Cognitive Therapy and Dialectical Behaviour Therapy: An Integrative Approach to the Conceptualization of Borderline Personality Disorder

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An individualised case conceptualisation helps organise complex information about a patient and is a blueprint for guiding treatment. Despite the development of manualised treatments for various disorders in cognitive behaviour therapy, there are compelling reasons for the continued use of individualised case conceptualisation. It has been suggested that manualised treatments could be combined with individualised case conceptualisation by using the components of validated protocols as the building blocks of individualised treatments. This idea fits well with the integrative model we propose where the treatment protocol of Linehan's dialectical behaviour therapy is combined with J. Beck's cognitive conceptualisation for individualised therapy, as illustrated with a client diagnosed with Borderline Personality Disorder.

Eells (1997) describes a psychotherapy case formulation as "a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems." A case formulation helps to organise complex information about a person, and is a blueprint for guiding treatment by assisting the therapist in choosing an intervention. It is a structure for enabling the therapist to understand the patient better, and in particular, the case formulation should help the therapist anticipate therapy-interfering behaviours or events, and to experience greater empathy for the client. As a case formulation is essentially a hypothesis, it may include inferences about predisposing or antecedent vulnerabilities based on early childhood traumas, a pathogenic learning history, biological or genetic influences, socio-cultural influences, currently operating contingencies of reinforcement, or maladaptive schemas and beliefs about the self or others. The nature of the hypotheses varies widely depending upon which theory of psychotherapy and psychopathology the clinician applies.

Rather surprisingly, Perry, Cooper, and Michels (1987) believe that a comprehensive formulation "is seldom offered and almost never incorporated into the written record" (p.543), despite the fact that most psychotherapists agree that case formulation is important and that clients would probably benefit more if a clinician developed and routinely constructed a case formulation for them. Perry et al. cite five "misconceptions" to explain why most clinicians do not routinely construct case formulations, which include reasons such as case formulation being primarily a training experience and therefore unnecessary for experienced therapists; it being an elaborate and time-consuming process, and the view that a loosely construed formulation "in one's head" is sufficient, as well as the idea that a therapist may be so invested in a formulation that they will not hear or accept contradictory client communications. Perry et al. counter these misconceptions by arguing that case formulations are best used routinely by all practitioners, regardless of experience; need not be laborious or time-consuming; are best in written form; and facilitate rather than hinder the therapist's understanding of therapy events that may not fit the formulation. They conclude that a need exists for therapists to improve their formulation skills.

With the development of manualised treatments for various disorders within cognitive behaviour therapy, it would be easy to dismiss the need for individualised case conceptualisations. However, Needleman (1999) argues that despite the availability of formal protocols, individualised case conceptualisations remain useful. He believes that there are three compelling reasons for using individualised case conceptualisations: (1) successful implementation of treatment packages depends on the therapist having an accurate understanding of the client's idiosyncratic cognitive, affective, motivational, and behavioural responses; (2) treatment packages designed for a specific clinical problem may not take into account clients who present with multiple problems; (3) case conceptualisations allow clinicians to understand and treat problems for which

there are no treatments protocols, but that may respond well to cognitive therapy.

Although the reasons for using individual case formulations are compelling, evidence of the efficacy of treatment based on case formulation is not so clear (Persons & Tompkins, 1999). The results of studies conducted so far, looking at less complex cases, demonstrate that the individualised treatments are no better than the standardised treatment protocols (Emmelkamp, Bouman, & Blaauw, 1994; Jacobson, Schmaling, Holtzworth-Munroe, Katt, Wood, & Follette, 1989; Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992). There has not yet been any research testing the hypothesis that individualised case conceptualisation is more important in the treatment of complex cases of clients with multiple needs.

Below we consider the current status of individualised case conceptualisation within cognitive therapy and dialectical behaviour therapy, and set the scene for the proposal of an integrative conceptual approach for borderline personality disorder.

Case Conceptualisation in Cognitive Therapy

The cognitive model provides the framework for conceptualising clients from a cognitive therapy perspective. Beck developed the cognitive model in the mid-1950's and as a result of extensive research since that time his theory has evolved into one integrative and comprehensive model of psychopathology. The various elements of the cognitive model include: cognitive content – core beliefs, intermediate beliefs, and automatic thoughts; information processing – the processes and structures that are responsible for people's psychological responses; properties of schemas – hypothetical structures in which beliefs reside; and modes – higher order organisations that work to mobilise an individual to achieve a particular aim.

