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Treatment approaches for personality disorders- Challenges and other issues

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Abstract
Personality disorders are seen by professionals and researchers as an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it. These patterns are inflexible and pervasive across many situations. These disorders typically aren't diagnosed until an individual is a young adult, often not until their 20's or even 30's. Most individuals with personality disorders lead pretty normal lives and often only seek psychotherapeutic treatment during times of increased stress or social demands. Personality disorders tend to be an intergral part of a person, There are many different forms (modalities) of treatment used for personality disorders: (Magnavita and Jaffery, 2004), Individual psychotherapy, Family therapy, Group therapy, Psychological-education ,Self-help groups, Psychiatric medications and Milieu therapy are applied...
Despite the divergences of their approaches, many psychologists agree that while treating personality disorders is not easy, it isn't impossible. That personality disorders are not treatable was a myth that occurred because there was very little empirical research on treatments. As more studies get published, we will see that start to change."

Keywords: Personality disorders, Treatment, Challenges, Psychotherapy, Self-help groups, Psychiatric medications and Milieu therapy

Introduction
Personality disorders form a class of mental disorders that are characterized by long-lasting rigid patterns of thought and behavior. Because of the inflexibility and pervasiveness of these patterns, they can cause serious problems and impairment of functioning for the persons who are afflicted with these disorders.
Personality disorders are seen by professionals and researchers as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it. These patterns are inflexible and pervasive across many situations. The onset of the pattern can be traced back at least to the beginning of adulthood. To be diagnosed as a personality disorder, a behavioral pattern must cause significant distress or impairment in personal, social, and/or occupational situations.
These disorders typically aren't diagnosed until an individual is a young adult, often not until their 20's or even 30's. Most individuals with personality disorders lead pretty normal lives and often only seek psychotherapeutic treatment during times of increased stress or social demands. Most people can relate to some or all of the personality traits listed; the difference is that it does not affect most people's daily functioning to the same degree it might someone diagnosed with one of these disorders. Personality disorders tend to be an intergral part of a person, and therefore, are difficult to treat or "cure."

Treatment Approaches for Personality Disorders
There are many different forms (modalities) of treatment used for personality disorders: (Magnavita and Jaffery, 2004).

- Individual psychotherapy has been a mainstay of treatment. There are long-term and short-term (brief) forms.
- Family therapy, including couples therapy.
- Group therapy for personality dysfunction is probably the second most used.
- Psychological-education may be used as an addition.
- Self-help groups may provide resources for personality disorders.

- Psychiatric medications for treating symptoms of personality dysfunction or co-occurring conditions.
- Milieu therapy, a kind of group-based residential approach, has a history of use in treating personality disorders, including therapeutic communities.

There are different specific theories or schools of therapy within many of these modalities. They may, for example, emphasize psychodynamic techniques, or cognitive or behavioral techniques. In clinical practice, many therapists use an 'eclectic' approach, taking elements of different schools as and when they seem to fit to an individual client. There is also often a focus on common themes that seem to be beneficial regardless of techniques, including attributes of the therapist (e.g. trustworthiness, competence, caring), processes afforded to the client (e.g. ability to express and confide difficulties and emotions), and the match between the two (e.g. aiming for mutual respect, trust and boundaries).

Response of Patients with Personality Disorders to Biological and Psychosocial Treatments (Tasman, Allan *et al*, 2008)

Cluster	Evidence for Brain Dysfunction	Response to Biological Treatments	Response to Psychosocial Treatments
A	Evidence for relationship of schizotypal personality toschizophrenia; otherwise none known	Schizotypal patients may improve on antipsychotic medication; otherwise not indicated	Poor. Supportive psychotherapy may help
B	Evidence suggestive for antisocial and borderline personalities; otherwise none known	Antidepressants, antipsychotics, or mood stabilizers may help for borderline personality; otherwise not indicated	Poor in antisocial personality. Variable in borderline, narcissistic, and histrionic personalities
C	None known	No direct response. Medications may help with comorbid anxiety anddepression	Most common treatment for these disorders. Response variable

Challenges in the Treatment of Personality Disorders

Research investigation have shown that about 30 percent of people who require mental health services have at least one personality disorder (PD)-characterized by abnormal and maladaptive inner experience and behavior. Personality disorders, also known as Axis II disorders, include obsessive-compulsive PD, avoidant PD, paranoid PD and borderline PD. Axis I disorders, on the other hand, include depression and schizophrenia-mental illnesses thought to be less pervasive but more acute.

People with personality disorders can possess very different personality disturbances, they have at least one thing in common: chances are their mental illness will not remit without professional intervention. However, exactly what that intervention should consist of remains a subject for debate. This, along with the disorders' notoriety for being problematic to treat, has posed challenges to their successful resolution, or at least management.

"People with personality disorders exhibit chronic, pervasive problems getting along with people in all kinds of different contexts," says Thomas R. Lynch.

As a result, people with the disorders often don't seek treatment, and those who do often drop out, he says. For example, people with borderline personality disorder (BPD)--the most commonly treated personality disorder--quit treatment programs about 70 percent of the time.

