinical settings.

Giesen-Bloo and her colleagues (Giesen-Bloo *et al.*, 2006) compared the effectiveness of schema-focused therapy with psychodynamically based transference-focused therapy in patients with borderline personality disorder. Eighty-eight patients were randomized and received outpatient therapy over a prolonged period of three years. In each condition, patients received twice-weekly therapy. Patients were assessed over two months and this served to test their motivation for long-term therapy. The main outcome measure was severity of borderline personality disorder assessed using the Borderline Personality Disorder Severity Index (Arntz *et al.*, 2003), which measures the severity and frequency of borderline personality disorder diagnostic criteria and problems. In the schema-focused therapy (Young *et al.*, 2003), therapists concentrated on four schema modes that are thought to be specific to borderline personality disorder. These modes, or sets of schemas, were detached protector, punitive parent, abandoned or abused child, and angry impulsive child. Change was presumed to take place through a range of behavioural, cognitive and experiential techniques including the therapeutic relationship, daily life and dealing with current problems, and past traumatic experiences. In transference-focused psychotherapy, change was assumed to occur through the analysis and interpretation of the transference relationship and the focus is on the present, not the past. In both treatment groups, patients showed clinically significant change across the three years, with schema-focused therapy showing a significant advantage over transference-focused psychotherapy in terms of recovery on borderline specific and general psychopathological measures. Both treatments showed that the greatest change took place within the first year of therapy. This trial was robust methodologically, and data was available on almost all patients throughout the trial, though as time progressed in the study, the blindness of assessors was difficult to maintain. Follow-up of these patients once therapy has ended will be important in establishing their longer-term naturalistic outcome.

These studies have all helped to decrease therapeutic nihilism for patients with borderline personality disorder. They suggest that systematic psychological therapy, particularly cognitive therapy, can help reduce the disabling and distressing problems that borderline patients experience. No randomized controlled trials are reported, as yet, for antisocial personality disorder. That these promising results can be repeated for another type of personality disorder, such as antisocial personality disorder, now appears a possibility but we cannot be overly optimistic without evidence.

Long-term outcome for personality disorder

Personality disorder has traditionally been thought of as a stable and unchanging disorder, that is, one that endures over time. Several long-term follow-up studies of patients with borderline personality disorder have been carried out, spanning 15- to 27-year follow-up periods (McGlashan, 1986; Paris, 2002; Stone, 1990; Plakun *et al.*, 1985) with several hundred patients followed up, all of whom had received relatively lengthy periods in hospital. All patients were of high socio-economic status except in the Montreal study (Paris, 2002), where the sample came from a general hospital and had more mixed socio-economic status. These longer-term studies appear to have similar findings. The overall suicide rate for the borderline patients in these studies was high (approximately 9%). Recovery or remission from the diagnosis of borderline personality disorder status was seen to continue into middle age. In terms of changes in type of problem, over time patients became less impulsive and relationships improved, though often at the cost of intimacy. Little change was seen in affective disturbance across age.

Prospective studies following up borderline personality disorder patients are fewer. Again, all of these studies are North American and so we cannot be certain that the findings would translate to patients from other cultures or other samples of personality disordered patients. So far, these studies have consistently highlighted a high suicide rate (5% in Links *et al.*, 1998). However, for those who do not kill themselves, there can be symptomatic improvement over six to seven years (Links *et al.*, 1998) and a change in diagnostic status over time, with up to two-thirds of patients no longer meeting criteria for borderline personality disorder at six years' follow-up (Zanarini *et al.*, 2003). These prospective studies are likely to be more reliable than other types of follow-up studies because of the assessments carried out. From these studies and others, several factors are known to predict whether outcome is poor in the longer term. For example, the initial level of severity of pathology, low IQ, lengthy admissions, self-harm, childhood abuse and comorbid substance abuse have been identified as predictors of outcome (Links *et al.*, 1998; Paris, 2002). Prospective studies are likely to be more reliable than other types of follow-up studies.

How do we explain personality disorder to our patients?

Most clinicians think it is doubtful whether the label "personality disorder" is helpful to an individual with such a disorder. Many believe that it may even be counterproductive in a treatment setting, creating negative expectations of the patients in staff members. It may also be potentially disturbing to an individual and to others as the label has very negative associations and has been used to exclude patients from services. As we now have evidence from research in this area and know more about the longer-term consequences and treatability of these disorders, using the label "personality disorder" might be a different matter. Evidence from long-term follow-up studies of patients, particularly with borderline personality disorder, suggest that the label may not be as discouraging as was once thought, as change in personality status does occur. Nonetheless, we have to consider what the label might mean to an individual. To many, it might imply that there is nothing they can do to change as personality is generally thought of as being fundamental to one's concept of self and therefore stable and unchangeable. The label has a pejorative connotation and this may imply a defective condition. There are probably some personality disorders that are more dysfunctional or severe than others. To the layperson, however, the distinction between a disorder such as avoidant personality disorder and antisocial personality disorder may not be meaningful. The salient term to the layperson may be personality disorder *per se* and the distinctions between disorders less salient and meaningful. While many researchers and clinicians also use the labels reluctantly, they are useful as a means of communicating a complex clinical entity even though agreement about what it is, and how reliable and valid its measurement may be, still varies.

That some individuals with personality disorder come to us distressed about their condition is incontrovertible. Some come because others have urged them to seek help and they may not appear to be distressed by the effect they have on others. However, even they may be aware that changing their behaviour and thinking could have positive consequences. Our assessment of their problems, both current and historical, gives us the opportunity to explain to them why we believe they suffer from a personality disorder but we have to be able to explain this in a way that makes sense to the patient, is non-pejorative, and allows the possibility of change.

How can cognitive therapy help?

We now have evidence that cognitive therapies are helpful in treating borderline personality disorder. All cognitive therapies rely on a relatively wide range of cognitive and behavioural techniques to help patients manage their problems more effectively. We are not yet at the stage of being able to specify the "active" ingredients in therapy. The best evidence, as can be seen above,

comes from randomized controlled trials with patients with a diagnosis of borderline personality disorder. Clinicians will know from experience that patients with the same diagnosis may be dissimilar in the range and type of problems that are presented. We may eventually find that different types of problems require different approaches and techniques to be efficiently and effectively treated. Or it may be that a psychological treatment that is systematically delivered and that makes sense to patients and therapists in helping them cope with difficulties will be helpful in producing change in key areas of dysfunction. Ideally, therapy should aim to reduce distress, improve interpersonal functioning, reduce harm to self and others, and reduce the health service costs and societal costs. Not all therapies may be evaluated using such outcomes but, as the diagnosis of personality disorders carries with it such significant personal and societal burdens, we should aspire to achieving these outcomes in therapy.

What we can now say is that cognitive therapies and working within a cognitive model are helpful. This allows a conceptualization of the disorder that can be shared with and understood by the patient. Habitual maladaptive behaviours and dysfunctional beliefs that have a negative impact on how the individual functions on a day-to-day basis, and on relationships, place a limit on the quality of life experienced. With guidance, in therapy, most individuals recognize these maladaptive patterns and can achieve changes in dealing with life problems, symptoms of distress and relationships.

Through the formulation of the patient's problems, cognitive therapy allows us to help our patients develop a better understanding of how earlier life experience may have influenced their extreme views of themselves and others. The interpersonal problems and unhelpful behaviours that are so common can be likewise understood and modified as new ways of perceiving, thinking and behaving can be tested within the relatively safe environment of therapy.

Chapter 2

Cognitive models of personality disorder

Aaron Beck and his associates, Jeffrey Young, Mary Anne Layden and her co-authors, have developed cognitive models of personality disorder that are both informative and useful for therapists and theorists (Beck *et al.*, 1990, 2004; Young *et al.*, 2003; Layden *et al.*, 1993). Marsha Linehan developed dialectical behavioural therapy for women with borderline personality disorder (Linehan, 1993). Her model can also be considered a cognitive model. All cognitive models emphasize childhood environmental influences as being important in the development of personality disorder and Beck *et al.*'s model (1990) brings an evolutionary perspective to bear on the origins of personality disorder.

Beck's evolutionary perspective

Individuals with personality disorder are characterized by inner experience and ingrained behaviour that deviates from that which is expected in the individual's culture. Beck and his associates (1990), taking an evolutionary perspective, suggest that humans and animals demonstrate some behaviours that are genetically determined or "programmed". The overt behaviour that is observable is the product of these programs and is shaped by the interaction between genes and the environment. These programs involve cognitive processing, affect, action, self-regulation and motivation and are likely to have evolved as a result of being essential to survival and reproduction.

It is thought that the programs influence automatic processes such as perception and affective and action responses. In personality disorder, behaviours that were adaptive and had survival value in more primitive settings have become problematic in the present culture because they may conflict with the prevailing norms of that society. For example, competitive behaviour might be appropriate in an environment where there are limited resources and rewards but will be excessive and inappropriate in a society that has sufficient resources and where a high value is placed on social cohesion. This poor fit between programmed strategies and environment may be a factor in the development of maladaptive patterns of behaviour and

traits in individuals who are diagnosed as "personality disorder". It is not that these strategies are necessarily inappropriate *per se*, it is more that they become maladaptive when they are exhibited in situations where they are inappropriate. These strategies are demonstrated in a rigid and inflexible manner and, importantly, are not inhibited in situations when this would be adaptive. It may be useful, for example, to be dramatic in some situations such as teaching where one has to get the attention of others, but such behaviour may not be fitting in other situations that require sensitivity and reciprocity. In those with personality disorder, certain behavioural strategies appear to be overdeveloped and used inflexibly and rigidly and are therefore not adaptive to situations as they are not used selectively.

Beck's model of personality disorder places importance on the interaction of the individual's environment with biological predispositions and the temperamental tendencies of the individual that are present at birth. Through experience, certain types of behaviours and attitudes will become exaggerated or minimized. The child whose temperament is naturally shy may develop clinging behaviour, which may in turn generate a response from others that is overly protective and nurturing. As the child develops, she may come to believe that she cannot survive without the protection of others; help-seeking and dependent behaviour become increasingly accentuated and others are perceived as dangerous and malevolent.

Just as clinical syndromes or disorders can be conceived of in terms of evolutionary principles of survival and adaptation, such as the fight/flight pattern of response in anxiety disorders, Beck *et al.* (1990) consider that personality disorders could be regarded as an exaggeration of patterns of behaviour that promote individual survival and reproduction. They also suggest that the natural variability in the gene pool could account for individual differences in personality that may have specific survival value. For example, one individual may appear sexually provocative whereas another makes no attempt at appearing attractive or seductive in a situation in which gaining the protection of a dominant male may be an advantage. The behaviours themselves may elicit a variety of different responses in others and these differences may have different survival values in certain situations.

In Beck's cognitive model of personality disorder, these patterns of behaviour or strategies are related to underlying cognitive, affective, motivational, action and self-regulatory schemas (see Figure 2.1). Cognitive therapy is based on information processing theory, which asserts that schemas develop as a means of organizing experience and are part of normal cognitive development. The products of schemas will reflect concepts of self and others. The theory suggests that in personality disorder, maladaptive schemas are hypervalent and thus evoked across many situations and are thought to drive overt behavioural strategies that may be dysfunctional in specific environments.

For example, it is likely that an individual with antisocial personality disorder who exhibits aggressive and combative behaviour will hold a core

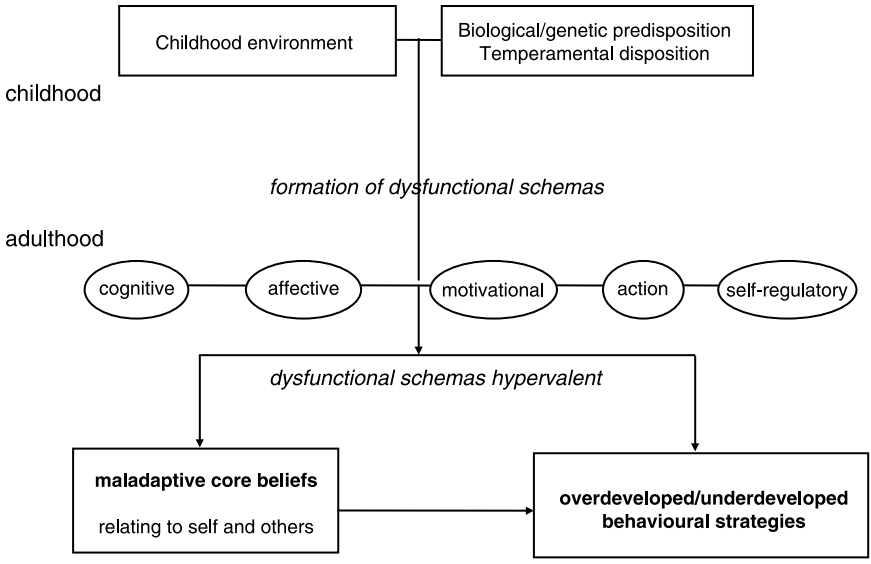

Figure 2.1 Cognitive model of personality disorder.

belief that other people are there to be exploited. The tendency to "act now and think later" will be linked to an overdeveloped action schema and an underdeveloped self-regulatory and monitoring schema. For other personality disorders such as borderline personality disorder, the association between core beliefs and behavioural strategies will be similar but the content different as illustrated in Table 2.1. Often individuals with borderline

Table 2.1 Core beliefs and associated behavioural strategies in antisocial and borderline personality disorders

Typical core beliefs	*Behavioural strategies*	
	Overdeveloped	*Underdeveloped*
Borderline personality disorder		
I am bad	Self-punishment	Self-nurturance
No one will ever love me	Avoidance of closeness	Openness to relationships
I cannot cope on my own	Overdependence	Independence
Antisocial personality disorder		
I can do what I want	Autonomy	Sharing
Other people will get in my way	Combativeness	Group identification
Don't get close to others	Self-sufficiency	Intimacy

personality disorder will oscillate between two opposing behavioural strategies, such as dependency on others and avoidance of intimacy with others, in association with beliefs such as "I cannot cope on my own" and "No one will ever love me". The strategies are opposing as one is compensatory and is an attempt to overcome core beliefs about inadequacy and defectiveness.

Beck *et al.*'s later book on personality disorder delineates cognitive and behavioural strategies to help reduce dysfunctional schemas and behaviours in personality disorder (Beck *et al.*, 2004). These will be familiar to cognitive therapists: identification of goals in therapy, identification and confrontation of schemas and conditional beliefs, imagery work to help cognitive restructuring of beliefs associated with childhood and past traumas, and techniques to help the patient develop more adaptive behaviours. Beck *et al.* (2004) also place emphasis on developing a collaborative relationship with the patient and the importance of developing a thorough case formulation.

Young's early maladaptive schemas

Schemas develop in childhood in response to biological predispositions and environmental influences. Jeff Young's view is that schemas that are maladaptive and lie at the core of personality disturbance and disorder result from unmet emotional needs in childhood (Young *et al.*, 2003). He introduced the concept of early maladaptive schemas (EMSs) to account for these unhelpful schemas that develop as a response to coping with early relationships with family members (Young, 1990). The content of these schemas is concerned with self-identity and relationships with others, and although developed during childhood, these are elaborated throughout one's life. EMSs are the cumulative result of early dysfunctional experiences with people in the child's immediate environment (Young and Lindemann, 1992). Each schema is thought to comprise cognitive, affective and interpersonal components. These schemas are concerned with themes relating to hypothesized developmental stages of personality. The most common themes noted relate to the need for security, autonomy, desirability, self-expression, gratification and self-control. Cognitive therapy for personality disorder aims to modify these early maladaptive schemas.

Young has developed an instrument for assessing early maladaptive schemas called the Schema Questionnaire (Young, 1990). This can be productive in generating an initial list of potential dysfunctional beliefs and in monitoring change in patients. In Young's original model of personality disorder (1990) he proposed that schemas are reinforced through three different processes: schema maintenance, schema avoidance and schema compensation.

Schema maintenance

This is the process by which information or evidence that would disconfirm the schema is resisted through cognitive distortions and by self-defeating behavioural patterns. This type of information processing appears to be common in patients with personality disorders. It is as if the patient cannot accommodate new information that would not fit with what they believe to be true of themselves or others. Information that would appear to be evidence that would directly disconfirm a belief is readily dismissed or discounted and may even appear to be totally ignored. This type of processing is illustrated by a patient with a borderline personality disorder who believed that she was worthless. This young woman could not make sense of several women at work repeatedly inviting her to go out with them, even though she kept refusing. Her explanation for the invitations was that her colleagues somehow knew that she had no friends and felt sorry for her or that they might need another person to make up numbers. Alternative explanations such as that they might want to get to know her better were given no consideration and dismissed as being impossible as she thought that everyone, including her colleagues, could see by looking at her that she was boring, worthless and had nothing to say. She could not conceive that her colleagues might have been acting in a genuinely friendly manner towards her.

Schema avoidance

When maladaptive schemas are activated, intense negative emotions are experienced which are so unpleasant that individuals will automatically attempt to suppress or avoid triggering the schema or the unpleasant affect associated with the schema. Avoidance can operate at a cognitive level where patients will not want to speak or think about an event that would bring a schema into sharp focus. Other avoidance tactics include suppressing or dulling down feelings (affective avoidance) and overt behavioural avoidance. A patient with a diagnosis of antisocial personality disorder, who held the dysfunctional belief that he was superior to others, avoided any challenges to this belief by never putting himself in the position of finding work that would have provided evidence of his talents and abilities. These processes of avoidance prevent opportunities for schemas to be modified and thus the subjective belief in negative schemas is reinforced.

Schema compensation

An individual may overcompensate for a negative schema by acting in the direction opposite to the schema's content; this process can sometimes appear to be functional. For example, a female patient with a schema concerning defectiveness and unattractiveness might behave in a manner that

demands attention and admiration from men. However, her attempts are likely to backfire as she is unlikely to be able to modify her behaviour appropriately and may get involved with men who may ultimately reject her, thus confirming her belief that she is unattractive.

Young's schema therapy

Traditional cognitive therapy used in the treatment of mental disorders has been adapted for the treatment of personality disorders. Young's schema therapy (Young *et al.*, 2003) is also a problem-focused therapy but differs from the cognitive therapy described here in that it has developed the idea of a set of highly specific schemas and makes more explicit use of imagery and experiential techniques to trigger the patient's schemas and to modify these in therapy. However, Young is cautious about using these techniques too early in therapy with patients who, like many individuals with personality disorders, have more severe schemas and who have difficulties in forming a trusting bond with the therapist (Young *et al.*, 2003).

In schema therapy, imagery can be used to identify the patient's schemas in the assessment phase of therapy. This helps both the therapist and the patient to understand the childhood origins of the schemas and link the schemas with the patient's current areas of difficulty. It also helps the patient experience the emotional states that are associated with the schemas that developed in early childhood. It is recognized that some patients may have difficulty in the process of visualization or bringing up specific memories in childhood as they have learnt to avoid painful recollections of previous experiences. This is described as the "detached protector state" whereby the painful memories that trigger a negative schema are avoided and feelings are cut off. In schema therapy, a therapist can patiently get round this protector state to gain access to areas of the patient's childhood that have made them vulnerable, but usually only if the therapist has first formed a secure and trusting bond with the patient.

Young's schema therapy also utilizes experiential, cognitive and behavioural techniques, as well as imagery. Experiential work is used to help change or "heal" schemas. The patient is carefully guided to an early image that is triggered by the schema and uses imagery dialogues with key figures in childhood to change the maladaptive schema. For example, if a patient had an overbearing critical father, the patient would first bring to mind a clear image from childhood of an encounter with the father but in this image, the unmet needs experienced in childhood would be able to be met. In this new image, the patient can say to the father that she needs to be loved and respected and not criticized unfairly. In therapy, this new mode of thinking is often reinforced with a letter that the patient writes to a parent.

Cognitive strategies help patients to voice more adaptive reasoning skills to evaluate and dispute the early maladaptive schemas and to develop a more

constructive adult type of reasoning. Young *et al.* (2003) provide an excellent description of the various techniques, such as flashcards and schema diaries used to "answer" schemas in a more adaptive manner. Schema therapy also places importance on helping patients make changes in maladaptive behavioural patterns. Using standard behavioural techniques learnt in therapy, patients attempt to change their usual coping styles that have been utilized to avoid or overcompensate for self-defeating maladaptive schemas.

Dialectical behavioural model

Dialectical behavioural therapy (DBT) (Linehan *et al.*, 1991, 1993) has been shown to be effective in women with borderline personality disorder. Although DBT has a strong cognitive element as a component of treatment and is therefore similar to cognitive therapies, it has some fundamental differences, particularly in the use of techniques derived from Zen meditation and the emphasis on behavioural treatment and acceptance.

In common with all therapies for personality disorder, Linehan (1993) places central importance on the therapeutic relationship. She regards the process of therapy as dialectic and observes that in therapy, patients may wish to remain the same and not change, yet these same patients are engaged in therapy, a process that is *de facto* about change. A synthesis is found by recognizing the dialectical tension within individuals and in therapy itself and managing this process of change in therapy. This dialectical process is observed in the behaviour of patients with borderline personality disorder in that they appear to oscillate between polarizing positions, for example, being clinging and dependent on others at one point in time and then, at other times, actively avoiding people. Neither of these two polar opposite positions is probably helpful to the patient, and DBT stresses that some synthesis of position needs to take place before the patient can change.

DBT also emphasizes the interconnectedness of a patient to her environment. Any behaviour change that a patient makes will have an effect on others in the patient's immediate environment. This may either facilitate the change that the patient is attempting to make or impede it. This concept of interconnectedness is useful, emphasizing the importance of taking a whole systems approach to identifying and managing change.

Linehan (1993) regards borderline personality disorder as primarily a disorder of emotional dysregulation. Dysregulation can also occur in other systems because emotions interface with other systems. As a result, dysregulation will also be evident in interpersonal relationships, behaviour, self-identity and cognition. Arousal in any one of these systems will result in dysregulation in all, or some, of the others. In addition, the impact of the environment will modify the level of emotional dysregulation, with the capacity to either increase or decrease arousal. This is similar to the cognitive model of personality disorder where patterns of behaviour or strategies

are related to underlying cognitive, affective, motivation, action and self-regulatory schemas. A disruption in one schema will cause disruption in others.

In the DBT model, the development of emotional dysregulation is thought to result from the combination of an individual's inherent biological disposition and dysfunctional childhood environment. A vulnerable child, brought up by adults who fail to validate the child's emotional reactions, will fail to learn how to label and regulate emotional arousal and therefore be less able to tolerate emotional distress. The child will also be unlikely to learn to trust in his or her emotional responses that arise from distressing interpersonal events. Such a child will be unable to have confidence in determining his or her reactions to, and interpretation of, interpersonal and stressful situations. These types of childhood environments are thought to invalidate the child's emotional experience. The DBT model therefore suggests that individuals with borderline personality disorder have learnt dysfunctional ways of managing or coping with their intense emotional experiences. The problems encountered in borderline personality disorder, such as deliberate self-harm or suicide attempts, substance abuse and dissociation, are all regarded as a means of regulating emotional experiences or as a way of avoiding intense and distressing emotional responses.

DBT includes a wide range of behavioural and cognitive strategies to overcome the pervasive skills deficits seen in borderline personality disorder. Much emphasis is on behavioural management of problems, with techniques such as contingency management and exposure used alongside a broad array of other strategies like problem-solving skills training and cognitive restructuring. Techniques derived from Eastern philosophy are also used, and these include validation and mindfulness.

Layden's cognitive behavioural model

Mary Anne Layden and colleagues have also developed a cognitive therapy perspective on borderline personality disorder (Layden *et al.*, 1993). Acknowledging that childhood trauma and neglect produce dysfunctional schemas, they suggest that paying attention to the stage of child development helps to illuminate the types of dysfunctional schemas that may develop. To do this they utilize Erikson's model of developmental stages (Erikson, 1966) and Piagetian models of cognitive development (Piaget, 1952). Erikson's developmental theory has its roots in psychoanalytic theory. He suggests that at each developmental stage a child needs to learn specific age-related skills and has to successfully master these to resolve critical developmental tasks. For example, infants up to the age of around one year are thought to develop basic trust in their caregivers, but if they are mistreated, they learn to mistrust their caregivers, resulting in an early insecure attachment to their caregivers. This is thought to lead to the development of a schema of mistrust in

adulthood as this period is regarded as being critical for developing trust in others. Following infancy and up to the age of three years, the child develops a sense of autonomy and experiences shame and doubt. For example, at this stage a child is learning to walk and manipulate objects, and is developing skills that lead to making choices and gaining a sense of independence. Children also complete toilet training at this age. If a child's efforts at independence repeatedly fail or are ridiculed, they may experience shame and doubt instead of a sense of mastery and control. It is not that doubt and shame are in themselves problematic, as children need to learn to have a sense of doubt about their actions to check if they are acceptable or safe. The problem is when the child is continuously thwarted in their efforts, fails to gain a sense of control or is given no guidance from caregivers about what is acceptable behaviour. If this stage is problematic, as an adult they may develop problems with individuation and dependence on others. Around the age of four, children begin to take more initiative and explore the world more actively. They become more aggressive and assertive as they attempt to take control over their world. If their efforts are rejected, ignored, constrained or punished by significant others, they may experience excessive guilt and shame that lead to schemas of dependence, incompetence, emotional deprivation and unlovability. Later stages are thought to be critical for the development of other schemas. Between the ages of six and eleven, children may experience failures and derision at a time when they are developing competencies in accomplishing the tasks of everyday life. If these competencies are not supported by the immediate environment, which now includes interactions beyond the immediate caregivers such as peer groups and school, or if children are less able to achieve these tasks due to other reasons such as suboptimal cognitive abilities, this can lead to schemas concerned with being incompetent. In adolescence and young adulthood, failure to negotiate the developmental task successfully can also lead to problems with self-identity and intimacy. It is clear here that earlier failures to negotiate a developmental stage successfully may impede progress at later stages.

Piaget's theory also suggests that the cognitive development of children undergoes stages (Piaget, 1952). Each of these stages represents a child's understanding of the world, and a child only develops abstract reasoning when they are around 11 years of age. Children are thought to be active participants in developing their knowledge about the world and to construct their own understanding of it. As children act on the world, they organize their experience and generalize from their experiences. So a child may learn that a cup holds water that can be drunk. Later, the child may also learn that an object like a cup can also contain other things such as sand that can be used to build sandcastles. So a cup, or an object that has the characteristics of a cup, can have different uses.

From birth to 18 months or so, children are at the sensorimotor stage: they use sensory and motor skills to act on their environments. The second stage

of cognitive development is the preoperational stage that lasts from 18 months to around six years. At this stage, children can use symbols and fantasy and develop language used in thinking and communication with others. Between the ages of six and eleven, children begin to think logically. The last phase is the formal operations stage in which older children and adolescents learn to think in a logical manner about ideas and hypothetical situations.

Although there is good evidence to support Piagetian theory, there is little empirical support for Erikson's theory as it is more general and therefore less able to be scientifically examined. However, there is evidence that the quality of early relationships is a major factor in determining later relationships. For example, many longitudinal studies have shown that secure attachment in infancy leads to more positive relationships with others and to greater social skills later in development (Thompson, 1998).

Layden and colleagues suggest that patients with borderline personality disorder may be able to operate cognitively at the Piagetian level of formal operations when dealing with everyday tasks and intellectual skills but they may regress to preoperational, illogical thinking when they encounter relationship problems due to the activation of early maladaptive schemas. They suggest that this has major implications for traditional cognitive therapy, with its reliance on standard techniques such as Socratic questioning where the patient is asked to examine the assumptions they hold about themselves in a logical manner that takes account of evidence. In therapy, Layden, like other cognitive therapists, places emphasis on the conceptualization of personality disorders, the critical childhood incidents, the dysfunctional assumptions and schema beliefs that arise from the child's experience, and the compensatory strategies, and therapy is designed to help patients overcome any missing life skills (Layden, 1998).

Developmental psychology as the key to the development of personality disorder

What is apparent from the above theories is that our knowledge of developmental psychology has important implications for the cognitive model of personality disorder, particularly in terms of the development of problems. Development can be thought of as a series of ongoing changes in biological, physiological, cognitive, behavioural, social and emotional structures, all of which occur in a family and social system embedded in a wider cultural context. A model of personality disorder must be multifaceted in order to account for these factors. The cognitive model of personality disorder may place emphasis on cognitive, emotional and behavioural factors but the origins of personality problems are likely to lie in the inherent temperament of the child, childhood development and childhood experiences. From our understanding of childhood development, attachment, the child's developing

internal working model of relationships, self-identity, self-worth and the emotional availability of the infant's caregivers are central to how the child develops and will shape the adult self-identity, how relationships and others are perceived, and behavioural and emotional coping responses.

Attachment

The relationship between the infant and caregiver is a key process in the child's development. Infants are likely to have a built-in propensity to attach to a caregiver (Bowlby, 1969). The nature of this attachment experience has a longstanding effect on attachment formation and helps support physical, perceptual and cognitive development in the early months of a child's life. Mary Ainsworth has described secure attachment (Ainsworth *et al.*, 1978). Children acquire a working model of relationships in which they regard the parent as a safe base from which to explore the world. Mary Main developed a method to assess an infant's attachment style (Main and Soloman, 1990). Securely attached children prefer their mother to strangers, will greet their mother positively after an absence and can be easily soothed if upset. Secure attachment will allow the child to explore their environment more actively and to have a more varied and richer experience, which in itself may enhance cognitive and neurological development.

It is the emotional availability of the parent that is essential to secure attachment (Biringen, 2000). If a parent is unable to be emotionally available for the child, is insensitive or unresponsive to the child's emotional needs, then the child will form an insecure attachment pattern. This may be due to the parents themselves having had poor parenting experiences in childhood and having been traumatized or neglected. For example, children of parents who have themselves been traumatized in childhood, or children who have been abused or lost a parent through death, form a disorganized or disoriented pattern of attachment (Cassidy and Berlin, 1994; Main and Hesse, 1990). These children may appear confused and dazed and show contradictory behaviour towards a parent.

Although a broad range of environments may allow the infant to have a good enough experience of attachment and to develop satisfactorily, other environmental conditions do not allow this to occur and will have a negative impact on the infant's cognitive development in particular. Related to this is the concept of internal working models (Epstein, 1991) that comes from the infant's experiences with other people. It is thought that an infant has a theory of reality and develops beliefs about the degree to which the world is a place of pain or pleasure, whether the world is controllable and predictable or chaotic and uncontrollable, whether people are threatening or not and whether the self is of worth or not. This suggests that through their relationships with others, infants develop important cognitive concepts, namely that the self exists and that relationships can have a negative or positive impact on

them. While the concept of attachment is more fully developed at an earlier stage, around the age of two years, the concept of self will undergo many changes with age. By the age of seven, however, children appear to have developed a sense of global worth (Harter, 1990).

If an infant's early environment is not good enough, basic development will be impaired. Patients with antisocial and borderline personality disorders may fall into this category by not having had an adequately loving and caring parent, from having been subjected to severe neglect or abuse or by being born into a severely deprived or chaotic family that is already under stress. All of these will have a major impact on the child's pattern of attachment, self-concept, exploratory behaviour and the way in which the child will think about and perceive the world. Follow-up studies of children who have had their attachment patterns assessed in infancy have found that those who were securely attached were assessed as being more self-confident and socially competent, developed more friendships and engaged in more complex activities in adolescence (Bee and Boyd, 2004). Children who had insecure attachment styles were more likely to show deviant behaviour, aggressiveness and isolation from peer groups.

Impact of social deprivation and stressful environments

An insecure pattern of attachment in childhood may therefore have a long-term impact on the quality of adult relationships and on social competence. Many patients with antisocial and borderline personality disorder have been abused, neglected or treated inconsistently by their caregivers in childhood. As suggested earlier, their parents and caregivers may similarly have been abused or neglected in their own childhoods. In addition, every child is part of a family and this family is part of a larger economic, social and cultural system, all of which have a major impact on a child's development. Having parents who are socially disadvantaged or economically deprived, especially if these parents were disadvantaged or traumatized in their own childhoods, is likely to have a major effect on the child's development through the child's experience in such an environment. The behaviour and emotional well-being of the parents, influenced by both current stresses and past stressful experiences in their own childhoods, cannot be ignored in terms of the impact on child development. The impact on the infant's development may or may not be obvious initially but will become more evident later as the infant reaches the age of two and beyond in the pre-school years of childhood. This intergenerational compounding of problems is probably enough for the development of emotional, behavioural and cognitive schemas that are severely dysfunctional.

Negative and abusive experiences in the first few years of life will affect the internal working models that are then applied to other relationships as the

growing child's relationships expand. If a child has experienced severe neglect or abuse from their primary caregivers, and has no compensatory experiences, then they will develop a cognitive schema of mistrust of adults. This cognitive schema is likely to be associated with high levels of arousal and anxiety and fear as the child is likely to associate adults with abuse, or with depressed affect, if the child has suffered severe neglect. Such children are also likely to develop behaviours that avoid closeness with others as there would be no expectation from these children that others would be able to meet their emotional needs. Or children may develop challenging and aggressive behaviour in response to situations in which they perceive humiliation and become aggressive as an attempt to redress feelings of powerlessness. However, such behaviour is likely to be responded to negatively. For example, mothers who are experiencing high levels of stress are more likely to behave in a punitive way towards their children, which may in turn result in the child becoming more defiant and aggressive (Webster-Stratton, 1988).

Patricia Cohen and her colleagues in New York State have also found a link between poor parenting and adolescents with conduct problems in their long-term follow-up of children (Cohen *et al.*, 2005). Other factors, emphasized earlier in this chapter, were also found to be important in the development of later personality disorder symptoms. These were low family socioeconomic status, single parenting, parental conflict, paternal and maternal sociopathy and parental illness. Again the quality of parenting and the parent–child relationships were shown to be important for the development of personality disorder.

Longitudinal data from the New York State study indicted that childhood behaviour problems, social isolation and poor health at age six also predicted personality disorder symptoms assessed around 16 years later. Other strong predictors included lacking clear goals, low IQ, poor achievement and having been suspended or expelled from school. Interestingly, by far the majority of children who experience trauma in childhood do not develop significant psychological problems in adulthood (Werner and Smith, 1992). Again the Cohen group has shown that personality disorder symptoms are consistently highest in early adolescence but follow an almost linear decline from age nine to the late twenties (Johnson *et al.*, 2000). In this latter study, the decrease was, in part, attributed to a decline in impulsivity, attention seeking and dependency with maturity and with increases in social competence and goal-related self-control.

As not everyone follows the same developmental trajectory, some individuals are clearly more resilient to the development of psychological disturbance and distress than others. Patients with borderline and antisocial personality disorders may have more frequent, enduring or extreme negative experiences than others as well as temperamental dispositions that render them vulnerable to being overwhelmed by their negative life experiences. They may also develop or learn less active coping styles in seeking more

adaptive and healthier social supports outside the immediate family that would act as a buffer to these experiences (Runtz and Schallow, 1997; Rutter and Rutter, 1993).

What happens to a child is therefore a product of the family, the child's temperament or tendency to respond in particular ways and the skills of the parent to discipline and reward the child. The parents' personalities, their ability to be sensitive to the child's needs, how they respond emotionally to the child's needs, as well as their behaviour towards the child and the context within which the family exists all have an influence on the formation of adult personality and subsequent ability to function socially and emotionally. Figures 2.2, 2.3 and 2.4 illustrate some of the factors that account for the development of beliefs about self and others and

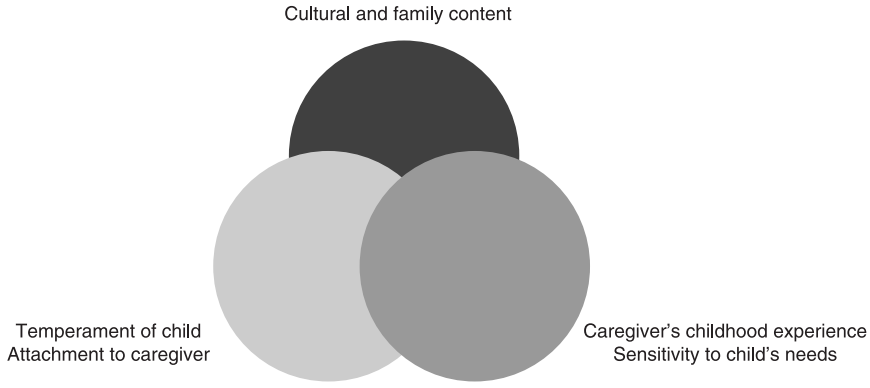

Figure 2.2 Influences on early child development.

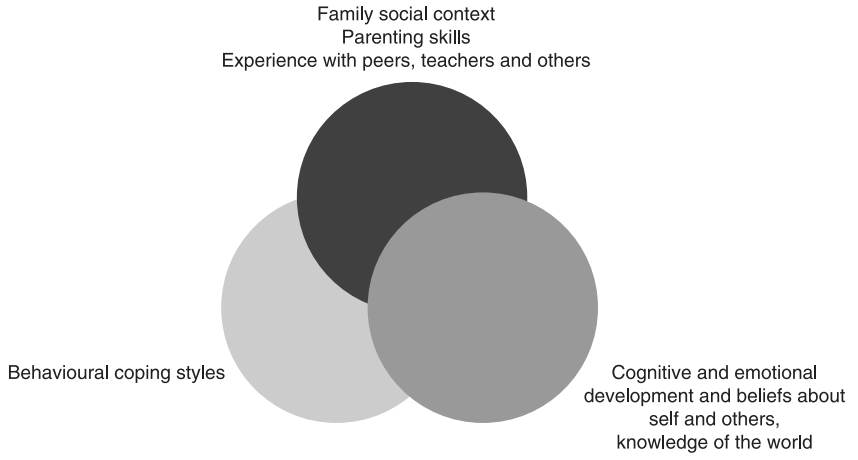

Figure 2.3 Influences on the development of the child into adolescence.

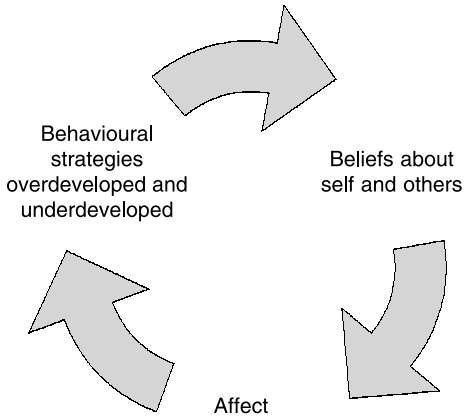

Figure 2.4 Adulthood self-identity and behavioural coping styles.

maladaptive coping behaviours in those with personality disturbance and disorder.

