THE INTEGRATIVE MODEL OF COGNITIVE-BEHAVIORAL PSYCHOThERAPY IN PERSONALITY DISORDERS

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Abstract
In their entirety, personality disorders represent specific clinical nosologies which affect areas of the patient’s functionality, especially in human relations. Cognitive-behavioral psychotherapy involves a number of guidelines/strategies, most of them benefiting from a solid empirical support; thus, this paper deals with personality disorders from the perspective of the general integrative model of CBT and not from the perspective of a specific therapeutic strategy.

Keywords: cold cognitions, hot cognitions, cognitive restructuring, the ABCDE model, borderline personality disorder, narcissistic personality disorder

INTRODUCTION
The current cognitive behavioral therapy (CBT) paradigm starts from an integrative model that is based on the scientifically proven effectiveness in the psychological treatment of personality disorder (PD) treatments, some therapeutic strategies being derived from other psychotherapeutic guidelines. Thus, CBT is the integrative framework which could facilitate the connection between psychological and pharmacotherapeutic treatments whenever there is scientific support for this co-association. It however, requires a revision of these integrative issues but it is well-known currently that the treatment of choice of PDs is psychological interventions (1).

Personality disorders can be defined as sustainable patterns of some inner experiences found at the behavioral level, which significantly contradict the expectations of the individual, the culture to which he/she belongs, these models being pervasive and inflexible. They are stable over time and occur in adolescence or early adulthood, and are responsible for the generation of stress and impairment (2). In terms of the model of cognitive-behavioral psychotherapy, personality disorders are associated with a dysfunctional pattern of thinking based and particularly influenced by dysfunctional beliefs/cognitive schemas, manifested at the behavioral level by difficulty in adapting and in relationships (3) (4) (5). The central beliefs that occur in PD are specific patterns of thinking derived from the negative interaction of the patient and their genetic background with the disadvantaged physical environment in which the individual has evolved (6). Early maladaptive schemas (EMSS) are based on the dysfunctions that occur at one or more levels specific for attachment or development of the individual’s own identity since childhood, and which occur in adulthood in a latent/manifested way mainly in PDs, being biologically determined (by temperament) (7) (8) (9)(10)(11)(12).

There are several strategies/therapeutic guidelines that make up CBT, some representing new psychological methods, there already being empirical support that demonstrates effectiveness in the treatment of PDs (13) (14) (15). In terms of comorbidity between PD and a disorder from the non-psychotic psychiatric range, the result of the intervention CBT is as effective as in the case of the unique non-psychotic psychiatric one, especially in the case of co-occurrence between PDs and disorders of anxiety/depression (16).

Clinically, PDs are worsening and maintaining factors of disorders from the field of psychopathology, but this depends on the specificity and intensity of the PD (17). The complexity of these cases required finding methods and techniques to complement the standard intervention intervention of CBT so that together with psychopharmacotherapy the clinical picture can be improved by the flexibility of maladaptive thinking schemas and the change of some maladaptive behaviors (18).

THE INTEGRATIVE MODEL OF COGNITIVE-BEHAVIORAL THERAPY
Most cognitive theories are based on the assessment of the so-called “cold cognitions” (descriptions/inferences – e.g. “They are glaring at me and want to hurt me”), namely, what a person thinks in a difficult life situation about that particular situation, and under that assumption negative feelings arise because of these cold cognitions. This is only a half-truth, since “hot cognitions” are actually responsible for generating negative emotions, more precisely the significance a patient attaches to “cold cognitions” (e.g. “I need to be appreciated by people and it is catastrophic if they want to hurt me”). Thus, if a patient with avoidant personality attachment pattern is treated, the therapist will have to change the patient’s thinking to the so-called “hot cognitions” (e.g. “I am very important in this situation, I must be appreciated by others”, “They are looking at me and do not want to hurt me”).

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disorder has an automatic negative thought in a social situation, such as: “others will laugh at me” (cold cognition), it is not the thought that causes anxiety but the significance that the person gives to the thought: “if they laugh at me, others will reject me and this is an unbearable and unacceptable thing” (hot cognition) (19) (20) (4). Both automatic negative thoughts (surface) and maladaptive cognitive schemas (depth) refer to/ include both hot and cold cognitions, which may occur in one of the two forms (1).

