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Commentary
A cognitive-behavioural perspective on Personality disorders with over-regulation of emotions and poor self-reflectivity: The case of a man with avoidant and not-otherwise specified personality disorder, social phobia and dysthymia treated with Metacognitive Interpersonal Therapy

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Dimaggio, Attina, Popolo, Salvatore and Procacci (2012) present a complex case of primarily avoidant personality disorder (AvPD) with additional dependent, depressive, paranoid and passive–aggressive personality traits, along with dysthymia, social phobia and erectile dysfunction. As the authors note, there is no treatment manual for such complex cases, and Metacognitive Interpersonal Therapy (MIT) seems appropriate for the case presented. As Emmelkamp et al. (2006) have noted, AvPD is highly prevalent in the community and is associated with even more impairment than major depression. Of all the personality disorders, it is the most persistent, and it tends to worsen over time. Thus, effective interventions for AvPD are needed.

Metacognitive Interpersonal Therapy appears to meet the criteria for effective treatment of personality disorders delineated by Bateman and Fonagy (2000). Treatments should be well-structured,concentrate on enhancing compliance, have a clear focus, be theoretically coherent to both therapist and patient, be relatively long-term, encourage a powerful attachment relationship between therapist and patient and involve an active therapist stance (Silk, 2010). At the end of 1 year of treatment, the patient is reported to no longer suffer from any personality disorder, and improvement in social phobia and sexual problems also were obtained. Given such a complex case with apparent failure to make clinically significant gains in 5 years of previous CBT for social phobia, the potency of MIT is well supported.

In the remainder of this commentary, I will suggest some details that would have been helpful to have about this case and suggest that cognitive therapy/CBT for AvPD and social anxiety disorder may be the preferred treatment. The authors report

that the patient previously had weekly CBT for 5 years. It would be helpful to know what this CBT consisted of. Was it an empirically based, manual driven CBT (e.g. Hope, Heimberg, Juster, & Turk, 2000) that is the most extensively validated treatment for social phobia? Given Leonardo's continuation to meet the criteria for AvPD, social phobia and other conditions, it appears unlikely. In fact, in one study, 47% of patients with generalized social phobia with an additional diagnosis of AvPD no longer meet the criteria for AvPD after 12 weekly 2.5-h group treatment sessions (Brown, Heimberg, & Juster, 1995). Further, newer generation CBT for social phobia treatments have been reported to lead to even better outcomes (Hofmann, 2010; Hofmann & Otto, 2008). Although Dimaggio and colleagues utilized exposure techniques, 'The therapist therefore first asked Leonardo to not avoid meeting girls' (p.10) and 'This interweaving of behavioural exposure and in-session reflection about mental states elicited by the encounter allowed Leonardo to recognize he felt a sense of self-efficacy during romantic rendezvous' (p.12); it is not evident that such techniques were used in a consistent, structured way. Systematic, hierarchical exposure to a broad spectrum of anxiety-provoking and /or avoided situations, a central element of CBT for AvPD and social phobia, may have provided greater benefits and in a shorter duration of therapy.

Cognitive therapy has much to offer in the treatment of patients with more than one personality disorder. Beck et al. (2004) list beliefs that are most strongly associated with specific personality disorders. For example, patients with AvPD endorse such beliefs as, 'I am socially inept and socially undesirable in work or social situations' and 'Being exposed as inferior or inadequate will be intolerable'. Examples of beliefs endorsed by patients with paranoid personality disorder include, 'If people act friendly, they may be trying to use or exploit me' and 'Other people will deliberately try to demean me' (p. 61). Thus, cognitive therapy provides a conceptual model that guides the therapist to address the relevant maladaptive beliefs and resulting maladaptive emotions and interpersonal problems, regardless of diagnosis.