Many patients with antisocial personality disorder appear to have learnt different social rules from those without antisocial personality disorder through being brought up in non-dominant subcultural contexts from the majority. Patients with this disorder frequently refer to having "learnt" different rules from their therapists and often state that they do not understand how others, usually from more advantaged backgrounds, might think, feel and act. They may have learnt different ways of interpreting other people's behaviour and motives. As therapists we need to unpick the social rules that govern relationships that they have learnt so that we can understand these. By doing this, we can uncover the beliefs about the self and others and how these relate to the patient's motives, behaviour and emotions.

Many patients with borderline and antisocial personalities have found school and school work problematic, even if they are theoretically intellectually capable of coping with these demands. Low self-worth, hypersensitivity to criticism, poor peer relationships and impoverished or harmful relationships with parents or caregivers compromise their ability to cope with this challenging period of development. Patients with borderline personality disorder have developed beliefs whereby they view themselves as defective, unlovable and unworthy. Those with antisocial personality disorder may share similar beliefs about themselves as unworthy, powerless and unloved. These two groups of patients appear to have similar beliefs in some ways but the associated learned response to these beliefs is different. Borderline patients respond to these beliefs by being self-punitive. Those with antisocial personality disorder have learnt a different coping response, one that is usually an attempt at compensating for the belief they hold. They externalize their difficulties, shifting the blame onto other people. They frequently believe that

"others are to blame" for their difficulties and do not want to take responsibility for their actions. They react with anger and aggression to the belief that they are weak to avoid being viewed by others as weak and to cope with the anxiety and feelings of vulnerability that are associated with this belief.

The application of developmental theory to therapy

One of the essential features of cognitive therapy for borderline and antisocial personality disorders is the historical account of the patient's childhood development and background. Therapists need a sound grasp of child development to gain an understanding of the potential impact of childhood factors on the development of the adult personality disorder. Although adult patients may not have accurate recall of their early years of infancy, the parental and family history will give important information to a therapist about the adult patient's likely early experiences.

One goal of therapy is to identify the core beliefs that are linked to affect and to overdeveloped behavioural patterns that prevent the individual from functioning in an adaptive manner, particularly in interpersonal contexts. Therapy focuses on beliefs that concern core concepts about the self and others that have developed from childhood onwards and associated behaviours that have developed as coping strategies. The content and meaning of the beliefs have had an impact on past and present relationships and are likely to impact on the therapeutic relationship. These beliefs, formed through negative, possibly abusive and neglectful experiences with others, are likely to have resulted in low self-esteem, hypersensitivity to criticism and poor relationships with peers, caregivers and others in adolescence. Although therapists cannot undo past experiences, the patient can benefit from understanding why they hold negative beliefs about themselves and others and begin to make the connection between how they think, feel and respond to others and to themselves. This is achieved through the initial stage of therapy where the therapist takes a careful developmental and social history to arrive at a formulation. Cognitive and behavioural strategies to change maladaptive coping styles and belief then come into play in the next phase of therapy, after a clear, agreed rationale for change is established.

Chapter 3

Key characteristics of cognitive therapy for personality disorders

Cognitive therapy for personality disorders has been developed from classical cognitive behaviour therapy. As such it will share many aspects with cognitive therapy for Axis I disorders such as depression, but there are also some important differences in characteristics and emphasis. Before emphasizing the main differences, it may be useful to summarize briefly the main components of cognitive therapy for the emotional disorders. From this comparison, we can see that there are many shared components, as outlined in Table 3.1.

Cognitive therapy for emotional disorders

Cognitive therapy has many distinct advantages over some other forms of psychotherapy. It is a brief, time-limited treatment. The techniques used are readily accessible to patients, and cognitive therapists can acquire expertise in these through practice and supervision. For example, cognitive behaviour therapy has been extensively evaluated and has been found to be at least as effective as pharmacological treatments and other forms of psychotherapy in ameliorating the symptoms in depression (e.g. Hollon *et al.*, 1992; Murphy *et al.*, 1984), and most importantly, it can reduce the likelihood of relapse (Simons *et al.*, 1986; Blackburn *et al.*, 1986; Shea *et al.*, 1992; Evans *et al.*, 1992; Jarrett *et al.*, 2001).

In depression, individuals experience a bewildering array of changes to normal functioning. Someone with depression may experience extreme feelings of sadness and hopelessness, have difficulties concentrating, experience low self-esteem, suicidal thoughts, guilt and shame, and ruminate over past negative experiences and memories. They may have difficulty motivating themselves to do things and have problems carrying out tasks due to being slowed down or agitated. Behavioural avoidance may also be common. In addition, they will experience changes in bodily functions such as sleep, appetite and sexual desire and performance. Depressed individuals are known to attend selectively to the most negative aspects of themselves, perceive their world as making overwhelming demands and view their futures as bleak and unchanging.

Table 3.1 Differences in style and characteristics of therapy

	Clinical disorders	*Personality disorders*
Length of treatment	3–4 months	12 months or more
Pace of treatment	Brisk	Variable
Problem timescale	Here and now	Here and now and lifetime
Therapeutic relationship	Collaborative	Collaborative; clear client–therapist boundaries
Problem content	Client's world, present and future	Client's world past, present and future; therapeutic relationship
Problem focus	Behaviour, cognition, emotion	Behaviour, cognition, emotion, therapeutic relationship
Emphasis in intervention	Automatic thoughts	Behaviour, schemas
Homework	Automatic thoughts, data collection, daily activity schedules	Data collection, developing new beliefs, by practising new behaviours
Scientific method	Experimental	Experimental
Learning model	Maladaptive learning	Maladaptive learning or failure to learn through lack of appropriate opportunity
Openness	Explicit	Explicit
Supervision	Recommended	Essential

Negative automatic thoughts

Beck's cognitive theory of the emotional disorders emphasizes three related components: negative automatic thoughts, logical errors or distortions and dysfunctional schemas. Negative automatic thoughts are those fleeting negative thoughts that occur just outside the focus of immediate awareness but are accessible to the individual once drawn to their attention. The content of these thoughts is negative in tone and may include images, day dreams, memories and specific verbal thoughts. The individual does not question whether the content of these automatic thoughts is true.

Systematic thinking errors

These are the distortions or errors in cognitive processing that maintain the negative bias in the content of thought in depression. These errors systematically bias the way information from the environment is interpreted. The most common thinking errors that describe the cognitive processes of depressed patients are outlined in Table 3.2. These categories are not necessarily

Table 3.2 Systematic logical errors

Logical error	*Definition*
Selective abstraction	Focusing on one aspect of a situation while other, more relevant, information is ignored
Arbitrary inference	Drawing a conclusion in the absence of sufficient evidence
Overgeneralization	Drawing a general conclusion on the basis of one aspect of a situation or an isolated case
Magnification and minimization	Exaggerating the importance of events or discounting positive aspects of an event
Personalization	Relating external events to oneself when there is no basis for making such a connection

mutually exclusive. A negative thought can have more than one systematic error and the errors themselves may overlap somewhat. In addition, the difference between normal and pathological processing is a matter of the frequency with which these errors occur and the extent and degree of bias in thinking.

Dysfunctional schemas

Schemas are stable knowledge structures that represent an individual's total knowledge of self and the world. This knowledge will be based on the individual's past as well as more recent experience, and any new information is processed through pre-existing schemas. In depression, depressogenic schemas may have been developed over many years but will only be evident when activated by stressful events or low mood. For example, a depressed woman may hold a potentially depressogenic assumption or belief concerned with motherhood, such as – "If I am a good mother, my children will be happy and successful". If the child of this imaginary mother experienced few difficulties, appeared happy and successful in his pursuits, this mother would be unlikely to experience dysphoria, guilt or anxiety. If, however, her child became unhappy and did poorly at school, such events would be likely to be perceived as stressful and the schema concerned with "good" mothering, which was previously dormant, would become activated. As the schema became activated, it would be applied to a variety of situations and contexts and there would be an increase in the negative bias in information processing. For example, the mother might become increasingly aware that the child was withholding information about his school performance, stayed out longer after school without explanation, confided less in his mother, and so on. This, in turn, will lead to an increasingly negative affective state that would further increase the negative cognitive bias in perception, with the mother

experiencing lowering of mood, and being more aware of the child's difficulties to the point that behaviours previously regarded as normal for a young boy are perceived as being problematic and indicative of her failure in general. Without any ameliorating factors to counter this process, this mother would be likely to become depressed.

Cognitive behaviour therapy for the emotional disorders is designed to deal with these negative automatic thoughts, assumptions and beliefs (Beck *et al.*, 1979). Individuals are taught how to monitor and evaluate their negative thinking. Through guided discovery, therapists aim to decrease the bias in thinking and to coach the patient to challenge their negative thoughts by becoming aware of alternative, more reality-based, views of the same situation. Therapists encourage their patients to test out the reality of their negative thoughts or assumptions through behavioural tasks. Patients are encouraged to practise coping skills in situations in which they would have previously had difficulties, and they learn to become more adept at problem-solving. Therapists aim to provide some understanding of underlying dysfunctional beliefs and the impact of these on the individual. As patients with emotional disorders such as depression have access to more functional non-depressogenic beliefs and have not always experienced depression-related problems, they can more readily access alternative, more adaptive schemas and have within their behavioural repertoire adaptive coping behaviours and skills. For those with personality disorder, there is no alternative experience of self and the world and no flexibility in behavioural strategies. The dysfunctional core beliefs that are so evident in those with personality disorder are longstanding and there is no alternative, more adaptive belief that is accessible. For the therapist, the task is to engage the patient with personality disorder in finding less absolute and more adaptive beliefs and behaviours. The therapy therefore needs to be adjusted to aid this process.

Key differences in cognitive therapy for personality disorders

There are four main differences in emphasis in cognitive therapy for personality disorders: these concern the central importance and function of formulation in guiding therapy, the nature of the patient–therapist relationship, the emphasis on core beliefs and the importance placed on behavioural change to promote changes in beliefs about self and others. In addition, not all cognitive therapists may want to, or believe that they can, acquire the necessary skills to treat individuals with personality disorders. Included here is a speculative list of the qualities and attributes that may be helpful and desirable in therapists.

Formulation

The most important therapeutic tool is the therapist's formulation of the patient's problems within a cognitive framework. A formulation, in the case of personality disorder, is essentially a hypothesis that ties together the patient's longstanding problematic behaviours, interpersonal problems and hypothesized underlying dysfunctional core beliefs, which have arisen largely as a result of childhood experiences. The first stage of therapy involves arriving at a formulation. This is explicitly shared with the patient and helps both the therapist and the patient to understand the patient's difficulties. It has a pragmatic application in determining which strategies are likely to be the most useful in promoting effective change in the patient. Arriving at a formulation also helps the therapist to anticipate where difficulties might arise in therapy and informs the therapist of potential difficulties in establishing a relationship with the patient, what mechanisms underlie the patient's problems, and where behavioural and attitudinal changes can most readily be made. It takes time to develop a formulation as it includes a historical account of the difficulties experienced. Although it is possible to arrive at an adequate working formulation in three sessions, it can take more sessions than this to understand fully the links between past and present problems. Not infrequently, a therapist may change an initial formulation later in therapy as further information and details become available.

One important aspect of the formulation in cognitive therapy for personality disorders is that it is shared with the patient and made explicit. This allows the therapist and patient to work from the same canvas. Patient and therapist can collaborate on what needs to change and the patient benefits from having a model that makes sense of how his or her problems may have arisen and been maintained. Without an adequate formulation, the therapist will tend to carry out treatment on a problem-by-problem basis and, as patients with personality disorders have a tendency to present the therapist with a shifting array of problems, the therapy may never proceed to any satisfactory conclusion. More detail on developing a formulation is to be found in Chapter 5.

Formulation for antisocial personality disordered patients

However, there are some exceptions to the above, particularly for those with antisocial personality disorder. Some, though by no means all, individuals with antisocial personality disorder are difficult to engage in the first stage of therapy with its emphasis on developing a formulation that links past experience and behaviour with problems in the present. Some are impatient and want a "quick fix" for current problems. For these patients, time spent discussing the past appears to be a "getting nowhere". They may have a very rudimentary understanding of their past and its effect on them and see no point on dwelling on this. Current problems are of pressing concern and

they want something done now. Concentrating on the present may be an appropriate strategy for the therapist in these circumstances, and past history can be woven into future discussions and information-gathering in sessions to understand the drivers of the problems, the over- and underdeveloped behaviours and core beliefs that maintain the problems.

Discussing the past, particularly their childhood and adolescence, is often traumatic for antisocial personality disordered persons, and therefore emotionally distressing. Borderline patients equally have distressing events and circumstances in childhood and adolescence but they will tend to have dwelt on these and may be more familiar with the associated emotional distress. They may also use emotional avoidance less. Unlike borderline personality disordered patients, many with antisocial personality disorder have attempted to avoid emotional distress throughout their lives. Discussion of the past can lead them to reflect on this further and, consequently, increase the likelihood of their becoming more aware of past failures and negative affect. A full exploration of the past may therefore be overly traumatic and distressing at this stage of therapy, especially if the patient has few appropriate or effective skills to cope with distress. Being aware of this possibility, a therapist has the option of making a judgement that he has developed a good enough understanding of the key past events, the overdeveloped behavioural strategies and core beliefs that are maintaining current problems, to move to the next stage of therapy. Explicit and detailed sharing of the formulation with the patient may also be unwise in such circumstances as it is likely to be overly emotionally arousing and may be misinterpreted by the patient.

Patients may have difficulty attending to what the therapist is saying to them when sharing the formulation and, rather than grasping the bigger picture, they may selectively attend to the more negative and distressing content of the formulation. What a patient may hear the therapist say is, for example, "you think you are a loser" and he may misinterpret this as the therapist confirming his loser status, rather than understand that this is a belief he has about himself and not an incontrovertible fact.

In these circumstances, it is usually wiser to give a relatively brief understanding of the patient's problems and to go on to discuss what needs to change for the patient to have a better quality of life. Discussions about what behaviours appear to be underdeveloped, and a greater emphasis on a behavioural approach to problems, may be more likely to be acceptable and beneficial to this type of patient. More cognitive aspects of therapy, such as beliefs about self and others, can then be integrated into therapy as they relate to the maintenance of the overdeveloped behaviours.

The patient–therapist relationship

As individuals with personality disorders tend to have a wide array of problems, including difficulties in establishing constructive relationships,

therapists can begin to feel overwhelmed and negative about their relationships with these patients. Treating individuals with personality disorders requires considerable clinical skill and experience, an ability to work in a structured way, and the ability to formulate the patient's problems within a theoretical model of therapy to guide treatment. To expect all clinicians who come into contact with patients with personality disorders to have the above characteristics is clearly unrealistic. It is not uncommon, for example, to find well-meaning therapists who overcompensate by putting more and more diffuse efforts into trying to be helpful to the patient, with the result that the main goals in therapy become lost and the boundaries of the therapeutic relationship become blurred. This almost inevitably leads to more problems as there is a drift away from clear goals, increasing confusion of expectations within the therapeutic relationship and less overall resolution of problems. As a result, many therapists feel at a loss when faced with such patients and are unlikely to effect any change in their patients, who may then suffer more as a result of having seemingly failed in treatment and, in addition, may find themselves alienated from service providers. There is a need for therapists to acquire the necessary skills and knowledge to engage and treat this group of patients so that the patients themselves can benefit and are not merely labelled as difficult or even untreatable.

The general stance of the cognitive therapist working with patients with personality disorders is one of openness and interest in the patient. The therapist should be clear about the aim of therapy, which is to increase adaptive behaviour and thinking and to decrease maladaptive behaviours and modify dysfunctional rigid core beliefs. This clarity is essential to the therapist in that it prevents the therapist from being drawn into condoning potential negative and self-defeating behaviours and beliefs in the patient. The therapist aids the patient to do the right thing at the right time and to act in such a way as to promote adaptive self-enhancing behaviours.

One of the hallmarks of an individual with a personality disorder is the presence of persistent interpersonal difficulties. Individuals with personality disorders have difficulties understanding and negotiating interpersonal relationships, and these same difficulties are likely to manifest themselves within the patient–therapist relationship. The therapist needs to be aware of these problems in carrying out treatment and has to be sensitive to the relationship difficulties that can arise between them and the patient. This highlights an important difference between the treatment of clinical disorders (Axis I) such as anxiety and depression and the treatment of personality disorders: the therapeutic relationship itself can become a focus of treatment in personality disorder if there are problems with engagement in therapy or serious disruptions to progress in therapy that arise from misinterpretations of either the patient's or the therapist's expectations, motives or behaviour.

Persons and Bertagnolli (1994) have suggested that keeping therapy focused on overt problems aids the development of a collaborative relationship. In

cognitive therapy for individuals with personality disorders, the emphasis is on change to both underlying core beliefs and self-defeating behaviours or behaviours that may cause harm to others. By sharing the cognitive formulation with a patient, the relationship between core beliefs and longstanding maladaptive behaviours is relatively easily comprehended by patients and concentrating on the overt difficulties relating to core beliefs aids both the change process and a collaborative style in therapy. One of the main emphases therefore is on identifying and modifying self-defeating behaviours or behaviours that disrupt relationships. Encouraging the patient to endorse and experience the advantages of modifying these behaviours promotes a positive working alliance with the therapist.

Very few patients with personality disorders come to therapy with the expressed aim of changing their personality traits. Rather they are referred with problems such as failing to maintain relationships, getting into trouble with the police, repeatedly self-harming and experiencing high levels of distress that cannot readily be accounted for by their circumstances. Once the main problems have been established and phrased in such a way that positive and adaptive change can be recognized and assessed, the aims of treatment are readily apparent and there is less room for misunderstanding to develop. Difficulties that appear to be related to the therapist–patient relationship can likewise be treated as problems to be resolved.

The relationship laboratory

In cognitive therapy, therapists can use the relationship between themselves and their patients as a "relationship laboratory". Therapists have an opportunity to observe a patient's interpersonal behaviour at first hand as well as gaining a historical account of persistent difficulties in other relationships. Although cognitive therapy does not use the therapeutic relationship as a vehicle for change in itself, as in some forms of psychodynamic therapy, the patient–therapist relationship can be utilized either directly, or as an example of relationships with others if there are problems with engagement or progress in treatment due to potential misinterpretations about the relationship.

The following example of how the patient–therapist relationship is utilized in a situation that would disrupt therapy may be helpful. A patient with an antisocial personality disorder presented behaviours that interfered with progress in therapy and were unacceptable in a clinical setting. On two consecutive occasions he arrived late for his appointments and on the second occasion he became angry and verbally hostile to a member of clinic reception staff who drew his attention to the fact that he was late again. Other patients in the waiting area complained to staff and were clearly rather frightened by his explosive behaviour. In addition, the therapist observed that he attempted to change the topic when talking about difficulties in his relationship with his partner, who had left him for another man while he was in

prison. The former of these incidents threatened the viability of his attending the clinic and the latter hampered progress in therapy. His behaviour towards the therapist and reception staff and his lack of punctuality had to be addressed if therapy was to continue. The therapist explicitly told him why this issue was being addressed and that she had to understand what his difficulties were in attending on time and in discussing his relationship with his partner, as he had stated that he wanted help in maintaining relationships. The therapist asked him to view his behaviour from her perspective and that of others. She asked him to think about the disadvantages of being late for appointments and how he thought she might view his late attendance and how others might react to his shouting verbal abuse in the waiting area. At first, he found the task of taking the perspective of another perplexing and did not see the point of this, but eventually he became aware that his behaviour in the waiting area might be regarded as inappropriate as he saw no one else behaving in this manner. With regard to being late for appointments and not keeping on topic in sessions, it became apparent that he held a belief that he should always be the "one with the upper hand" in relationships and he had to show people who was in charge by his dominant or aggressive behaviour, otherwise he would be "pushed around by others".

The above theme was evident in his history. He had little experience of collaborative relationships and his behavioural strategies and attitudes towards others would have militated against cooperation. His childhood had been both emotionally and economically deprived. He had not known his father, and his mother had lived with several men, some of whom had beaten and humiliated him. Other than being beaten, for the most part he had been neglected. His only way to establish some sense of identity had been through his peer group. It was with them that he learnt to fight and behave aggressively in order to get what he wanted, which was mostly some validation that he existed and could have some influence over others. Clearly an early task in therapy was to reach some joint understanding of this problem through evaluating his basic belief about being "in charge" and, as one of his goals in therapy was to improve his relationships with others, he agreed to keep an open mind about the effectiveness of aggressive behaviour as a means of getting what he wanted. He attempted to change his behaviour towards the therapist and agreed to stick to the agenda as an experiment. It was pointed out to him that if he wanted to learn how to approach people in a manner appropriate to gain their respect and cooperation, his relationship with the therapist would be a good starting point. He would get honest feedback and help to improve his social skills, and any fears he had about not being "in charge" could be evaluated. Had the therapist not brought these difficulties into the main agenda for therapy, the therapy would most likely have reached an early impasse.

Therapist qualities and skills

There may be some attributes and skills that make some therapists more suitable than others in dealing with patients with personality problems. Treating individuals with personality disorders takes time and patience and there are probably no quick routes to success. Cognitive therapists who have worked with patients who have Axis I disorders exclusively will be used to being able to assess patients within relatively few sessions and to embarking on change strategies within the first stage of therapy. Patients are highly likely to comply with homework suggestions early on and will report progress, or not, readily. Therapy remains focused as patients usually have clear goals that they wish to achieve such as getting back to work, being able to stand up for themselves, experiencing fewer swings in mood. The difficulties may not have been experienced throughout life, as the patient will have had times when they were well. Personality disordered patients can present with an apparently overwhelming list of difficult issues that are longstanding, such as criminal and legal problems, child custody issues, breakdown in relationships and high levels of emotional distress. Assessment may not be straightforward and may not follow a coherent and logical order. Some patients with personality disorders may not be motivated to seek treatment but may be doing so to achieve some other goal, such as reducing violence to others to gain credit from spouses so that they can get access to their children or avoid a custodial sentence. These types of issue may raise moral and ethical issues for therapists.

One talented therapist described the experience of her first sessions assessing a man with antisocial personality disorders as being akin to assessing a talking washing machine, with serious and grave problems being described in an incoherent, illogical manner and at a fast spin. She found it hard to grasp the scale and extent of problems as the man talked continuously and would not accept interruptions. This man had very little previous contact with mental health services and had not therefore been inducted into the method of clinical assessment with its rather logical enquiry into the history, maintenance of problems and background factors. This was not the patient's fault, nor the therapist's for that matter, but was a useful reminder that patients and therapists may have different expectations about the content and flow of the first few sessions of therapy.

The following are some personal attributes and skills that may be helpful:

- A thorough understanding of the theoretical framework of cognitive therapy.
- Experience in treating a wide range of patients using cognitive behavioural therapy.
- A personal therapeutic style that is collaborative, warm and open.
- An ability to frame behaviours and attitudes of the patient using non-pejorative language.

- A sense of humour.
- An ability to be flexible and inventive.
- Knowing when to say you could be mistaken, and openness to correction.
- Promoting an experimental, problem-solving attitude in therapy.
- Being accepting and not judgemental about the patient, even when giving or getting difficult feedback.
- Knowing how to give constructive criticism.
- An ability to be firm and to set limits on anti-therapeutic behaviours and attitudes while remaining collaborative.
- Sensitivity to negative feelings from patients and oneself and an ability to discuss these relationship difficulties objectively with a colleague or supervisor.
- Therapists, like patients, will have their "bad" or "off" days and times when they may be under personal stress. At these times, therapists may find themselves less tolerant and supportive of their patients. Therapists and their supervisors should be aware of these difficulties and approach them in a problem-solving and helpful manner, which will optimize the therapist's ability to carry out therapy.

Core beliefs are the automatic thoughts in personality disorder!

In cognitive therapy for clinical disorders, one of the main tasks is eliciting and modifying automatic thoughts. In depression, for example, patients are asked to pay attention to the stream of negative thoughts elicited by situations, mental images or memories that result in or arise from dysphoric mood states. In depression, there is an increase in negative automatic thoughts about the self, the world and the future. These negative automatic thoughts are the end product of systematic distortions in the way information is processed. In cognitive therapy for personality disorders, the main cognitive task is identifying the key dysfunctional core beliefs and modifying these so that they become more adaptive, less rigid and less absolute. Dysfunctional core beliefs in personality disorders are manifestations of stable underlying unconscious cognitive structures. Information from the environment is integrated into meaningful configurations through schematic structures. In personality disorders, dysfunctional schemas are thought to have arisen in childhood and are assumed to be hypervalent in that they are likely to inhibit or dominate more functional schemas and are activated in a wide variety of situations, resulting in a consistent bias in the interpretation and meaning of events.

It is the persistent bias in the interpretation of events, whether these be interpersonal, situational, memories or mental images, that needs modification in personality disorders. In therapy, the core dysfunctional beliefs in personality disorders are the main cognitive data set that the therapist seeks

to modify. These dysfunctional core beliefs concern central concepts about self and others. Changing core beliefs requires the collection of data that can be evaluated in the light of a modified belief or an alternative, more adaptive, less rigid belief. The therapist's task is to lead an examination of the adaptiveness of the old core belief in the patient's current life and, through a collaborative process, to develop a new, more adaptive belief or modify a pre-existing belief. Then, through Socratic questioning, data that were previously ignored, negated or distorted can be judged by the patient for their degree of fit with the new, modified belief.

The importance of behavioural change

Individuals with personality disorders are seen as having developed self-defeating behavioural patterns that are overdeveloped to the detriment of other patterns of behaviour, which are underdeveloped (Beck *et al.*, 1990). Within the cognitive model, these patterns of behaviours are thought of as being a product of learning to cope and adapt to persistent dysfunctional early experiences with important others such as family members and peers. Schema-driven behavioural patterns may have been adaptive in a child's early environment but as the child develops and enters into other relationships and explores different environments, those behaviours become self-defeating and dysfunctional. Behavioural, cognitive and affective patterns are thought to be reinforced through the processes of schema maintenance, compensation and avoidance (Young, 1990). Behaviours that are self-defeating and maintain dysfunctional cognitive schemas therefore need to be changed. In order to achieve this, therapy has to focus explicitly on identifying and modifying behavioural strategies that are not adaptive and that are self-defeating. As a result, therapists need to be skilled at utilizing behavioural change strategies as well as cognitive change strategies. There is a symbiotic relationship in the treatment of personality disorders between changing schemas and behaviours. Schema changes are unlikely to be achieved or maintained unless the patient has also learned to change his or her behavioural strategies. Through an experimental model of treatment, the patient has an opportunity to learn and attempt new ways of behaving, to evaluate the impact of new behaviours and to use the observable data to help strengthen new, more adaptive beliefs.

Chapter 4

Basic structure and style of cognitive therapy for personality disorders

One of the main ways in which therapists can maintain a collaborative working relationship and keep therapy focused is to keep in mind the overall structure of therapy. Although the actual content of therapy will focus on understanding the development and maintenance of the patient's beliefs and behaviour, and on resolving the patient's current problems and consequent distress, each session of therapy will follow a recognizable pattern. Without this basic structure to therapy, both patient and therapist are likely to find themselves getting caught up in specific problems without ever having reflected on how they got there and without a clear direction to progress therapy. Having a clear structure allows therapy to progress in incremental stages, each building on the previous one.

Therapists report several problems in carrying out treatments that are likely to be helped by paying attention to the structure of therapy. These are:

- problems with engagement in treatment
- shifting problems and goals
- repeated crises
- losing focus on the aims of therapy
- therapy becoming more unstructured as time goes on
- non-compliance with assignments.

These problems will be familiar to all therapists as they are commonly reported in psychological therapies and are observed when carrying out therapy with a wide variety of problems, not just with those who have personality disorders. In cognitive therapy for personality disorders, some of these problems are managed in a different way from standard cognitive therapy.

Length of treatment

Treatment is longer for individuals with personality disorders compared to cognitive therapy for clinical disorders because individuals with personality disorders may have more difficulty engaging in a therapeutic relationship, and

it will take longer to develop an adequate formulation of the patient's long-standing difficulties and to make the necessary changes in habitual and persistent patterns of behaviour and thinking that have developed and been reinforced over years. However, as the research in the treatment of patients with specific personality disorders has included a variety of therapies varying in the length of treatment, the optimum length of treatment for those with a personality disorder remains an open question. It is likely that some patients with personality disorder may require periods longer than a year in therapy but we now know that important cognitive and behavioural changes, such as reduction in serious self-harm, changes in dysfunctional beliefs and improvement in relationships with important others, can be achieved within a year of cognitive therapy for those with antisocial and borderline personality disorders (Davidson and Tyrer, 1996; Davidson *et al.*, 2006a). Longer-term, naturalistic follow-up of patients will help to establish whether changes made in therapy can be maintained without further therapy.

The phases of therapy

Grouping sessions with regular reviews

In order to achieve a structure and focus, treatment is organized in blocks of sessions; this allows for problems to be defined and worked on and outcome assessed, and helps keep the therapist focused and task oriented. The length of treatment is therefore not left open-ended as both the patient and therapist have to agree that one phase of treatment can end and the next phase begin. As therapy centres round the idiosyncratic understanding of the individual patient and their presenting clinical problems, the therapist has to ensure that the case formulation makes sense in understanding the patient's current problems, even though reference is made to the past history in developing this understanding. So, before the therapist can target the patient's presenting problems, idiosyncratic beliefs and behavioural patterns, he has to ensure that enough information on past and present problems has been brought together so that both can agree the formulation. Getting this information takes time and may take between four and ten sessions, depending on the complexity of the history, the patient's ability to be a good raconteur and the therapist's ability to assemble the pieces in a logical order and present these in a narrative form to the patient. This step is so crucial in therapy that it is worth taking time to get it right. It is this step that builds trust between patient and therapist and engages the patient in therapy as they come to feel that the therapist is capable of listening and understanding and can accurately reflect back their problems and the personal history that relates to these. In these early sessions, the therapist will be actively listening to what patients say and prompting them with more open, as opposed to closed, types of questions.

Borderline personality disordered patients tend to have had more experience of the process characteristics involved in the assessment and treatment of psychological problems than those with antisocial personality disorder. Contact with psychiatric and psychological services usually begins in late adolescence or early adulthood for patients with borderline personality disorder and they seek help more readily than some patients with other personality disorders, such as antisocial personality disorder, for the problems they experience. They are therefore more familiar with both assessment and therapy and appear to engage with therapy more readily than those with antisocial personality disorder, who often do not seek help for the problems they experience. This latter group of patients may have had prior contact with services but are likely to have had little help in the form of structured formal therapy. They may therefore need more time to settle into the first phase of therapy, and may also need a more explicit introduction about how therapy is structured and what they can expect of each session, and likewise some education about the aims and process of therapy itself.

From the outset, therapy is organized in blocks of at least six to ten sessions, with a review of progress at the end of each block. Problems that the patient stated at the beginning of treatment are reviewed and an assessment is made by both patient and therapist of whether or not the initial stated goals have been achieved. On the basis of this information, therapy proceeds or does not proceed. This would seem to have the advantage of being able to review progress with the option of carrying on or stopping at any juncture. Given that those with personality disorder can vary in their degree of psychopathology, it is likely that some patients will require more treatment than others and multiple blocks of treatment may be required. However, when progress is no longer evident, treatment should be ended.

This blocking of treatment sessions has three main advantages. First, it provides a regular opportunity for both patient and therapist to review goals and progress. Second, specifying that the treatment will be regularly reviewed prevents both the therapist and the patient from feeling overwhelmed and discouraged by an apparently lengthy treatment. Third, it helps to keep the pace of treatment focused and makes good use of valuable therapy time.

Pacing of therapy

Generally, the first phase of therapy is at a relatively faster pace in terms of information-gathering (though not necessarily in terms of sessions) than other stages of therapy that concentrate on change strategies. This first phase allows the foundations of what will go on in therapy to be built. The therapist will be asking open types of questions and will draw inferences from the patient's responses and history to develop a case formation. A patient's role here is not simply to give information. Therapists' questions and reflections

back should help the patient begin to make links and develop an understanding of their problems, both past and present. Therapists will be asking questions to find out more about the patient's early experience, such as "what happened to you at that time?", "how did you feel about your mother/father at that time?", "what thoughts did you have about this situation when you were that age?", "how did you react to that situation?", "what did you do to cope at that time?", as well as asking similar questions to gain an understanding of the patient's thoughts and feelings in the present.

The following phases of therapy may have a different tempo from this first phase as the ground work will have been established and the parameters of treatment delineated. The pace of treatment may then vary according to the types of problems the patient experiences and is attempting to change. Methods used to change core beliefs require persistence on the part of the therapist and patient and can be interwoven with behavioural changes that reinforce schema changes. Changing behaviour is crucial and patients will need to gain experience of practising new ways of behaving until they have attained a level of proficiency in "acting" differently and therefore feeling and thinking differently. The therapist therefore needs to be resourceful and inventive in designing ways of reinforcing behavioural and cognitive changes that keep the patient motivated and to allow patients to experience success in making these crucial changes. Trying to cover too many problems at once is a mistake and suggests that the individual patient's problems have not been correctly identified through the shared formulation. Rather, tackling a few clearly defined presenting problems that exemplify the patient's main dysfunctional core beliefs and overdeveloped behavioural patterns encourages better learning, collaboration and progress.

Frequency of sessions

Most patients are seen on a weekly basis at the beginning of therapy in order to develop a shared formulation that links past and current difficulties. However, as the therapy proceeds, the patient will be attempting to make changes that require either data collection or an attempt to develop new ways of behaving and the new ways of thinking that are reflected in the underdeveloped behavioural strategies. Collecting evidence that helps modify a core belief may involve several behavioural experiments carried out over more than one or two weeks. During this phase of treatment, the patient may well attend fewer face-to-face sessions with the therapist. Many therapists make good use of telephone contact during this time, to hear reports on progress and as a means of encouraging motivation for change. For example, a patient who had a belief that she could not cope without help from other people, including her therapist, would be encouraged to test out a new belief that she could do some things for herself. For this patient, treatment sessions were organized with gaps of varying lengths between sessions to test the

validity of her assumption that she would not cope without the therapist's help. Between treatment sessions, she was encouraged to carry out tasks that she would normally have relied on others for help with, such as choosing clothes, deciding on and booking a short holiday and completing an occupational assignment on her own without seeking unnecessary advice and reassurance from colleagues. Younger patients may prefer keeping in touch between face-to-face sessions by email or text messaging. These types of contact work well provided they are interwoven with face-to-face sessions. They are not a substitute for meeting with the therapist.

Therapy takes on another change in pace as it comes to the end. Sessions often have to be increased in frequency in order to help the patient work through any dependency issues that may have arisen within the patient–therapist relationship and to concentrate on and work through potential relapse prevention strategies. Chapter 11 deals with ending treatment.

Establishing ground rules of respect

Ground rules are helpful for patients with personality disorders, and to some extent, they mark and define some of the more obvious limits of the patient–therapist relationship and the style of therapy, which is both open and explicit. These ground rules are really about educating the patient about what to expect in therapy and to convey that the therapeutic relationship is perhaps different from the patient's relationships to date, in that it will be built on trust and mutual respect but is essentially a formal non-reciprocal relationship with a specific purpose. It is essential to convey a sense of this early in therapy as some patients, particularly those with borderline and antisocial tendencies, may seek to find the boundaries of the therapist's patience and tolerance. Having some limits set at the beginning of therapy is helpful in providing a sense of security, which then allows a more productive working relationship. To have to set limits, such as those below, later in therapy is usually the result of a misinterpretation of the therapeutic relationship, and can result in the patient feeling chastised and resentful.

Time-keeping: therapist and patient

The patient and therapist are both expected to attend appointments on time. It is good practice to avoid extending the treatment session if the patient is late; rather, finish the session at the set time. Most patients understand that therapists will be pleased to give them full attention for an hour of their time every week at the beginning of therapy and that they have other patients in treatment. Occasionally patients may seek out more time with a therapist, bringing up important information or a current critical issue at the end of sessions, or arriving late to a session and expecting the session to be extended beyond the time it would normally end. This type of behaviour is common in

patients who have entitlement beliefs. It is possible to deal with this issue early in therapy by educating the patient about the importance of using the hourly session to deal with what is important and that they can contribute to setting the agenda and prioritizing what is discussed for that hour of therapy. Later in therapy, any core beliefs about entitlement and how these impact on relationships can be explored more thoroughly.

Missed appointments and cancellations

How the therapist and patient deal with missed or cancelled appointments highlights to the patient the time-limited nature of therapy and the need for compliance with treatment. It seems reasonable that the patient and the therapist would provide some notice if an appointment is going to be cancelled. In exceptional circumstances, this rule may be broken as unexpected or urgent problems may arise, but it should be emphasized that such circumstances would be rare. The patient is expected to take responsibility for missed appointments, although most therapists will send a letter or phone the patient offering a further appointment. However, if a patient misses more than two consecutive appointments, it seems reasonable to ask the patient to get in touch with the therapist to arrange another appointment. It is reasonable to ask for a realistic explanation to account for the non-attendance and for some demonstration in the following sessions that there is a commitment to carry on working. Usually the reason for non-attendance is related to the patient's beliefs about the relationship with the therapist or to pessimism about treatment helping, and it is usually helpful to discuss these reasons with the patient and to encourage a "try therapy and see if it works" attitude. If, however, a patient simply fails to attend after missing a few sessions, it is useful to write a letter indicating that treatment has ended and to describe the stage of progress reached in therapy during the time the patient was seen. These are guidelines only, and there will be exceptions for patients who have more difficulty establishing relationships and who seem to be ambivalent about therapy. Such issues need to become a focus of therapy once they are understood in the context of the case formulation. This pattern may have been repeated many times in the patient's life with other people.