The application of cognitive techniques combined with behavioral and relaxation one, but mainly the focus of the therapist on modifying hot cognitions, belonging to Cluster C in PD, will result in modification and flexibility of some dysfunctional beliefs, which contributes to remission of comorbidities and to the change of some maladaptive behaviors (21) (22). There are cases in which PDs have a unique, complex, and high intensity specificity (such as Borderline PDs) so that identifying and changing dysfunctional cognitions (hot cognitions) requires a completion through the use of experiential techniques. This is due to the fact that in severe personality disorders causality implies traumatic life events such as sexual/ emotional/ physical abuse in childhood (23) (24).

In the case of such PDs, a storage of traumatic memories in the amygdala is determined by a mechanism similar to posttraumatic stress syndrome, as well as a storage of cognitive traumatic memories in the hippocampus and neocortex (11), these being mediated by the prefrontal cortex. In such cases, CBT is effective on the one hand because of the inhibition of the response of the amygdala that generates negative emotions associated with trauma and which bypass the cognitive system and reasoning, and on the other hand because CBT boosts the response of the prefrontal cortex (PFC), cognitive restructuring having the purpose of alleviating dysfunctional cognitions related to trauma, since the activation of the dorsal prefrontal cortex (DPFC) causes a decrease in activation of the amygdala. This implicitly suggests that the cognitive conscious processes have a role in emotional regulation (25) (26) (27).

As a result, experiential, gestalt, mindfulness techniques and those which address the relationship of the object, cognitive-behaviorally conceptualized, may contribute to increased therapeutic efficacy in PDs, especially when the patient has a history of a trauma or psychotrauma in early childhood. The effectiveness of these techniques is given by the direct approach to early trauma using imagery and role-play, and by associated cognitive restructuring in order to increase the flexibility of dysfunctional beliefs with the aim of determining phenomena of awareness in these patients (28) (29). The resulting therapeutic benefits that stem from cognitive restructuring and awareness are essential in the process of changing maladaptive behaviors in PDs. Theory and, primarily, clinical practice indicates that, generally, PDs are egosyntonic, the patients are not aware of a multitude of reactions and maladaptive behaviors that they have in different life situations (30) (31). Due to this egosyntonic character, in terms of cognitive theory, we might consider that some of these types of behavior are determined by unconscious information processing (32). Identifying unconscious beliefs along with the conscious ones during the therapeutic process contributes to: 1) determining cognitions/ beliefs/ dysfunctional cognitive schemas associated to specific PDs (33), 2) flexibilizing them through cognitive restructuring techniques, 3) the assumption of adaptive thought patterns (34).

In designing the treatment plan specific for CBT, the PD conceptualization of the case has to include a causal/ inter-determination relationship of the stressors such as negative life events (triggering stimuli) and maladaptive cognitive schemas of the patient (which also include biological vulnerability). This interdependence determines the cognitive, subjective/ emotional, and behavioral symptomatic manifestations in these patients (35).

Conceptualization in PDs is important because the patient thus understands the causes and manifestation manner of their psychological problems; this is essential in establishing the therapeutic goals together with the patient. Especially in PDs, a correct conceptualization is done after at least three sessions of clinical psychological evaluation. From a psychometric point of view, the most useful instrument to identify the PD is SCID-II. Structured Clinical Interview, the degree of validity of this instrument being directly proportionate to the therapist’s clinical experience (21).

A model of conceptualization that can be applied simply and effectively in PDs (but also in other psychopathological disorders) is the ABC (DE) model. Hyland, and Boduszak (2012) citing Ellis (1958, 1962, 1994), David and Freeman (2015), David et al. (2010) have shown that the ABC model can describe psychopathology in that cognitions are considered determinants of emotional, behavioral, and attitudinal reactions of a patient. In other words, when a person relates themselves to negative life events (A) through a set of central irrational beliefs (cognitive B-schemas: “I value nothing as a human”) he/ she will generate surface dysfunctional beliefs (B-automatic thoughts: “I will not succeed”) which then support the dysfunctional negative emotions and maladaptive behaviors (C). Identifying these irrational beliefs/ central and surface dysfunctional thoughts and their debate/ change (D) contributes to replacing them with rational/ alternative beliefs, which clinically contributes to the remission of the disorder and adopting a style of thinking effectively and rationally (E) (1) (36) (19).