Significant contributors to the field of individual case conceptualisation in cognitive therapy include Judith Beck (1995), Freeman (1992), Muran and Segal (1992), and Persons (1989, 1993, 1997). Persons (1989, 1993, 1997) has written extensively on the theory and development of individual case conceptualisation. Persons and Tompkins (1997) argue that case conceptualisation occurs at two levels: the "case" level and the "situation" level. Persons and Tompkins describe the case level as being a conceptualisation describing all of the client's problems, their interrelationships and the mechanisms underpinning and explaining them. At the situation level the therapist examines a particular problematic situation and develops a hypothesis about the mechanisms underpinning or explaining that situation.

Beck, J. (1985) has developed a workable diagrammatic cognitive case conceptualisation, which has considerable clinical utility. The diagram depicts the relationship between core beliefs, intermediate beliefs, and current automatic thoughts, and helps to organise the enormous volume and complexity of data with which clients present. In order to maximise the usefulness of this form the therapist seeks the fewest number of underlying beliefs and processes that can comprehensively explain the patient's behaviour and problems (Persons, 1989).

Beck, J. (1995) suggests it is best to start with the bottom half of the conceptualisation diagram, where the therapist records three typical situations in which the client has experienced a high level of negative affect. For each situation the therapist fills in the automatic thoughts, the meaning of the key automatic thought, and the client's emotional and behavioural reactions. The meaning of the key automatic thought for each situation should be logically connected with the Core Belief box near the top of the diagram. To complete the top of the conceptualisation diagram the therapist identifies how the core belief(s) originated and how they were maintained. The data obtained in this box may often include significant childhood events such as parental divorce, sexual abuse, or other adverse life conditions such as growing up in poverty, facing racial discrimination and so on; or may be more subtle, such as a child's perception that they were less favoured as a child, or the perception that a child did not live up to the expectations of significant others. Core Beliefs are written in the box below relevant childhood data, and are unconditional beliefs about the self, world, and others. The next box in the diagram is for intermediate beliefs (rules, attitudes, or underlying assumptions), which help the patient to cope with the painful core belief. And finally to complete the top half of the formulation diagram the therapist identifies compensatory strategies/behaviours which again allow the client to cope with the core belief. Beck (1995) points out that the conceptualisation diagram needs to make logical sense to the therapist and client, and should be continually updated and refined as additional data are collected. The conceptualisation is shared and explored with the client in a collaborative process.

Case Conceptualisation in Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT; Linehan, 1993a, 1993b) is a cognitive behavioural treatment for clients diagnosed with borderline personality disorder (BPD). Linehan developed the treatment for women with a history of parasuicide who met criteria for BPD, and the treatment was then standardised in a treatment manual. DBT is based on the theory that the clients who exhibit "borderline" behaviours do so as a consequence of failed emotional regulation. Linehan suggests that emotion dys-regulation is the result of a biological dysfunction in the emotion regulation system and an invalidating environment (bio-psycho-social theory of BPD). The most typical of the maladaptive "borderline" behaviours is parasuicide/self-harm, which is thought to ameliorate unendurable emotional pain. However, the short-term consequences of the self-harm (e.g., reduction of the emotion) ends up reinforcing the dysfunctional behaviour of parasuicide itself.

DBT is a treatment that blends cognitive-behavioural interventions with Eastern meditation practices and shares elements in common with psychodynamic, client-centred, Gestalt, paradoxical, and strategic approaches (Koerner & Linehan, 1997). It has been demonstrated in empirical trials to be more effective than treatment usually offered in the

community (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Heard & Armstrong, 1993; Linehan, Tutek, Heard & Armstrong, 1994).

Koerner and Linehan (1997) propose that case formulation is essential for efficient, effective DBT, and state that *"theory-driven case formulation is the cornerstone of DBT"* (p. 342). Linehan (1993) and Koerner and Linehan (1997) have written extensively on case formulation for Stage 1 of DBT, and although they believe the principles of case formulation are consistent throughout all stages in DBT, they believe the *"focus"* of the case formulation does vary with the stage of therapy. One of the goals of Stage 1 of DBT is to decrease suicidal/ parasuicidal behaviours that interfere with the client's quality of life. Case formulation at this stage uses a chain analysis for repeated and detailed review of particular instances of problematic behaviour. This helps to identify the unique antecedents and consequences that maintain the chain of environmental and experiential events leading to the problematic behaviour. Through this process, the therapist identifies skills deficits, cognition, emotional responses, and contingencies that interfere with more functional behaviour. The therapist uses this information to select the appropriate change strategies.