Contact with therapist between sessions

It is becoming popular in psychological therapies for individuals with personality disorder to have the therapist's phone number so that contact can be made at times of crisis or when the patient feels that some extra therapist coaching is required to deal with a specific problem. Although this may make sense from the patient's perspective, it can be problematic for therapists working in non-private settings who have more fixed hours and who wish to

protect valuable family and personal time. Indeed, working with this patient group can be demanding and therapists value their time away from work. The therapy described here has been conducted and assessed in public health sector settings; we have found that it is wise not to disclose personal details and therapists prefer that the patient does not have their home telephone number or personal address. This does not stop or discourage some patients from contacting their therapists. All patients can contact the therapist by telephoning their office between sessions but very often, the therapist will be unable to receive the call due to other commitments and may have to contact the patient at a later time. No special arrangements need to be made for patients with personality disorders. If some patients were telephoning with greater frequency than others and were attempting to use such calls as a means of increasing therapeutic input, this would become a legitimate item to be discussed in the next face-to-face session with the patient.

General outline of treatment sessions

The number of sessions required at each phase of therapy varies with individual patients. Some therapists take longer to assess patients and the formulation may require some modification to fit with the existing personal data given by the patient. This is no fault of the therapist, as many patients cannot give a coherent account of the past and present and inconsistencies need to be considered carefully in terms of the formulation as these are often not simply mistakes in recounting but a strategy that the patient uses to present different aspects of themselves, albeit that they cannot remember which aspect of self has already been presented to the therapist. For others, this phase may take less time and the formulation is more obviously reached. Antisocial personality disordered patients who are less familiar with the therapy process may need more time to get used to the structure and process of therapy, though they may also be impatient for solutions to their problems. Careful judgement on the therapist's part, and through the use of supervision, guides the length of this phase.

The general order in which treatment phases are carried out will be as shown in Figure 4.1.

Phase 1 of therapy

Engagement and education about therapy, assessment, formulation, and aims of treatment

- Establish rapport and collaboration by being respectful, warm and empathic towards the patient. The therapist needs to establish why the patient is seeking help and gain a clear understanding about current problems. The therapist will listen carefully to what the patient has told

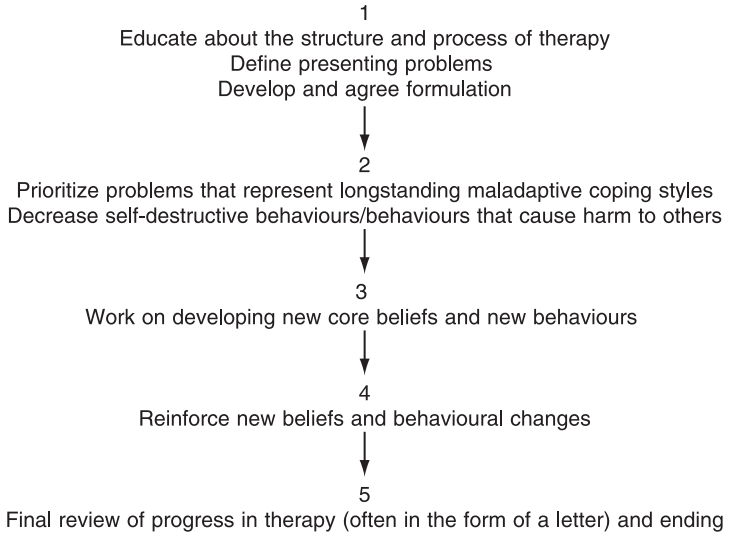

Figure 4.1 Phases of therapy.

her and feed back to the patient her understanding of the patient's problems in a manner that will be perceived as being an accurate understanding of the problems. The therapist should also be explicit about the aims of each session by making a clear agenda with the patient. Although the agenda in the first phase of therapy is likely to be largely set by the therapist, whose task is to develop the formulation and get a clear idea of presenting problems, patients can also be invited to prioritize the content of the session. A patient may prefer to give more emphasis to the present than the past, though the therapist also needs to find out if current problems are linked with past experiences and relationships.

- If possible in this first phase, interview someone close to the patient, especially as the patient's problems are often interpersonal. Those close to the patient will often give a clear account of the patient's difficulties and how they affect others. This is valuable information for the therapist and for the patient. This option has to be presented sensitively to patients and they may need to feel that the therapist is trustworthy and supportive of them before embarking on this strategy, so it may not always be possible.
- Developing an initial formulation of the patient's difficulties within the cognitive model is one of the main tasks of these first sessions. Although there are some exceptions, this formulation is shared with the patient; it acts as a guide to treatment and orients the patient to the cognitive model.

- The other main task of this first phase of therapy is to establish a problem list and agree a priority list that will guide therapy. Establishing which problems should be given priority is helped by the formulation as these will be examples of longstanding behavioural or interpersonal problems linked with associated core beliefs.

Orienting the patient to the therapy

One of the main aims of the first phase of therapy is to develop an adequate formulation of the patient's problems. This is used to help the patient understand the links between overdeveloped behavioural patterns and the associated core beliefs that have been instrumental in developing these behavioural patterns and that may now serve to maintain them. The most effective way of putting across the idea of core beliefs is to use the patient's own life history and words to illustrate why the patient may have come to think and behave in a way that is currently problematic. The handout entitled "core beliefs" (see Appendix) can be given to the patient after the therapist has introduced the idea of core beliefs or schemas. Patients are then introduced to the idea of working collaboratively with the therapist to develop new ways of behaving and new ways of thinking that will support the changes that the patient wishes could take place in their lives. This may involve various techniques such as goal setting, monitoring behaviour and working with the therapist to acquire the skills necessary to achieve desired goals. In the treatment of personality disorders, reducing self-defeating and self-harming behaviour and any other behaviour that causes harm or distress to others is often given priority after such behaviour is understood within the context of the formulation.

Any behaviour, attitudinal or motivational problems that may impede therapy should be dealt with at the time they arise. Problems such as not turning up to appointments or turning up persistently late, not carrying out assignments, changing the agenda of sessions in a haphazard manner or behaving in a hostile manner impede the progress of treatment. These problems require attention and need to be resolved if therapy is to progress in a satisfactory manner.

Phase 2: Prioritizing problems

The problems to be prioritized in therapy are decided in collaboration with the patient. The cognitive model of personality disorders stresses the importance of maladaptive behavioural strategies and associated core beliefs, and these are the focus of therapy. Patients, however, come to therapy because they are distressed about current problems in their lives and may not, at first, make links between core beliefs and the behaviours that are driven by these in an attempt to compensate or cope with these beliefs about self and others.

The therapist has to pay attention to the current problems and then link these with the attempts to cope. In other words, the problems that relate to the cognitive formulation will be dealt with in therapy but specific life crises that are externally driven may have to be resolved before the patient can settle into therapy. As such, some of the patient's current problems may be due to specific circumstances that have arisen and may not be connected to core beliefs and maladaptive behavioural strategies employed to cope with these. The therapist has to attempt to distinguish between problems that are likely to be connected to underlying schemas and associated maladaptive coping styles and those that are unconnected to these. This is where having a good historical account of past problems and the patient's prevailing style of coping aids the therapist in making a judgement about those problems that relate to more longstanding dysfunctional ways of coping that will be the focus of therapy and those that are likely to be unrelated and due to external circumstances or crisis. Current problems that are related to external circumstances may need to be resolved or managed first so that the patient can concentrate on therapy, and the therapist may have to help the patient deal with these first or find other sources of support to deal with them.

Marsha Linehan's work with parasuicidal borderline patients suggests that it is important that suicidal, parasuicidal and life-threatening behaviours should be given priority in treatment (Linehan, 1993a). As this guide to therapy is designed to treat a broader range of patients, some of whom will have antisocial traits, any behaviours that endanger or cause harm to others should equally be given a high priority in treatment. Self-damaging behaviour related to self-loathing or threatening others with physical violence and acts of aggression related to beliefs that disparage others warrant being targeted early in therapy, as they are likely to be related to longstanding underlying core beliefs and overdeveloped maladaptive coping styles. These beliefs and behaviours have the greatest impact on the individual and those around them and often result in the most distress. We have found that the engagement of patients in therapy through listening and structuring past and present experience within a formulation can, in itself, lead to a reduction in self-harm. This may not be enough to maintain a reduction in self-harm, and further help is often required to change what has become an overly learned pattern of behaviour. Chapter 9 gives more specific details on how to reduce self-harm.

Following a reduction in the above behaviours, the therapist should then attend to the other changes that the patient and therapist have agreed in treatment. These changes should be specified behaviourally if possible so that progress can be easily monitored and the patient and therapist are clear about what changes are desired. These will be the reciprocal of the overdeveloped behaviour patterns, that is, those behaviours that are the opposite of what has been over-practised and over-learned.

At the end of the first and second phases of treatment, the patient should have a clear understanding of the development of his or her problems. It is

helpful to give a patient a written account of the formulation and the aims of therapy. As this has been shared with the patient and is a summary of what has already been discussed in sessions, the written account of the formulation helps engagement in treatment and agreement on goals and priorities for therapy. Some therapists are reluctant to provide a written formulation, and are concerned that the therapist appears all-knowing. If the therapist and patient have shared the formulation and arrived at it through collaboration, this problem is avoided. It can also be emphasized that the formulation may change as more information is gathered and a deeper understanding of how the patient's problems have developed and been maintained is uncovered.

Phases 3 and 4, sessions 11 to 20(+): developing new core beliefs and new behaviours

In general, therapy does not move to this next phase unless there is agreement that the patient can benefit from working in a structured way, that the goals of therapy are established, and there is reduction in self-harm or self-defeating behaviours. If a patient is having difficulty reducing self-harm, but is engaged in treatment and shows evidence of being able to work in a structured manner, then the next sessions will continue to focus on self-harm or behaviour that causes harm to others, as these are likely to relate to core beliefs and longstanding maladaptive behavioural coping styles.

If appropriate, the therapist and patient may wish to continue or increase involvement of significant others in this phase of treatment. This can be particularly helpful with patients who have antisocial behaviour, and involvement of others may improve compliance with treatment, provided that the therapist remains non-partisan.

The main work of this phase of therapy is, however, in developing new ways of thinking about self and others and behavioural patterns that will improve the patient's quality of life and be less self-destructive. Any change to ways of thinking and behaviour has to be reinforced by a variety of behavioural and cognitive assignments. This work is thorough, repetitive in theme by necessity, and requires a fair degree of persistence and innovation from both patient and therapist.

At the end of this phase of therapy, a review of progress is recommended before a further block of sessions is negotiated. At this stage, therapy sessions may be spaced out to allow behavioural tasks that reinforce new ways of thinking about self or others.

Often antisocial and borderline personality disordered patients are socially isolated and disconnected from their wider communities, and it is important to build up constructive contacts and relationships in these communities. This helps to reduce dependency on the therapist and to increase opportunities to develop other relationships. For some patients this may involve seeking voluntary or paid employment or at least structured activity of some

sort. This can be as basic as finding out the types of daily activities that patients find satisfying, as their days may lack structure altogether. Some personality disordered patients who have got into trouble with others and the police may have problems going out of their homes as they fear reprisals from others. Finding satisfying structured activity may involve a therapist contacting other agencies and support services for this group of patients.

Final phase: around five sessions

The final phase of treatment is different from the others. The focus here is explicitly on ending therapy and relapse prevention. This phase provides a final opportunity to put together all the information gained in therapy and to review the progress that the patient has made towards acquiring new beliefs and a new, more adaptive, behavioural repertoire. It allows the patient to reflect on the difference between pre-therapy problems and gains made in overcoming these problems in therapy, what has been useful or not in therapy, and which strategies they have found most helpful in learning to cope more effectively with problems. A letter to the patient, written by the therapist, that documents this information is always welcomed by patients and serves as a powerful reminder in the future of what has been achieved.

Some patients may have become dependent on the therapist during the course of therapy. In many ways, this is an understandable consequence of sharing so much information with the therapist, especially for individuals who have had experience of others as being untrustworthy and perhaps abusive. Although there are exceptions, we have generally found it helpful to the patient to increase the frequency of sessions in this phase to once per week. This allows the therapist to help the patient deal with and contain feelings of loss without resorting to self-harming or self-defeating behaviours or behavioural or affective avoidance.

Over the course of treatment, the patient will have been working on developing an array of strategies to aid self-care or improve the quality of relationships. These new strategies will have been reinforced through treatment and provide the basis for relapse prevention. Documenting these during therapy as well as providing a list of "first aid" and longer-term behavioural and cognitive strategies is useful in this final phase, and can be incorporated into the ending letter to the patient.

Maintaining a working alliance

Several aspects of therapy help to maintain a collaborative stance and allow progress, such as keeping the therapy problem focused, giving regular feedback on progress and on the level of understanding reached about how the problems arose, as well as maintaining a professional and respectful attitude to the patient.

Keeping structured and active

Cognitive therapy applied to clinical disorders such as anxiety and depression is a short-term focused treatment. Many therapists treating patients with personality disorder who require longer-term therapy have a tendency to be less structured and focused, particularly as therapy proceeds. The opposite is required: there is a need to remain more problem-oriented and structured with patients with personality disorders. By doing so, the therapist and the patient are less likely to become discouraged and are more likely to develop a better therapeutic relationship as well as both being clear about the aim of therapy and the desired outcomes. The purpose of structuring therapy is not to constrain or limit the content of therapy but to provide a format that can help therapy progress in a manner that can be easily followed by the patient and is predictable. Sometimes flexibility is required, as in the case of an antisocial personality disordered patient with a pressing need to talk about his problems, and in this case it was more productive initially to have a more limited agenda and let the patient talk to gain information about his overall state of mind, and to assess his level of control over his thinking and behaviour.

Many patients with personality disorders will have had prior experience, not necessarily positive, with mental health service professionals. In order to build up a positive therapeutic relationship, the patient needs to feel secure within the relationship. The therapist has to convey a non-judgemental attitude towards the patient. This attitude will be evident in the therapist's respect for the patient as an individual and in the interest conveyed in learning about the patient's problems. In addition, the patient needs to have a sense of the content of the therapeutic relationship and where the boundaries of this relationship lie. The patient needs to know that this relationship will be built on trust and mutual respect. The therapist needs to know that the patient has understood the nature of the relationship so that they can work together effectively. In order to aid the establishment of a therapeutic relationship, the therapist can make certain features of the relationship explicit.

When not to be too structured

As discussed above, often from the very beginning of the first session patients with personality problems may talk about a number of serious problems, many of which are distressing to the patient and seem to need urgent attention. Individuals with antisocial personality disorder, in particular, present with an alarming number of serious problems such as violent behaviour, impending court cases, relationship breakdown and feelings of uncontrollable anger. This list of problems is unlikely to be given in a logical order and the patient may also talk rapidly, encouraged by an enquiring therapist with a

great deal of patience who is trying to make sense of what he says. If this were a depressed patient, the therapist would probably acknowledge that there were likely to be many problems and help the patient to list and prioritize the problems, thereby bringing a sense of manageability to the patients' problems and reducing distress. This is not so easy, nor is it necessarily appropriate, with a patient who has antisocial personality disorder and is reporting the above problems. The therapist may find it hard to grasp and understand the patient's problems but it can be counterproductive to try to interrupt the patient's "flow" as he may say things that are very useful at a later stage and the therapist has to gauge the patient's level of understanding about his own problems. The therapist's task is to make a judgement about which problems are related to longstanding core beliefs and maladaptive coping styles and which are externally driven and unrelated to these, and therefore not a focus of therapy, though they may need to be resolved to allow therapy to proceed. In the following sessions, the therapist can introduce a summary of what the patient said and then bring in more structure such as an agenda and an agreement to prioritize problems to build up a good understanding of the patient through a cognitive formulation.

The style of sessions

The therapist's style is open and collaborative while being professional and respectful. The therapist and patient are both expected to contribute to setting an agenda for the session and there is an agreement to work on the most important problems and not to become side-tracked unnecessarily. In cognitive therapy, patients are asked for feedback about progress of the session and treatment as a whole. As patients may experience interpersonal problems within the therapeutic relationship itself, the therapist has to be particularly sensitive to any potential or actual threats to the relationship being one of collaboration. A therapist can provide many good examples of repairing breakdowns in communication and collaboration during therapy. For example, let us say that it became evident that a male patient with antisocial personality disorder gave a previous account of an event that was then shown to be inaccurate and had left out some highly salient information that would have shown him in a negative light. He may have given an initial biased account to appear less blameworthy to the therapist and to maintain self-esteem. A scenario such as this gives the therapist very valuable information that can then be used appropriately in therapy. What is clear is that the therapist should not challenge the patient by pointing out the inconsistency in the story or by seeking to establish the truth in this situation, as the patient is likely to react to a challenge by being defensive. If this patient held beliefs such as "everyone is out to get me", the therapist's open challenge to the inconsistency would reinforce his belief that he was being "got at" or found out (*which, indeed, he probably is*). To avoid the patient feeling attacked, the

therapist might use a strategy that gently acknowledges the patient's inconsistency but shows curiosity about the different versions of the story and the patient's role in the events. This is often best done in a later session when a similar theme emerges. Phrases such as "oh, I wonder if I understand what happened more clearly now" and "it is sometimes hard to remember everything at one time, isn't it?" or "let me see if I have this right now; you told me a few sessions ago that . . . and now I am not sure how that fits with what you just told me" help ease the way for the patient to be more open. The therapist then has an opportunity to discuss the meaning of an event with the patient (how he thought about himself and others then and now) and what he would now want to do in a similar situation. Acknowledging that these difficulties occur and the therapist's careful use of gentle challenging can enhance the relationship with the patient. By doing so, the therapist also provides the patient with an example of one way of approaching problems of this kind.

Patients with personality disorders often behave in ways that can be interpreted negatively. They often hold extremely rigid negative beliefs about the behaviour and motives of others and act in ways that confirm some of these beliefs. Understanding the reasons behind such negative attitudes and behaviours can help the therapist use non-pejorative explanations for the patient's behaviour.

Assignments

Devising relevant assignments can challenge many therapists; likewise, many patients have difficulty in attempting and completing assignments. A key to successful learning is that assignments be directly and explicitly related to the patient's problems and the task should be relatively easy to complete and appropriate for the phase of therapy. This will also facilitate the likelihood of compliance. Therapists have to enquire if patients feel able to undertake a task and ensure that they have the necessary skills to carry out the assignment as a means of extending the influence of the therapy between sessions and to challenge maladaptive beliefs and behaviour. The onus is on therapists to be inventive in drawing up useful and relevant assignments and thinking of ways to motivate patients to take part in these, as well as coaching patients in the skills necessary to undertake the task.

Therapist's written feedback to patient

After a particularly helpful session of cognitive therapy and routinely after a group of sessions, therapists may give patients a written account of what was learned and achieved. This is not a verbatim account but a summary of what went on in the session, with an emphasis on helping patients to understand their problems within a cognitive therapy framework. This account will

often finish with a rationale for behavioural or cognitive assignments and a description of any task agreed by the therapist and patient. Such accounts are useful in aiding collaboration as they serve a checking function for both therapist and patient.

Example of account of session

7 March

For Susan: my account of our 5th and 6th sessions

We discussed how your father reacted to you when you were not doing well at school. He appeared to lose all interest in you and then when you got into trouble with the police, he told you he wanted no more to do with you. This made you feel unwanted and all alone in the world. You believe that he hated you. From that time, you think that you began to feel very angry and hated everyone. You said that your behaviour got worse and that you got into fights because you did not care if you got hurt and as you disliked other people so intensely at this time, you thought they deserved to get hurt. You thought that everyone would hurt you.

You now think that your behaviour of lashing out at others served to protect you from getting hurt by others as you behaved in a manner which kept others at bay. You now think that this may not only have kept others away but may also have made other people lose interest in you as you made it so difficult for them to get close to you. This may be why you felt so lonely and abandoned. You think that your behaviour now serves a purpose in that it stops you getting close to people and this then prevents you from taking the risk of getting hurt. You described this strategy as "I'll hurt them before they hurt me".

In the second half of the session we looked at your past to find out if you had ever been close to people or trusted people and not been hurt.

(We looked at the evidence for this belief, remembering that you tended to have ignored evidence in the past. Is it possible that you have got close to someone and not been hurt?)

You found it very hard to think of anyone. You did, however, remember that your granny had been very nice to you when you were very young. Sadly, she died when you were seven.

Assignment to be carried out this week:

We agreed you would think about the past and see if you could rate the degree to which you trusted the people around you as a child (mother, aunts, uncles, grandparents, brothers and sisters, cousins, teachers, friends).

The exercise that we began in the 6th session suggested that you tend to rate people in an "all or nothing" way in relation to trust – you tend to place everyone we discussed at the opposite ends of trustworthiness. For example, your father was 0% trustworthy. We have included some people who you know now (as an adult) as well as others you knew in your childhood in this exercise to see if you are able to place them on a continuum according to how you judge their level of trustworthiness using your new belief.

Susan's response to this assignment was as follows:

If I trusted someone I would expect them to be prepared to look out for me at least *some* of the time. It is not realistic to expect this 100% of the time.

Someone whom I trust will not deliberately harm me, either emotionally or physically.

(See Figure 4.2.)

Supervision

Working with people with personality disorders who have serious problems and also difficulties relating to other people is stressful for therapists. We regard clinical supervision as an important element in successful treatment. It gives therapists the space and time to reflect on the patient's problems in a structured manner and to clarify the cognitive formulation in discussion with their supervisor.

Reflection in supervision is particularly important when treating patients who have highly dysfunctional beliefs and behaviour. Therapists do not always have the capacity to attend to both the content and the process of what is going on between themselves and the patient within a session. With personality disordered patients, the atmosphere of therapy can be, at times, highly emotive and the therapist has to attempt to manage this if they are to remain in control of the session. Forming a therapeutic relationship with patients with antisocial personality disorder who present a risk of violence and who have a history of violence is a challenging task. The therapist has to

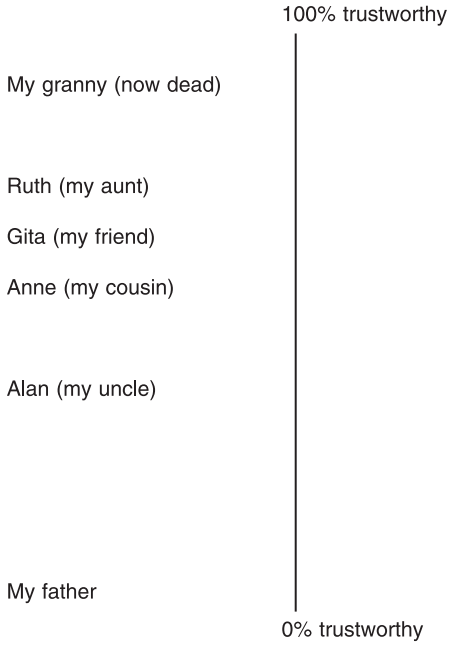

Figure 4.2 Susan's continuum.

build up a therapeutic relationship where the patient can trust the therapist but at the same time, the therapist must be able to make a judgement about the content of the patient's description of acts of violence. Patients with antisocial personality disorder may become highly emotionally aroused when discussing acts of violence to others, but without any suggestion that they have an ongoing capacity to reflect on the consequences of the acts. At these times, the therapist has to be aware of the function of what is being said as well as the content and should not get drawn into becoming an audience for the patient. Training in cognitive therapy has used recordings of clinical sessions in supervision and this can be invaluable in allowing the therapist to process some of these types of difficulties that can arise while "doing" therapy. This act of listening to therapy recordings, for which the patient has given consent, is invaluable for the supervisor and therapist's learning, monitoring and assessment of therapy progress.

Supervision also helps to keep therapy from drifting and losing its structure and helps to anchor therapy in problem-solving mode. Importantly, it provides an opportunity for therapists to deal with negative feelings towards patients that may arise at times. Supervision can encourage a therapist to be realistic about what can be achieved in treatment as well as encouraging a therapist to carry on when setbacks occur. All therapists at times have the

feeling of being stuck with their patients and believe that therapy cannot progress. Supervision is particularly helpful here in reviewing what has happened to date and helping the therapist think through what the blocks to progress might be. It also helps to stop a therapist getting drawn into making negative assumptions about what is possible in terms of change or acquiescing with a patient's dysfunctional beliefs and behaviour instead of attempting to modify these. Clinical supervision can therefore help to clarify and resolve some of these issues and thus help the therapy to reach a more satisfactory conclusion.

Chapter 5

Arriving at a formulation

Formulation has central importance within cognitive therapy for personality disorder. It provides the patient and therapist with a joint understanding of the patient's difficulties, both historically and currently, and acts as an overall framework to guide treatment.

Initial interview

The first interview is an important initial step in assessing the patient's problems and personality difficulties and, as this is the first point of contact, therapists have to attempt to engage a patient immediately in treatment. The general demeanour of the therapist is therefore of relevance and the therapist has to convey a professional attitude while being warm and understanding of the patient's difficulties from the outset. Therapists also have to be aware of the potential difficulties that may arise in the patient–therapist relationship. Although an initial interview may aim to cover an assessment of some of the patient's presenting problems, the history of these problems, personal history, family history and, lastly, what the patient hopes to gain from therapy, this assessment will, in reality, take more than one session. Those with personality disorder will have complex and longstanding problems whose assessment requires structure as well as thoroughness, and it is not possible to hurry this process. Therapists have to be alert to problems which may emerge within the therapeutic relationship that mirror interpersonal difficulties in the patient's life. The nature of these problems may only be more clearly understood as therapy develops, but it is wise to consider what they may be during the development of an initial formulation. These difficulties draw our attention to potential schisms in the patient–therapist relationship that may threaten the viability of therapy if they are not averted or used constructively.

Ask a close friend or relative to attend

After establishing that the patient's problems might meet diagnostic criteria for personality disorder (for example, ICD-10; World Health Organization,

1992a) and a formal method of assessment has been carried out, it may be useful to ask the patient's permission to interview someone who knows them well, such as a close friend or relative. This suggestion is sometimes resisted initially but once therapy is under way and a therapist has gained the patient's trust, the therapist can, once again, ask if the patient would agree to someone who knows them well being interviewed. The rationale for interviewing a person well known to the patient is that individuals with personality difficulties have interpersonal problems that are directly experienced by those who know them well and therapists can gain a greater understanding of these problems by interviewing a significant other. Clinical experience suggests that significant others are usually particularly willing to come and talk to the therapist and regard the patient entering therapy positively, as it signifies a willingness to explore changing behavioural patterns and attitudes that interfere with the quality of their relationship.

A friend or relative can often be very helpful in providing additional information about the patient's difficulties, and the therapist can ascertain the nature and extent of the problems identified by both the patient and the accompanying person. Longstanding difficulties can be highlighted as well as more recent problems.

Aims of the interview

One of the main aims of the first phase of therapy is to reach a satisfactory formulation of the patient's problems and establish the patient's diagnosis. This is achieved by finding out what the patient's problems are and placing these in the context of the patient's personal and family history. Past contact with psychiatric services should give additional information about the history of problems. In addition, interviewing a close relative or friend is helpful in establishing more precisely the nature of problems and whether these are longstanding or represent a recent change in the patient's functioning. One particular difficulty of assessing patients within a mental health setting is that the patient may have been referred in an acute phase of a psychiatric disorder and the nature of other difficulties that may be related to personality disturbance is more difficult to establish in such a state. Only after the acute phase of illness has passed can a more reliable assessment of personality disturbance be made, and the relative's view and account of difficulties can help to differentiate longstanding traits from illness-related problems. By the end of the assessment, a therapist should also have some idea about whether the patient would be a suitable candidate for cognitive therapy, although it is difficult to predict the specific characteristics of patients who will respond to cognitive therapy for personality disorder due to lack of available studies in this area. Nonetheless, patients with personality disorders who suffered from depression in the NIMH collaborative research study of depression had as good an outcome as, or did better than, patients without personality disorders,

indicating that this form of treatment may well be promising (Shea *et al.*, 1990). From a therapist's point of view, being unable to arrive at an adequate formulation is likely to be a negative indicator for therapy. In terms of patient-related variables, a high degree of avoidance, in schema activation as well as behaviour, might be a negative predictor, as change will be less likely to take place.

Motivation for change

The patient's attitude to the referral and to their problems might be important in establishing their attitude to any treatment that may follow. For example, a patient who disagrees with the referring agent about the nature of their problems is unlikely to begin an interview feeling that they are understood. Patients with personality disorders may not present their problems in the same way as individuals who have a disorder such as depression. The problems will often be more diffuse and will represent the patient's usual functioning as opposed to a change in functioning. As such, the patient's distress cannot necessarily be accounted for by a specific change in circumstances or mental functioning. Sometimes patients will have agreed to referral because someone else has thought that they were having difficulties, or they were the direct cause of problems for someone else. For example, one patient was referred because his wife could not cope with him behaving aggressively towards her and had began court proceedings to keep him away from her. If this patient had not come to the first interview (or subsequent interviews) of his own accord, problems would probably have arisen in engaging him in therapy. There had to be some advantage to him in turning up for his initial appointment. In his case, the main advantage was to prevent his wife leaving him, even though the relationship was, by then, very hostile. He did not, at first, perceive any advantage of changing his behaviour towards her as he believed he had done nothing remarkable in hitting her, as other men he knew would have behaved similarly if provoked by their wives. The fact that he wanted to remain with his wife and to stop the court proceedings that would have resulted in him being banned from going near her was at least a starting point for engagement in therapy. It allowed the therapist to help him identify the way his life would be enhanced if he was to improve his relationship with his wife and others and to contemplate changes in his behaviour and thinking that might reduce the seriously negative impact he had on other people.

History of problems and current difficulties

As the patient's history is of relevance to the development of a personality disorder, a general overview of longstanding difficulties and level of functioning is sought. It is important, however, that the initial interviews do not

get sidetracked into gathering too detailed an assessment of lifetime functioning and problems. Lifetime functioning is clearly important, but in the assessment phase only an overview is required. Instead, the patient's current problems should be emphasized as these will have brought the patient into therapy and, in the case of an individual with a personality disorder, they are likely to be representative of longstanding difficulties.

Establishing rapport

The patient's prior experience with health professionals and authority figures may play a part in their attitude towards therapy. A patient may have been referred to mental health services before and may well have been told that "nothing can be done to help". Helplessness, mixed with frustration and anger, is not an uncommon reaction to treatment attempts. Any signs of the therapist being negative, overwhelmed or having difficulty in understanding the patient's problems can lead to the patient concluding that the treatment will fail and that nothing can indeed be done to help them.

Using summaries and reflecting back the essence of what the patient has communicated helps to establish that the therapist is interested in the patient as an individual and has listened carefully and taken their problems seriously. In addition, by summarizing and clarifying the nature of the patient's problems, the therapist gives an impression of order and manageability to problems where often there has been little. At all times, the use of non-pejorative language in summaries of the patient's difficulties is essential in aiding collaboration and engagement.

Encourage hope

Many patients with personality disorders will have been seen by other professionals in the past and may have been told that little can be done to help them. Although a therapist cannot offer any easy solutions to their problems, the patient can be encouraged to think that change is possible. They can discuss what changes the patient would like to make and how these would be beneficial. If a patient is unrealistic about their goals in treatment, a therapist may suggest a modified goal and seek the patient's agreement that this would be acceptable. Clearly an element of judgement is required in deciding what is a "realistic" goal, but if a therapist keeps in mind that the goal of time-limited treatment is to start a change process, then goals can be modified accordingly. Finding a partner, for example, would be an unrealistic goal, as a therapist and patient have no control over all the factors relating to this endeavour. However, learning to behave in a more assertive or a friendlier manner would be more readily achievable.

Therapists have to encourage their patients to have an experimental attitude towards the difficulties they experience. The life-long strategies patients have

utilized may not be effective anymore and will have resulted in problems. However, as these are the only strategies the patient has used, he or she may not have an idea of how it is possible to change and what the consequences could be. If a patient is sceptical, a therapist should accept this as realistic or even encourage this attitude of scepticism alongside a "let us try it and see what happens" approach.

Developing a case formulation

The cognitive formulation of the patient's problems is the foundation of therapy. An adequate formulation will aim to explain the patient's symptoms and problems within a particular theoretical framework. Without this, therapy will lack direction and the therapist will lack a conceptual framework within which to understand the patient and their problems, both past and present. Figure 5.1 outlines questions that aid formulation.

Historical data

The details of the patient's life history help in developing an understanding of the nature of his or her longstanding difficulties. Salient childhood and adolescent experiences are likely to be important in the formation of core beliefs about self and others. These experiences may be traumatic but infrequent or more repetitive and insidious, such as having been brought up by neglectful, uninterested parents.

Core beliefs

The cognitive model of personality disorder emphasizes dysfunctional core beliefs that are hypothesized as having had their origin in childhood. The dysfunctional core beliefs concern self and others and in those with disorders of personality, these beliefs behave similarly to automatic thoughts in that they are observable in the patient's narrative. These beliefs are characteristic-

1 Why has the client come for help now?
2 What are the core dysfunctional beliefs?
3 Which emotions/feelings are dominant?
4 What are the overdeveloped and underdeveloped problematic behavioural patterns?
5 Are there significant earlier experiences in the client's life that may have influenced the development of problematic behaviours and beliefs?
6 How did the client's beliefs become maintained or reinforced?
7 What, if any, specific interpersonal problems are likely to be manifested in the therapeutic relationship, and are these typical of how the client relates to others?
8 Are there factors in the client's environment that will impede progress and change?
9 How will this client respond to cognitive therapy?

Figure 5.1 Developing a case formulation.

ally inflexible and rigid, accepted as truths and phrased in unconditional terms such as "I am strong" and "other people are weak". They are thought to arise from underlying structures or schemas that are hypervalent and therefore dominant and, as such, more adaptive schemas are less likely to be operational or within conscious awareness. Consequently, the therapist should be able to detect evidence of dysfunctional core beliefs from the patient's account of past and present difficulties and from the attitude and behaviour displayed during treatment.

Patients with personality problems may have difficulty in entering into a therapeutic alliance as treatment involves challenging long-held assumptions and core beliefs about themselves and their worlds. Although these core beliefs are dysfunctional, the patient's past and present experience has been systematically processed to fit into the core schema. Information that would have weakened the schema has either been distorted to be accommodated into the core schema or ignored.

For many patients with personality difficulties, early negative experiences with care-givers and others who played a significant role in the child's life will have led to the formation of core schemas that may have been adaptive and made sense of the child's experience at one point but became autonomous and out of synchrony with reality over time and therefore dysfunctional. In other words, they may indeed have had early experiences that would make sense of the dysfunctional beliefs held in adulthood. However, by behaving in a manner consistent with the early core schemas, the schemas become reinforced rather than weakened and more adaptive schemas are not developed. The personality traits arising from the dysfunctional schemas are therefore also longstanding, rigidly held and pervasive.

The task for therapists is to actively seek information that would weaken the dysfunctional core beliefs and allow more adaptive alternative beliefs about self and others to develop. As the patient's dysfunctional core beliefs may have been adaptive at an earlier stage in their life, making sense of early experiences, patients may initially be resistant to making changes to these beliefs. The functional aspects of the core beliefs have to be considered as these beliefs have been longstanding and may, at times, have been of apparent short-term benefit to the patient. Ambivalence towards change is thus understandable.

For example, a woman who had been fostered as a six-month-old baby held core beliefs concerning her worthlessness and abandonment. She had evidence of literally being abandoned by her mother in early childhood and, after that, of receiving little affection and nurturance from adults due to having being cared for in children's homes. In adolescence and adulthood, she continued to view herself as being inherently bad and undeserving of affection and love, and believed that those to whom she got close would leave her. She developed behavioural strategies related to her core beliefs: in an attempt to compensate for being worthless and her fear of abandonment, she avoided being on her

own and would form overdependent relationships with others. However, in adolescence she would frequently act to disrupt and test these relationships by behaving unreasonably and frequently ran away from home, which led ultimately to others being worn down and rejecting her. She also had relationships with older boys who were emotionally and sexually abusive to her. It appeared that schema compensation and schema maintenance were the processes operating to reinforce her behavioural strategies and core beliefs. In therapy, changing her behaviour was anxiety-arousing for her as she risked being independent and more autonomous and being liked by others at the same time: two conditions that she had not believed possible at the beginning of therapy.

Emotions

Those with borderline personality disorder may have severe difficulties in being able to regulate affect and consequently may show great instability in both the range and the intensity of emotions expressed. This can lead to feeling overwhelmed by emotions such as depression or anger. Incidents that would normally upset most people will generate highly intense emotions in patients with borderline personality, much beyond those that others would expect to experience. Often this emotional instability is difficult for others to cope with and can lead to the patient feeling misunderstood and alone. Such emotional instability can lead the patient to a sense of helplessness and hopelessness.

Some patients may speak of their difficulties in an emotionally detached manner. Such avoidance of feelings is not uncommon and can often be considered as understandable given the personal history that the patient presents. Often patients will have had experiences in childhood that encouraged the suppression of emotions or may never have experienced having their emotional needs met or taken seriously by adults. John, a patient with antisocial personality disorder, was able to give several graphic accounts of the circumstances that led to him avoiding painful emotions. One of these was that at the age of seven he witnessed his father dying in hospital and was told by his grandfather to stop crying as this was upsetting to other people, and that if he could not do this, he should leave or receive a beating. His mother gave him no comfort at that time, or indeed at other times, and generally ignored him. None of his immediate family seemed to have been able to express their emotions, and instead drank heavily or became aggressive and acted irresponsibly. Patients whose emotional needs have been ignored or unrecognized by others are likely to be unable to express emotions appropriately or to recognize the functional nature of emotions.

Behavioural problems

The cognitive model of personality disorders would predict that when core dysfunctional beliefs are activated, behavioural problems are likely to be evident. As the core schemas are activated across a wide variety of situations, manifested by the persistence of problems, behavioural problems may be evident in many areas of psychosocial functioning. Behavioural strategies that are overdeveloped and maladaptive, in that they undermine the patient's ability to lead a more satisfactory life, are of prime importance as targets of change in therapy. Both the therapist and the patient need to be clear about which behaviours are to be considered as the focus of treatment. Self-harming and behaviours that harm others, if present, should always be a focus of treatment and this should be made clear to the patient. Should a patient not wish to change behaviours that are potentially life-threatening or threatening to others, it is unlikely that therapy can continue.

This does not imply that patients in treatment will not behave in ways that are self-destructive. The point is that the therapist has to be sure that the patient wants to stop behaving in a way that is self-destructive or destructive to others. Patients may, from time to time, feel hopeless and behave in ways that are self-destructive, if not necessarily life-threatening. Nonetheless, provided that the patient in general has a desire to live and to optimize functioning, the therapist can engage the patient in attempting to overcome such behaviour. Again the therapist should make it clear that he or she is making the assumption that the patient wants to improve the way in which they cope and the quality of their lives and has a desire to work on the problems they experience.