In a case report, Hofmann (2011) presented 'the most severe case of social phobia/AvPD that was ever seen at the clinic' (p.3) (Center for Anxiety and Related Disorders). After 27 h of individual treatment, the patient no longer met the criteria for any DSM-IV axis I or II disorder, and these gains were maintained at a 1-year follow-up assessment. Further, in a randomized controlled trial, Emmelkamp et al. (2006) compared 20 sessions of CBT vs. brief dynamic therapy for patients with AvPD and found CBT to be more effective at post-treatment. Gains were maintained at 6-month follow-up, where 91% of patients no longer met the criteria for AvPD. Although the treatment of Leonardo led to improvement with a year of therapy, the empirical evidence suggests that CBT may be a more efficient intervention.

As Dimaggio et al. note, 'Leonardo always believed he was unworthy and inept; he feared criticism and was prone to feeling scorned' (p.6). DSM-IV-TR criteria for AvPD include a prominent role for viewing 'self as socially inept, personally unappealing, or inferior to others' and preoccupation 'with being criticized or rejected in social situations' (American Psychiatric Association, 2000, p. 721). Converging research supports the centrality of self-criticism and negative self-evaluation as potential core processes in AvPD and social phobia. Cox, Walker, Enns and Karpinski (2002) in a CBT for generalized social phobia study found that changes in self-criticism were significantly associated with outcome and concluded, 'Our findings suggest that fear of negative evaluation may be linked to a more pervasive disturbance about self-worth' (p. 488). Vogel, Ryum, Stiles and Svartberg (2009) recently reported that increased self-acceptance predicted improvement in both cognitive-behavioural psychotherapy and short-term dynamic psychotherapy of Cluster C personality disorders (Svartberg et al. 2005). Recently, Cox, Turnbull, Robinson, Grant and Stein (2011) reported that a follow-up of nearly 300 patients (266) with AvPD from the

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Collaborative Longitudinal Personality Disorders Study (McGlashan et al., 2005) 'found that feelings of personal inadequacy at baseline was one of the most stable criteria of AvPD, along with social ineptitude' (p. 254). Cox et al. (2011) also suggest that 'the self-criticism construct could also be a common psychological diathesis that underlies comorbid AvPD and GSAD' (p.254). These observations are consistent with the growing recognition of the pervasiveness of self-criticism throughout many forms of psychopathology (Warren, 2011). The central role of self-criticism in both AvPD and social phobia suggest that patients like Leonardo would benefit from treatments that directly target this destructive process that maintains low self-esteem and shame.

Currently, there is a burgeoning new literature on the psychological benefits of self-compassion and its advantages over striving for self-esteem (Neff, 2011), and psychotherapeutic interventions to foster self-compassion to address self-criticism, low self-esteem and shame are underway (e.g. Gilbert & Procter, 2006; Shapira & Mongrain, 2010). In Leonardo's case, experiential exercises such as compassionate letter writing to himself, compassionate imagery and the two-chair dialogue technique might be used to cultivate self-compassion in response to rejection rather than self-criticism and shame. Cognitive therapy for personality disorders is increasingly finding a variety of imagery techniques effective in reducing negative emotions elicited by intrusive memories (e.g. Brewin et al., 2009) and altering maladaptive schema of patients with personality disorders (Arntz & Weertman, 1999; Weertman & Arntz, 2007). For example, imagery rescripting could be used with Leonardo to address memories of past abuse. Leonardo could be guided to vividly imagine the friends stealing his wallet and urinating on him after showering and feeling humiliated and powerless. Next, Leonardo would be asked to modify the image so that he responded in a way that he successfully stood up to the bullies, or perhaps he would imagine the therapist entering the image, chasing away the bullies and offering compassion to Leonardo.

In conclusion, MIT appears to meet the criteria for an effective treatment for personality disorders (Bateman & Fonagy, 2000), and the case of Leonardo is illustrative of how this model conceptualizes and treats a patient with multiple pathologies. However, traditional cognitive therapy also offers a coherent theoretical model and is the most evidence-based treatment. Cognitive therapy is well suited for the incorporation of interventions that might best target core elements of AvPD, social phobia and related emotional disturbances, such as self-criticism. Recently, imagery-based interventions and methods for increasing self-compassion are being incorporated into cognitive therapy and may hold promise in increasing treatment effectiveness.

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