Toward an Integrative Model

The model presented here draws heavily on J.Beck's (1993) cognitive conceptualisation diagram and Koerner and Linehan's (1997) flowchart diagram and chain analysis. J. Beck's (1993) conceptual model occurs at the case level, and provides an understanding of the case in its entirety, particularly the relationship between the client's presenting problems and the schema that appear to underlie many or all of the problems. However, in our experience simply using this case conceptualisation alone is insufficient in providing the detail needed to analyse chronic problematic behaviours, such as self-harm. Koerner and Linehan's (1997) flowchart diagram and chain analysis is at the situate ion level, and is crucial for understanding and treating life-threatening, therapy-interfering and life-interfering behaviours during Stage I of DBT. This type of analysis, however, does not provide the therapist with a comprehensive understanding of the mechanisms that underpin the presenting behaviours.

A more comprehensive conceptualisation is not only essential for Stage II work within the DBT model where the focus is on reducing posttraumatic stress, but is necessary for work with this client group because of the diversity in presentations. Layden et al. (1993) believe there are at least three separate but related subtypes of the borderline diagnosis: borderline-avoidant/dependent; borderline-histrionic/narcissistic; borderline-antisocial/paranoid, which may all be hypersensitive to interpersonal abandonment, but each of the subtypes will differ in the expression of this schema. It therefore appears important to be able to provide interventions that are tailor-made for the client, rather than the diagnosis. Furthermore, in order for the therapist to be prepared for and understanding of any therapy-interfering behaviours that will inevitably occur, they must have an individualised case conceptualisation to understand the significance or meaning of such events.

Integrating the two models of J. Beck (1995) and Koerner and Linehan (1997) allows for the underlying mechanisms to be added to a more specific functional analysis, thereby combining a formulation at the case level with a formulation at the situation level, and combining the covert conceptualisation elements, with the overt ones. This also balances the need in Stage I of DBT, for an immediate focus on functional analyses of self-harm behaviours, with the importance of developing an individual conceptualisation for the other reasons outlined above. This notion of combining a standardised treatment protocol with the individualised conceptualisation is not a new one: as Persons and Tompkins (1999) have suggested, the standardised components of treatment manuals could be used as the building blocks of individual treatments.

Case Example

We offer the following case example, where an integrative case conceptualisation was developed for a client diagnosed with Borderline Personality Disorder who was part of a Dialectical Behaviour Therapy (DBT) programme.

Rachel (not her real name) is a woman in her 30s, in a de-facto relationship, who is employed in the health sector. She reported that she had been suffering from the following problems for 'as long as she could remember': low mood, mood dys-regulation, poor restless sleep, passive death wish, over-eating, worry and anxiety, interpersonal difficulties, self-harm behaviour, stealing, difficulty trusting others, difficulty with criticism, negative thinking, and low self-esteem. Various medications had been prescribed over many years with little benefit, and she had obtained no significant relief from other therapies. At the time of seeking therapy she was prescribed 20mg of Aropax.