Occasionally, some of the patient's core assumptions may be activated within the therapeutic relationship. For example, a patient who assumed that people were always ready to put him down and to interfere with his right to do as he wanted, interpreted the therapist's suggestion that he should cooperate with social workers involved with his family as indicating that the therapist was also against him. The therapist needed to be aware of this possibility as it might have led to an impasse in treatment if it was not dealt with at the time. Giving a rationale for social work involvement was key to his understanding of the therapist's actions, as his children required a separate assessment of the risks to their health and well-being and their right to care, independent of what went on in therapy. As he had some concern for his children's well-being but was aware that he could not give them adequate care, he was able to tolerate social work involvement.

The patient's environment

The patient's everyday milieu can also be a potential barrier in treatment. The therapist has to be cautious in assuming that they understand the patient's

background and current milieu as it may be outside of their own direct experience. Criminal activity, early severe emotional and physical deprivation and abuse, and extreme poverty and neglect can be comprehended by a therapist but they should guard against making assumptions based on their own (potentially) more limited direct or vicarious experience.

Some patients are likely to have reading and writing difficulties and most will not report this directly. Often patients are ashamed of their poor literacy skills and cover up for these. For many school may have been a humiliating experience. The therapist should enquire about possible problems in these areas if patients have poor school attendance records or have not achieved scholastically. As well as being a source of confusion and frustration for an individual, literacy problems can hinder therapy if the therapist is unaware that such difficulties exist. Using appropriate language and adapting written materials to the level of comprehension of the patient is essential. Encouraging the patient to attend adult literacy classes may be highly appropriate and worthwhile in helping them to cope more easily with the outside world.

Discussing the formulation with the patient

Around the middle of the first phase of therapy, once the therapist has developed a coherent enough understanding of the patient's problems and history, the patient should be introduced to the cognitive model of treatment through the formulation. From this framework, the goals and treatment strategies will emerge.

Example of formulation

A patient, Jane, stated at the very first session that she was a failure in all areas of her life. Her explanation for her global sense of failure was that she was unlovable and was not worthy of anything good happening to her. She said that even when things seemed to be going well for her, this would be by chance only, and she would manage to make a mess of things by being unable to see them through. When questioned about this further, Jane said that she had always felt unloved and incompetent. Her parents had never believed that she would be able to do well at school. She said that her parents had wanted her to leave school early and get a job. She was the second youngest child in a family of four. She believed that her parents had wanted a baby boy when she was born. Her only brother had died in a car accident and her sisters were, in her view, more attractive, socially skilled and extroverted than her. Her parents had mourned the death of their son and their home contained many reminders of him such as photographs. As children, her sisters had seemed close to one another and had not wanted her company as she was much younger than them. Her family had been regarded as a "problem family" in

the neighbourhood where she grew up and as a result, the school teachers, neighbours and youth leaders with whom she had come in contact had also regarded her as a problem and no one had ever taken her seriously as an individual. Formal assessment revealed a diagnosis of borderline personality disorder. A schematic formulation of the problems she presented is shown in Figure 5.2.

The therapist used this example to illustrate how a dysfunctional core belief might arise and operate and how cognitive therapy might change this.

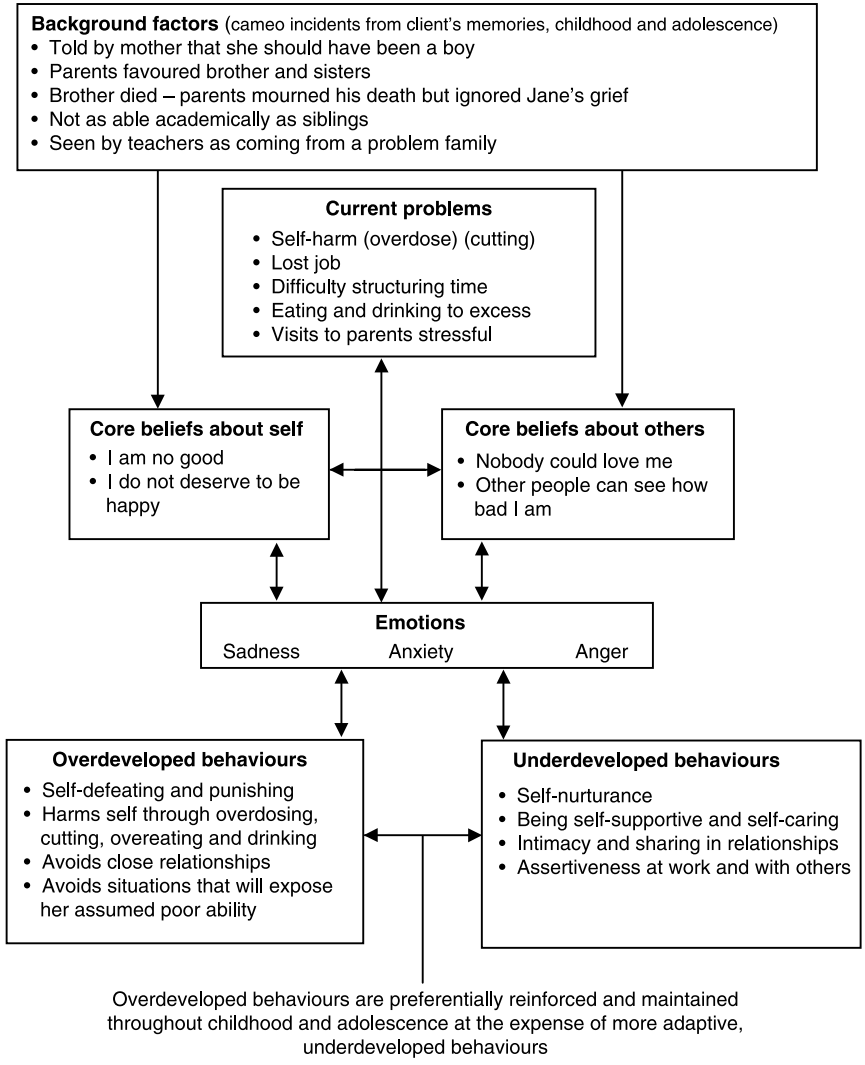

Figure 5.2 Schematic cognitive formulation of Jane's problems.

Extract from therapy

Therapist: From what you have told me, your experience in childhood gave you a strong message that you were "no good". Right from the start you believed that your parents did not want you, they wanted a boy. Your sisters seemed to have been close to each other and you felt excluded by them. Your brother died and your parents, who appear to have regarded him as special, have kept his memory alive. All this has made you feel alone and unwanted in this family. At times, even as a child, you wished that you could escape from your family. Sometimes you wanted to die, like your brother, in the hope that your parents would be sad about you and show that they cared. No one seemed to be interested in you as an individual. No one believed that you could do anything with your life, not even school teachers. It makes sense, given this background, that you felt you were unloved, unwanted and you still have difficulty believing that you will achieve anything in your life. As a child you developed ways of behaving that may have helped you survive in this family. I don't know much about these yet, but from what you have told me you became quite withdrawn and quiet so as not to draw any negative attention to yourself. At times you tried to block out your feelings as a way of not feeling depressed.

Some of these behaviours and beliefs about yourself have remained. They made sense when you were a child but now they do not seem to be working in a positive way for you. It seems that you often feel low and angry and sometimes feel so overwhelmed that you want to harm yourself. Cognitive therapy might help you to deal with some of these problems. It works by helping you to become more aware of how you think and feel about yourself and other people and to assess if these old patterns of thinking and behaviour are still appropriate as an adult. Together we can assess if these old ways of thinking, feeling and behaving are the most effective ways for you to get what you want out of life. It also can help you change some of the ways in which you cope with other people. For example, it does not seem to help you to see your parents when you are feeling low, but it does help if you go into town shopping. When you are on your own you often dwell on the belief that you are "no good" and that you are all alone in the world and this seems to lead to you wanting to hurt yourself. Cognitive therapy is about doing what works best for you and learning new ways of behaving and thinking.

The therapist's provisional formulation of the patient's problems should be conveyed to the patient at an appropriate point in the first phase of treatment. The formulation should be presented as the way in which the therapist has made sense of what is happening in the patient's life, past and present.

Chapter 6

Identifying core beliefs

Cognitive techniques for other disorders focus on identifying and modifying automatic thoughts and dysfunctional conditional "if . . . then . . ." assumptions. These are modified in cognitive therapy for personality disorders as well, but the main focus of techniques is at the structural level of core beliefs. These are the unconditional beliefs about self and others.

Explaining core beliefs to patients

Greenberger and Padesky (1995) use a gardening metaphor to explain automatic thoughts, assumptions and core beliefs to patients. Automatic thoughts are likened to the weeds in a garden. Dysfunctional thought records and behavioural experiments are the tools that help an individual to cut down the weeds to ground level to make room for the flowers. However, some weeds are more persistent and keep popping up again, getting in the way of the flowers. These weeds need to be tackled at their roots, underground. These roots are like assumptions and core beliefs and need different techniques and methods to be dealt with effectively. They have taken longer to develop and are more firmly embedded.

Assumptions and core beliefs are not always obvious to us but can be inferred by our actions. Assumptions are sometimes thought of as "If . . . then . . ." statements and are less rigid and inflexible than core beliefs. For example, Susan held the following assumption: "If I am really nice to other people and do what they want, then they will like me". In therapy, she was able to modify her assumption through examining the advantages and disadvantages of trying to please others and by testing an alternative assumption behaviourally, such as asking friends to do something she wanted to do rather than always agreeing to do what they wanted.

Core beliefs are different from dysfunctional assumptions. They are formed in early childhood and are unconditional statements about self and others. They act like strict rules that are over-learned and over-obeyed and we cannot discern when the rule might be wrong. What we learn as children may not always apply to our lives as adults. Take Margaret, for example, whose

childhood was characterized by emotional and physical cruelty. She held a core belief that she was "bad" and deserved to be punished. As a child she made sense of being physically beaten and shouted at by her parents by assuming that she must have done something wrong. Her reasoning was that she must be a bad girl to deserve so much punishment. From her viewpoint as a young child, parents did not behave cruelly towards their children without good reason. It did not occur to her to question her parents' cruel behaviour towards her. As a result, her core belief that she was a bad person was strengthened and her behaviour changed, with her becoming increasingly lacking in confidence. She found it hard to try new activities or make friends, as others would also know she was bad. As an adult, she continued to believe she was "bad" and suffered from low esteem and episodes of depression and self-harm. She was also afraid of letting others close to her as they would find out how bad she really was; as a result, she was socially isolated. In addition, she had never tried to find work because she thought she would inevitably fail to do anything properly and be criticized and possibly dismissed. In therapy, this core belief had to be modified by strengthening a competing new belief that she was "okay" as a person and by keeping records of her behaviour that provided evidence in favour of this new belief. Changing a core belief takes more persistence than challenging automatic thoughts, as the old belief is often taken as being an absolute truth, and the associated behaviours that have developed to cope with the belief have been over-practised.

Table 6.1 gives some examples of possible core beliefs that are likely to be particularly associated with specific personality disorders. Individuals with personality disorders accept these core beliefs as *a priori* truths. As these beliefs have developed over a lifetime and are held rigidly, they are resistant to change (Young, 1990). The aim of cognitive therapy for personality disorders is to weaken maladaptive core beliefs and strengthen alternative, more adaptive beliefs.

Table 6.1 Examples of core beliefs associated with selected personality disorders

Personality disorder	*Core belief*
Borderline	I am worthless
Antisocial	I should get my own way
Narcissistic	I am a special person
Dependent	I need to have others look after me
Paranoid	I must be vigilant about others at all times

Identifying maladaptive core beliefs

In many ways, the main difficulty for the cognitive therapist is not in identifying core beliefs but in weakening the degree to which these beliefs are held and in strengthening new, alternative beliefs. Core beliefs are thought of as originating in early childhood and are unconditional statements about self and others.

"Follow the affect"

Core beliefs are associated with strong affective responses. Christine Padesky (1994) has suggested that "following the affect" can help the therapist to identify the content of a schema. She suggests useful questions such as "what does this say about you?" when a patient is upset about an external or internal event, asking "what does this say about other people?" if someone is distressed by the actions of others, and asking "what does this say about your life or how the world operates?"

As cognitive, affective and behavioural schemas are interconnected, modification of one schema will be likely to effect a change in others. In cognitive therapy for personality disorders, as the emphasis is on changing dysfunctional core beliefs and maladaptive coping styles, there will be modulation of the affective response that is associated with these schemas.

Methods of accessing core beliefs

Several methods can be used to access core beliefs. Figure 6.1 gives a list of these methods.

1. The meaning of events

In the course of therapy, patients report events, either past or present, that result in high levels of distress or intense emotional reactions. These reports come through verbal discourse about events and through written homework assignments. The therapist may also observe that the patient appears distressed or ill at ease during sessions. By asking about the meaning of events

1 Ascertaining the meaning of events that are causing high levels of distress
2 Events within the therapeutic relationship
3 Imagery techniques
4 Exploration of memories, childhood experiences, dreams and daydreams
5 Dysfunctional thought and core belief records
6 Behavioural problems/difficulties
7 Reading relevant books or literature, watching films
8 Self-rating questionnaires

Figure 6.1 Methods of accessing core beliefs.

that appear to be distressing to the patient, a therapist can gain access to themes directly related to core dysfunctional beliefs.

For example, Patricia had been describing her family life during childhood. She had described how her parents often fought with each other and how she was briefly taken into care at the age of 11 after her mother had died in an accident. Although it may seem obvious to anyone that these events would be distressing, the meaning of the events for the patient needs to be established.

T: Which part of your childhood do you think was the worst? (*Direct question*)
P: It was all pretty bad but the bit where my mother left me and my granny told the social services that she couldn't look after me and they put me in a home . . . (*i.e. children's home*)
T: Do you remember how you felt then?
P: I just remember being very upset and confused.
T: What did it say about you when your mother left you and your granny said she could not look after you?
P: Nobody wanted me. I was a "nobody" that everyone wanted to be rid of.
T: Is this still how you feel – unwanted by everyone? (*Inductive question*)
P: Yes. (*Looks away, tearful*)
T: I can see that this must be a very distressing thought. (*Therapist validates the patient's feelings*) I wonder what it is about being unwanted by everyone that *you* find so terrible?
P: I don't exist – I'm nothing. I must be, because everyone just left me – as if I didn't exist.
T: That seems to be two strong beliefs – that you are unwanted and that you don't exist, or are of no importance, to others.
P: (*Looks at therapist and nods head*)
T: (*Therapist tries to link beliefs with past events and current behaviour*) I remember that you told me something like this when you want to cut yourself? (*Patient nods*) Are there other times that you can identify thinking like this?
P: I have always thought that no one wants me. If anyone ignores me, I feel like I don't exist. I'm not important to anyone and no one cares about me. That's the way I think.

2. *Events within the therapeutic relationship*

Patients with personality disorders have problems in relationships with other people that may also occur within the therapeutic relationship. The relationship with the therapist could be regarded as a microcosm of all relationships, within which difficulties can be safely assessed and resolutions attempted. This relationship is one possible relationship in which an individual can test

whether their assumptions about others are true or not and learn about the impact of their behaviour on others. Unlike other relationships, where a patient may have been neglected or abused, this relationship is built on trust and respect and may be a relatively safe relationship in which to assess some assumptions.

Mood changes within the session and physical or verbal reactions to what the therapist does or says are cues to the patient's maladaptive core beliefs. The therapist can encourage the patient to test the reality of their beliefs directly in the patient–therapist laboratory. A young male patient (with a dependent personality disorder and depressive disorder) attempted to delay the departure of the therapist on holiday by refusing to exit her office at the end of a treatment session. He began to cry and stamp his feet in anger. She initially acknowledged that he was distressed but did not draw attention to his angry behaviour (as this was regarded as probably being secondary to the activation of his primary core belief that the therapist was abandoning him). She asked what it meant to him that the session had come to an end and she was going on holiday. He said that she must not like him and that she was leaving him at a crucial stage in treatment because he was so awful and she did not care what happened to him. His core belief was that he was unworthy, unlovable and helpless. It had previously been noted that he was afraid that others would abandon him, particularly when he was in great need.

3. Imagery techniques

From a patient's account of his or her life history and specific memories, a therapist will have some idea about the nature and content of the patient's core beliefs. By choosing an incident that appears to be significant, a therapist can help the patient to increase the vividness of recall by using imagery, and by doing so may trigger a core schema and access the core belief. This technique is most often used to help change traumatic events by then getting the patient to imagine a dialogue with the person who has distressed or abused them in some way, so that they can experience being empowered to have their childhood needs met (Young *et al.*, 2003). The therapist asks the patient to close their eyes and report the scene in detail: where the incident is taking place, who, if anyone, is there, and what is happening. It is more powerful to have the incident described in the present tense and using the first person. For example, "I'm in the bathroom. I'm bleeding . . ." Also it is important that a patient experiences some of the strong emotion that is connected with the incident. Encouraging the patient to recall the incident by trying to feel their way into the scene and increasing the level of descriptive information can be helpful. If a patient is describing a scene that took place in their bedroom as a child, some questions to increase the vividness of the scene are useful, such as "Can you describe the scene to me? What colour is

your bedroom? Is there anyone in the room with you? What time of day is it? How old are you?" Asking patients how they are feeling as they describe the incident helps them to recall the associated feelings and to recall the incident with greater accuracy and vividness. Once it has been recalled vividly, a therapist can ascertain the meaning of reported event.

Some patients may try to distance themselves from upsetting events in order to avoid experiencing distress (schema avoidance). They will describe the incident in an overly general and superficial manner. Or they may not be able to bring any image to mind. At these times, it may be necessary to try another path to access the patient's beliefs or to revert to a safer topic as the patient may have insufficient trust in the therapist and the relationship needs to be strengthened further. If imagery is used too early in therapy, patients may be afraid of gaining access to highly distressing material and decompensating. A fuller explanation of imagery as an experiential technique can help encourage patients to try using imagery. Reassuring a patient that the imagery experience will be contained within the session and that there will be time at the end of the session to reduce any associated distress is important. Once the exercise is over, chatting to a patient about ordinary everyday things of life is often necessary at the end of a session so that the patient leaves feeling back in the here and now, and levels of distress are contained and back to normal.

4. Exploration of memories, childhood experiences, dreams and daydreams

As schemas are formed in early childhood, focusing on the patient's childhood experiences will help to identify dysfunctional core beliefs. Asking the patient to highlight the happiest and the most upsetting memories of childhood focuses the therapist and patient to select relevant meaningful events. Memories, which are connected with high emotional tone from any stage of development, are likely to be useful in identifying core beliefs. Ask the patient to identify these memories and discuss them within sessions.

Daydreams can be regarded as "what if?" fantasies. Asking the patient to actively daydream and report how they would wish their world and important relationships to be can help to point to underlying core beliefs. For example, a patient with an antisocial personality disorder fantasized that others would ask him for advice and that he would be able to have power and influence over the lives of others. When asked if this was how he usually thought, he reported that he was certain he was superior to others in many aspects but when asked about how he thought others saw him, he acknowledged he had difficulty getting others to recognize his superiority. At work, he had frequent disagreements with other men about work practices and about current affairs. He regarded his workmates as stupid and openly dismissed their opinions, alienating himself from them.

5. Dysfunctional thoughts and core belief records

The records of automatic thoughts commonly used in the treatment of Axis I disorders can also be useful in a modified form in the treatment of personality disorders. The forms can be used to record examples in the patient's current life when a schema is active. For example, one patient kept a record of the type of situation in which she felt that other people were rejecting or humiliating her (see Figure 6.2). This allowed the patient and therapist to assess the impact of her core belief and was helpful in convincing the patient that her belief operated in a variety of settings and that it might not have always been adaptive.

6. Behavioural problems or difficulties

Behavioural problems, often in the form of difficulties with other people, are a hallmark of personality disorders. Specific avoidance of certain behaviours also may point to underlying core beliefs. Some case examples are described below.

GRAHAM

Graham is a 22-year-old man (avoidant personality disorder) who was referred for treatment by his general practitioner for treatment of his anxiety symptoms. The referral letter contained very little information other than that he had reported feeling very anxious in social situations and this was having an impact in his finding a job, although he had reasonable passes in school qualifications. Part of the initial assessment of Graham's problems involved obtaining information about his pattern of relating to other people.

State belief: Other people will try to humiliate and ridicule me

Degree to which you believe this to be true: 99%

Situation	*Degree to which belief is accurate*	*How did you react?*
Woman at bus stop pushed in front of me.	95%	I pushed her back.
The gas meter reader did not turn up to read my meter.	90%	I phoned the company and got angry. They put the phone down on me.
My sister told me I was getting fatter.	100%	I did not speak to her, then I told her she was not so wonderful herself.

Figure 6.2 Record to identify the impact of my core belief.

Graham was initially reluctant to provide much information on this topic. He sat, twisted round in the chair looking out the window, or would hold a tissue to his nose for long spells, making communication difficult and awkward. He stated that he had not had the opportunity to develop friendships but could not explain why this was. After several sessions in which the therapist had been non-confrontational but interested in finding out more about his problems, he began to give the therapist more information about his problems with others. He described patterns of behaviour that suggested he was very guarded and tended not to get involved with other people. He had no friends and spent his time alone. He was afraid of applying for jobs or courses for two main reasons: he might be turned down and, if he did get an interview or a job, he could not face being with other people in a situation where his performance would be scrutinized. He described childhood behavioural problems such as refusing to play with others, avoiding sports at school and having been bullied at one of the primary schools he attended. His parents had been strict with him as a child and had not allowed him to play with children who lived around his home as they had regarded these children as being too rough. Although his parents had never explicitly said as much, Graham had always had the impression that he was not the clever and talented son that they had wished for and was really not good enough. They had been lukewarm about his school performance unless he had been in the top 10 per cent of the class. His lack of sportsmanship had been a source of disappointment to his father, who was a keen golfer. As an adolescent, he had been terrified of speaking to girls and remembered being teased by girls at his school when he had no one to sit beside in science classes. He had been very afraid of blushing or stammering if asked a question by a teacher, and had skipped classes without being caught.

From Graham's account of some of his childhood and adolescent experiences, it appeared he was afraid of showing signs of anxiety or social discomfort to others. His initial reluctance to speak to the therapist and to apply for courses or work suggested that he was overly concerned with his performance, sensitive to signs of disapproval from others and could be easily hurt. Although there was evidence that he was at least of above average intelligence, he had underachieved both at school through avoidance of classes, and as an adult through not applying for further education courses or appropriate work. His past and present behaviour suggested an avoidant personality disorder. He held two core beliefs: "other people will think I'm peculiar" and "I'm no good".

CAROL

Carol, a 28-year-old woman who had a diagnosis of borderline personality disorder, was referred for therapy after an overdose. She had a history of deliberate self-harm, both overdoses and cutting. She also reported several

other problematic behaviours such as overeating when she was alone, taking on too much responsibility for others then being unable to meet her commitments and difficulty establishing regular sleeping habits. These behaviours were each discussed in therapy. From her account, it appeared that she overate to avoid negative feelings and thoughts about herself such as "I am ugly" and "nobody likes me". By stuffing herself with food, she became less aware of her thoughts and surroundings and more focused on eating, thus at least temporarily blocking out her negative feelings and negative view of herself. It was obvious that this was not an adaptive behaviour, as she would eventually become very distressed by bingeing and believed that she was disgusting and would never be liked or accepted by others. Her self-harm behaviour was similar in that it initially blocked out her negative feelings and view of herself, but only temporarily. Taking on too much responsibility for others appeared to be directly related to her desire for others to like her, although she was ambivalent about getting too close to others as they might reject her when they realized that she was "no good". She believed that others would like her if she did things for them. As it was often at her own expense in terms of energy and time, this strategy often backfired and she was unable to keep her promises of help, thus confirming her beliefs that she was "no good" and others would not like her.

7. *Literature and films*

One patient became so distressed describing her childhood experiences that she suggested to the therapist that she watch a film that she had found deeply upsetting. This allowed the therapist to make links between the female character in the film and the patient's childhood. Later, the patient was able to experience some of the anger and sadness she had felt at school and at home but without becoming overwhelmed and thinking that she was unable to cope. Various beliefs were uncovered concerned with her view that she did not deserve happiness of any sort and that vanity in any form was an unforgivable sin.

A male patient who had been sexually abused in childhood said he tried to avoid thinking and talking about what the experience meant to him but could not stop being upset about it. His therapist asked if he would be willing to watch a documentary about sexual abuse with the therapist and discuss it afterwards. The very suggestion of doing such a thing increased anxiety in the patient and when asked about this, he told his therapist that he thought she would regard him as weak and disgusting and he would feel so ashamed that he would not be able to cope (his dominant belief).

8. Self-rating questionnaires

THE DYSFUNCTIONAL ATTITUDE SCALE (WEISSMAN AND BECK, 1978)

The Dysfunctional Attitude Scale (DAS) is a self-report inventory of basic attitudes or beliefs, derived from Beck's (1967) cognitive theory of depression, which are assumed to underlie depressive thinking. The scale contains items that relate to "if . . . then . . ." assumptions that were collected from patients without personality disorder undergoing treatment. This scale can aid the therapist in determining dominant themes, which may then be related to core beliefs such as achievement, love, approval, perfectionism and autonomy.

SCHEMA QUESTIONNAIRE (YOUNG AND BROWN, 1990)

This self-completion questionnaire contains items that relate to 16 schemas or themes that are thought to be relevant to personality disorder. These themes are emotional deprivation; abandonment; mistrust and abuse; social isolation; defectiveness and shame; social undesirability; failure to achieve; functional dependence and incompetence; vulnerability to harm and illness; enmeshment; subjugation; self-sacrifice; emotional inhibition; unrelenting standards; entitlement; insufficient self-control and self-discipline.

These questionnaires are a useful starting point if patients and therapists are having difficulty in assessing schemas. In addition, if used in the assessment phase of treatment, they may provide therapists with a means of evaluating the degree of change in beliefs as therapy progresses.

Chapter 7

Changing core beliefs

In cognitive therapy for personality disorders, the emphasis is on developing new, more adaptive beliefs rather than trying to modify old, existing core beliefs. The rationale is that pre-existing core beliefs are rigid and inflexible and in this model of personality disorder they have a pervasive impact on maladaptive behaviours. Attempting to modify these core beliefs through standard cognitive techniques is likely to fail as they have formed in childhood as a result of adverse events and dysfunctional relationships, and from the child's perspective, these beliefs will have made sense of their experience. The overdeveloped behaviours that are an attempt to cope with childhood experiences are maladaptive in adulthood and are as ingrained as the core beliefs that go along with them. If the therapist is to help the patient acquire more adaptive and optimal coping skills in adulthood, new patterns of behaviour and thinking have to be developed. These behavioural patterns are the reciprocal of what has been learnt in childhood, the underdeveloped behavioural strategies, and it is necessary to learn new ways of thinking about self and others that would support and maintain these new behaviours.

Cognitive therapists can utilize schema change techniques from standard cognitive therapy to modify dysfunctional assumptions with personality disorders (see Blackburn and Davidson, 1995), but these techniques may not be as effective with core beliefs, which are more rigid and inflexible and believed absolutely. Changing core beliefs in those with personality disorder requires persistence, and several different techniques may be required to change the same belief. Our clinical experience also suggests, as stated above, that core beliefs will be related to maladaptive behavioural strategies that have to change in conjunction with strengthening new, alternative beliefs.

Methods of changing core beliefs

Christine Padesky (1994) has described the first three of the following change strategies that can be used in therapy (see Figure 7.1). The fourth strategy is used for core beliefs that impinge on interpersonal relationships.

1 Continuum
2 Historical test of schemas
3 Notebook to strengthen new beliefs
   - Behavioural tests (new ways of behaving – decreases maintenance of schemas)
   - New ways of thinking (learning not to discount evidence in support of new schema or contradictory to old schema)
4 Involving significant others

Figure 7.1 Methods of changing core beliefs.

1. Continuum

Patients with personality disorders tend to accept their core beliefs as accurate representations of self and others. Having never questioned or challenged these beliefs, they often state that they believe a core belief to be absolutely true. In other words, they simply accept that the belief is correct. Through schema maintenance, avoidance and compensation processes (Young, 1990), evidence against the schema will have been ignored or distorted to fit the schema in order for the schema to persist. By using guided discovery and questioning the evidence for a core belief, a patient may become less rigid in the degree to which they endorse a specific belief and, importantly, become more aware that the belief is no longer useful and may, in fact, be self-defeating by leading to an exacerbation of current difficulties.

The therapist can aid the development of alternative beliefs by utilizing various continuum strategies.

Uni-directional continuum

Paula believed that she was "a total failure". It was evident from Paula's description of herself that she believed this absolutely and she was able to list many examples of her failure and worthlessness: she had never done well at school and had failed exams; although she made friends with girls her own age with relative ease, she had always fallen out with them and therefore not sustained relationships; she had been in employment twice since leaving school but both jobs had come to an end, in one case when she resigned and in the other because she had failed to turn up on several occasions without giving any excuse. She was currently unemployed.

The therapist decided to use a continuum that ranged from 0 to 100 per cent using alternative beliefs, i.e. "I am okay as a person" and "I can manage to cope with my life" (see Figure 7.2). These alternative beliefs were chosen after discussing with Paula what she regarded as acceptable and possible in terms of more adaptive beliefs. She was asked to place herself on each of these continua and rated herself 10 per cent on the first and 0 per cent on the second. Through earlier questioning of her belief that she was a failure, she

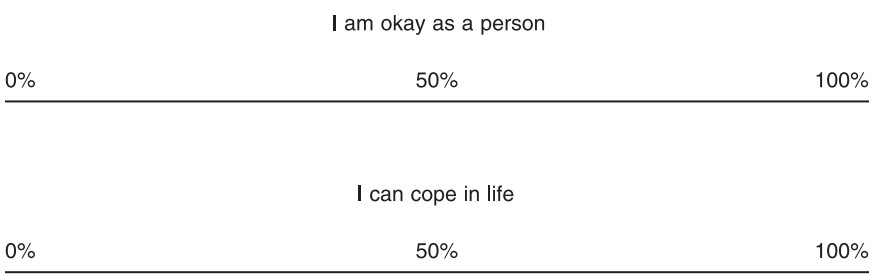

Figure 7.2 Example of uni-directional continuum.

had become aware that she had some evidence that she was an acceptable, "okay" person. For example, two days before coming to a therapy session she had helped a neighbour to cope with a newly born baby who was crying all the time. Paula had looked after her own siblings when they were young and had experience of dealing with babies and small children. However, she had difficulty maintaining this stance as she would either ignore the evidence or tell the therapist that she had not described all the details, and if the therapist knew all the details of her failures, she too would agree that Paula was a total failure.

Educating Paula on how schemas and core beliefs functioned was helpful in that she became more adept at recognizing how she dismissed or ignored evidence that would have strengthened the new alternative core views of herself as being "okay" as a person and able to cope in life. Developing specific criteria by which Paula could assess her new beliefs was essential, as she had difficulty with abstract concepts and would judge herself in very global, black and white terms. A key step in this process was getting her to list how she judged other people. They were usually regarded as being happy and much more able to cope and make a success of their lives, and she seldom thought about other people having to cope with problems.

These continua were used in every session of therapy and any examples of her being "okay" or "coping" from the days between sessions were recorded and kept in her personal file, which she brought to therapy sessions. Those shown in Figure 7.3 were gathered over several sessions. Eventually Paula became more able to recognize events, behaviours or thinking that fitted her new beliefs and was able to record these in her personal file during the intervals between sessions.

Throughout therapy the continuum can be used to measure progress in treatment. For example, after several behavioural experiments where a patient deliberately did not seek extra help or reassurance from her friends and relatives, she rated her alternative belief, "I can survive without the help of others", as 40 per cent as opposed to 0 per cent at the beginning of treatment.

Criteria for being okay as a person

- Other people ask for my help and they say I am good to them.
- I don't have to agree with everyone. My opinions are valid.
- Everyone has intrinsic worth.
- I can enjoy myself sometimes and can be sad sometimes and both are normal.

Criteria for coping with my life

- I get up every morning and take care of myself.
- If I don't get a job, it does not mean that I am a failure and will never get one.
- I have decorated the bedroom in my flat, which shows that I have practical skills and can finish projects.
- Talking and spending time with people I like (neighbour, neighbour's children, June and Robert, my aunt Annie).
- Going to therapy to learn how to help myself.
- When I get upset, I don't always cut myself.

Figure 7.3 Paula's criteria for being okay as a person and for coping with her life.

I am helpless	
0%	100%
I never ask for advice	I always need others to help me make decisions
I always travel on my own	I always have to travel with someone else
I always spend time on my own	I always want others around me

Figure 7.4 Keith's belief and criterion continuum.

As many patients have idiosyncratic beliefs, the meaning of these may not be transparent. For example, Keith, the dependent young man mentioned in the previous chapter, held the belief that he was helpless. In order to clarify what he meant by this belief, criteria were developed. He was then able to reassess and evaluate the degree to which he had been helpless in the past and present. His criterion continuum is set out in Figure 7.4. By polarizing, or making extreme, his statements, both ends of the continuum were clearly not realistic or particularly adaptive. He was able to reevaluate his more independent behaviour and his belief in his helplessness as being somewhere between 40 and 50 per cent.

Two-dimensional continuum

A patient held two interrelated beliefs about achievement and pleasure. He had always worked exceptionally hard in his occupation and had achieved a great deal but increasingly over the years he had derived little pleasure from work. One of the main reasons for this lack of pleasure was that he believed he had to achieve in order to have any sense of self-worth. He had not paid attention to other aspects of his life and had devalued anything that was not work related. Unfortunately, the company he worked for had financial problems and his job had been downgraded. He had taken this personally, believing he was a failure, and as a consequence had become depressed. He perceived achievement and pleasure as dimensions of his life that were unrelated and, in many ways, almost diametrically opposed to one another. By using a two-dimensional continuum, the therapist was able to break down this belief (see Figure 7.5). He was able to place work, other activities and even relationships with his parents and children on these two dimensions and realized that they were not always opposed. For example, he believed that he had a reasonably good relationship with his children, which he had

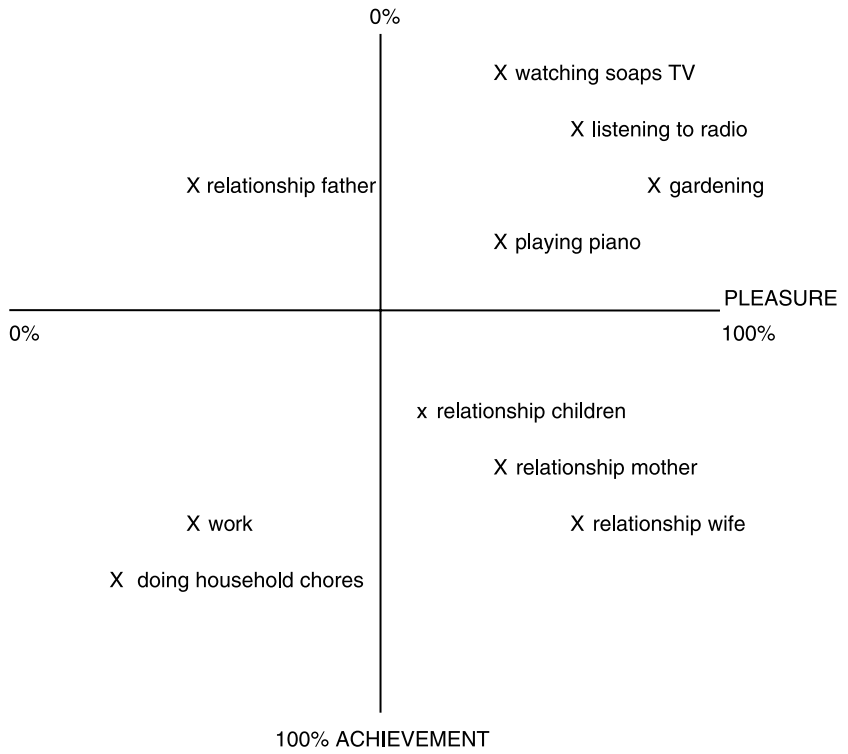

Figure 7.5 Example of two-dimensional continuum.

been instrumental in developing and which was a source of pleasure to him. As therapy progressed, he was able to add other sources of pleasure that were not achievement oriented, such as gardening and playing the piano.

2. *Historical test of schemas*

As it is assumed that core beliefs develop in childhood and are maintained and reinforced throughout a lifetime, a review of a patient's life history can be carried out to test out the validity of a belief. Padesky (1994) recommends that the patient and therapist make two lists of evidence, one list supporting the belief and another disconfirming the belief. Suitable developmental time periods are selected such as infancy, early childhood (ages 2 to 4) and early school age (5–10). The selected lifetime periods will depend on the experiences of an individual and may relate to relatively abrupt lifestyle changes such as changes in schooling, the loss of a parent or other salient events. One of the aims of the historical test of schemas is for patients to become more aware of the positive and negative experiences they have had over their lifetime and to develop a sense of compassion towards themselves as they become aware of their earlier childhood traumatic experiences and the influence these had on their sense of self and developmental trajectory. An example of a historical schema is shown in Figure 7.6.

Some patients are able to give only sparse details about their early years. One patient, John, had the core belief "I am different" and had severe interpersonal problems. He had no information about his first four years and had nobody close to him that he could ask, as his parents were both dead, he had no siblings and he was not close to his other relatives. The exercise was nonetheless useful as he realized how unusual his early life had been and

Evidence that supports the old belief: Other people think I am strange

- My family lived a very different lifestyle from other families around us.
- My mother had breast cancer and died when I was eight.
- My father was a bit weird after my mother died.
- Both my parents were members of an unusual religious sect.
- Both sets of grandparents disapproved of my parents' religion.

Evidence that supports a new belief: Being different from others does not mean I am strange or weird

- There were other children at school who lost a parent through death.
- I played football with other boys.
- I was always picked for the school choir because I could sing well.
- Other kids at school had different religions too and I did not think they were strange.
- I could not do anything about my Mum dying and my Dad being depressed and they could not do anything about this either. It was not their fault that they both died when I was young.

Figure 7.6 Example of historical test of schema (age 8 to 12 years).

began to understand why he had such difficulties relating to other people and to his own two sons.

John's core belief was that other people thought he was strange and different. This had led to him having problems relating to others, who he thought did not understand him.