In PDs, this model must be completed and insisted on more, particularly on the relationship between B (beliefs) and C (consequences). Due to cognitive and dysfunctional behavioral patterns, it is necessary to complete the ABCDE model, where D (discussion/ modification) may be supplemented by cognitive diffusion techniques and E by changing the relational framework. Even if diffusion cognitive techniques appear to some extent in cognitive restructuring specific for traditional CBT (37), in the case of PDs they should be applied systematically. This is due, for example, to the thought-action fusion phenomenon that usually occurs in obsessive-compulsive disorder (OCD) (38), but also in several other PDs (31). Hence, a patient with comorbid OCD may think: what if I am going to hurt children? This thought (assessed by hot cognitions “I must not hurt them and it would be catastrophic if I harmed them”) triggers feelings of anxiety because for the patient thinking is synonymous with acting. Cognitive diffusion will focus
on the separation of the thought of event/ the person itself, the way semantics can influence the development of dysfunctional negative emotions being already demonstrated (39) (40), the patient regarding it as a mental construct, stringing phrases, etc., that is, the patient is taught not to identify themselves with the thought or the thinking process. Also, another effective technique in these patients is framework changing/ relational context. With its aid, the patient with PD acquires coping adaptive mechanisms that help them learn to accept themselves as a person, to realize that thoughts are just thoughts, to live the present moment and to define the values of life, all of these being the attributes that belong to a psychological flexibility (41) (42).

Generating change in patients with PD is not achieved by using the therapeutic relationship as a framework for change, but by applying an ABC conceptual model in which the autobiography/ life history of the patient is brought to date “here and now” and faced with the current issue of the patient's life. For example, a patient with a narcissistic/ passive-aggressive PD can develop hostile behavior toward the therapist. In that particular moment, using the Socratic dialogue technique (asking questions the answer to which is mostly known by the therapist) the patient is asked “please let me know when, in your entire life, you have felt something identical, how you are feeling toward me/ behaving with me now (hostile feelings), or more precisely under what circumstances?” Reference to similar events in the history of life and reporting to the present with subsequent extrapolation through the same ABC model to a problem that is present in the patient's life makes them understand the source of their problems and thus generate change by changing irrational beliefs/ dysfunctional thoughts (43).

Another important aspect of CBT intervention in PDs will be based on the autobiographical versus semantic cognition model (19). Perhaps more than in any other psychiatric condition, in PDs cold/ hot cognitions affect autobiographical memory, which in turn changes the sense of semantic cognitions. For example, cold cognition in narcissistic PD: “I am special and others must respect me” is related to semantic memory and is interrelated with it. Thus, hot cognition is associated with semantic cognition and determines: “It is terrible and unbearable not to be respected” (as cited by David, 2003) (44). This dysfunctional type of thinking specific to PDs is determined by maladaptive cognitive schemas which, through the bio-psycho-social tendencies they incorporate, influence the behavioral and attitudinal patterns of the patient. Confronting these schemas in PDs can be done both in a cognitive way and through (experiential) imagery with the purpose to change some of the maladaptive behavioral patterns (45) (46) (47). Mindfulness techniques can also be used, but caution is advised in their implementation, particularly because of excessive detachment of the patient from life events, which prevents them to confront their own schemas due to decreased motivation (48).

Since behavioral techniques consist of exposure to the anxiogenic stimuli and behavioral experiments, they can be implemented by combining them with cognitive techniques, first by exposure in the psychotherapist's office (in-vitro), followed by gradual exposure to real anxiogenic stimuli (in-vivo) (49) (50).

CONCLUSIONS:

CBT interventions in PDs require a holistic approach in which treatment involves customization depending on the particularities and specificities of the PD so that the therapeutic plan for these complex cases be based on a multimodal approach. The ABC model is defining both in terms of psychopathological conceptualization, and in terms of the therapeutic intervention itself, focusing on the application of a “bridge over time” in which the patient’s past problems are brought to the present, the change thus being generated by modifying irrational beliefs “here and now”. It is necessary that the scientific support as known to date be supplemented with other studies that have immediate clinical application, this relieving the pathology associated to PDs and improving the relating of these patients.

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