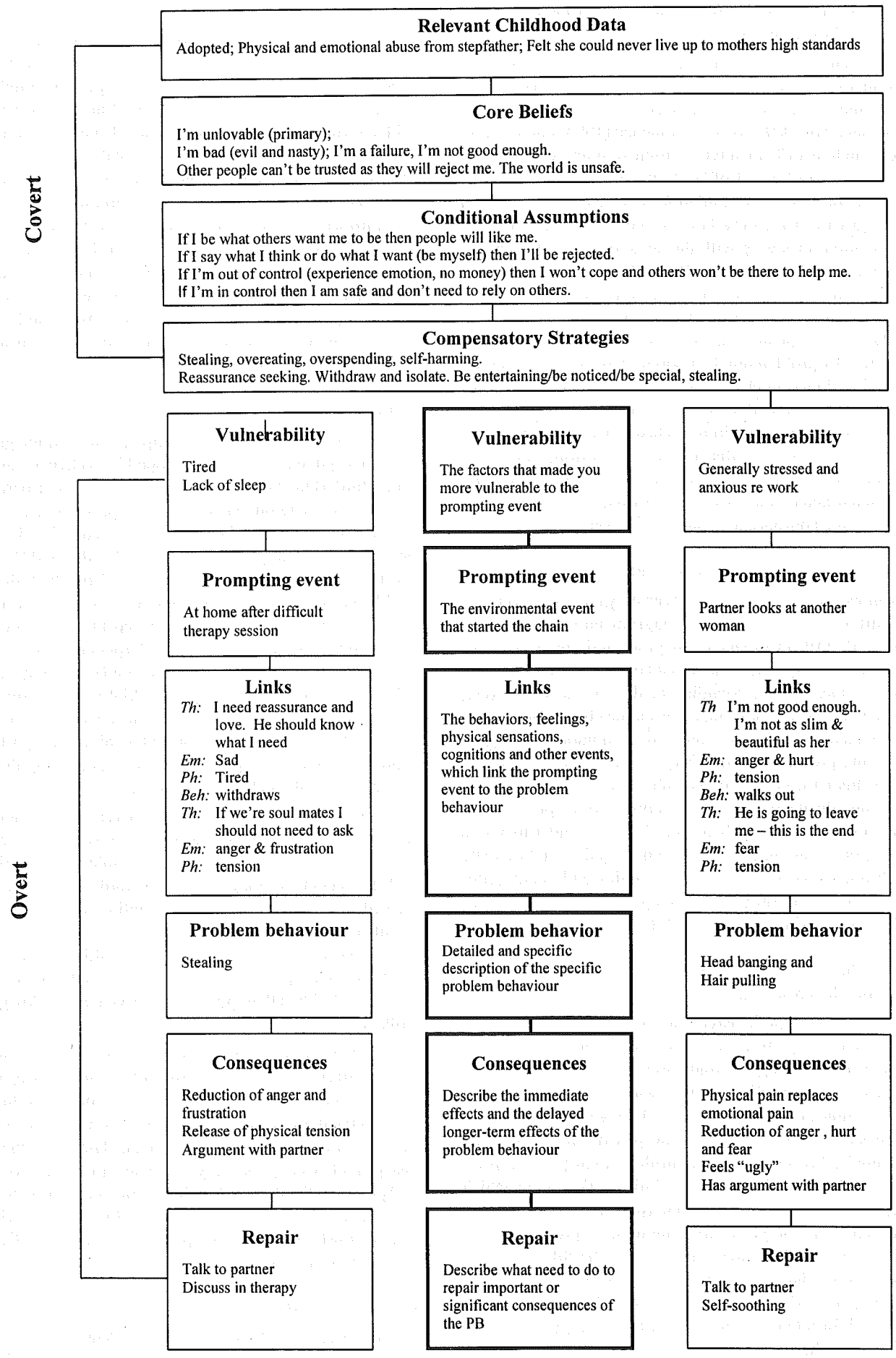
After a lengthy assessment process, which included the Structured Clinical Interview for Axis II DSM-IV Disorders (SCID II; First, Spitzer, Gibbon, & Williams, 1994), Rachel was diagnosed with Borderline Personality Disorder (BPD), as well as presenting with prominent avoidant, passive-aggressive, depressive, anti-social and paranoid personality features. She was offered a place in a DBT treatment programme, which required her to attend weekly individual therapy sessions as well as weekly group skills training sessions.

Individual sessions focused on Stage I target behaviours, decreasing self-harm and stealing. During these sessions numerous chain analyses were completed to gain an understanding of the antecedents and consequences of the self-harm and stealing behaviours. The chain analyses also provided an opportunity for Rachel to apply new skills and provided the therapist with material and information to begin to develop a conceptualisation at the covert case level. This is illustrated in the completed case conceptualisation summary form (Figure 1).

Case Conceptualisation

Historically, several factors and life events were likely to have contributed to Rachel's development of BPD. Rachel

Figure 1. Integrated CT/DBT Case Conceptualisation



was adopted at 6 weeks, and she described growing up with her adopted parents in an extremely invalidating environment. This included physical and emotional abuse from her step-father, and a mother with 'high expectations' whom Rachel felt she could never do well enough for.

Her primary negative core belief about herself was 'I'm unlovable', and Rachel also had a number of secondary core beliefs that fed into this; 'I'm bad' (which meant 'I'm evil and nasty'), and 'I'm a failure', or 'I'm not good enough'. Her core beliefs about other people and the world included 'Other people can't be trusted because they will reject me', and 'The world is unsafe and unpredictable'. Conditional assumptions which guided her behaviour in order to prevent Rachel from exposing her painful core beliefs included 'If I be what others want me to be (entertaining, slim, beautiful, etc.) then people will like me', and conversely 'If I am myself then I'll be rejected', and 'If I am out of control (experience emotions, have no money) then I won't cope and others won't be there to help me', and conversely 'If I am in control then I am safe and don't need to rely on others'.