John's historical test of schemas took many weeks to complete. Some of the historical test was completed as homework assignments and some was completed during sessions when evidence became available through discussion of the past or present. At various times during the exercise, John was asked what he thought the evidence implied about his belief that other people thought he was weird. Although he had initially been convinced that his belief was correct, later in therapy he changed his degree of certainty about this belief. Instead, he saw that some people had been kind and generous to him in the past even though they knew his family might have had different views on religion than his own. Others had been accepting of his family's religious beliefs and had not made this a divisive issue in any way. He also realized that he had been deprived of loving and caring parents through their deaths and that he had a right to be upset about this. His father had died, following a stroke, when John was 12. He had been a reserved, serious man who looked after his wife diligently and without fuss. John became aware that his father had little time to spend with him as his mother had been ill. He had nonetheless cared for John in a practical way, ensuring that his physical needs were met though he might not have been demonstrably affectionate and able to meet his young son's emotional needs. John gathered information about his mother and discovered that she had been seriously ill with cancer for most of his childhood and had undergone repeated treatment with chemotherapy and operations. He stated on several occasions that she had been very brave and stoical about her illness and he had the impression that she had always tried to do the best thing for him. As therapy went on, he remembered how some women in the village where he lived would come to the house to help his mother when she must have been ill. He surmised that, unlike his grandparents, they had been accepting of his family's religious beliefs and had not made an issue of these. Whether this was true or not, he at least developed some flexibility in his belief that others saw him as weird. He stopped ignoring and distorting evidence that suggested that other people might be acting in a neutral manner or even a positive manner towards him.

3. Notebook to strengthen new schema: behavioural tests and new ways of thinking

Another powerful method of changing beliefs is keeping a positive data log (Padesky, 1994). Essentially, this involves the patient keeping a data record of all experiences and thoughts that would support a new adaptive belief. The main change technique here is getting the patient to challenge the core belief

by learning not to distort or ignore information that would fit with the new, more adaptive, belief. Sylvia had a core belief that she was stupid. She could list numerous examples of her stupidity and no evidence that suggested she was as intelligent as most people. For example, when she re-calculated a gas bill and telephoned the company pointing out their mistake, she was asked by the therapist if this was an example of her behaving "intelligently". Paula told the therapist that anyone could have done what she did. Paula ignored or distorted evidence that suggested she behaved intelligently. Even when she conceded having behaved intelligently, she thought that either exceptional circumstances were involved or it was just a one-off case.

Like Paula, patients have to learn not to ignore, discount or distort evidence that is supportive of a new, more adaptive, belief. At first, it is as if the patient has to learn where to place this information as the new belief is only held intellectually and there are few corresponding emotional or behavioural links with this belief. The therapist has to help the patient grasp and hold on to evidence that would strengthen the new belief. Having a notebook to record evidence that fits the new alternative and adaptive belief is essential in recognizing new ways of coping. Sometimes it is easier for a therapist to record this at first and then, after a few sessions, hand the notebook over to the patient to record examples during the days between sessions.

The notebook is useful for recording examples of new ways of behaving as well as new ways of thinking about self and others. It is important that the therapist keep attending to what is recorded in the notebook so that these new beliefs and new ways of behaving are reinforced. The notebook literally provides a store for evidence that fits a new belief where previously the patient had no schema for this information (see Figure 7.7 for an example from Paula's notebook).

4. Involving significant others

The patient's immediate environment is often a major factor in maintaining schemas or core beliefs. It is possible that partners or family unwittingly

Old belief: I am stupid
New belief: I am as intelligent as most people

Monday:	Read the newspaper in the library. Discussed news with neighbour when I got home from library.
Tuesday:	Man came to door selling house stuff – told him I did not need anything and he went away.
Wednesday:	
Thursday:	Susan, another neighbour, asked me over for coffee with her friends. Did not know anyone there but managed to join in the conversation. Thought afterwards that I can make myself understood and can enjoy being with people I do not know.

Figure 7.7 Example from Paula's notebook to strengthen new belief.

reinforce a patient's core belief about themselves or others. Sometimes an individual will inadvertently "choose" relationships that are unhelpful and these relationships then confirm the patient's negative self-concept, especially when they are ultimately detrimental. Working with significant others is not always a possibility, as such individuals have to be committed to enhancing their relationship with the patient. Often relationships have reached a point where there is little chance of repair; indeed, it is sometimes more helpful to help the patient get out of a destructive relationship than to stay in it, especially if the relationship reinforces the patient's dysfunctional beliefs about themselves.

During assessment and treatment, therapists will form an opinion about which relationships serve to maintain a patient's negative view of self, and whether those involved could be part of the patient's therapy. Creating an opportunity to work with a significant other to change the patient's negative self-view is important in developing a new, alternative view of self. A therapist may have to work hard with the significant other as that individual may have also developed a rather rigid view of the patient. One way of producing a change in the relationship is to ensure that both individuals benefit from any changes that may take place and that the relationship works better and is more effective than it was before.

One patient with borderline personality disorder (Carol) became dependent on her "foster" sister Mary, whom she idealized. Carol believed that she could not cope without Mary's help. Carol had difficulty recognizing that Mary had her own life to lead and would phone Mary at any hour of the day or night. Apparently Mary never complained about this. Mary unwittingly reinforced Carol's idea that she was helpless and could not cope with a crisis, regardless of how small this might be.

A meeting with Mary revealed that she was glad to help Carol as she found this satisfied her need to be useful to others. The therapist fed back that their relationship with each other was mutually satisfying, then enquired if there were also some drawbacks. Both women were initially rather resistant to the idea that there might have been disadvantages in the way they related to one another. However, when the therapist then gave several examples from the experience of other couples, both were able to list some disadvantages. Mary in particular was relieved to be able to discuss her relationship with Carol, as she had been finding herself stressed by Carol's phone calls and demands for help. Carol said that she never learnt to cope on her own and that she knew that Mary could not always be available for her. Mary was relieved that she did not have to go on attending to Carol's every need, and was able to state that she would be able to use her energies more effectively to help Carol if she was clear that it was a real crisis, and would support her endeavours to become more independent.

Chapter 8

Typical behavioural problems: antisocial personality disorder

This chapter concentrates on some of the typical behavioural problems presented by patients with antisocial personality disorder. Some of these problems – for example, alcohol abuse – may be common to more than one type of personality disorder.

In cognitive therapy, treatment is guided by the therapist's formulation of a patient's problems but at the beginning of therapy, a therapist draws up a list of the most important current behavioural problems with the patient and these will usually be the focus of treatment. In antisocial personality disorder, these problems are very obvious and are usually the reason for a referral for cognitive therapy. Those with antisocial personality disorder often come to therapy only when their habitual ways of coping have stopped working and relationships have broken down, or they have got into trouble with the law or are likely to hurt someone.

Treatment focus on overdeveloped behavioural strategies

Although a therapist will focus on current problems, in personality disorders longstanding overdeveloped behavioural strategies need to change, and these in turn will be related to underlying dysfunctional core beliefs. If a patient had an aggressive overdeveloped behavioural strategy that caused, for example, harm to others, the therapist would give this a high priority in therapy by targeting it first. This problem is also highly likely to be a major source of current problems with others or the law. The cognitive formulation should clarify how this behaviour has become overdeveloped and how it relates to the patient's beliefs about self and others. The types of behavioural problems that reflect long-term maladaptive behavioural strategies do require systematic assessment. Changes to behaviour involve developing behavioral strategies that are underdeveloped, and this has to be carried out in conjunction with changes in related core beliefs. The patient's old style of thinking and behaving has to be weakened and replaced by new, more adaptive ways of

thinking about self and others, which are developed in parallel with new more effective ways of behaving.

Cognitive therapy for antisocial personality disorder aims to improve social functioning, social problem-solving, and the ability to function in a more morally aware manner by changing the way in which an individual construes himself in relation to others (Beck *et al.*, 1990). Patients with this disorder are regarded as having a developmental delay in moral maturity and cognitive functioning. Patients with antisocial personality disorder are often found to have intellectual difficulties that have been described, using Piagetian concepts, as a tendency to operate at a concrete rather than an abstract level of intellectual functioning. As a result, they will have difficulty taking the perspective of another. They will tend to react to situations in immediate terms without first considering the possible longer-term consequences of their actions. In general, patients with antisocial personality disorder will lack problem-solving skills as these skills require an ability to reflect on and identify problems and their consequences and to generate potential solutions to problems.

Grading the treatment tasks to the patient's level of understanding

Treatment goals have to be graded in complexity and sophistication according to the cognitive level at which an individual is functioning (Beck *et al.*, 1990). If the treatment goal is overly complex and the patient has difficulty understanding how the goal is relevant to his problems, he will lose interest quickly and fail to comply with therapy. At the most basic level, patients will be solely concerned with self-interest and will be unable to consider the consequences of their actions beyond immediate rewards. The task in therapy is to attempt to increase the patient's ability to consider his actions and to consider the longer-term advantages and disadvantages of behaving in a manner that may be counterproductive. A therapist has to try to engage the patient by helping him do what works best to improve his quality of life and ability to cope with other people, and to stay out of trouble with the law. Any move towards the patient considering the "possible" in preference to reacting impulsively to what is happening in the immediate environment can be praised.

The therapist has to attempt to understand the patient's view of themselves and how the patient relates to other people. The beliefs that underlie such behaviour and cognitive functioning will tend to be rigid and simplistic. Patients with antisocial personality disorder often believe that they can do exactly what they feel like doing, regardless of others, and that other people are there to be used and exploited by them. Any change in attitude away from this view or change in behaviour that demonstrates that the individual has considered his actions and the implications such actions may have for him and others has to be reinforced by the therapist.

Once a patient has begun to be able to consider the longer-term consequences of his behaviour, a therapist can attempt to move to a more advanced level of cognitive functioning. At this level, patients will be able to consider a range of possible ways that their behaviour might be different. This requires taking a step back and being able to see what effect this behaviour has on one's relationships and overall quality of life. The patient's beliefs about others and self can be explored further at this stage. The idea that the patient may not always be right and that other people may be affected by his behaviour may be introduced at this stage. Beliefs such as "I do what I like because it feels right" and "other people should see things my way" are examined in terms of how useful they are and if they help improve the patient's quality of life.

Behaviours that cause harm to self and others are given the highest priority in treatment. Interviewing a patient's close family member or partner provides useful information on problem behaviours as well as potentially underlining to the patient that others are affected by his or her behaviour. Although the therapist may be concerned about the effect of the patient's behaviour on others, the focus continues to be centred on the patient's behaviour and needs. The therapy attempts to alter the patient's dysfunctional behaviour and thinking. Table 8.1 gives some examples of problems that are responsive to behavioural techniques.

Table 8.1 Examples of targets of behavioural techniques

Problem	*Technique*
Alcohol abuse	• Self-monitoring (e.g. weekly diary) • Pros and cons of drinking • Stimulus control • Finding alternatives to alcohol
Anger	• Feelings vs. actions • Self-monitoring (e.g. frequency count) • Pros and cons of behaving aggressively • Stimulus control • Assertiveness training • Social skills training
Relationships	• Behavioural contracting • Increasing positive behaviours
Poor literacy skills	• Attend adult literacy classes
Poor work record	• Graded assignments • Scheduling work finding

Behavioural techniques

Many of the techniques listed below will be familiar and are standard behavioural change tools in a therapist's repertoire. These techniques are used throughout treatment alongside cognitive techniques. Carrying out a functional analysis of behavioural problems is an essential first step in being able to attempt a solution. This will provide information on the antecedents, behaviour, and consequences of behaviour. Once a clear picture has emerged of the behaviour, potential solutions can be generated by both therapist and patient.

Useful tools to assess progress in therapy

Self-monitoring

Patients with antisocial personality disorder are usually deficient in self-monitoring skills. Through training in such skills, patients can learn to be more careful observers of their own behaviour and this enhances their ability to stand back and observe themselves as opposed to being egocentrically focused. Training in this skill can be therapeutic in itself as it can have an indirect effect on the behaviour being monitored. Methods used in self-monitoring and examples of target behaviours are listed in Table 8.2.

Structuring activity using a weekly activity schedule

The therapist can use several methods to obtain information about specific behaviours but there is also a need to grasp how patients spend their time and to get a bird's eye view of their regular routine. A weekly activity schedule will provide information on all activities and can be useful for building up a picture of the patient's daily life. We have found by asking patients to complete a weekly activity schedule that antisocial personality disordered patients sometimes have very few activities in their daily lives. One patient seldom left home as he was avoiding a gang who had threatened to harm him. His daily activity consisted of watching films on television that

Table 8.2 Example: self-monitoring methods

Self-monitoring method	*Examples of targets*
Diary keeping	Positive behaviours; alcohol consumption
Activity schedules	Daily activities; recording work
Frequency counts	Feeling angry
Time sampling behaviours	Speak to children; speak (pleasantly) to wife

he had recorded, and cooking meals for himself. He seldom got out of bed before noon and went to bed long after midnight. Keeping a record of his activity made him more aware that he was very bored and both he and his therapist thought that he would be unable to sustain this lifestyle without becoming frustrated and possibly acting impulsively, thereby getting into further trouble. This gave the therapist an opportunity to discuss how he could improve his adopted lifestyle while remaining away from the gang threatening him.

Keeping a diary of specific behaviours can be used for behaviours that may be less frequent, such as shouting at other people in anger and throwing objects at things or people. Or it can be used positively to concentrate on more adaptive behaviours, acts that show more consideration of others such as talking about a problem without shouting, walking away from a potentially explosive situation, listening to another person's viewpoint without challenging them. Frequency counts are useful for recording high-frequency events such as feeling angry. Time sampling can also be used for such high-frequency behaviours or events.

Not all patients with antisocial personality disorder will comply with assignments that involve writing, as many have had humiliating experiences at school and have truanted from school, resulting in little formal education. If a patient has these difficulties, the task can be simplified to suit the patient or, alternatively, the therapist can gather sufficient data within sessions to form a reasonable picture of the patient's behaviour.

Specific problems

Alcohol abuse

Alcohol abuse and its consequences often constitute a major problem for this group of patients. Abstinence from alcohol may be an appropriate goal of treatment if an individual is dependent on alcohol or if the consequences of his or her alcohol consumption are serious, and usually cognitive therapy cannot proceed until the patient's dependence is reduced. However, many patients with antisocial personality disorder do not regard their consumption of alcohol as problematic even though they could be classified as abusing alcohol. Most regard their consumption of alcohol as being within the range that is normal in their social networks. Drinking patterns may vary and binge drinking may be common. For example, one patient who rarely drank alcohol nevertheless encountered problems of such severity that abstinence was recommended. On consuming alcohol, he usually drank more than he had intended to, and on more than three occasions in his recent past history had become involved in serious physical fights that had led to several charges of assault. For him, although consuming alcohol was a low-frequency event, his drinking was a high-risk activity as it often led to acts of aggression.

Even when alcohol dependence is not present, excessive alcohol consumption may bring about problems in several areas of an individual's life including mental and physical health, relationships, work and the law. Patients may not recognize the role played by alcohol in generating or maintaining problems in several areas of their lives. They may even deny that alcohol consumption and its consequences could be a problem for them. A careful assessment is required to tease out problems that may be related to the consumption of alcohol.

Self-monitoring in the form of keeping a daily diary gives useful information on quantity and frequency of drinking as well as on the consequences of alcohol consumption. This can provide a baseline measure of the quantity of alcohol consumed, which can then be compared with alcohol consumption after a treatment intervention. Patients may sometimes not be aware of the effect or impact of alcohol on their problems, and a drinking diary can help to elucidate the relationship between problems and alcohol consumption.

Table 8.3 gives an example of an extract from a drinking diary. From the data in the extract, the patient and therapist deduced that going out earlier in the evening and drinking alcohol in the presence of Bobby and Malcolm might lead to undesirable consequences.

For some individuals, reducing alcohol consumption may be a more appropriate goal than abstinence. This is often a more difficult option as it involves sticking to agreed levels of consumption and being vigilant about where and when drinking takes place. For patients who have difficulties in self-monitoring or who do not believe that their drinking is problematic, this task may be too difficult at first and the patient may resist any change. In such a case, the therapist may explore with the patient the advantages and

Table 8.3 Example: drinking diary

Date	*Time*	*Where*	*Who with*	*Alcohol amount*	*What happened?*
20/8	9pm	Cross Keys Bar	John Robert	3 pints beer	Felt fine
21/8	6pm	Cross Keys Bar	John Robert Malcolm Bobby	7 pints beer 2 whiskies	Began to argue with Malcolm. Bobby egged me on later.
	11pm	Bobby's flat	same people	5 cans beer	Malcolm not talking to me.
22/8		Home			Next day. Row with wife – hit her. She says she'll leave me.

disadvantages of drinking and abstinence from alcohol, and setting limits on drinking. Table 8.4 gives an example of this.

Finding alternative non-alcohol beverages (e.g. alcohol-free beers, non-alcoholic drinks) and alternative activities to drinking (e.g. playing football, going to the cinema, playing pool, attending Alcoholics Anonymous), and setting limits on when and where alcohol might be consumed (e.g. only with certain individuals, after 9 pm) help to maintain the chosen drinking goal, whether of abstinence or of reduced consumption.

The above are relatively simple techniques that can be used with patients who have problems with substance abuse. Often the patient's problems may indicate more severe dependence on substances that requires greater focus and intervention before the patient can be fully engaged in therapy for their personality disorder-related difficulties. The reader can gain further understanding of cognitive approaches from more specialized texts (Beck *et al.*, 1993; Graham *et al.*, 2004) that would help with patients with substance use problems and comorbid severe mental health problems.

Anger problems

A problem often associated with those with antisocial personality disorder is aggression. Difficulty in tolerating feelings of frustration and anger are common among this group of patients. In addition, many may have difficulty expressing anger appropriately. Problems with inhibiting aggressive responses to situations that are perceived as threatening lead to poor control of anger

Table 8.4 Example: advantages and disadvantages of drinking and giving up alcohol

Advantages of drinking	*Disadvantages of drinking*
• I can go to pub with friends	• I drink too much and make a fool of myself
• Like the taste	• Spend too much money
• Helps me relax	• Wife doesn't like me drinking
• Alcohol makes me feel good	• Get into serious trouble with the law
	• Have to buy drinks for people I don't like
Disadvantages of giving up alcohol	*Advantages of giving up alcohol*
• I'd have to find other things to do	• More money
• I don't think I could stick to having no alcohol	• Feel fitter
• Miss my drinking friends	• Could handle a job better
• How would I relax?	• Wife would like it and it would stop her nagging me

and impulsive behaviour, often with serious consequences for other people as well as the patient.

The function of anger is often misunderstood by patients. Anger can be regarded as a useful emotion that signals that something unjust has taken place. It also signals displeasure to others and it can be used to influence and direct the behaviour of others. However, the way in which feelings of anger are acted upon is often inappropriate. It is often necessary to explain to patients that it is normal to feel angry but not appropriate to behave aggressively towards other people. In general, patients who have problems with aggressive behaviour have difficulty understanding this distinction. A therapist can help to explain the distinction between feeling angry and acting aggressively by asking questions that help a patient to analyse the situation that has engendered feelings of anger and an aggressive response.

Through questioning, a therapist can elicit the relationship between feeling angry and behaving aggressively and can help a patient to become aware of how they can make an effective response as opposed to an aggressive response that would lead to further trouble. Joe had been in frequent fights with other men and reported intense feelings of rage and anger, even when the situation was apparently only mildly provoking. Below is an extract from a treatment session in which the therapist is asking Joe about an incident in a bar.

EXAMPLE: ANALYSIS OF SITUATION IN WHICH JOE FELT ANGRY

Joe went to a bar alone, knowing he would find many people in the bar that were drinking friends. The bar was very crowded and people were jostling each other to get a space at the bar. Just after Joe paid for his drink, a man pushed him and his drink spilled. Joe said he had felt very angry.

Th: What did you want to do? (*Emphasizes doing*)
J: I wanted to smash his face in.
Th: How angry did you feel? (*States feeling*)
J: . . . I was very angry. He just tried to walk away. In fact that's just what he did and I really lost my head. I shouted at him and some of the other men told me to calm down.
Th: What did you want to happen? (*Goals*)
J: I'd have liked him to apologize and buy me another pint, but he left.
Th: What stopped him buying you another drink then? (*Seeks alternative explanation*)
J: Because he is an idiot.
Th: Any other reason? (*Seeks alternative explanation*)
J: Because he's a coward and ran off.
Th: Was that because you were shouting at him?
J: I suppose so.
Th: The pub was busy – did he notice as he knocked your drink over?

J: No – he did not even notice – see how stupid he is?
Th: That doesn't sound like stupidity to me. It sounds like he just did not realize he had knocked over your pint. Is that possible? (*Gives alternative explanation*)
J: I suppose so.
Th: So if someone does something and they don't notice what has happened, could it be just a mistake or an accident?
J: Yes, I suppose it could have been an accident.
Th: So you would have smashed his face without thinking this through first, eh? How would that have made you look? (*Asks for consequences of behaviour*)
J: Stupid!
Th: So let's say you had evidence that he had noticed what he had done. He was aware that he had knocked over your pint of beer and just turned away. You feel angry and you respond by wanting to smash his face. What would that achieve? (*Consequences of original action*)
J: He would be on the floor – out cold.
Th: And he would not be able to either apologize or buy you another pint – is that right? (*Achieve goal?*)
J: Yeah.
Th: So in one quick moment you have really lost out. He does not get the opportunity to say sorry, and you don't get your pint of beer.
J: Yeah, I see your point. But he was an idiot.
Th: Could you have used your angry feelings to help you instead of hinder you from achieving your aim? After all, it was your pint he knocked over.
J: You mean I could have said something to him?
Th: Such as . . .? Remember you are angry but this time you want to get what you want. (*Seeks alternative way of solving problem*) You want him to get you another pint or at least say he's sorry.
J: I could have said "Hey pal – you knocked over my pint. How about buying me another one?"
Th: Well that certainly sounds direct and straight to the point, and it gives you a good chance at getting what you want from the situation.

The aim of this questioning was to teach Joe that he could have achieved what he wanted if he had perceived the other man's behaviour differently and not "lost his head". To do this, he would have had to take account of factors that were not immediately obvious to him, such as the bar being crowded and busy and that the man bumped into him accidentally. One of Joe's core beliefs was that he had to be on his guard against other people as they would exploit him. This situation in the bar would have triggered Joe's belief as he would have perceived what happened as being non-accidental – in this case, other people would think that they could get off with knocking over his beer and not replacing it. So, rather than getting what he wanted, he got angry and

the other man left. Helping Joe to be aware that there may be many factors influencing other people's behaviour and that his aggressive responses were unlikely to be as effective as an assertive response in achieving his goals was a key aspect of therapy.

As aggressive behaviour is likely to have resulted in problems, listing these subsequent problems is useful (see Table 8.5). Many patients find that the list of consequences can be long. Listing the pros and cons of using aggression can then be explored.

Other emotional responses

In therapy, patients with antisocial personality disorder sometimes report that they do not recognize feelings other than anger. Feelings such as sadness are often denied at first and it can be hard to gauge what emotions are being experienced in response to situations. In childhood, these patients may seldom have had emotional states, other than anger, described to them by parents and will have had little opportunity to express emotions. There may have been confusion about what emotions can be freely expressed and patients give many examples of being criticized or even punished for expressing emotions such as sadness. As a result many emotional states go unvalidated and unlabelled, and the patient may not have a sophisticated emotional vocabulary. Careful questioning can help the patient to begin to express emotional states and to label them more accurately.

Social skills training and assertiveness training

Many patients will have few behavioural or cognitive skills to deal with anger. Social skills training and assertiveness training are often a highly appropriate part of treatment. Helping patients to develop body language and verbal skills that decrease the likelihood of an angry interpersonal situation escalating is essential, including how to remove oneself from a scene without loss of face. Some patients will have difficulty expressing themselves appropriately with partners. Anger and aggression are often directed at

Table 8.5 Example: pros and cons of behaving aggressively

Advantages	*Disadvantages*
• I get my own way	• The fights get worse
• It gets people off my back	• I'm getting older and I can't fight so hard
• It deals with problems quickly	• The problems don't go away
	• It costs me money in fines for breaches of the peace and I'll end up in deeper trouble

partners. Interviewing a partner is essential for a full picture of the nature of the relationship, including its strengths and weaknesses.

For example, if the patient reported aggressive episodes a therapist might carry out a detailed functional analysis. Antecedent factors such as the history of relationship problems, previous arguments, and difficulties in modulating physiological arousal need to be considered along with current situational factors. Pre-existing but related factors such as current alcohol and drug consumption need to be taken into account also. A behaviour should be described in detail (e.g. was physical aggression used, were weapons used and towards whom?). The consequences of the behaviour would include what happened immediately after an incident and what the likely pay-off (reinforcers) might be for having acted aggressively. Both long- and short-term consequences should be considered. Only by carrying out such an individualized analysis can the therapist begin to understand the specific individual and situational factors involved, and the functional significance of the behaviour itself.

Behavioural contracts between partners

Behavioural contracts between partners may be helpful in moderating aggressive behaviours. A therapist can work on increasing problem-solving skills and assertiveness skills in both partners to reduce aggressive outbursts. Both partners need to be clear about the goals in reducing aggressive behaviour and the potential problems involved in attempting to make such changes. New, more adaptive behaviours need to replace more destructive behaviours. Agreeing and implementing such a contract between partners requires skills in negotiation on the part of the therapist. The therapist should avoid taking sides. New behaviours need to be rehearsed frequently and the aim of developing these new, more adaptive ways of resolving conflict has to be restated over many sessions with both partners. If both partners can see an advantage in changing behaviour then they are more likely to work on the problems jointly and effectively.

Behaviours that interfere with progress in therapy

Behavioural contracts with the therapist are also helpful in decreasing behaviours that impede progress in therapy. These do not need to be formal written contracts but need to be explicit so that the new "rules" are clear and the reasons behind these make sense to the patient, so that they understand it is in their interests that changes should be put in place. Contracts can be used to change specific behaviours such as non-attendance and verbal aggression within sessions. A 42-year-old man, Bill, with a diagnosis of antisocial personality disorder initially did not attend therapy sessions on a regular basis. This interfered with treatment, as little consistent progress could be made.

After checking with Bill that he did want help with his problems, the therapist asked him to agree with her about improving his attendance at sessions so that he could make progress and she would not have to wait around wondering whether he would attend, which was not good use of her time. She would continue to see him, over a number of sessions, provided that he attend every session or give appropriate notice of cancellation. She also agreed that Bill would be phoned on the day before appointments to remind him of the time he should attend and that he could confirm then whether not he could attend. If he failed to attend on two occasions without agreed notice or an appropriate reason, she would discharge him. Had Bill not wanted help with his problems, she would have discharged him. This worked well and allowed the therapist to then work on the other main problem impeding progress in therapy, namely verbal aggression. Bill would raise his voice, often swearing, and get agitated if he was talking about an incident he had been upset about. Staff in the adjacent clinical rooms had complained to the therapist about Bill's loud swearing, as it disturbed other patients. In order for the therapist to continue seeing Bill in that clinical setting, he would have to modify his level of verbal aggression. Once Bill had clearly begun to attend regularly, the therapist chose a time when he was not too emotionally aroused to discuss his loud swearing. She asked him if he was aware of shouting loudly at times when he was "stirred up" and if he knew how this affected others. Bill was aware of shouting and swearing and said that he thought others would know not to interfere with him when he was like this. The therapist agreed with Bill that others would probably stay away. She then told Bill that other therapists in the clinic had told her that their patients had complained about overhearing him shouting and swearing. This statement produced an immediate shift in Bill's perspective on this matter as he believed that he had been "talking in private" to the therapist and had clearly not considered the possibility that he could be overheard by strangers. He did not want others to hear him discussing his problems with his therapist. The therapist then discussed other possible disadvantages that Bill's behaviour might have had in the past. After some discussion, Bill agreed that he did not want others to hear his business and he agreed with the therapist not to raise his voice beyond a level that was acceptable to her or so that could be heard through the clinic wall by others. They agreed that during treatment she would raise her hand as a signal to him that his voice was too loud and that he would abide by her signal. They also worked on ways in which Bill could become less agitated, using brief relaxation or breathing techniques so that he could keep his arousal level down to manageable levels.

Developing and maintaining positive relationships

Patients with antisocial personality disorder are likely to have difficulty maintaining positive and stable relationships with others, though many patients

with this type of problem may be living with a partner. The quality of the latter relationship may be poor, though examples come to mind where this was one of the few positive relationships in the patient's life. Although relationships may break down for many reasons, in antisocial personality disorder patients typically disregard the feelings of others and have difficulty viewing things from someone else's perspective. They tend to blame others rather than themselves for things that go wrong.

Given that the childhood experiences of those with antisocial personality disorder are often characterized by neglect or severely abusive relationships, they have little understanding of how to develop and maintain more positive relationships. Patients will often state that they do not understand the "rules" that govern other people's relationships. They simply have little experience of positive relationships, as their own emotional needs were not met in childhood. Emotional attachment to parental figures is likely to have been highly problematic. Emotional inhibition and avoidance are understandable in this context.

From a therapist's perspective, there may be limits in terms of how much one can do to counteract the severe effects of such early childhood abuse and neglect. Patients with this background are unused to being able to relax in relationships and are likely to be controlling of others as a way of coping. They may regard other people as potential threats to their self-esteem and their ability to keep in control of what happens to them. Letting one's guard down in relationships does not seem realistic to these patients as it would leave them highly vulnerable. As a result, they develop coping behaviours that control and intimidate others or keep others at bay. The aim in therapy is to understand these overdeveloped behavioural strategies and associated beliefs about others, and to attempt to change them to ones that will improve interpersonal relationships. This involves the patient developing new beliefs about others that may be more adaptive for adulthood relationships, where there can be a choice of friends and partners. The new beliefs will support new behaviours that are more reciprocal and less controlling of others.

Poor literacy skills

Difficulties in reading and writing are common and are highly likely to be evident in this group of patients. This may be due to childhood problems that resulted in an inability to benefit from schooling. Often patients with antisocial personality disorder report having attended school irregularly or to having been uninterested in school work. Being unable to fully comprehend written language can be a source of frustration and confusion and can lead to a sense of alienation. Sensitivity is needed when asking about reading and writing ability, as most people hide such difficulties from others. During initial sessions with a patient, a therapist will have an opportunity to cover the patient's school experience and attendance and this can provide an

opportunity to ask about reading and writing skills. As many patients are ashamed of having such difficulties, it is often helpful to point out that these are relatively common problems and that most people have some problems in this area. Patients who have such problems can be encouraged to attend adult literacy classes.

For patients with such difficulties, any written materials will need to be adapted appropriately. Using diagrams to explain a formulation, using highly structured forms and adapting homework records and clinic handouts are all essential to overcoming poor literacy skills. Patients will have developed ways of coping with written communications, and these methods can be exploited by the therapist.

Constructive work

A poor work record may be common in patients with personality disorders. The therapist should attempt to consider a history of employment and to differentiate where such problems are due to factors such as the individual's attitude towards work, specific interpersonal problems that result in difficulties at work, or more local economic factors such as availability of suitable work. Graded tasks can be utilized to improve such problems as poor work attendance and concentration at work. For those that are unemployed, and who are seeking employment, scheduling work finding can be helpful. Setting aside specific times in the week to visit job centres or read the jobs vacant columns in newspapers as well as telephoning for information and completing applications are some examples. In the absence of available work, or when the patient appears unwilling to consider employment, the patient and therapist have to consider finding alternative satisfying activities to structure daily life. Constructive use of one's time is a clear expectation of therapy as this is assumed to improve both quality and satisfaction of life. Some patients will need to develop skills before applying for work and this is probably best left until therapy has finished. By this time the patient may have developed techniques to manage their time more effectively and behave less impulsively and once these skills are in place, there is more likelihood of tolerating and benefiting from suitable work-related courses.

Chapter 9

Typical behavioural problems: borderline personality disorder

The previous chapter outlined some of the more typical behavioural problems associated with antisocial personality disorder. This chapter concentrates on the wide range of behavioural problems that are common in individuals with borderline personality disorder. Targeting specific behavioural problems with appropriate behavioural techniques is vital to the success of cognitive therapy. As in all personality disorders, changes in behaviour are matched with changes in dysfunctional core beliefs. Again a detailed cognitive behavioural formulation and an analysis of problem behaviours is an essential first step in treatment. Sometimes this task is made more difficult because borderline patients often lack analytical skills and tend to describe problems and situations in a global, undifferentiated style. A therapist may have to spend a considerable amount of time in training a patient to analyse a situation or problem behaviourally, but the effort involved is well spent as this step is important in effective treatment.

Treatment focus

The problems of borderline patients may vary, but can be characterized as being within the affective, cognitive, interpersonal and behavioural domains. Although the cognitive model places central importance on an individual's beliefs and assumptions, these are regarded as "influencing the perception and interpretation of events and in shaping both behavioural and emotional responses" (Beck *et al.*, 1990, p. 186). As borderline patients see themselves as unacceptable, powerless and vulnerable, and the world and others as malevolent, they are likely to behave in ways that relate directly to these themes. For example, patients often wish to harm themselves and have a tendency to form unstable relationships with others. Borderline patients frequently have a tendency to have periods of relative stability followed by crisis when feelings of powerlessness and unacceptability predominate. As a result, they have difficulty behaving in a consistent manner in terms of their desired life goals, at times appearing to have a clear idea of the direction in which they wish to change their lives but at other times being much less

clear that any changes can be made and appearing defeated and unmotivated to continue. In addition, individuals suffering from borderline personality disorder may present to health professionals with a wide variety of psychiatric disorders such as depression, anxiety, psychosomatic disorders and eating disorders and with problems resulting from childhood sexual or physical abuse or neglect. These disorders and problems need to be treated along with the problems relating to personality disorder.

Borderline patients require a variety of different treatment strategies; again, case formulation is the key to establishing an overall understanding of the problems and which problems should be given priority in treatment. Problems such as suicidal behaviour and deliberate self-harm are given priority early in treatment. Table 9.1 gives some examples of the types of problems that clinicians may encounter in treating borderline patients and the treatment strategies that may be helpful in their management.

Order of treatment tasks

Suicidal behaviour is given a high priority in treatment as this is potentially life-threatening. Self-harming behaviour such as self-mutilation is also an early target of therapy and is usually managed by being understood in terms of the case formulation, as it is likely to be driven by dysfunctional core beliefs and maladaptive overdeveloped behavioural strategies. If, however, either suicidal behaviour or self-mutilating behaviours are not discussed, understood and managed early in therapy, they are unlikely to decrease, with

Table 9.1 Problems and treatment strategies in borderline personality disorder

Problem	*Treatment strategies*
Suicidal ideation or attempt	• Therapist management • Risk assessment • Assessment of depression • Problem list • Reasons for living • Self-care and making the environment safer
Deliberate self-harm	• Functional analysis • Motive for behaviour • Understanding the emotion • Alternative adaptive behaviours • Self-nurturance
Mood disturbance	• Distraction • Meditation • Opposite mood induction • Knowing it will pass

the result that patients may be prevented from making good progress with underlying problems.

Assessing suicidal risk

Therapists treating patients with borderline personality disorder are usually aware of the risk of suicidal behaviour. This involves paying attention to thoughts of suicide as well as to suicidal behaviours, especially when patients appear to be in a crisis, or overwhelmed by their problems, or seem emotionally cut off and defeated by problems they regard as insurmountable. At these times, therapists should assess the degree of risk of a patient completing a suicidal act and might wish to consider hospitalization as an option. This can be both an appropriate response and beneficial to the patient if there is an immediate requirement for the patient to be in a safe environment. The act of removing an individual from the immediate environment helps to let a crisis period pass, provided that the therapist can continue to support the patient and that the admission is kept short.

A therapist should attempt to assess the strength of the patient's intention to commit suicide. Asking about symptoms of depression, levels of hopelessness and specific plans to commit suicide will help the therapist to assess the risk involved. Questions relating to the method of suicide that the patient may have considered, the availability of support from others and whether or not the patient has told anyone else might also be taken into account in assessing risk. If in any doubt, seek a medical opinion or the opinion of a supervisor in assessing the risk of suicide and whether the patient might benefit from hospitalization.

Suicidal ideation or attempt

The therapist has to make an assessment of the patient's reasons for considering making a suicide attempt. The assumption in cognitive therapy for borderline patients is the same as in cognitive therapy for depressed patients: the individual patient has his or her own motives for considering suicide and has come to the conclusion that this may be a desirable option (Blackburn and Davidson, 1995). Conveying to the patient that the problem is being taken seriously and being empathic and understanding of the patient's distress can help to relieve a patient's sense of isolation and distress. The therapist's goal is then to redress the balance in favour of living rather than dying. The therapist has to do this in a very direct manner, often providing evidence for the patient that the balance is in favour of living. In order to accomplish this, the therapist has to use evidence from the patient, the patient's personal history and how the patient has overcome difficulties in the past. It can also be useful to provide accounts of other patients' difficulties and how these were overcome. It is assumed that the patient's view of their

problems has become extremely narrow and that the patient has lost sight of other potential ways of resolving problems.

Hopelessness, depression, overwhelming social, financial and personal problems, or trying to influence or even get back at others are common motives given for considering suicide. Negative automatic thoughts associated with hopelessness can be elicited and modified using standard cognitive techniques. Establishing a problem list and breaking this down into smaller, more manageable problems that can then be discussed helps to reduce the patient's sense of feeling overwhelmed. If there are problems that the patient has no influence over and are external to them, such as housing, these can be put to one side and possibly dealt with by other agencies or members of the clinical team. A therapist has to remain problem-oriented yet empathic to the patient's level of distress. As the patient is likely to have a negative view of self, world and future, cognitive techniques can be used to modify dysfunctional thoughts and perceptions.

Reasons for living

Patients and therapists can draw up a list of advantages and disadvantages for living and dying (see Table 9.2). Being specific about reasons for living is known to be important as many patients who wish to die have only vague reasons for living and find providing highly specific reasons to remain alive a difficult task. By listing the advantages and disadvantages of dying, a therapist pays attention to the patient's reasons for dying as well as tipping the balance in favour of living. It is useful to give a copy of the work done in the session to the patient to take home. This will provide evidence that may help reduce future feelings of hopelessness, as a patient may continue to be vulnerable when alone.

Many patients also benefit greatly from discussing ways in which they can keep themselves safe from self-harm, and this can help to decrease their sense of hopelessness and being out of control. Some agreement with the therapist about what plans or safety strategies will be implemented is necessary before arranging another appointment. For many patients, this involves making their home environments safer by throwing away unused medications, razor blades and alcohol.

Some patients will resist getting rid of all excess medication or cutting instruments at first, claiming that they wish to have the option of harming themselves should things get really awful for them. It is worth exploring the motivation behind this. Ask the patient whether having these substances or instruments at home makes them think less or more about harming themselves. Does it remind them of their previous episodes of self-harm and does this make them feel better or worse about themselves? What would they say to someone who was dependent on alcohol keeping a bottle of alcohol hidden in the wardrobe? After the disadvantages of keeping such substances or

Table 9.2 Example: advantages and disadvantages of living and dying

Advantages of dying	*Advantages of living*
1 I won't feel anything	1 I am getting help to solve my problems
2 I will get rid of my problems	2 I will see Carol's children grow up. The children like me and I am important to them
	3 I can ask John and Carol for help in getting work. They can help me to write application forms
	4 Carol and John have told me that I can stay at their house if I feel down and lonely
	5 My mother would be very distressed if I killed myself. She would always feel that I did not ask her for help. Although we have a difficult relationship, I have never really spent time talking to her about her life and how she feels and how she managed to cope when she and my father got divorced
Disadvantages of dying	*Disadvantages of living*
1 Carol and John would feel terrible	1 I will have to put up with the way I am
2 I won't ever know if my life could have been better	
3 There would be no going back	

instruments has been explored, it is important to re-attribute the patient's view of self-harm as the sole option available to them. For all patients, an episode of wanting to self-harm is an important signal to take the opposite action, to seek help and to protect, rather than self-harm.

Another strategy recommended by Thomas Ellis and Cory Newman (1996) involves encouraging the patient to delay suicidal impulses by reflecting on all the things they have been meaning to get round to doing in their lives but have, for some reason, put off. They suggest getting the patient to generate a list of things and why they might be important to the patient. One patient, Sarah, wrote that she wanted to visit the Scottish Highlands as she had never had the opportunity and had always felt better when surrounded by nature's beauty. She also wrote that she wanted to learn how to draw and paint as a way of expressing herself. Sarah wanted to take her nieces out to the theatre and had never been able to afford to do this, but made a plan to save a little money every week and take them to see a pantomime as a Christmas present. These plans helped Sarah to buy into life again and to become less hopeless about her future.

Some patients can repeatedly use parasuicidal behaviour or threats of

suicide as a maladaptive behavioural strategy to gain attention and help from others. Therapists have to attempt to understand the function of such behaviour for the patient and the consequences of such behaviour. For some, repeated overdoses are a means of generating crisis situations that, in turn, are attempts at eliciting helping and caring behaviour from others. The patient's behaviour is inadvertently reinforced by the attention they received from others, which in turn increases the chances of such suicidal behaviour being repeated. This is seldom an effective strategy for the patient in the longer term. Those who may have responded in a caring and supportive manner to the patient in the past often find that their efforts to help appear to be insufficient or rejected when the patient attempts self-harm again. "Helpers" become frustrated in their attempts to care for the patient and may withdraw their support. Patients who repeatedly self-harm are often very angry and irritable and their unstable moods make it difficult for others to remain sympathetic. In order to decrease the frequency of such self-harming behaviour, the therapist has to attempt to change the contingencies in such a way as to reinforce more adaptive ways of signaling distress while reducing self-destructive behaviours.

A therapist does this by taking the patient very seriously. Understanding and acknowledging that the patient's life is difficult, and that the problems they experience may seem overwhelming, is the first step in this process. By taking a patient's attempts at serious self-harm or suicidal threats seriously, a therapist acknowledges the patient's distress and current situation. The idea that there may be other ways than suicidal behaviour of resolving problems can then be introduced. In dialectical behaviour therapy (Linehan, 1993a), therapists take a non-negotiable position on reducing deliberate self-harm as this behaviour does not improve the patient's quality of life and may lead to an increased likelihood of subsequent suicide.

A problem that can arise is the patient's attempts at drawing the therapist into a parasuicidal crisis. If a patient telephones a therapist having taken an overdose, the therapist has to make an assessment of the medical seriousness of the overdose. If this is not possible, the patient's medical practitioner has to be informed. If the therapist is confident that the patient has not taken a serious overdose, the therapist should tell the patient that it is his or her responsibility to seek appropriate medical help, if necessary. A patient has to be managed sympathetically but firmly. The therapist should then ask the patient to attend at the next available appointment to discuss the incident and the problems he or she is experiencing.

Self-nurturance

Patients with borderline personality disorder have difficulty in acting in a self-nurturing manner as a result of not having had their emotional needs met in childhood. They often try desperately to elicit protective and nurturing

behaviour from others, but appear to be unable to gain this effectively. They may readily recognize that this is the case but still have little idea about how to go about caring for themselves. A therapist's task is to aid the patient in developing self-nurturing behaviours. Borderline patients often recognize that they are able to be nurturing to others. A therapist may have to explicitly instruct patients to protect and nurture themselves. For some patients, this can be as basic as agreeing with the patient that they will eat regular meals and get enough rest and sleep. For others, the task is more complicated as they appear to act impulsively and in a chaotic manner. Learning to slow down, think before acting and behave in a protective manner towards themselves is helpful. A patient, Susan, developed a "stop and protect myself" motto for times when she began to feel out of control. She had several strategies to help her at these times, the two most favoured being to phone or visit a person whom she trusted to be fair-minded and whose opinion she valued, or to do something soothing such as stroking and cuddling her cat.

Another patient who was finding her lack of employment and her home life intolerable decided that the best way in which she could be kind to herself would be to have some "time out". She would go to bed and ask her family to leave her alone for a few hours. During this time, she cosseted herself and tried not to attempt to resolve any problems. She arranged the bed so that it would be comfortable and she had some of her favourite books and music tapes around her if she wished to be distracted from her problems, although the main aim was to rest quietly. This patient described her strategy as helping to build a solid floor underneath her so that she would not fall through into an abyss. One of the main advantages of her strategy was that she was not, at these times, faced with her own expectations that she should solve her problems and so run the risk of experiencing the intense sense of failing to resolve anything. In addition, giving her permission to take time out and not judge herself brought about a shift in her basic assumption that she was to blame for everything that went wrong and should be punished or humiliated.

When the sky is not the limit

Some patients appear to take on too much when they begin to feel better about themselves, have experienced more stable mood and have reduced self-harm. It is as if the non-coping self is switched off and they have to move rapidly into a super-coping mode where they expect themselves to be able to take on new challenges and immediately resume previous commitments. At these times, patients may be particularly vulnerable to relapse. A naïve therapist may welcome this stoical aspect of patients but it is often more appropriate to explore the patient's core beliefs and assumptions at these times. A patient whose core belief was "I am useless" described how at times of greater stability she would "flip" to a belief that she *should* be able to cope with everything. She also thought that if she did not cope at these times, it

would prove that she was useless. This suggested that her core belief about being useless was still dominant but operating in a dichotomous, all or nothing, manner. The important lesson for this patient was to learn not to try to do too much at these times. Instead she was encouraged to carry out behavioural experiments where she tested how much she could do without feeling overwhelmed and unable to cope. This incremental approach allowed her to build up her capacity to cope with more active days and more interaction with others without feeling stretched to capacity. She called this process "learning not to reach for the sky".

Deliberate self-harm

Individuals with borderline personality disorder often deliberately harm themselves by mutilating their bodies. This behaviour is not necessarily the same as harming oneself with the aim of ending one's life. Cutting arms and legs with razor blades, severely scratching wrists and forearms with sharp instruments, and stabbing at stomachs and breasts are examples of this type of self-harm. Usually it is carried out in private but borderline patients will often covertly display scars to a therapist and hope that these signs of distress are noticed. Usually this type of self-harm occurs in response to dysphoric mood states. Patients will sometimes say that they feel "nothing" before cutting or that the action of cutting resulted in a sense of relief from a mood state that was intolerable. The antecedents of this behaviour often need careful assessment. Self-report studies and laboratory studies studying proxy behaviour strongly suggest that deliberate self-harm serves to regulate negative affect (Klonsky, 2007). Although the behaviour may be in response to dysphoric mood, and a wish for self-punishment due to self-loathing, there may be a triggering event that the patient has been unable to cope with effectively. Having a disagreement with someone or feeling rejected by a partner or friend are common examples of these triggering events. For some, however, no apparent antecedent event can be found and it appears that the self-harm behaviour is in response to mood state alone. The aim of therapy is to reduce such behaviours and help the patient to deal more effectively with dysphoric mood states. Table 9.3 gives an example of a functional analysis of self-harm behaviour.

Mood disturbance

Patients who repeatedly self-harm often feel intensely angry with themselves and with others but feel ashamed of these feelings and find it hard to discuss this with their therapists. Such emotions can become overwhelming as the patient struggles to either avoid or control strong emotions. Those who have experienced being neglected or abused in childhood have had their emotional needs for protection and nurturance unmet. Marsha Linehan (1993a)

Table 9.3 Example: functional analysis of self-harm behaviours

What happened before self-harm?	• Two hours before – meal with parents • They were not talking to each other • I felt stuck in the middle, couldn't eat • I just wished they would not ignore me and that they would sort out their differences
Feelings leading up to self-destructive act	• Anxiety then numbness
Associated thoughts	• I feel nothing. I am nothing
Self-destructive behaviour	• Scratched thighs with razor blade in the bathroom
Feelings	• No one feeling • Pain on cutting
Associated thoughts	• At least I feel pain • I can feel something
Consequences	• More marks on thighs • Blood on clothes • Feel ashamed • Hate myself • Have to avoid swimming • Problems still there • Cannot avoid them
Alternative to slashing	• Go to bed and sleep or listen to loud music • Tense my muscles really hard then relax • Phone my friend • Chat to people on internet

describes how borderline patients may have experienced invalidating environments in childhood where the child's emotional responses to a situation were not just unmet or ignored but responded to in a way that suggested the emotion response itself was invalid. An example of this would be being told as a child that you should not cry or be upset because you are cold, hungry and tired and cannot go to bed when in fact it would be reasonable and understandable to be upset and want to sleep. Linehan (1993a) describes the conflict that such patients experience as they struggle to invalidate and suppress their own emotional experience. Having learnt through experience that expressing intense negative emotions is punished, the patient fails to trust their own emotional responses and is unable to articulate and express these emotions. Behaviours that may help cope with emotions then also become maladaptive.

Many patients have difficulty tolerating dysfunctional mood states. For most patients the main difficulty will be in dealing with distressed emotional states that may last for several days at a time (most will tend to be more transitory, although no less intense and distressing). Using cognitive techniques

will be helpful here, but increasing the patient's tolerance of these negative mood states is also important. The patient has to be willing to experience the dysphoric mood state and not suppress it.

Tolerating dysfunctional mood states

Jon Kabat-Zinn and others (1992) have suggested that meditation or mindfulness techniques can be helpful in learning to tolerate dysfunctional mood states. Essentially, the patient is trained to concentrate by focusing on a restricted field. For example, one could focus on breathing, or the way one's body feels sitting on a chair. By this focusing of attention a patient can become aware of thoughts and feelings but now be able to observe these in a dispassionate way. Essentially the patient learns to "stand back" from the distressing feelings and thoughts and to become a participating observer. Thoughts and feelings are simply accepted and experienced as "objects" rather than as imperatives to action. This has the effect of emotions being accepted for what they are and not reacted on. This is a skill that requires practice in order to gain a sense of mastery. Several authors have highlighted this need to practise skills regularly to gain proficiency, and a fuller account of this experiential method applied to preventing relapse in depression is described by Zindel Segal and his colleagues (Segal *et al.*, 2002).

Linehan (1993a) has developed core mindfulness skills as part of dialectical behaviour therapy (DBT) for borderline patients. These skills involve rather similar techniques. DBT teaches patients to attend to events that may be distressing and to experience whatever is happening rather than trying to stop the emotion. The idea here is based on exposure as a method of extinguishing automatic responses of avoidance and fear. Mindfulness is described as participating with attention (Linehan, 1993a). Patients are also encouraged to take a non-judgemental stance and to do what is "effective" as opposed to what may seem to them to be "the right thing to do".

Other techniques involve doing the opposite of mindfulness: using distraction and finding activities that will allow the patient to concentrate on the task in hand to the exclusion of the negative mood state. The idea here is that by deliberately taking attention away from feelings such as guilt, hopelessness and low mood the patient can gain some reprieve from the mood state. These activities have to be absorbing and involve an activity that is physically or mentally effortful. Examples are scrubbing the kitchen floor, doing aerobic exercises, taking a brisk walk, having a cold shower and reading aloud.

Inducing incompatible mood states

Another technique for tolerating dysfunctional mood states involves deliberately inducing mood states that are incompatible with or opposite to the negative mood state (Linehan, 1993b). Playing pleasant, soothing or upbeat

music, watching a funny or spellbinding film, meeting a friend who is more positive about life, moving face muscles into a smile or doing something to help someone else are all possibilities.

Reminding the patient that the mood state will pass

Some patients find the knowledge that negative mood states can pass helpful. To convey this, seek evidence from the patient about how they have coped in the past with negative mood states. Patients find that keeping a readily accessible written record of the evidence that distressing mood states are temporary can be useful. For example, one patient kept a card with this information at her bedside and in her handbag as a reminder.

It can also be helpful to place some intrinsic value on having suffered, telling the patient that those who have suffered are often better and more understanding of other people's problems as they have personal experience that has deepened and widened their understanding of both negative and positive aspects of life (Linehan, 1993a).

The motivation for self-mutilation and other self-destructive behaviours needs to be understood. Again a detailed functional analysis of the antecedents, behaviour and consequences and the associated thoughts and feelings needs to be conducted by the therapist. After the therapist has understood the motivation for self-mutilation, more functionally adaptive behaviours can gradually be substituted for the self-destructive behaviours.

Childhood sexual abuse

Some researchers have found a link between borderline personality disorder and childhood sexual abuse (e.g. Brown and Anderson, 1991). This will not apply to all patients with this disorder, but therapists need to be aware that at least some of their patients will have suffered sexual abuse as children. Although some patients will divulge this at assessment or during treatment, others will remain silent on the subject, perhaps feeling unsure about whether or not to trust the therapist with such a disclosure. The therapist should therefore take the initiative in broaching the subject with patients. The following factors and problems are regarded as indicators of sexual abuse:

- women with a history of repeated victimization
- alcohol- or drug-dependent women
- women whose mothers were ill or absent from home
- women who had taken on an adult care-taking role in childhood
- responsibilities for home and family from an early age.

These indicators can be kept in mind when seeing any patient. A straightforward question such as "Have you at any time been touched by someone in

a sexual manner when you did not want to be?" allows the patient the opportunity to tell the therapist if any form of sexual abuse has ever occurred. Some patients may not feel able to bring up the topic, even when asked directly, and so the therapist may give the patient other opportunities to do so if they think this is indicated.

The following are possible ways of helping patients to feel comfortable about disclosing childhood sexual abuse:

- ask directly if sexual abuse occurred during childhood
- use a structured questionnaire to obtain a complete sexual history
- define incest for the patient
- ask about best and worst experiences of childhood.

If a patient does disclose that they have been sexually abused in childhood, or for that matter in adulthood, the reaction of the therapist is important in determining what happens next. Both men and women who have been sexually abused are frequently hypersensitive to the attitude of other people towards them. They may feel disgusted and ashamed, and any slightly negative expression or act on a therapist's part can reinforce the patient's negative attitude towards themselves and may confirm that they should not have told anyone. It is also important that the therapist does not express a quick opinion about the abuser, as the patient may have positive as well as negative feelings towards the abuser. How the patient views the sexual abuse and the exact nature of their relationship with the abuser need to be clarified. This does not mean that the therapist should condone the abuse; rather, he or she should seek to find out the facts of the case and whether or not the abuse continues. After a patient has told the therapist that they have been sexually abused, it is important that the therapist does not then ignore what the patient has said. A calm, empathic stance and encouragement and praise for having disclosed such a difficult experience helps the patient to feel a sense of trust in the therapist and a sense of relief for having told someone about the abuse.

The treatment of problems that may arise from childhood sexual abuse can be undertaken in a cognitive therapy framework. The psychological meaning of the abuse should be the focus of treatment rather than specific details of the abuse, although some patients do find it helpful to go through specific incidents of abuse with the therapist. In general, the patient's view of themselves and others is likely to be the focus of therapy. Issues of trust, autonomy, responsibility and sexuality are likely to be raised by the patient.

There are many useful texts on the assessment and therapy of adults who have been sexually abused as children. Hall and Lloyd (1993) and Burke Draukher (1992) are particularly recommended for female patients, and Mendel (1995) for male patients.

Chapter 10

Clinical evaluation of change

As cognitive therapy aims to change specific and agreed targets, therapists and patients are able to evaluate changes in these targets with treatment. With patients with personality disorders, the change may not be as dramatic or as quick as with other patients, and the therapist has to be realistic in her expectations about what can be achieved. Nonetheless, important and clinically significant changes can be achieved with some, if not all, patients. As many of the patient's problems are longstanding, changes in cognition, emotion and behaviour may happen slowly and will need to be maintained to have any lasting effect. Regular evaluation of the effectiveness of therapy is essential if the therapist and patient are to know whether therapy is succeeding and should be continued or whether the approach is not helpful and should be discontinued.

Using standardized measures

There is, at present, no agreed overall measure of change for personality disorders, though one can measure change in several important areas of functioning and in personality disorder diagnostic status itself. Careful consideration of the patient's problems and targets of treatment will guide the therapist in making choices about measures. As mentioned before, some patients may have relatively poor reading skills and may need some assistance in completing measures, if these are seen to be necessary for assessing progress in therapy. Zanarini and her colleagues (Zanarini *et al.*, 2003), for example, have shown that patients no longer meet diagnostic criteria when followed up over a number of years and this, in itself, is useful information for patients currently undergoing therapy. Although diagnostic interviews may be appropriate in the longer term, they may show little change in the relatively short period that therapy takes place. Studies evaluating outcome from therapy for patients with borderline personality disorder have tended to use a wide variety of measures, reflecting the wide array of problems that these patients experience. Changes in suicidal behaviour and self-harm tend to take place relatively quickly and can be assessed using the Acts of Deliberate

Self-Harm Inventory (see Davidson *et al.*, 2006b) (in Appendix). This inventory allows therapists to distinguish between suicidal acts and acts of self-mutilation such as scratching, cutting and burning. The inventory can be used to assess these acts in the six months prior to entering therapy and again at an appropriate point in therapy or when therapy is completed.

A wide array of reliable and valid measures can be used to assess other problems such as social functioning, self-esteem, depression, anxiety and interpersonal problems in borderline and other personality disordered patients. With antisocial personality disordered patients, anger and aggressive behaviour may also be measured using appropriate standardized measures.

Cognitive therapy aims to change beliefs as well as behaviour. Significant changes in schemas have been shown in a randomized controlled trial (Davidson *et al.*, 2006a) using Young's schema questionnaire (Young and Brown, 1990). This questionnaire is also useful for assessing the patient's dysfunctional beliefs about self and others.

Tailoring measures to suit the patient

Evaluating the outcome of therapy for an individual patient begins at the start of therapy when the target problems have been defined and agreed. For each patient there will be a unique set of problems, and agreed targets of treatment can be measured at the beginning of therapy and changes assessed as therapy progresses.

Measuring change in target problems

The therapist has to know to what extent or magnitude the problem affected the patient before he or she came to therapy. For some problems, the patient can provide a clear retrospective account; for example, patients can often provide information on the number of times they shouted at someone within a limited time frame. For other problems, baseline data may need to be gathered before a clear description of the frequency or degree of the problem can be assessed. Any changes in the target problem with therapy can then be evaluated against baseline or retrospective accounts of the problem.

Some target problems are relatively easily defined and measured whereas others need to be restated in order to measure change. Some problems, such as a difficulty in tolerating unpleasant mood states, are more difficult to define and measure. This type of problem is common in patients with borderline personality disorder; similar problems, such as feeling angry, are common in patients with antisocial personality disorder.

The following example illustrates how this type of problem might be monitored during treatment.

Example: the assessment of feelings of anger

Stage 1: Therapist and patient define the target problem

An agreed definition is reached with the patient of feelings of anger that arise in response to some event or when thinking about past events. This is best phrased in the patient's own words, such as "I feel keyed up and sometimes my heart starts to race"; "I often feel like I want to smash someone or something"; "Occasionally I smash something"; "At the worst, I have hit someone".

Stage 2: Measurement to be used (scale of 0 to 5)

- 0 = no feelings of anger
- 1 = slight feeling of being a bit annoyed or angry; no desire to smash something or someone; I can easily distract myself from this feeling
- 2 = recognize I feel angry but still able to control these feelings and to stop thinking about it, but needs more effort than in 1; no desire to smash something or someone
- 3 = moderate degree of feeling anger but still in control of desire to smash something or someone; I have difficulty in stopping thinking about whatever has made me angry
- 4 = feeling very angry; want to smash something or someone but do not; cannot stop thinking about whatever has made me angry and getting really worked up
- 5 = intense feeling of anger; smash something or someone

Stage 3: Agree on the frequency of measurement

From preliminary information about the frequency of feeling angry, it was agreed that recordings would be taken in the morning, afternoon and evening and any precipitating event noted so that discussion of the events could take place in sessions.

Stage 4: Method of measuring

This patient monitored his feelings of anger on a weekly diary (Table 10.1) and the example shows that enough information was collated to help discussion in sessions. Asking this patient to record incidents in more detail would have been counterproductive as he was not practised in recording information.

Table 10.1 Weekly diary: rating of the degree to which I felt angry

Mon	*Tues*	*Wed*	*Thurs*	*Fri*	*Sat*	*Sun*
Morning		Letter from ex-wife demanding money	Phone for advice from lawyer	Went out fishing with friend		
0	0	2	3	1	0	1
Afternoon		Phoned lawyer				
0	0	3	3	1	1	0
Evening		Frustrated	Spoke to my friend			
0	0	4	2	2	0	1
Late evening		Still frustrated	Calmed down			
0	0	4	3	1	0	0

Stage 5: Assess progress regularly

As therapy is arranged in blocks of treatment and overall progress is reviewed at these points, the therapist can collate and summarize the patient's data on target problems to gain an overview of progress.

The weekly records were summarized in chart form to assess progress in treatment over 10 sessions. The total weekly anger scores were then recorded on a chart. This chart (see Figure 10.1) showed an overall reduction in the degree to which he felt angry over the 10 weeks of treatment. Although not shown here, this patient's baseline data indicated that he was scoring in the

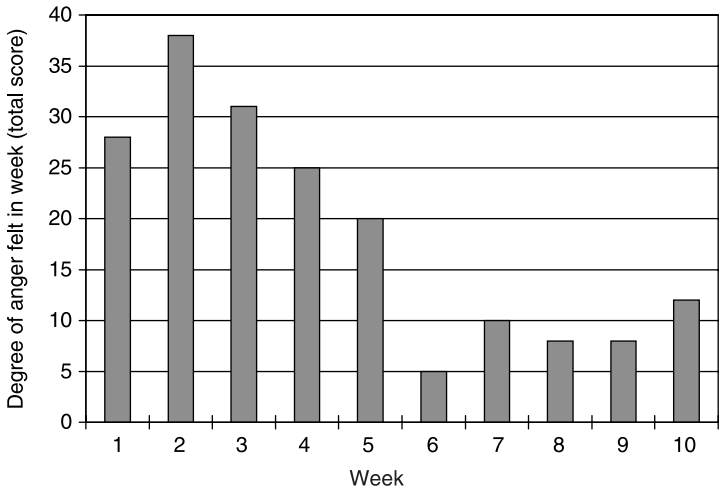

Figure 10.1 Degree of anger (total scores per week) recorded over 10 weeks.

range between 25 and 35 in the weeks before his problem with feeling angry became a treatment target.

The chart allowed both the therapist and patient to see at a glance that he had felt less angry over the 10 sessions. Daily ratings of degree of anger could have been presented to the patient but as these would have shown quite large fluctuations, the therapist preferred to demonstrate change using a summary score of degree of anger recorded over each week. Presenting data in a visual, as opposed to a numerical, form is an effective method of conveying a relatively large quantity of data to a patient.

Record of new, more effective ways of thinking and behaving

The information gathered as part of working on schema change is also a measure of progress in treatment. The patient's notebook used throughout therapy contains valuable information on how the patient has changed their thinking and behaviour and is a permanent record of progress in treatment. For example, change in core beliefs can be assessed regularly on a continuum and new behaviours that are indicative of such a change can be recorded.

As a patient's overall social functioning is important in the treatment of personality disorder, a record of this can be kept throughout treatment. Jackie, a patient with a diagnosis of borderline personality disorder, stated at the beginning of treatment that she had few social contacts and had difficulty developing friendships. At the beginning of treatment, Jackie and the therapist made a record of the names of people with whom she came in contact. After a few sessions, Jackie selected four women at work who she thought were friendly and trustworthy and recorded her social contacts with them. As she had difficulty making friends, she was encouraged to take steps in getting to know these individuals. After the first 10 sessions of treatment, her record of contacts with these four women was evaluated in terms of the number of social contacts that had been pleasurable (see Figure 10.2). This "positive log" helped Jackie to be more aware of people who were friendly in her immediate social network. Deliberately recording these pleasurable social contacts helped Jackie to focus her attention on those whom she could trust and be friendly towards rather than on her core belief that she was bad and that no one would like her. Her new, more adaptive belief was that she was "okay" as a person and that other people might like her some of the time. Her summary was as follows.

> I have been able to talk to these four women regularly and although at first I was quite worried that they would not like me and that they might make fun of me, I have got to know them a little better and we seem to get on well. They have told me some things about themselves and I have begun to tell them some things about myself. Jenny has asked me over to

Week	Jenny	Caroline	Wilma	Sarah	Total contacts
1	✓✓	-	-	✓	3
2	✓✓✓	✓	✓	✓	6
3	✓✓✓	✓	✓	✓	6
4	✓✓✓✓	✓✓	✓	✓	8
5	✓✓✓	✓✓✓	-	-	6
6	-	-	-	-	(had flu)
7	✓✓✓✓	✓✓	✓	✓	8
8	✓✓✓	✓✓✓	✓✓	✓✓	10
9	✓✓✓✓✓	✓✓✓✓	✓✓	✓	12
10	✓✓✓	✓✓✓	✓	✓✓	9

Figure 10.2 Number of social contacts that were pleasurable.

her flat for the evening and I have taken the risk of asking Caroline to come with me to the canteen for lunch and she was positive about this. I'm still a bit apprehensive about making friends but now I notice when others are being friendly towards me.

Asking significant others

In addition, if therapy has involved significant others, either in the assessment of problems or in therapy itself, their view of the patient's interpersonal functioning is very useful in monitoring change and their assessment of progress with treatment is often pertinent and hopefully encouraging for the patient. There are, of course, occasions when the therapist might judge that asking a significant other for feedback would not be appropriate. For example, it would not be wise to ask for feedback from a significant other who undermined a patient or who was in a damaging relationship with the patient and where part of the therapy had focused on how the patient might change this relationship.

The therapist's ending summary of treatment

By the end of treatment the therapist may have written several summaries of sessions for the patient and will have given the patient a copy of the agreed

formulation. These summaries to the patient can be placed in a special folder and presented as a record of treatment. Most patients appreciate this gesture and the record provides an *aide-mémoire* for the future. Below is the therapist's final summary to Jackie.

July 10th

To Jackie

We have now met on 32 occasions over a year to work together on your problems. When you first came to see me we talked a lot about the problems you had been experiencing and how these had arisen. We have tried to understand these difficulties. Your main problems last June were that you were very isolated and had no friends and that you were cutting yourself. You described your mood as being seriously up and down and you did not know what you wanted to do with your life or indeed who you were. Many of these problems were longstanding and you felt very hopeless about your future.

In therapy you became aware that you believed that you were a bad person and that you thought others would not like you. You were very scared of being friendly and open with other people because you thought that they would reject you or make fun of you. You found it very hard to cope with your negative moods and when you felt overwhelmed, you were often tempted to take an overdose. You cut yourself when you felt "frozen" emotionally or when you had some memories of your childhood, particularly of when you were sexually abused by your stepfather.

Some of the first few years of your life were quite happy but you also remember your mother and father arguing and fighting and your mother crying a lot. Your parents divorced when you were six years old and you never saw much of your father after that point. When he left, you thought that you must have been bad as he did not get in touch with you for many months. As a child it was easier for you to think that you had done something wrong rather than assume that the adults around you were uncaring. Through talking to your mother again, you are now aware that she did not want your father to see you as she wanted to punish him for leaving her for another woman. You, of course, did not know this as a child. Your mother became quite depressed after your father left and you think that she may have been drinking heavily at that time. This was a very confusing time for you as your mother stopped showing you affection and did not seem to notice that you were also very upset about losing your father. You thought

that you were bad and that you should not be upset as this would upset your mother.

Your mother married again when you were nine years old and from the beginning you did not like your stepfather. He always wanted you to cuddle him and when he was drunk, he abused you. Again you thought you were bad as he told you not to tell anyone. Now you realize that he was wrong to do this and that you were *not* responsible. You were a little girl whom no one protected.

When you were 14 you tried to tell your mother about what your stepfather was doing to you but she did not believe you and spoke up in his defence. This was very confusing for you and you thought that no one cared about you or believed you. What happened to you was awful and no one deserves to be treated like this. It seems that all of these experiences led you to conclude that you were a bad person and as you had no one whom you could trust and talk to, this belief was never challenged. You left home after you took your first overdose. This was a courageous step for you to take as you had little experience of the world and you felt alone and no one seemed to care, except the social worker and your doctor.

In therapy, you have tried to develop new ways of thinking about yourself. You know that you are not bad – you now think and believe that you are a worthwhile and "okay" person. You have kept a very clear record of examples of being "okay" as a person. This has been difficult for you to do, as before you really did not notice things that would have suggested you were "okay". The old belief that you were bad seemed to dominate the way you perceived everything. Your new belief is strengthening and I'm glad that you can now recognize that you have intrinsic worth as a person as well as many examples of new ways of thinking about yourself as "okay".

You have also been developing new strategies to look after yourself. You are making friendships with some women and they have welcomed you into their lives. You have started to eat better food, take more breaks from work, and to keep yourself safe when you feel like harming yourself. I think you have done very well at making these changes and I know how you have struggled to keep up these changes.

We have concentrated on your future more recently. You have decided to do another course to give you better qualifications. You went and asked your manager to support you in this and he has agreed to fund you through the course. He told you that your work was valued and that you have shown yourself to be a diligent and capable colleague. Previously you would not have believed someone who told you this but his actions of supporting you in getting on to the course have helped convince you that you are okay and indeed, your work is valued. You have also decided not to put off doing some things that you would like

to do such as buying yourself a new music system and going walking with a ramblers' group. This is part of your new desire to look after yourself and to be generous to yourself. You have always been generous to others, both in kind and in giving of your own time. Now it is time to be good to yourself too.

I wish you well in your future, Jackie.

With my best wishes

Chapter 11

Ending treatment

The final stage of therapy is as important as any other stage, but it is often neglected by therapists. The significance of treatment ending, particularly in the treatment of those with personality disorder, is likely to depend on two factors: the quality of the therapeutic relationship and the patient's specific beliefs about loss and how they have coped with this in the past. The end of therapy is implicit at the beginning of treatment, as cognitive therapy is not open-ended and involves separate phases of assessment and treatment with regular reviews of progress, thereby emphasizing a limited number of sessions and progress towards the end goals of therapy. Patients who are afraid of abandonment, or who have experienced loss in the past are likely to be particularly sensitive to the finite nature of therapy and for them, this may even have implications for engagement in therapy. For the patient, being in therapy involves trusting the therapist and feeling safe enough to be open about problems and showing vulnerability. If someone has not been able to trust others to do this in previous relationships, particularly in childhood, engagement in therapy will be slower and the finite nature of therapy may be regarded as anxiety-provoking for the patient, as the therapist will not be able to meet the patient's emotional needs in the longer term. Some patients may protect themselves against the threat of being vulnerable and the loss of a therapist by simply not engaging in therapy. For these patients, the beliefs about loss and abandonment need to be addressed at the beginning of therapy as little progress will otherwise be made (i.e. the end of therapy begins at the beginning).

For some, therapy in itself can be the main focus of life and the therapist may be one of the few human contacts the patient experiences on a regular basis. It is important that the therapist addresses this explicitly and conveys clearly to the patient that therapy is not an end in itself and that part of the aim of therapy is to improve social relationships or, in some cases, make the beginning of relationships with others. Many patients are extremely socially isolated, have limited financial resources and have little opportunity to meet other people socially. Making social contacts or finding satisfying and purposeful structured activities involving others would be some of the main behavioural goals in treatment in these cases.

Negotiating the ending date

As the final stage of therapy approaches, it is helpful to have a clear ending date. As cognitive therapy is goal-directed and progress in therapy is regularly reviewed, the treatment will have clearly defined phases. An ending date should be negotiated with the patient as the final stage of treatment is reached to signal that therapy is coming to an end. This date can be set collaboratively, with some discussion about what can realistically be achieved within the final stage of the current therapeutic contact. The length of the final stage will depend on the individual patient but as a general rule this should be neither rushed nor drawn out unnecessarily. We have found that five or six sessions over a period of two months or so may be adequate, but for a minority of patients the final phase may be longer than this.

Meaning of separation

The final stage of therapy may have different meanings for individual patients and one cannot assume that all patients will find this stage difficult. For some, ambivalence may be dominant; for others, the ending of the therapy and the therapeutic relationship may have little significance; for yet others the emotions of sadness, anger and guilt may be dominant and the meaning of loss and separation needs to be explored. Therapists can have difficulty asking patients how they feel about therapy ending, and many avoid this topic. If one considers that the therapy is important to the patient, and that the therapist is significant to the patient, then at least some reaction to the final stage of therapy is likely. Often discussing other endings, such as a personal loss that the patient may have experienced and life transitions such as leaving home or a job, can help to introduce the issue of endings and also highlight that the experience of loss may be both normal and upsetting at the same time.

Many patients who have difficulty with ending therapy may have brought up these issues earlier in therapy. The experience of real or perceived losses in the past is a characteristic of this group of patients. These patients have also experienced difficulties maintaining close relationships. During the main phase of therapy, the therapist is likely to have looked at the assumptions the patient makes about why relationships failed and examined the repertoire of social skills available to the patient for maintaining relationships. As stated before, improving social relationships is usually a goal of therapy. In addition, the breakdowns in the therapeutic relationship itself are used to illustrate misunderstandings that may arise in relationships and to make explicit some of the normal rules of relationships. Asking the patient to think about what problems might be envisaged when the end of treatment approaches and to anticipate difficulties is helpful in highlighting these issues earlier in treatment.

Keeping goal-directed

In the final stage of cognitive therapy, a patient with a mental disorder such as depression is clearly less symptomatic and is returning to a recognizable "normal self" state, and patients with depression recognize that there is no longer a need for therapy. One of the differences with treating an individual with personality disorder is that "normal" functioning is the state that treatment is aiming to change. Defining from the outset what the patient wants to change is a key characteristic of therapy and if these changes are stated appropriately, and are realistic, then the end point of therapy will also be clear. The goals of therapy can be renegotiated as difficulties become more evident during treatment but should not be greatly different from those stated at the beginning, as these will relate to overdeveloped maladaptive behaviours and dysfunctional core beliefs. If defined clearly enough to allow for progress to be monitored, the final stage of treatment will largely consist of consolidation and maintenance of these goals. Along with this consolidation of new beliefs and behaviours, the final phase of therapy is about how this different way of being in the world can be continued without the help of the therapist. In order to accomplish this final phase of work, the therapy has to remain goal-directed as well as dealing with the issues that may specifically arise as a result of the meaning of termination for the patient.

As only so much change can be undertaken during any one therapeutic contract, some patients may need help again in the future. For the patient, the awareness of changes accomplished is heightened by the collection of written summaries that have been gathered as treatment has progressed. To mark the transition of ending therapy, it is appropriate to give another summary or letter of what has been achieved by the patient and how the difficulties faced have been surmounted. Given the longstanding nature of problems that those with personality disorder experience, it is likely that some problems will not have resolved fully; the therapist should help the patient to acknowledge this and express regret or frustration, if appropriate.

The possibility of an increase in self-harm

In the final stage of therapy, patients who have self-harmed as a means of reducing distressing emotions such as anxiety or frustration occasionally decompensate by increased use of self-harm. This problem is anxiety-provoking for the therapist and often puts the therapist in a dilemma about the pending discharge of the patient. This might lead inexperienced therapists to extend the discharge date or even assume that the therapy has been totally useless. Other therapists may not know what to do when this happens and feel at a loss as to how to proceed. It is important to deal with this behaviour in a problem-focused manner and not avoid it. The meaning behind an increase

in self-harm should be gently explored with the patient. It is possible that if self-harm has led to expressions of concern from significant others, including the therapist in the past, an increase in self-harm might be purposeful in that it might lead again to the therapist expressing concern and caring for the patient. The patient may not be entirely aware of this as a motive, and may only be aware of a panic reaction to a sense of being abandoned. Another patient might view the therapy ending as confirmation of unworthiness and view the therapeutic relationship as having been a sham and the therapist as uncaring and uninterested. Others who increase self-harm at the end of therapy may waver a great deal between apparently valuing therapy and acknowledging the gains made while, on the other hand, devaluing the whole treatment process, using the self-harm as evidence that they are no better at coping than they were when they first entered therapy. The key point is that the therapist has to understand the meaning of the increase in self-harm and put this in the context of treatment as a whole and the patient's difficulties coping with treatment ending.

Is it helpful to reduce the frequency of contact in the final stage of therapy?

Although it is often helpful to space out appointments during cognitive therapy to allow patients to practise specific behaviour and schema-change techniques, this is more appropriately carried out in the middle phase of therapy. Decreasing contact with the patient in the final stages of treatment is usually not helpful and it is not a matter of the patient getting used to not having contact with the therapist. As treatment approaches the end, a decreasing frequency of appointments can be easily misinterpreted by some patients. For example, patients may interpret the therapist's behaviour as indicating a loss of interest in them, or that the therapist is being punitive and uncaring. Patients sometimes will articulate that this is evidence that they are unworthy of therapy or that they have been "bad" patients. If the patient has an abandonment schema, increasing the time between the final appointments may increase a sense of abandonment rather than allow the opportunity to work through the meaning of this for the patient.