In response to her underlying assumptions Rachel engaged in a variety of compensatory strategies in order to prevent her core beliefs being exposed. These included 'regulatory' strategies to maintain a sense of control, like self-harm (hair-pulling and head-banging), over-spending, over-eating and stealing, as well as more avoidant strategies like withdrawing and isolating. Rachel also sought constant reassurance from others, and attempted to be entertaining/ be noticed/be special, in order to have others like her/ approve of her.

The completed case conceptualisation summary form illustrates how this formulation at the covert case level has been linked with two examples of chain analyses collected during therapy. In the first chain analysis Rachel self-harmed in response to thinking she was not slim or beautiful enough (which linked to her core-belief of being unlovable and therefore being rejected). The prompting event was having her partner look at another woman while out at lunch. Links in the chain of events included Rachel thinking 'I'm not as slim and beautiful as her', 'I'm not good enough', 'He is going to leave me', 'This is the end', feeling hurt and angry, experiencing tension in her body, and walking out of the restaurant. This resulted in self-harm behaviour where Rachel deliberately banged her head and pulled hair out of her scalp. The immediate consequences of these actions were a reduction in physical tension, experiencing physical pain rather than emotional pain (therefore emotionally regulating by taking control), and having an argument with her partner. And the long-term consequences lead to a complete reinforcement of Rachel's core schema 'I am unlovable', 'I am bad', 'I'm a failure' as she perceived herself as not being how others would want her to be (ugly because of the hair pulling) and as having lost control.

Progress in Therapy

Rachel has been seen for 18 months individual therapy as well as attending DBT skills training group for 12 months. All self-harm behaviours (i.e., hair-pulling, head-banging) and the stealing stopped during the 18 month period of therapy, and the abstinence has been sustained for the last three months. Other changes of note included emotional regulation in and outside therapy (Rachel presented as more 'contained' in therapy sessions), better decision making (Rachel was able to make an informed decision about changing jobs rather than impulsively leaving), and sustaining interpersonal relationships (Rachel got married 9 months into therapy and was able to 'trust' her partner's wanting to be with her, as well as managing interpersonal difficulties she encountered in the skills training group). These changes are consistent with the goals of Stage One DBT and were supported by pre- post-therapy monitors.

Therapeutic Relationship

The conceptual framework above provided useful information for the therapist in understanding many of the issues with which Rachel presented interpersonally in therapy. Rachel had difficulty establishing trust and believed the therapist would terminate therapy if she discovered what she was really like, so Rachel frequently attempted to terminate therapy herself before the 'inevitable happened' (i.e., the therapist rejected her). The therapist was able to not only contain these 'therapy interfering behaviours' through set session structure, and treatment contracting (usual practice for DBT programmes), but also used the conceptualisation to understand the underlying belief structures which were driving the presenting behaviours.

Conclusion

The brief summary of case material presented here illustrates how the chain analysis (a formulation at the situation level), provides a detailed understanding of the antecedents and consequences of the self-harm behaviours. This detailed understanding is crucial for selecting the appropriate intervention, and for addressing the self-harm behaviours effectively and efficiently in the early stages of therapy. When the chain analysis is positioned in the context of an integrated CT/DBT case conceptualisation, it provides the therapist with an enhanced comprehensive understanding of the covert mechanisms that underpin the client's self-harm behaviours. The integration of conceptualisations at the case and situation level allows the therapist to more fully understand the significance of a particular presenting problem for a client, and to be able to anticipate and respond appropriately to any "therapy-interfering" behaviours that will inevitably occur. As Layden et al (1993) have pointed out, even if the underlying issue of interpersonal abandonment is central, the expression of this schema will be different for each individual and therefore the therapist must understand their individual client. The integration of the "manualised approach" to DBT with the more individualised case conceptualisation therefore, works with an individual understanding of the patient rather than the diagnosis of "Borderline Personality Disorder" itself.

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Note. This model was developed in the context of an intensive supervisory requirement for the PGDiploma in Cognitive Behaviour Therapy (PGDipCBT, Massey University). K. Van Kessel has completed the 10-day intensive training course in Dialectical Behavior Therapy (2000) run by trainers from the Behavioral Technology Transfer Group (Seattle).

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