Building up community resources and contacts with others

Community resources that can be accessed by patients with mental health problems exist in most cities and patients can be encouraged to find out about these and explore options at an early stage in therapy. These should not be regarded as replacing therapy when it ends but as an adjunct to treatment and extending the patient's opportunities to meet others in a relatively supportive but less intensive environment.

Many patients with personality disorder have impoverished and dysfunctional social relationships, and one aim of therapy is to improve the patient's social relationships. This might include involving significant others in therapy or building up a patient's social skills and confidence to begin new relationships and activities. This helps to reduce the dependency on the therapist. By the end of therapy, patients will ideally have formed some relationships or put in place some purposeful outside activity such as a voluntary job or even paid employment. These relationships may sometimes still be at a relatively fragile stage, but they are more adaptive and more reality-based in the longer term than a sole relationship with a therapist.

Chapter 12

Therapy in action: a case illustration of antisocial personality disorder

This is an example of cognitive therapy with a man with antisocial personality disorder. The personal details are disguised to protect the patient's identity.

Jim, a 37-year-old single man, was referred to cognitive therapy from forensic services by his general practitioner, who had known him for around three years. He had been referred for an assessment of his aggressive behaviour and had a history of offending. He wanted help to control his aggression as this kept getting him into trouble. He had previously been in prison for drug dealing in his early thirties. He had a conviction for serious assault when he was in his mid to late twenties and served a brief prison sentence. After his assessment at forensic services, he was referred for an assessment of his suitability for cognitive therapy.

Assessment period

The first session with Jim was cancelled as he could not find his way to the clinic and arrived late for his appointment. He was very agitated about being late and in spite of having been given explicit directions and a map, he complained that there were no clear signs to tell him where to go. In the next session, Jim arrived on time.

The aim of this first interview was to make an assessment of Jim's current problems and related history. In addition to the above problems in the past, Jim said he kept getting into trouble by fighting with other people and did not know how to stop this. He said he reacted very quickly to situations where he thought other people were getting at him by becoming aggressive, shouting and often punching or kicking other people. He said he had never hit a woman, only men. Some questioning revealed that he got "wound up" if things did not go his way. During this session the therapist found it hard to interrupt him and had to be very assertive to stop him to ask questions.

In the following three sessions, Jim began to allow the therapist to ask more questions. She had to firmly interrupt him, stating that she needed to ask some things to clarify his problems and to understand him a little better.

He lived in a deprived area in the east end of the city, in a flat that was rented from a housing association. He had been in this flat since he was released from prison and had been rehoused away from the area he had used as his drug-dealing circuit. She discovered that Jim did very little and was socially isolated as a way of avoiding getting into trouble with other men. He had been avoiding going to bars and to places where he knew there would be people he had offended in the past, as he feared these people wanted to kill or hurt him. He spent his time watching television and films that he had recorded from television. He made meals for himself and liked to cook. He had no job, though he had some money from "wee jobs" he did for other people. He was reluctant to describe what type of jobs these were, and it was not clear if they involved criminal activity. Other than these activities, he described being very bored.

He had no current relationship but had previously been married at the age of 21. This relationship had ended after five years. Jim blamed his wife for the breakdown in the relationship as she had an affair with another man. There were no children from this marriage. Since then he had been out with several women but had never wanted to get married to any of them. None of these relationships had lasted more than a few months.

To construct an adequate formulation, the therapist needed to know more about Jim's background and early upbringing. However, she judged that this could be interwoven into the first phase of therapy and aimed to agree a problem list with Jim. At this stage she was not sure whether Jim would be able to benefit from therapy but decided to continue at least for a few sessions as Jim had no experience of working psychologically, was relatively unaware of his emotions and thoughts, had a lengthy criminal history and appeared to be poorly educated. She decided it would be useful to give him some idea of the process and content of therapy and some education about how it might work for him. Jim's problem list was as follows.

Initial presenting problems

- Angers easily and becomes violent towards others
- Lack of constructive activity (leading to boredom)
- Social isolation (to avoid fighting)

Jim's main reason for coming into therapy was to stop fighting to avoid reprisals from those he had offended or attacked. The therapist decided to ask more about why he wanted to change this and Jim described being frustrated at not being able to go out without risking getting into fights. He took no responsibility at this stage of therapy for his past behaviour, stating that other people were to blame. The theme of problems being other people's fault

was emerging strongly. The therapist decided to seek out information about Jim's past life.

Personal history: childhood and adolescence

Jim had been born in the city and raised in relative poverty. Both parents had been unemployed for most of Jim's childhood. He no longer knew his father and had not known him well even as a child. His father had left home for periods of several months at a time and had lived with other women and their families. Jim thought he might have other siblings but was not sure and said he was "not interested". His mother, during his father's absences, had relationships with other men and eventually remarried when Jim was around 11 years old. His stepfather worked as a labourer in the building trade. He had formed an uneasy relationship with his stepfather. He did not like him as he favoured his own children from a previous relationship. Jim knew how to get "round him" as he was his mother's favourite. He would threaten his stepfather with telling bad stories about him that he had heard in the neighbourhood. His mother had relied on Jim when he was young to do things round the house and go out on errands, and had called him "her wee man". His mother had let Jim do as he pleased at home, provided he helped her. He liked his mother and, as an adult, had been able to give her the material things he thought she should have through his earnings as a drug dealer. Although he admitted that he took drugs, he said he never lost control of this behaviour, unlike the people to whom he sold drugs. He clearly regarded drug addicts with some disdain. He also said that he could not openly spend his drug-related money on himself as it would have raised suspicion from the police.

He had two siblings, a brother and sister, both his stepfather's children. He described his stepbrother as a do-gooder and had little to do with him. This stepbrother had informed the police of Jim's drug dealing and this had led to his arrest and conviction. His stepsister was "okay"; she still lived at home with his mother and stepfather and was working as a shop assistant in a pharmacy. He liked her but did not want to get any closer than he was to her as she might act as tell-tale to his mother and stepfather.

He had never liked school and had truanted from an early age. He recalled being told to read aloud in class as he was having problems reading and thought this was a deliberate attempt by the teacher to humiliate him. He had, after that, refused to "play the game" at school and had been deliberately disruptive in classes, if he attended. He had been suspended from school many times and had been expelled from two secondary schools. As a result, he had been at school very little. His truanting from school had been condoned by his mother, who had liked having Jim around the house to do things. On formal assessment of his literacy skills, he was found to be below average.

He had poor social relationships with peers as a child. He hated being left

out of gangs as a boy and would try to start his own gang to get revenge on those who had excluded him. He learned to fight as a way of getting what he wanted from other boys and said he did not care if someone had got hurt. His biological father had told him that he had to fight his own battles and stand up for himself. If he returned home from a fight with other boys and had not stood up for himself, he was punished by his father for being "soft". He said he came to realize there was no option but to hurt other people if they got in his way.

His only peer relationship that did not involve conflict of some sort seemed to be with some male cousins and his stepsister, though they were no longer close.

This extra information allowed the therapist to make a tentative cognitive formulation.

Initial cognitive formulation

Diagnosis

Antisocial personality disorder (DSM-IV)

Significant childhood experience

- Largely absent father
- Father insisted he stand up for himself and punished him if he did not fight
- Mother had problems setting limits
- Poor and inconsistent school attendance; suspended and expelled
- Humiliation by teachers
- Poor relationships with peers except with some family members

Significant adolescent and young adult experience

- Expelled from school
- Drug dealing
- Prison sentences for serious assault and later drug dealing

Possible core beliefs and dysfunctional assumptions

- I have to be right
- No one gets to humiliate me
- Other people are to blame for things that go wrong
- I need to be alert if I am to stop people getting the better of me

Emotional responses

- Cold, uncaring for most part
- Anger

Overdeveloped behavioural strategies leading to the following current problems

- Acts aggressively if perceives humiliation or threat
- Suspicious of others
- Overly controlling of others

Underdeveloped behavioural strategies

- Containment of anger
- Reciprocity in relationships

Environmental factors

- Relative poverty in childhood
- Brought up in area where fighting to get what you want was the norm
- Lives in area where there is a possibility of revenge attacks

Potential problems in therapy

The therapist's reaction to Jim was important here. She found him rather cold emotionally and he was controlling in sessions. She did not particularly like him and was unsure if she could work with him. She discussed Jim and her reaction to him in supervision and became aware that she felt intimidated by his need to be in control and the fact that he could become angry if aroused. His core beliefs suggested that he might perceive negative information about himself as a threat of humiliation and might use anger and aggression to maintain his self-esteem and to control others. It was agreed that Jim would have difficulty forming a trusting relationship with the therapist as he did not form such relationships, except with his mother. He tended to regard people in an instrumental way. She said she would find it hard to set limits with him. She thought her initial reactions were similar to those she had previously when working with antisocial personality disordered patients. She also observed that she had usually been able to form a therapeutic relationship with patients with these problems, provided there was not evidence of psychopathy. She wondered if Jim was psychopathic and she took up the supervisor's suggestion to discuss this with the colleagues in forensic services who had referred him as they might have formed an opinion about this issue. She thought that if she was to feel secure proceeding with Jim's therapy, certain conditions would need to be observed.

Treatment plan

First, she should continue to see Jim in a secure out-patient clinical setting where help was at hand if needed. She should have weekly supervision to help keep therapy focused and to deal with her own issues as they arose. She should work behaviourally, with limited goals, at first and although the formulation would help guide therapy, this should not be shared with Jim at this stage at least. This could be reviewed at regular intervals. Jim's literacy problems and reactions to school teachers suggested that he would not comply with written homework and that any new ways of behaving would need to be well understood by Jim and be seen as being relevant to his presenting problems and to his advantage if he was to attempt behavioural changes. His moral sense of what was right was driven by his own beliefs about how he survived and coped and he did not seem to be aware that hurting other people was morally wrong. Jim's progress in therapy was likely to be slow and would be monitored and reviewed regularly with him.

Continuing first phase of therapy (sessions 4 to 10)

Jim attended the next sessions without defaulting. As he had little idea of therapy, the therapist introduced him to what to expect and enquired about his expectations. The following extract illustrates some of this.

Th: So Jim, we have had a bit of time to look at your past and your current problems. I wonder which problem you want to work on first from the list you gave me.

Jim: I'm really getting fed up with having to stay in all the time. It's driving me mad, I'm really bored and feel like I'm going to do something.

Th: What do you think you might do Jim?

Jim: I might just go out and get smashed [drunk] 'cause I can't stand it any longer.

Th: You sound very frustrated with staying in. Can I ask about this a bit more? I think I now know why you stay in. It's because you don't want to get into trouble – is that right?

Jim: Yeah, but I can't go on like this. It's driving me mad – I can't watch the television all the time. I'm missing out.

Th: But the problem is that going out and getting drunk often leads to you getting into a fight.

Jim: Yeah.

Th: So we need to look at this carefully. We need to work on your anger so that you don't react so quickly with being aggressive. But . . . I wonder about if you are ready to go to the places that you get into fights yet? Can I tell you the way I see it and see if you agree?

Jim: You maybe don't understand what it's like in my situation.

Th: I maybe don't but I want to see if therapy can help you. What if we decided on helping you find something to do that interested you and would make you feel less bored and frustrated and once that is in place, worked on you learning some new ways of dealing with anger so that you did not get into fights so much?

Jim: Like what?

Th: Well, this may take a bit of time but stay with me for now. Can you think of something else you could do that gives you some feeling of satisfaction in your day?

Jim: (*Pause*) No.

Th: Take last week: was there any day better than another? You know – a day or part of a day when you felt more in control or did something you liked?

Jim: Well, I like going to see my Mum.

Th: Okay, and you saw her last week. She came to your flat? Is that right? (*Jim nods*) What's good about seeing your Mum?

Jim: She understands me.

Th: What stops you from going to her house?

Jim: I have to go through bits of the city where I'm known and there are people who want to get me.

Th: Can you take another route? Can you afford a taxi?

Jim: I didn't tell you I lost my [driving license] . . . My Mum could come for me?

Th: Does she drive?

Jim: Yes, she does.

Th: What about that then? Could you try to go over to your Mum's house for a day or evening?

Jim: (*Nods*)

Th: When could you go over?

Jim: I'll ring her now. (*Reaches for his mobile phone*)

Th: Okay, but what about doing that after the session? I'll remind you. It's a good idea. I know that you are feeling frustrated right now but that is a good suggestion about getting out. What about we think of other ideas to help structure your day? I'm trying to help you build up your ability to cope with these feelings you have that get in the way of you leading a better life. What if we spend the next 15 minutes thinking about that?

This extract illustrates the practical help Jim needed to think about solving his problems. In this instance, Jim needed help to use his time constructively to avoid boredom and the possibility he would act impulsively and go out, get drunk and get into trouble with others. The therapist had to break down the problems and help him think through each step to resolving these. He found it hard not to just act on his feelings but was able to think

about how to resolve problems with specific focused problem-solving types of questions. Later in that session she asked Jim for his expectations of therapy.

Th: Okay, you have come up with some ideas and that's good. This is really how we will work together to try to help you think through how to solve your problems. It's just as much you doing this as me. I need you to work with me. How do you like working in this way?
Jim: It's okay but I need to get this fixed.
Th: Do you think it may take a bit of time to really fix your problems? After all, from what you say, these have been around for a long time. What is really good is that you have begun to work on them. How does that feel?
Jim: Will it work though? Can you fix me?
Th: No, it's not about me fixing you, Jim, though I maybe wish it was that easy. I need you to be on board with me here to work together. I'm being straight with you when I say it will take time. I could just tell you what to do but I know that you would not like that. You like to be in control I think and I want you to keep that bit but learn to work with me to help you solve your problems. This therapy is about us acting together in a partnership. Other people in your situation have taken a bit of time but have got there in the end and been in less trouble than before, with the law for example.

Jim and the therapist continued to work over the next sessions on structuring his time so that he did not become frustrated and act out by going and getting drunk with the risk of getting into fights. Jim, who liked cooking, began to cook more meals for himself and began to exercise at home during the day. After a few weeks, he bought a mountain bike and began to take cycle rides in the evening out of the city; his confidence in going out without being attacked increased, though he was avoiding direct contact with people.

Anger management was introduced towards the end of this block of sessions. Particular attention was paid to how quickly he took offence and perceived threat where none might have been intended. The idea of having a belief that might not be true was introduced as a "rule" he had lived by up to now. The conditional belief that "I need to be alert if I am to stop people getting the better of me" seemed to be totally true to him. The therapist validated this belief by introducing the idea that it had come from his childhood and made sense of what happened at that time. She then looked at the pros and cons of believing this in the here and now and although Jim had poor reading ability, she wrote this exercise down for him as a way of helping him distance from the belief. Jim was able to think of more disadvantages than advantages, though he needed a lot of questioning from the therapist to bring out the disadvantages at first. This exercise took part of several sessions

but was worthwhile for Jim and showed that he had a capacity to reflect and to begin to think that his belief was not adaptive.

Old belief: I need to be alert if I am to stop people getting the better of me

Advantages of believing this

1 It helps me stay alive.
2 Other people know I'm the boss.

Disadvantages of believing this

1 It keeps other people at bay.
2 I fight with people too quickly.
3 I'm getting fed up with falling out with people. I just can't be bothered anymore.
4 I can't go about my business now that there are so many people out to get me.

Continue with therapy if agreed

At the end of the tenth session, the therapist and Jim agreed that progress had been made and agreed a further block of 10 sessions to work on his anger problems. The therapist was by now more comfortable with Jim and was beginning to feel more empathic towards him through discussion of the formulation with the supervisor.

Sessions 11 to 20

(Continue with behavioural changes; begin changes in dysfunctional core beliefs.)

- Work on reduction of aggression.
- Work on interpersonal problems.
- Review and document progress.

The main focus of the next 10 sessions was on reducing Jim's overdeveloped behavioural strategy: his tendency to react to situations he perceived as a threat by becoming aggressive. Although Jim saw that there were disadvantages to believing that he should be on the alert if he was to stop people getting the better of him, he needed a great deal of help to think and act differently. The therapist decided to continue with a largely behavioural approach that encouraged Jim to stop and think before acting. This was

described as a "new rule" as Jim was by then frequently stating that he did not understand how things could be different, and in particular he said he did not understand what the new rules were if he was to stop fighting.

From discussing his early upbringing, he understood that this had influenced his response to situations. He understood that his response to potential threat was overdeveloped. He needed to learn how to control this response behaviourally and to develop cognitive and social skills that could help him be able to decide whether a situation was threatening or non-threatening. New rules were established.

As stated above, the first of these was to stop and think before acting. Jim and the therapist practised words he could say out loud and then quietly to himself, to enhance his ability to do this. "Stop and think" was the simplest of these; others were "if it [the situation] looks dodgy, get out – walk away" or "keep cool". These new rules were necessarily relatively simple in content if Jim was to stay in control of his impulse to act aggressively. He began to walk or cycle to shops in his neighbourhood and to talk to people whom he knew. This allowed him to bring examples of encounters to therapy and the therapist could enquire about whether or not he had regarded the encounters as being threatening to him. He was encouraged to think more analytically about his encounters with people and to distinguish between aspects of situations he would have previously regarded as threatening. The following extract from therapy illustrates this.

Th: This is a good example for us to work on, Jim. You met this man whom you had previously had a fight with, though I understand this was several years ago. Now nothing happened that day and you did exchange a few words. What did you think about him when you saw him coming up the street towards you?

Jim: I saw him coming and I could not get away. I knew he would be out to get me back.

Th: Do you mean, you wondered if this was a possibility? Not necessarily true?

Jim: Yeah, I tried to keep cool. I couldn't avoid him as he was quite near.

Th: So you thought "keep cool". That's good – you used your new rule. Then what?

Jim: He looked at me – straight in the eye. I didn't like that. I thought he's going to have a go at me [i.e. attack him in some way].

Th: But you were thinking you had to keep cool? (*Jim nods*) So what made you think he might have a go at you?

Jim: He looked serious. Angry.

Th: Can you show me his expression? Can you put that expression on your face so that I can see? (*Jim does this*)

Th: Okay, I see. Can I show you that expression on my face Jim? (*Therapist imitates Jim's expression*) Do you think I'm going to get you?

Jim: No, not you. You just look a bit like a teacher to me! A bit stern. But I know you would not attack me. I don't have a problem with women.
Th: How else might I be feeling with this expression on my face? (*Imitates the expression again*)
Jim: Well, maybe a bit upset about something – like worried maybe?
Th: Yes, that's right – I'm worried that I can't act this one out (*laughs*) but I think you can now see that I might be feeling one of several possible feelings with an expression like this. As you say, I could be angry, I could be serious or I could be worried. How would you know which one it was?
Jim: Well, I couldn't – not without talking to you.
Th: That's probably right, Jim. You do not know for sure – you can only guess without asking me about how I am feeling. So what does all this tell you? What's another new rule, then? Can you think of one?
Jim: Like you keep saying, don't jump to conclusions.

Jim and the therapist went on to develop this idea that Jim might have jumped to conclusions in the past and although he might have been right some of the time, equally he might have mistaken people's facial expressions as being angry. They then discussed the man's body language and also debated what this meant to Jim. Both came up with different ideas that helped Jim distinguish between threatening and non-threatening postures in others. It remained a possibility that people were out to get him, but at least this was now relegated to a possibility, rather than a fact, to be dealt with. How Jim reacted was also important and he now was aware that his reactions to people, particularly his expression and how he behaved, might aggravate a situation.

Jim continued to practise meeting people as he was much less restricted to staying indoors by this stage in therapy. With the therapist, he practised changing his facial expression from one that could be interpreted as being slightly menacing to one that could easily be interpreted by others as being friendly. These more friendly and open signals were greeted positively by others and Jim was aware that people were more friendly towards him too. In a review of his progress, he agreed that he was now much less isolated, calmer, and able to face people on the street without feeling he was going to be attacked. He was seeing his mother regularly and had been out one evening with his stepsister to a party and a nightclub, and had been able to enjoy these occasions without getting drunk and aggressive. Importantly, he was using the stop and think rule to good effect and was less impulsive.

The next stage was to work on what Jim said to people, as he had a tendency to follow his own agenda and was not a good listener. Getting Jim to practise good listening skills was a challenge as he now knew his therapist quite well and found it relatively easy to talk and to listen to her. Another therapist needed to be involved in his therapy to provide him with practise

with a stranger. He had to accept that conversations might drift on to topics he usually evaded or that he might give the other person too much information such as his past history. He had very little idea about how to build relationships through increments in trust and reciprocity. It was agreed that this should be the next and final aim of therapy and a further batch of five sessions was agreed to concentrate on this.

Sessions 21 to 25

One of Jim's core beliefs was that other people would humiliate him. This stemmed from his childhood problems at school and teachers' reactions to his learning difficulties. In addition, he was suspicious of other people, believing that they might seek to take advantage of him, and he preferred to be on the alert and in control of social situations as a way of coping. These beliefs and overdeveloped behavioural strategies had been partly ameliorated by ongoing therapy. However, his understanding of how relationships might work was poor. He had experience of very few meaningful relationships. The strategies that he needed to develop were those that would promote better social relationships, building trust rather than suspicion, and reciprocity, so that he did not have to be so controlling in relationships.

In order to build more reciprocal relationships, Jim needed to develop better social skills, particularly being able to ask questions, listen carefully and follow up on what others said to him. He also needed to have some idea of how trust builds in a relationship, and when to disclose more personal information and when to hold this back. He needed to have more contact with others at this stage to practise these skills and to bring in problems to therapy sessions. This had been mentioned before and Jim had struggled to come up with ideas, but he now agreed to go to a job centre to enquire about a job. He had been told at his local job centre that he might need to go on a training for work course. He had been quite angry as he had been asked to complete some forms that he had found difficult and the staff had been offhand when he asked them questions. He had "kept cool" but was discouraged by his attempt to help himself. The therapist suggested that Jim might like to attend an adult literacy class and, after some persuasion, he agreed to try this as it might help him in the longer term to get a job and also to be able to read more efficiently.

After a month or so, Jim had enrolled in an adult literacy class and had attended a session. This gave an excellent opportunity to discuss a new social situation that was potentially quite threatening to Jim, given his past history of not trusting people and the potential for feeling humiliated. He had decided not to say anything at the first session, but the class tutor had been very encouraging and eventually he had told her, and the other men and women in the class, that he had some problems at school and had not learned to be good at reading and writing. He did not divulge his experience with

teachers or any other problems. He had, however, then felt very anxious, wanted to escape the situation, and had told the tutor he needed to leave as he had an appointment with his doctor. The tutor had said the class should break for coffee and, probably guessing that Jim felt uncomfortable and had made an excuse to leave, had followed him outside and asked him to come back. She had reassured him that he would not be alone and wondered if he could come back the following week. He was now unsure about what to do, as he felt he had made a fool of himself. Using problem-solving, Jim was asked to think about two possible solutions to his predicament. His first idea was not to go back. The pros and cons of this idea were discussed and Jim was asked to think about returning to classes from the viewpoint of what he gained if he did not go back. He agreed this was a possibility and it would not help him in the short or long term. His next idea was to speak to the tutor, though he could only see her at classes. The therapist asked him what he would say to her and Jim eventually thought he wanted to ask her if the others had said anything about him. The possibilities about what others had said about him, if anything, and how he might react to these were explored. Jim agreed to go early to class and ask the tutor. He found out that after the coffee break, nobody had mentioned him but they had also disclosed that they had problems at school, or had missed school for various reasons or had problems with the English language because it was not their first language. He had been invited to stay on until the class began and had a cup of tea with the tutor. She asked more questions about him that he had found helpful as it made him realize she was genuinely interested in his problems and wanted to help. She had even made him laugh when she joked that he was not the only person to have made an excuse to leave a class.

Jim's experience in the adult literacy class was helpful to him from several angles in that he became more confident at reading and writing and more able to act in a reciprocal manner in relationships, albeit in a relatively safe and formal setting. He did not disclose any information about himself unless he thought it would be appropriate, and he found that others were patient and tolerant towards him.

After these five sessions, the therapist reviewed Jim's progress and suggested that he might like to continue to develop and maintain his new skills. Jim did not want to continue in therapy, as he thought he'd learned "enough to be getting on with".

Ending session

Although it is recommended that there be a series of final sessions, the therapist agreed to have only one final session with Jim. The rationale for offering only one appointment was that she wanted to increase the chance of Jim attending a session so that she could review his progress. She recorded this session so that Jim had a record, although she was now aware that he was

more confident in his reading ability. They agreed that there had been progress in Jim's presenting problems in that he was now less likely to act aggressively towards others. He could control his temper better by using "stop and think" and "keep cool" as new rules. He was more aware that he had a role to play in situations that ended in fights, and that both his belief about others getting to him and his behaviour had a strong influence on the outcome of situations he had previously regarded as threatening. He said he understood the rules about relationships a bit better, although he was still wary with other people. He was no longer as socially isolated as he had been at the start of therapy and his skills at talking and listening to people had improved. Though he had few close relationships, he did not want to seek these out.

Chapter 13

Therapy in action: a case illustration of borderline personality disorder

Jean, a 28-year-old, single, unemployed woman was referred for cognitive therapy by a Community Mental Health Team. She had been in psychiatric treatment following a serious overdose and had been diagnosed as having a depressive disorder that had partially responded to a combination of medications. She had a lengthy history of self-harm, which included cutting herself and overdosing. Although her self-harm had decreased in the recent past, her psychiatrist was concerned that this behaviour was longstanding and had not substantially altered as her depression had improved.

Assessment period

Some of the information included here as being part of the initial assessment period was obtained at a later stage of therapy but is mentioned at this point to increase coherence. In addition, details have been altered to protect the patient's identity.

An assessment of Jean's problems and background took place over the first three sessions. It was important not to hurry this as Jean had little idea of what help she wanted but was very distressed. She acknowledged that her self-mutilation was now seriously affecting her physical integrity, as her arm was so badly damaged that any further damage might entail the risk of her losing the full use of one of her hands.

Main presenting problems

During the first three sessions, Jean revealed features that were indicative of borderline personality disorder. As well as recurrent suicidal behaviours and self-mutilation, she reported that she had difficulty with her mood and described herself as being on an emotional roller-coaster, seldom able to maintain any emotional equilibrium. Her antidepressant therapy had helped to stabilize her mood but she continued to feel vulnerable emotionally and she still experienced intense "black moods" that lasted for several days at a time. At these times, she thought nothing had changed and that antidepressants

had not changed her underlying feeling of desperation and anxiety. She had at various times in her life had eating problems, both starving herself and bingeing, but had never received help for this difficulty. Her current weight was within the normal range and she said she did not have current difficulties with eating, although she was drinking heavily. Roughly once a month, she would consume a bottle or two of wine over a few hours.

Jean had few social contacts and found it hard to make and keep friendships. She was afraid of other people letting her down and said that she thought others were likely to criticize and reject her. She had worked until four years previously, as a nanny, but had been sacked from this job after an overdose. She said she had not found a job or occupation to suit her and had now given up trying to find work, despite the economic hardship that she faced as a result. She spent most of her time alone in her flat, rarely going out.

Personal history

Jean was the youngest child and only daughter in her family, having two older brothers. She described an unhappy childhood and adolescence. Jean had been brought up in a village in the South of Scotland. When she was a baby, her parents had returned to Scotland from abroad to run their own business. Jean had few specific memories of her early childhood. She said she had been lonely as a child and that she had not seen much of her parents as they had been building up their business. She and her brothers had been looked after by a series of au pairs and housekeepers, none of whom appeared to stay with the family for long. Her older brothers preferred to play with each other than with her. They had been sent off to boarding school when they were eight while she had been kept at home and attended the local school until the age of eleven. She had not made many friends at primary school and she had avoided inviting other children home to play as her home life was different from theirs, partly because her parents were not at home and the local children were not looked after by au pairs. Her parents discouraged her from bringing friends home from school as they were often not home until later in the evening. On occasions, she had been to other children's homes after school and was struck by the happy atmosphere. Her image of other families' lives appeared to be of noise, people chatting and having fun, all of which was far removed from her own rather silent home with an au pair sitting drinking coffee in the kitchen, or in her room with the door locked to keep Jean out.

Adolescence

Jean had gone to a boarding school in the South of England and had been miserable for most of that period. She had felt she was being sent away from home because she was a nuisance to her parents. She found it oppressive to be constantly surrounded by others and to have little privacy. She was bullied by

some of the older girls at school and made to carry out their chores for them. The girls her own age were no easier to get on with. Jean's mother had discouraged her from paying attention to her appearance and had insisted on plain clothes and sensible shoes. Jean regarded herself as "a plain Jane" and from an early age had believed that it was wrong to be vain and to put effort into making herself look attractive. At school, how one looked and dressed appeared to be the main focus of conversation. Jean, who had few fashionable clothes, and short curly hair, quickly became an object of ridicule in the dormitory. Girls made fun of her and would offer to dress her up and then laugh at how she looked when she stood awkwardly in front of them. By her second year at boarding school, she had made some friends. These were not comfortable relationships but characterized by a continuous struggle to be in with the "right group". Being thin was a highly desired state at school and several girls developed anorexia. Jean had hidden food during meals in order to lose weight and was seen by the school doctor at the age of 15 because she was underweight and menstruation had stopped. Her parents visited the school and discussion took place about removing her from school. Jean, who was not happy at school but even less happy at home, promised to eat and was allowed to continue her education at boarding school. She forced herself to eat, started to binge on sweets and crisps, and put on weight so rapidly that she began vomiting in an attempt to control her weight. This bulimic behaviour, carried out in private but also practised by several other girls, remained in place until she left school. Later, she did develop a friendship with a girl. This friendship was intense and the two girls relied a great deal on each other, helping each other with homework and swapping clothes and books. Jean had not seen her friend since leaving school.

University

Jean's school performance improved in her senior years as she felt more settled having made a friendship and she did relatively well in her exams, leaving school with enough qualifications to gain entry to a Scottish university to study modern languages. At university, she had problems coping with a mixed-sex environment. At first, she felt ill at ease in tutorials and blushed when she was expected to speak in front of male students. She tried to compensate for her social difficulties by avoiding social activities and achieving high marks in her academic studies. She obtained good marks but she became increasingly isolated from others and concerned about her looks. She began to binge on food and then had periods when she did not eat regularly, which resulted in her weight fluctuating. Her mood around this time began to become depressed and she had frequent suicidal thoughts. She also began to scratch her arms. She was not sure why this behaviour began, other than it coincided with her mood being low and anxious. Despite these difficulties, she did well in her first two years and was admitted into honours.

She did not go home during summer vacations, preferring to stay in the city. Her parents sent her money and came to see her regularly but made no comment about her not coming home.

At the end of her second year, a classmate persuaded her to go to a party and she met a lecturer there who asked her out. Although awkward and anxious with men, she agreed. By this time she was lonely and had made no close friends except some classmates whom she saw during the day but seldom accompanied to parties or to bars in the evening. Jean's relationship with Simon lasted, off and on, for two and a half years. Simon was older than her by seven years and had also experienced a difficult childhood. She found it hard to describe him other than that he was rather moody, quiet and very intelligent. When asked about what the relationship had meant to her, she replied that she had wanted to have a boyfriend as she felt so alone and he made her feel as though she was important, partly because she was dating a lecturer. She had wanted to love Simon but found it difficult to become emotionally involved with him as she was anxious he would be critical of her and reject her. The relationship eventually became a sexual relationship and she asked him if she could move into his flat. He was initially reluctant to make this commitment, saying that he needed his space to do his work, but by the end of her third year he had agreed. She was, in her own words, desperate to cement the relationship but afraid he would tire of her. Her parents had met this man and her father had commented that he appeared to be a "decent enough" person. She became pregnant, by mistake, after Christmas of her fourth year, and was so panic-stricken by this she told nobody and arranged to have an abortion. By this time, she thought that Simon had lost interest in her and would have regarded the pregnancy as a trap into a permanent relationship. After the abortion, she became depressed and suicidal and took an overdose of antidepressants. Simon, who by this point had found out about the pregnancy and abortion, was kinder than he had ever been initially but once she was feeling better, he abruptly ended the relationship. This left her feeling desperately alone and suicidal and she took a further overdose. A classmate, hearing of her plight, came to her rescue and offered her a room in her flat, which Jean accepted. Although this woman was sympathetic, Jean felt that her story was being spread around her class and that everyone knew that she had taken an overdose and had an abortion. She felt ashamed, humiliated and misunderstood. Her self-harm increased; she became depressed and had to be admitted to hospital for four months and was unable to sit her final exams. She was awarded an unclassified honours degree on the basis of her course work.

Early 20s

After her discharge from hospital, her parents took her home. She spent about a year doing very little. Her mood continued to be low and she cut her

arms frequently, which she tried to hide from her parents. They, in turn, appeared to ignore her distress and did not talk about her difficulties. Jean once again felt that nobody cared about what happened to her and she began to feel rather disengaged from what went on around her. After many months, she began to drink heavily and her mother, finding her unconscious one evening, called in the local doctor who found out she had taken some of her mother's sleeping pills with alcohol. He referred her to a private alcohol problems clinic. She attended there and was told that she was abusing alcohol and given counseling. While attending the clinic's group sessions, she met Ray, a 50-year-old divorcé. She formed an intense and unstable relationship with him. He wanted to marry her within a month of meeting but she resisted this as she felt she could not trust him. In addition, she felt uncomfortable and anxious when Ray was around but alone and depressed when she was not with him. The relationship continued but was stormy, with Ray continuing to drink too much and arguing with her. She would try to end the relationship, feel alone and empty and would then become self-destructive, drinking and harming herself, and would plead with Ray to come back to her. He would return to the relationship but be emotionally distant and then if she threatened to end the relationship, he would become charming and conciliatory towards her, all of which resulted in her doubting her judgement and feeling very vulnerable emotionally. She overdosed on many occasions during this relationship, sometimes with the intention of dying. Finally after several months, Ray left one evening after an argument and then refused to answer her phone calls and letters. She saw his wedding photograph in the newspaper a year later.

Several months after her relationship with Ray came to an end, her parents, without her knowledge, contacted some friends in London and, without mentioning all Jean's problems, asked if Jean might have a job as an au pair, looking after their children. This couple agreed and Jean, unsure about what to do next and aware that she was drifting aimlessly, went to London. The couple had three young children and Jean liked looking after them as she seemed to find children easier to get on with than adults. The first few months in this job passed uneventfully; Jean felt as though she had finally found something to do that she liked and, more importantly, being away from home helped her forget about Ray. However, she made no friends and found the couple she was working with unfriendly towards her. They took her on holiday to look after the children, and her employer's brother raped her one night after they had all been drinking heavily. Her employer noticed that she was upset and asked if she had a problem. She told the brother's wife, who immediately implied that Jean was to blame. Jean stole some medication from her, took an overdose and, after a brief admission to hospital abroad, was sacked and sent home. Jean then went to live with one of her brothers in London and found that she could not cope with him or his wife as they kept telling her what she should do with her life. She began cutting her arms more than before; she loathed herself, and had difficulty tolerating her unstable

mood state. Her brother appeared to be uncaring and she decided to return to Scotland and rented a small flat with the money she had saved from her job as an au pair.

Over the next year she saw only her parents, who visited her infrequently. She found it hard to look after herself, her eating became irregular, she was not sleeping well, and she continued to cut herself. She lost interest in her appearance and did not wash regularly, did not go out, and felt worthless and hopeless. She contacted various telephone helplines and eventually a volunteer worker from a mental health association visited her regularly and tried to get her to attend a group the organization ran for women. Jean took a serious overdose in the spring of the following year and was referred for a psychiatric assessment. She was diagnosed as being depressed and prescribed antidepressants. Personality disturbance was also noted and a tentative diagnosis of borderline personality disorder was given. After a further nine months, she had made a partial recovery in that her sleep and appetite had improved but she was continuing to self-harm and believed herself to be worthless. She was referred for cognitive therapy.

Relevant family history

Jean had described her parents as aloof and emotionally distant figures. She said she did not know them well. Her mother was the daughter of a missionary family and had lived abroad most of her childhood. Jean described her mother as austere, anxious, observing everything that went on and rarely stating an opinion, except a negative one. She did not feel attached to her mother. Her father was warmer than her mother and would occasionally joke with her as a child. She thought that he was hard-working and she was sure that he was highly regarded in the local community, where he did much charity and church work.

Jean's mother had suffered from depression, as had her maternal grandmother and aunt. Jean had no knowledge of this until later in therapy when she had asked her mother about mental illness in the family. Her father had no history of psychiatric illness.

Both her brothers had married, although one was now in the process of obtaining a divorce. She did not know her brothers well and felt that they were strangers to her, being older and having been away from home most of her childhood.

Initial cognitive formulation

Diagnosis

- Dysthymic disorder, major depressive disorder (in remission)

- Borderline personality disorder confirmed on formal assessment (DSM-IV)
- Features of avoidant personality disorder

Past diagnosis

- Major depressive disorder
- Anorexia nervosa (binge eating/purging type)
- Alcohol abuse

Possible predisposing biological factors

- Maternal family history of affective disorder
- Anxious, shy child

Significant childhood experience

- Emotionally unattached parenting by mother
- Little bonding experience with siblings
- Experienced self as different from local children
- Interpreted going to boarding school as being "sent off" because she was a nuisance

Significant adolescent and young adult experience

- Ridiculed at school for being unattractive
- Difficulty making friends within peer group at school and university
- Heterosexual relationship characterized by fear of rejection and of emotional involvement, and emotionally abusive
- Unable to talk to anyone about her pregnancy and abortion
- Isolation and social anxiety at university
- Sexually assaulted
- Difficulty asserting self with parents and others
- Self-harming behaviour (overdose, cutting and self-neglect)

Possible core beliefs and dysfunctional assumptions

- If I get close to someone, I will be overwhelmed emotionally
- I am worthless
- I am ugly
- Nobody will ever love me
- Others are cold, critical, rejecting

Emotional responses

- Predominantly depressive or anxious/avoidant

Overdeveloped behavioural strategies: self-punishment and degradation, abandonment, emotional deprivation, social isolation, subjugation leading to the following current problems

- Self-harm (overdoses and cuts self)
- Abuses alcohol
- Avoids or is ambivalent towards closeness and intimacy
- Passive in relationships (even when these are destructive)

Underdeveloped behavioural strategies

- Self-nurturance
- Assertiveness in relationships
- Intimacy

Environmental factors

- Lives alone and is socially isolated
- Family uninterested or potentially will interfere, with changes she has not agreed to

Potential problems in therapy

- Likely to have difficulty engaging in treatment as she may be reluctant to trust the therapist and will be afraid of being criticized
- Ending of treatment may be problematic as she has few other supports and may become overly dependent on the therapist

Over the next two sessions the above initial formulation was discussed with Jean. The therapist made explicit links with Jean's past and current problems, all of which were longstanding. Jean's view of herself and of others was adequately reflected in the core beliefs. Several aspects of the formulation particularly made sense to her: Jean agreed that she avoided emotional involvement with others because she had experienced criticism and rejection in childhood from her mother and fellow school pupils. In addition, the link between the lack of affection and spontaneity in her childhood and adolescence and her belief that others were emotionally cold and unavailable to her made sense to her. With the therapist, links were made between these beliefs and her behaviour. Her lack of experience of affection, her mother's critical stance towards her and being "sent off" to boarding school had all led her to try to protect herself from others. She knew she isolated herself from others but she also recognized that this strategy led to her feeling more alone. She was concerned that she would never find anyone who could fulfil her need to be loved. Her more physically destructive behaviours – cutting, overdosing and abusing alcohol – were related to her desire to cut off from

strong emotions and thoughts about how useless and worthless she felt about herself.

Once the therapist and Jean had made these links between her over-developed behavioural patterns and core beliefs, they discussed how to proceed in therapy. Her therapist suggested a further five sessions, as Jean had attended five already. This allowed Jean to commit herself without feeling overwhelmed and allowed progress with this style of therapy to be reviewed. As Jean had relatively serious problems and the level of her personality disturbance was moderately severe, the therapist emphasized behavioural rather than cognitive work for the first phase of treatment. The following treatment plan arose out of the formulation.

Treatment plan

Sessions 1 to 5

- Assessment and introduction to cognitive model
- Shared formulation
- Agree treatment aims

Sessions 6 to 10 (concentrate on behavioural change)

- Decrease self-destructive behaviours
- Increase self-care
- Review aims and progress

Continue with therapy if agreed

Sessions 11 to 20 (mesh behavioural changes with changes in dysfunctional core beliefs)

- Work on interpersonal problems
- Decrease self-destructive behaviours
- Review and document progress

Continue with therapy if agreed

Sessions 21 to 30 (mesh behavioural changes with changes in dysfunctional core beliefs)

- Maintain behavioural changes
- Develop new ways of thinking about self to maintain behavioural changes
- Review and document progress
- Negotiate end of treatment date and increase frequency of sessions

Sessions 31 to 35

- Work on maintaining new ways of thinking and behaving
- Work on ending treatment issues

Although it is helpful to negotiate a treatment contract that stipulates an expectation about attendance, the therapist decided not to emphasize this in Jean's case. From the initial formulation, it appeared that Jean's past was characterized by others making decisions for her and avoidance, and in order to establish a collaborative relationship, it would be better to inform Jean that the process of therapy would allow her, to some extent, to set the initial pace of therapy. To introduce Jean to the collaborative style of therapy and to help her become more assertive, the following discussion took place.

Th: It seems from what you tell me, Jean, that other people have made decisions for you throughout your life and that you may not have thought that you have had a choice about what happens to you. Is that the case?

Jean: (*Nods in agreement*)

Th: Do you think that therapy might be like this? Or do you think that you have choices about what happens here?

Jean: I don't know. With the psychiatrist, I went to appointments every month to begin with but I missed several and a nurse came to visit me at home.

Th: I want you to feel that we are working together on your difficulties, and this does involve a commitment from you. Would it help if you were able to feel more able to decide what happens in our sessions?

Jean: (*Pauses*) . . . Probably.

Th: What would stop you coming?

Jean: (*Pause*) I sometimes find it hard to talk about myself.

Th: And that is why you might not attend? (*Jean nods*) Well, this therapy is about you, and we will agree what to talk about and what we are working on so that you know what to expect when you are here. I want you to tell me if you are finding it hard to talk about yourself or if you think I'm being pushy. How easy do you think that would be for you?

Jean: Quite difficult.

Th: What if I asked you to decide what we were to talk about each time and if I think something is very important, we can see if you are up to discussing it? If you are finding it too hard, you can say so and I'll agree to stop talking about that. I may bring it up again later in another session, and again you can say if you want to discuss it. Would that make things easier for you? (*Jean nods*) I do want you to come to sessions but only if they are helpful to you. Each time, I'll ask

you for feedback about the session and you can tell me what you honestly think about it. Would that be okay with you?

Jean: It sounds okay.

Th: If you don't come for some reason, what would you do?

Jean: I don't know.

Th: Would you want me to phone you to offer you another appointment?

Jean: (*Pause*) I'm not sure about that. (*Pause*) I'd find that a bit intrusive.

Th: Okay. What would you like to do in that event? How will I know if you want another appointment? Would I write to you with an appointment or would you phone me?

Jean: Could you send another appointment?

Th: Okay. I'll make a note of that.

The next two sessions were spent socializing Jean to the therapy and agreeing the aims of treatment. Priority had to be given to Jean's punitive and destructive behaviours, particularly cutting herself, and as Jean had realistic concerns about losing the use of her hand, this was agreed without difficulty. Jean, like many with personality disorder, was unsure of what other things she wished to change about herself and it was agreed that the formulation might be useful in guiding her decision about this. As a result, the therapist and Jean put together the initial formulation in the fourth session. The therapist was interested in Jean's conceptualization of her difficulties and found that this was poor. Making links between her current difficulties and her past relationships led to Jean beginning to have a better understanding of why she found relationships problematic. Specifically, Jean became aware that her fear of criticism and rejection might have its roots in her childhood. When asked how she wanted to change, Jean became distressed about how she had never been able to have close relationships and how she wanted to have a partner. She became quite angry in the session at this point, stating that she noticed the therapist's wedding ring and how the therapist could have no idea what it was like to be all alone. The dialogue continued as follows.

Th: Jean – I can see that you would like to have someone that was close to you. You are very isolated living on your own and it seems from what you have told me that you have had difficulties in relationships. I can see that this is important to you and I can see that this is distressing for you. Do you want to work on this together – trying to improve how you get on with others?

Jean: Yes, I do. (*Still angry*) But how can I do anything about it? Nobody would ever like me. I'm ugly, useless and I can't cope with relationships. It's fine for you – you're married.

Th: How much do you believe that nobody could ever like you, Jean?

Jean: I try not to think about it. It's too painful to know that I'll always be on my own.

Th: What about Simon? Does that relationship count in your opinion?

Jean: Only a bit. We were both odd . . . lost souls together. I was still lonely in that relationship.

Th: But does it count as a relationship, albeit in the past?

Jean: No, because it failed.

Th: Jean, just because a relationship fails, does it mean it doesn't count towards our experience in life? (*Jean tentatively shakes her head*) In this therapy, we will try to understand why your relationships have not been successful and what you need to do to improve your relationships with other people. By the end of treatment you may not have an intimate relationship but you may have more ideas about what kind of relationship you would like to have. Can we learn from our failed relationships in your view?

Jean: (*Pause*) In theory. But it is too painful for me to contemplate another relationship. I had that disaster with Ray and I don't want to go through that again.

Th: You seem afraid of attempting to have other relationships, yet you desperately want to be in one?

Jean: Yes, I know.

Th: But you want to have someone close to you? Do you mean a man here?

Jean: Yes, but I can't even have relationships with women.

Th: Would you like us to talk about this later on in therapy? Go over the relationships you have had and see what has happened more clearly and why you are so afraid?

Jean: Yes. But I don't know how to relate to other people. I'm shouting at you and I'm scared you are seeing me as scum . . . (*Cries*)

Th: (*After some moments*) I can see this upsets you and I am glad you have told me how you feel and how you think I might view you negatively. I know from your history that others have been critical and rejecting of you. We have to work on this together, on the same side. That means that I will be open with you about relationships, ours included. What gives you the impression that I see you as scum?

Jean: You are married and I can't have relationships. That makes me a failure in everyone's eyes and because I push people away, they see me as nasty.

Th: If I am married, do you think that means I cannot understand that other people have problems in relationships?

Jean: No, I suppose it doesn't.

Th: Most of the people I see here do not have relationships or are having problems in relationships. In my life outside work, I know many men and women who have problems in relationships. It seems to me that this is normal and that it also causes a lot of distress. Do you now think that I believe that those who do not have relationships, or who have problems because they are afraid of being rejected, are scum?

Jean: No.
Th: Shall we work on relationships in our sessions together? We appear to have started on our relationship! (*Both laugh*) I guess it helps to clear the air of misunderstandings when they arise, eh?
Jean: (*Smiles and nods*)

By the end of session 5, the aims of therapy were specified and were as follows.

1 Decrease self-harm behaviours (cutting, overdosing).
2 Increase self caring and nurturance (eating regularly, self-presentation, sleep schedule etc.).
3 Monitor alcohol consumption and note how this affects mood.
4 Once self-harm is reduced, and Jean has more control over this, work on establishing and maintaining relationship.

Sessions 6 to 10

The overall aims of sessions 6 to 10 were to decrease self-harm behaviours and increase self-nurturance as Jean had an overdeveloped behavioural strategy of self-punishment and degradation. Jean had not cut her arms since entering therapy but had reported experiencing several strong urges to do so. The main reason for not cutting herself appeared to be Jean's knowledge that this might cause potentially irreparable damage to her arm. The therapist used problem-solving techniques to help Jean explore ways in which she could keep herself safe from harm. Jean managed to generate a list of possible actions she could take to keep herself safe in the short and longer terms. Among her most favoured potential solutions were keeping only fixed safety razors in her home and keeping only a small supply of medication at any one time, including paracetamol. She set herself a goal of throwing away the stock of medication she had hoarded over a year, but would agree to throw out only a little at a time. The therapist agreed that this would be an adaptive strategy for Jean even though she would have preferred Jean to make the medication less accessible. Jean would not agree to getting rid of all non-essential medication and said she "needed" to know it was there if she got desperate. Given that the therapist was trying to ensure a collaborative relationship with Jean and was encouraging Jean to make decisions for herself, this appeared both appropriate and realistic. The therapist emphasized that Jean had options available to her, including harming herself, and that therapy aimed to increase Jean's ability to look after herself in a positive and nurturing way, that is, the behavioural strategy that was underdeveloped.

It was increasingly evident from further discussion with Jean that she harmed herself in response to certain mood states and situations. Jean would cut herself after a period of being intensely upset, and when worn out and

exhausted, she would begin to feel disengaged from everything around her. In this state, she would cut herself in order to feel physical pain as opposed to mental pain. The sight of her own blood, she said, had a calming effect on her and she would set about cleaning the wound or going to an Accident and Emergency Department if necessary. She hated attending hospital to have stitches as she found the attitude of the staff humiliating and she felt that they did not understand her. In the recent past she had had to attend hospital as her arm was badly damaged and (fortunately) she wanted to avoid this eventuality. A plan was agreed with Jean to help her to avoid getting to the stage of being worn out and exhausted and cutting. First, as stated above, she agreed to having only safety razors in the house. She was asked to explore ways of not getting overly distressed and disengaged. She was beginning to find talking about problems more helpful, but, as the therapist was likely to be unavailable at times, other ways of managing her distress had to be found. She eventually decided to phone the male nurse who came to visit her and arranged to do this with his permission. She told the nurse that she might not be able to talk at these times but asked if he would just let her be on the phone for a while so that she felt his presence during these times of high distress. Other members of nursing staff were briefed that Jean might call in distress and that their role was to listen if she wanted to talk and just be there for a while on the phone if she did not want to talk. This strategy worked well. Jean used it several times over the next six months and in fact managed to talk to the nurses, until she no longer needed to do so. In addition, the therapist encouraged Jean to find other strategies that were more self-reliant. After several sessions, Jean decided on several that had worked in the past and that she would be able to utilize systematically. These involved going to bed if very upset and having "time out", wrapping herself in a blanket and lying on the couch, and playing music that she found soothing and that would not lower her mood further.

A common situation that led to Jean being distressed was her mother phoning her. She phoned once a week on average and the conversation was almost identical each time. Jean was asked what she had been doing, and as she had very little to report, her mother usually said very little; after several long silences, they both said goodbye. Jean thought that her mother called her out of duty rather than concern and that her silence implied criticism of Jean's lifestyle. Jean told her mother very little, mostly because she thought her mother was uninterested. Her mother knew she had attended a psychiatrist for depression but Jean had not told her about attending a cognitive therapist. When asked why she thought her mother was critical, Jean recounted several episodes in her childhood when her mother had made Jean stand in front of her and tell her what she had done wrong. Her mother heard these accounts in silence and then asked Jean what she was to do with her. Jean was then usually punished by being kept in her room or made to do extra chores around the house. Jean also said that her mother would enter her

bedroom at night when she was in bed and stare at her, saying nothing, and then leave. These episodes had frightened Jean as a child as she could not understand why her mother behaved in this way. Jean equated her mother's silence with these episodes in her childhood and interpreted them as her mother regarding her as a being bad, a nuisance, and at worst, a worthless individual. Given this information, it was understandable that Jean thought her mother regarded her negatively and viewed herself as worthless. Jean was asked if there were positive memories of her mother and little evidence of happier episodes emerged. Jean was at a loss to explain or reframe her mother's behaviour. The therapist speculated that her mother had been unwell, perhaps depressed, or had worries of her own that Jean did not know of and that she was unable to resolve. Jean did not accept such speculations but she did agree she did not know her mother well nor did she wish to know her better, as she found her so negative. Jean was asked if she thought that her mother's regular phone calls could be an indication of caring; she found this hard to accept. It was clear that Jean's mother had not been able to provide Jean with a caring and nurturing environment in childhood. After looking at several options for managing the phone calls, Jean agreed to take more control and initiate the calls herself. She planned to phone every ten days or so and, as she was paying for the calls, she could reasonably keep them short. She also thought it would be helpful if she could ask her mother questions about what she had been doing rather than have all the attention placed on her. This increase in assertiveness was highlighted by the therapist.

Jean was asked to keep a record of her alcohol consumption and how this affected her mood, but did not do so. The therapist systematically enquired about this each session and a relatively clear pattern emerged. Jean was not consuming alcohol on most days but if she did drink, she consumed at least half a bottle of wine. This usually sent her to sleep early but her sleep was then disturbed later in the night and her mood was low over the next two days. The therapist kept a record of this and gave a copy to Jean, but other than this no intervention was planned and sessions focused on reducing other forms of self-harm. Jean was also asked about her eating and agreed to try to eat regular meals and nutritious food.

At the tenth session, Jean did not think she had made any progress. She still felt she was worthless. The therapist, who had kept a record of her progress on the agreed tasks, asked about how Jean viewed these. Jean acknowledged that she had started phoning her mother and asking about what she had done. Jean had discovered that asking about her father was more productive, as her mother did not like speaking about herself. This had helped Jean cope better with her contact with her mother. She had not cut herself for several months and had put into operation some of the agreed strategies and found those helpful. The therapist summarized the changes as being mainly in Jean's behaviour and asked Jean whether she still believed she had made no progress and was worthless. An explanation was given about how the therapist

would not expect Jean to feel differently about herself as she had thought this way since she was a child. Changing her behaviour in such a short period was a surprise to Jean, and she agreed to enter the next phase of therapy, which would involve examining the way she thought of herself and others as well as behaviour change. Jean agreed to another 10 sessions and it was acknowledged that she was now more confident about being able to speak about herself in sessions.

Sessions 11 to 20 (mesh behavioural changes with new ways of thinking about self)

- Work on interpersonal problems.
- Decrease self-destructive behaviours.
- Review and document progress.

This phase of therapy took place over approximately three months. The focus was on Jean's view of herself and others as reflected in her core beliefs and the overdeveloped behavioural strategies that were related to these beliefs. The therapeutic task was to begin to develop alternative ways of thinking about herself that would be more adaptive and help Jean to maintain the change she had made in her self-destructive behaviour and assertiveness.

Most of the cognitive work took place within sessions, with Jean attempting to change her behaviour towards herself and others in the time between sessions. The belief that others were cold, critical and rejecting became the main focus of sessions as this was central to Jean's avoidant behaviour. In tandem, Jean carried out behavioural tasks that were designed to provide information to evaluate her core beliefs. From the first 10 sessions, it was evident that Jean believed that people would be critical of her and that even if someone appeared to be kind or warm, this was likely to be temporary and eventually she would find them to be cold towards her, critical and rejecting.

Several cognitive techniques were used to explore the adaptiveness and veracity of her beliefs, but the main technique used throughout treatment was the continuum. Jean was asked what statement she would put at the opposite end of a continuum that had at one pole the statement "Everyone is rejecting". After some discussion, Jean decided on a uni-directional continuum with the statement "Some people are reasonably friendly". The initial statement was phrased in this way to try to force Jean to begin to evaluate individuals in terms of friendliness as she clearly attended only to negative aspects of relationships, and ignored any friendly overtures from others. The continuum was as shown in Figure 13.1.

Initially, Jean believed that this statement was not true and rated this as 0 per cent, that is nobody was friendly towards her. Jean was then asked to detail the way in which she might judge someone to be friendly. The therapist also took an active role in this discussion and listed some of the ways she

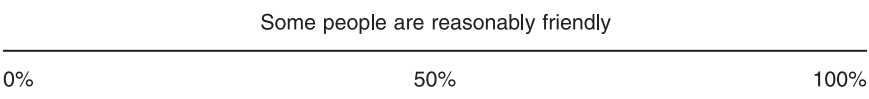

Figure 13.1 Jean's continuum.

thought others displayed friendliness. Jean was not asked to accept the therapist's view but to keep an open mind and develop her observation skills. After a few sessions, Jean listed some of the following characteristics of friendly behaviour in others – smiling, laughing with someone, looking at someone directly, listening attentively, standing quite close, etc. Armed with this information, Jean was asked to observe other people in social situations and chose to go to a café near her home to do so. This task was not easy for Jean as she had become used to staying at home on her own, and going to a public place was mildly anxiety-provoking for her. Nonetheless she carried out the assignment and reported that she had been able to observe friendly behaviour in other people. Whether or not others could be friendly towards her remained unanswered. She was asked to evaluate her contacts with shopkeepers, neighbours, and those she came into contact with. By session 14, she had some evidence that some people were friendly towards her but they were strangers to her and not people she wanted to have as friends. In order to test the proposition that she might be liked by others who might become friends, she had to find a way of meeting people who might share her interests. As she had studied modern languages at university, Jean suggested that she might want to maintain her interest in this and she was set the task of finding out how she might do this as well as other ways of meeting people.

This task proved to be too difficult, as Jean felt overwhelmed at the idea that she had to meet people. She telephoned the therapist saying that she wanted to harm herself and was feeling very low and had been drinking. She was instructed to keep herself safe by lying on the couch and not cutting and she was asked to remind herself that she had experience that these feelings would pass. The therapist asked Jean to stop drinking alcohol and try to go to sleep. The following session was brought forward and the therapist saw her again two days later. Jean had not cut herself and was feeling less depressed but still very overwhelmed. It was agreed that she might have taken on too difficult a task and that breaking the task down further might be helpful. Jean still felt she wanted to cut herself and was asked how she might keep herself safe from harm. She suggested that she would not drink alcohol, as this clearly made her mood and thoughts worse. The therapist then encouraged Jean to think of other strategies. Finally, they agreed that Jean would take "time out" on the couch, not drink alcohol, and make sure she was eating properly and not skipping meals, and would also try to go out of her house at least once a day. By the following session, Jean was feeling more in control and the task of meeting people was reviewed and broken down into less

anxiety-provoking goals so that Jean would not feel overwhelmed. She agreed the following tasks to be carried out over a month. The aim was to allow Jean opportunities to meet others and to evaluate the degree to which they were friendly.

1 Phone language centre to enquire about classes.
2 Visit language centre to pick up information on conversation classes.
3 Contact language school to find out about tutoring children in French and Spanish.
4 Offer to help elderly neighbour with her shopping.
5 Invite younger neighbour in for coffee.
6 Ask (local) brother's children out to cinema.

In addition, the therapist began working systematically on Jean's belief that she was worthless. Having succeeded in not cutting herself and reducing her alcohol consumption, Jean was surprised but did not appear to value this change in her behaviour. The therapist was positive about Jean having prevented more damage to her arm, and asked the following questions.

Th: Was it hard for you to resist harming yourself?
Jean: (*Pause*) It was very difficult. I've always cut myself at these times.
Th: So it was hard for you, especially when it was such a difficult time for you. How did you manage to not cut, Jean?
Jean: I tried to wait till the feelings passed and after a while, they did pass.
Th: Did you do anything else? What about not drinking alcohol?
Jean: I knew I shouldn't drink anymore. It just makes me feel worse and in a state.
Th: It sounds as if you managed to avert the crisis and then went on to look after yourself.
Jean: Yeah. I have to if I want to get out of this hole.
Th: What does looking after yourself mean to you, Jean?
Jean: I'm not sure . . . I suppose I want to feel better about me – not totally worthless.
Th: So where would you be if we think about a continuum "I do have worth?" Do you rate yourself 0 per cent or do you think you did better than that?
Jean: Maybe a bit along from 0 per cent – maybe 10 per cent.

Over the next few weeks, Jean managed to accomplish some but not all of the tasks set, and with each new encounter noted how she thought others had responded to her. She was still cautious about interpreting other people's behaviour as being friendly but could acknowledge that not everyone was unfriendly. Having coffee with her neighbour went well and her elderly neighbour turned out to be very friendly and had invited Jean to have supper with

her. She found out that conversational classes at an advanced level were available after summer and she had tentatively enrolled.

Jean was gathering as much evidence as possible about whether or not others could be friendly towards her and evidence that would refute the idea that she was worthless. Criteria were developed for her belief that she was worthless so that different types of evidence could be evaluated (see Figure 13.2).

During sessions, work was carried out on Jean's core beliefs. Initially, no difference had been noted in how Jean perceived herself as she tended to dismiss evidence and was not able to change the degree to which she believed she was worthless. By consistently challenging her old belief, by building on new, more adaptive ways of thinking about herself as having some worth and being able to act in a friendly manner to others, which was reciprocated, and using the behavioural evidence she was gathering, she gradually began to consistently shift the degree to which she believed that she was a worthy individual to whom others might like to be friendly. It was this consistent and systematic gathering of evidence and challenging of her view of others and self that appeared to shift her beliefs, and this in turn allowed her to become more confident in managing the behavioural tasks.

By session 20, Jean had made progress and wanted to continue with the same work and to talk more about her past, to which the therapist agreed.

Sessions 21 to 30

Jean's behavioural and schema work continued over the next 10 sessions, with Jean gathering as much evidence as possible about whether or not others could be friendly towards her and whether she had evidence against the belief that she was worthless. In addition, some parts of sessions were devoted to

Old belief: I am worthless

0%	50%	100%
I have never done anything useful in my life		I am always doing things that are very helpful to others
0		100
I am completely stupid		I am extremely intelligent
0		100
I am ugly		I am very beautiful
0		100
I am socially inept		I am very socially skilled
0		100

Figure 13.2 Continua developed for Jean's beliefs.

talking about Jean's past. The main topic was her relationship with her mother. Her brother's wife had told her that her mother had suffered from depression. When Jean asked more about this, she revealed that her mother had been depressed around the births of all three children, that she had found it very difficult to cope and that housekeepers and au pairs had been employed to help look after the children and allow her mother to recover from depression. Her sister-in-law had suffered from post-natal depression and had been told of her mother-in-law's depression at that time. Although this piece of information helped Jean to understand her mother's behaviour, she was increasingly resentful of how she had been ignored as a child and sent off to school. She believed that her mother's behaviour had resulted in her feeling worthless and guarding herself against others. It was obvious to Jean that she could not change the past and she was made aware, through further discussion, that she had begun the task of changing how she felt about herself and others and did not have to follow on with the legacy of her childhood. By this point in therapy, she had collected a dossier of evidence to suggest that she had value and that some people might be friendly towards her, even if she had no special relationship with anyone. She had also begun to be more assertive, with her mother and with other people. Further work was done exploring her childhood, using the historical test of schema, to evaluate her belief that others had been cold and critical towards her. This work was fruitful in altering Jean's view of her childhood and she was able to recall episodes of others being supportive and kind, particularly her grandmother and her father. An extract is presented in Figure 13.3.

Several sessions were devoted to discussing Jean's relationships with men, as this topic had come up several times before in connection with her fear of

Belief: Other people were cold and critical

Evidence supporting belief

- My mother never seemed to show any interest in me.
- My mother used to tell me she did not know what to do with me if I was bad.
- The au pairs we had at this time did not play with me.
- At boarding school, girls ridiculed my looks and clothes.

Evidence that supports a new belief

- Others were sometimes supportive and kind.
- Girls at my local school used to invite me to their homes.
- The teachers praised my work.
- One of the au pairs used to let me use her make-up and try on her clothes.
- At boarding school, another new girl helped me with maths homework.
- My father used to take me on walks in the countryside every weekend.
- My father used to play with me and my brothers during the school holidays.
- My grandmother used to give me sweets when my mother wasn't watching.
- My grandmother used to read stories to me at night and tell me jokes.

Figure 13.3 Extract from Jean's historical test of schema (age 8 to 12 years).

intimacy and rejection and her difficulties asserting herself in relationships and not having her needs met. She was now more aware that she had got involved with Simon and Ray as desperate attempts to cope with her feelings of being abandoned and unlovable but both men had been unable to meet her emotional needs. Although she was unsure of her ability not to get into this type of relationship again, she had a clearer idea of why she had done so in the past and did not want to repeat the pattern. She said that she needed to be more confident of her own strengths before embarking on a relationship, and in many ways less needy and more able to look after herself. It was agreed that getting into a relationship involves some risk but that it was worth taking if she was to find a meaningful relationship. Jean realistically thought that she should take relationships with men more slowly and build up a better idea of the man before getting too involved. She also knew that she had to become much less socially isolated if she was to find a partner.

As the 30th session approached, the therapist began to discuss ending therapy with Jean. By this time, the summer was over and Jean had been attending French and Spanish conversation classes, which she had found enjoyable although initially daunting as they had involved meeting other people. She had found it hard to answer questions about what she did, as she had no job and she had assumed that others would evaluate her negatively. This, and the thought of ending therapy, had precipitated another crisis in which Jean had cut herself. She had regretted having harmed herself and thought that all her progress had been for nothing. She had phoned the therapist and talked this through and, having challenged her view that she had made no progress, despite cutting again, Jean had managed to put the episode behind her and move on.

Sessions 31 to 35: the final sessions

The final five sessions were used to evaluate progress and to discuss ways in which Jean could continue with the work she had begun. These sessions took place approximately weekly to enable issues to do with ending therapy to be discussed fully within sessions. Jean was not confident about her ability to cope without therapy or the therapist. She believed that she would relapse without regular sessions and she said that she would miss seeing the therapist.

In reviewing her progress, Jean acknowledged that she had done well to cut down her alcohol consumption, had reduced the degree to which she self-harmed and had managed to establish regular contact with her neighbours and with others through her French and Spanish conversation classes. Her mood was less volatile and although she became distressed at times, these episodes were shorter and more contained. Her contact with the psychiatric team continued on an infrequent basis and the male nurse had agreed to continue to see Jean, when necessary, for crisis management. Her view of

herself and of others had been altered in the sense that she could begin to have some faith in her new ways of thinking about herself and others, and she was aware that at times when she was either anxious or low, she continued to ignore or distort evidence that would fit with these new beliefs about herself and others. She needed to continue with the behavioural changes she had made.

The end of therapy was difficult for Jean. She had managed to form a good relationship with her therapist and had been able to trust her. The therapist asked what ending therapy meant to Jean. She said it signified the end of their relationship and she was sad about that and she asked if she would be able to contact the therapist if she needed to. At this point, the therapist acknowledged that she was also sad that the relationship was coming to an end. The therapist asked Jean if she thought that she was being rejected, to which she answered that ending the therapy had brought some of the "old" feelings and thoughts about rejection to the fore and admitted that she had struggled with these feelings for several weeks, knowing that the end was to be expected as they had often talked about ending therapy in sessions. The therapist pointed out that therapy had to come to an end and that it was understandable that Jean should feel this way. Indeed, given Jean's past history, she had done well to recognize the feelings and thoughts. The therapist asked Jean how she was managing to deal with these feelings and thoughts. Jean said she had felt anxious about the end of therapy and had thought about taking an overdose. She had looked at the dossier of information she had gathered in treatment and although she had remained anxious, she had been able to counter her thoughts about coping on her own. She had evidence that other people liked her and that she was not worthless, and did not want to deliberately diminish the progress she had made by overdosing. She also said she wondered if the therapist would extend the treatment if she overdosed. She added with a wry smile that the therapist had concentrated on what Jean could do to improve her life and would be unlikely to be swayed by such an action. The therapist agreed with Jean's assessment of the situation and emphasized Jean's new ability to cope much better than before. She told Jean that she would be interested in how Jean fared in the future and if, after some time passed, Jean required further help, she could be assessed again.

Prior to the last session, the therapist gave Jean a letter summarizing what had happened in therapy and detailing the formulation that they had jointly endorsed. The letter pointed out Jean's strengths, what she had achieved during therapy and how she had learned to look after herself. In the last session, Jean was tearful but interpreted this as being normal after such a length of time in therapy. She was not particularly anxious about her future or her ability to cope without therapy, as she said that she had to try to do this if she was to develop a better life for herself. The final session ended with the therapist wishing Jean well for the future.

Appendix 1

Core beliefs

What are core beliefs?

Core beliefs are strong beliefs that you may hold about yourself or other people. You do not question these ideas about yourself or others; they simply seem to be true. Core beliefs are not always obvious and you may not always be aware of a core belief. However, these beliefs are very powerful and when your thoughts and emotions appear to be extremely negative and overwhelming, it is likely that a core belief is dominating the way in which you are viewing yourself and the world around you. It is likely that these beliefs develop in childhood, when you are too young to be able to evaluate whether or not they are true.

For example, Jenny had a belief that she was bad. She said that she had always thought this about herself; she simply thought this was how she was. She was not aware that she had learnt to think about herself in this way because of the experiences she had in childhood. When her therapist got to know her better, as expected, it did appear that she had thought this way since she was a child. She had been brought up by an aunt who had treated her badly. She had been neglected and had not had her emotional needs met as a child. Rather than thinking that her aunt was uncaring, she thought that she was to blame and that she was being punished for something she had done. The only way she could make sense of being ignored and sometimes beaten as a child was to believe she had done something wrong. As she grew older, other experiences were interpreted to fit in with this belief. When she was told off in school by teachers, when her school mates did not want to play with her, when no boys were interested in her as a teenager, she believed that she was bad and that no one could possibly think well of her. She believed this to such an extent that when something positive did happen to her, such as being invited to play with someone or, when she was older, when a young man asked her out, she thought that they were just being nice to her because they felt sorry for her. She believed that if they got to know her well, they would also be able to see that she was not worthy of their affection or attention.

Like Jenny, you may hold a deep and unshakable belief about yourself

or others. It seems that these beliefs are so strong that when something good happens, rather than experiencing pleasure, you systematically distort the information to fit the old belief.

How can cognitive therapy help?

In therapy we will examine some of the core beliefs that you hold about yourself and others. It will take time to change such strong beliefs. We will help you to evaluate and weaken these beliefs, and to build more adaptive, new beliefs. We also know that these powerful beliefs are also likely to affect the way in which you behave. Cognitive therapy will also enable you to make changes in your behaviour, which we hope will improve the quality of your life. Therapy will help you build up new ways of thinking about yourself and others and new ways of behaving towards yourself and others that will help you to cope better with your life.

Appendix 2

Formulation

Why has the client come for help now?

CHILDHOOD ENVIRONMENT & SIGNIFICANT EARLY EXPERIENCES

CURRENT PROBLEMS including interpersonal difficulties

DOMINANT EMOTIONS

CORE BELIEFS ABOUT:
SELF **OTHERS**

OVERDEVELOPED BEHAVIOURS **UNDERDEVELOPED BEHAVIOURS**

Historical test of schema

Evidence that supports the old belief

State old belief:

Age _____ to _____ years

Evidence that supports a new belief

State new belief:

Age _____ to _____ years

Appendix 3

Acts of Deliberate Self-Harm Inventory

Kate M. Davidson

This instrument is designed to ensure accurate collection of data about attempted acts of suicide and incidents of self-harm.

For the purposes of gathering information about acts, this inventory codes data categorically. The interviewer should decide if a particular episode meets the criteria for either a suicide attempt or self-harm. **The instrument is not a measure of severity.** The aim of the interview is to assess the frequency of attempts of both suicide and self-harm over a six-month period.

SUICIDAL ACTS

The criteria for a suicidal act are that the act:

1) **is deliberate**

This means that the act could not be construed as an accident and planning was involved. The subject accepts ownership of the act: for example, an act where one claims not to have read the indications on a bottle of medication before taking it in excess would not be considered a suicidal act.

2) **is life-threatening**

The subject's life was deemed to be seriously at risk, or he or she thought it to be at risk, as a consequence of the act.

3) **resulted in medical intervention, or intervention would have been warranted**

The subject may have sought or would have warranted medical intervention, or medical intervention was sought on their behalf. Medical intervention need not be treatment but at the minimum a physical examination is implied.

INTERVIEWER:

Please note that acts refer to the **six months prior to the interview**.

SUICIDAL ACTS

1. Over the past six months have you attempted to kill yourself?
(The interviewer should describe to the patient the definition of an attempt at suicide given above.)

YES NO **If no, go to Part II**

2. On how many occasions can you recall trying to kill yourself? Number ☐

List in chronological order (*most recent first*):

	Date	Method	accuracy (a,r,q,i)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

If more use separate sheet

3. Interviewer should assess the accuracy of these statements at the end of the interview.

a - accurate **r** - reasonably accurate **q** - questionable **i** - inaccurate

4. Date of first suicidal act for this time period _____
(not at baseline)

The interviewer should then elicit the following information for each act commencing with the earliest attempt over the past six months.

Suicidal Act 1

1. Date of the event: _____
2. What was the method used? *Please circle below*

1. Overdose	1	*(please list in Question 6)*
2. Self-laceration	2	
3. Burning	3	
4. Swallowing sharp objects	4	
5. Hanging	5	
6. Shooting	6	
7. Jumping from height or under train	7	
8. Car exhaust fumes	8	
9. Other – please specify _____	9	
10. Two or more (please circle)	10	

(Only include life-threatening self-induced injury here e.g. overdose necessitating hospital assessment or admission, self-laceration leading to severe loss of blood requiring transfusion or stitching, razor blade ingestion leading to surgical intervention.)

3. Were plans made? (a plan is a set of systematic, premeditated, coordinated events, even if carried out impulsively at the time)

   Yes (1) No (2)

4. Did the patient contact anyone about the possible attempt?

   Yes (1) No (2)

5. Did the patient leave a note indicating that the act was suicidal?

   Yes (1) No (2)

6. What drugs &/or alcohol were consumed during the act and in what quantity?

a) Alcohol	Yes	1	
	No	2	Number of units _____
b) Paracetamol	Yes	1	
	No	2	Number taken _____
c) Antidepressants	Yes	1	Type _____
	No	2	Number taken _____
d) Other drugs	Yes	1	Please specify _____
	No	2	Number taken _____

7. Which hospital was the patient admitted to or treated at (if any)?

Name of hospital _____

This page should be copied as multiple acts may be recorded

Suicidal Act ____ (please enter act number)

1. Date of the event: _____
2. What was the method used? *Please circle below*

1. Overdose	1	*(please list in Question 6)*
2. Self-laceration	2	
3. Burning	3	
4. Swallowing sharp objects	4	
5. Hanging	5	
6. Shooting	6	
7. Jumping from height or under train	7	
8. Car exhaust fumes	8	
9. Other – please specify _____	9	
10. Two or more (please circle)	10	

(Only include life-threatening self-induced injury here e.g. overdose necessitating hospital assessment or admission, self-laceration leading to severe loss of blood requiring transfusion or stitching, razor blade ingestion leading to surgical intervention.)

3. Were plans made? (a plan is a set of systematic, premeditated, coordinated events, even if carried out impulsively at the time)

   Yes (1) No (2)

4. Did the patient contact anyone about the possible attempt?

   Yes (1) No (2)

5. Did the patient leave a note indicating that the act was suicidal?

   Yes (1) No (2)

6. What drugs &/or alcohol were consumed during the act and in what quantity?

a) Alcohol	Yes	1	
	No	2	Number of units _____
b) Paracetamol	Yes	1	
	No	2	Number taken _____
c) Antidepressants	Yes	1	Type
	No	2	Number taken _____
d) Other drugs	Yes	1	Please specify
	No	2	Number taken _____

7. Which hospital was the patient admitted to or treated at (if any)?

Name of hospital _____

DELIBERATE SELF-HARM (not suicide act)

The criteria for an act of deliberate self-harm are that the act:

1) **is deliberate**

This means that the act could not be construed as an accident and that the subject accepts ownership of the act.

If a patient reports self-harm events that occur within hours of each other (for example, scratching wrists or cigarette burning), these are to be considered as one event. **ONLY** when 24 hours has passed between events are they to be considered as separate acts.

2) **resulted in potential or actual tissue damage**

You may wish to ask for clarification if appropriate.

1 Have you harmed yourself in any other way over the past six months? For example, by cutting or burning?
(The interviewer should describe to the patient the definition of self-harm given above.)

Yes No

2. How many times have you harmed yourself in any of these ways over the past six months?

Number ☐

Note most recent act first.

	Date	Method
2		
3		
4		
5		
6		
7		
8		
9		
10		

Key
1. Cutting, scratching or stabbing
2. Burning
3. Other (specify)
4. Two or more (in same episode)

If pattern or method is different to responses above for remainder of acts, please provide details in above format.

3. Interviewer should assess the accuracy of these statements at the end of the interview. _____

a - accurate **r** - reasonably accurate **q** -questionable **i** - inaccurate

4. How many acts were associated with alcohol and/or drugs? _____
5. How many acts were associated with alcohol only? _____

Signature of interviewer_____

Date_____

ACTS of DELIBERATE SELF-HARM INVENTORY
Author: Kate M. Davidson

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Index

Note: Page references to tables and Appendix 3 are shown in **bold**.