Lynch is the view point that hope is on the horizon as researchers begin the search for effective treatments. So far, the bulk of research has focused on BPD, he notes. While the challenges are numerous and the research is preliminary, two interventions in particular--dialectical behavior therapy (DBT) and cognitive therapy (CT)-show promise for BPD.

Psychologists seeking to treat the other nine personality disorders face a paucity of existing research. Both the stubborn character of these disorders and of the people who have them may, in part, account for the lack of proven treatments. The good news is that new theories on the underlying emotional regulation, interpersonal styles and thought patterns characteristic of these less-studied PDs have laid the groundwork for developing interventions.

The management and treatment of personality disorders can be a challenging and controversial area. This often involves interpersonal issues, and there can be difficulties in seeking and obtaining help from organizations in the first place, as well as with establishing and maintaining a specific therapeutic relationship. On the one hand, an individual may not consider himself to have a mental health problem, while on the other, community mental health services may view individuals with personality disorders as too 'complex' or 'difficult', and may directly or indirectly exclude individuals with such diagnoses or associated behaviors, (Davison, 2002) [2]. The disruptiveness that people with personality disorders can create in an organisation makes these, arguably, the most challenging conditions to manage.

Apart from all these issues, an individual may not consider their personality to be disordered or the cause of problems. This perspective may be caused by the patient's ignorance or lack of insight into their own condition, and their personality that prevents them from experiencing it as being in conflict with their goals and self-image, or by the simple fact that there is no distinct or objective boundary between 'normal' and 'abnormal' personalities. Unfortunately, there is substantial social stigma and discrimination related to the diagnosis.

The term 'personality disorder' encompasses a wide range of issues, each with different a level of severity or disability; thus, personality disorders can require fundamentally different approaches and understandings. Some disorders or individuals are characterized by continual social withdrawal and the shunning of relationships, others may cause *fluctuations* in forwardness. The extremes are worse still: at one extreme lie self-harm and self-neglect, while at another extreme some individuals may commit violence and crime. There can be other factors such as problematic substance use or dependency or behavioral addictions.

Therapists in this area can become disheartened by lack of initial progress, or by apparent progress that then leads to setbacks. Clients may be perceived as negative, rejecting, demanding, aggressiveor manipulative. This has been looked at in terms of both therapist and client; in terms of social skills, coping efforts, defense mechanisms, or deliberate strategies; and in terms of moral judgments or the need to consider underlying motivations for specific behaviors or conflicts. The vulnerabilities of a client, and indeed a therapist, may become lost behind actual or apparent strength

and resilience. It is commonly stated that there is always a need to maintain appropriate professional personal boundaries, while allowing for emotional expression and therapeutic relationships. However, there can be difficulty acknowledging the different worlds and views that both the client and therapist may live with. A therapist may assume that the kinds of relationships and ways of interacting that make them feel safe and comfortable have the same effect on clients. As an example of one extreme, people who may have been exposed to hostility, deceptiveness, rejection, aggression or abuse in their lives, may in some cases be made confused, intimidated or suspicious by presentations of warmth, intimacy or positivity. On the other hand, reassurance, openness and clear communication are usually helpful and needed. It can take several months of sessions, and perhaps several stops and starts, to begin to develop a trusting relationship that can meaningfully address a client's issues, (Mcvey and Murphy, 2002) [5].

Controlling the Emotions

People with the most-studied of the disorders, borderline personality disorder, provide many challenges to practitioners. They frequently seek out help, but they also tend to drop out of therapy. They can be quick to open up to a therapist, and perhaps even quicker at shutting down. And while individuals with BPD often crave approval, a small provocation can trigger abusive and even violent behavior toward those trying to help them.

To help clients negotiate this push and pull between two behavioral extremes, Marsha . Linehan, 2000, has developed dialectical behavior therapy, which includes weekly one-on-one counselor and group training sessions on skills such as distress tolerance, interpersonal effectiveness, emotion regulation and mindfulness skills.

Many people with BPD harm themselves to regulate their emotions, says Linehan, who conceptualizes this disorder as primarily one of emotional dysregulation. In an effort at self-stabilization, some use physical pain-which has been demonstrated to reduce emotional arousal.

Linehan and other DBT practitioners encourage BPD patients to develop alternative ways to control their frequently overwhelming and confusing feelings. For instance, a therapist may teach mindfulness, a concept borrowed from Zen Buddhism. Practicing mindfulness allows clients to observe their emotions without reacting to them or seeking instant relief through self-harm.

The therapist needs to appreciate the reality of the client's emotions. BPD patients require emotional acceptance--a DBT staple--because they often lacked it as children, says Linehan. In an invalidating environment, for example, a child might express anger and be told by a parent that she is jealous. "They never gain a sense that their needs, wants and desires are reasonable," says Lynch, adding that such circumstances can lead to emotional difficulties and a problematic sense of self. DBT helps these people restore their sense of self, and legitimizes their emotional experience.

Evidence seems to back DBT's efficacy. In one study published in the *British Journal of Psychiatry*, 58 women with BPD were either assigned to DBT or treatment as usual--generally a weekly session with a psychotherapist. In the study, a team of clinicians from the University of Amsterdam, led by Roel Verheul, 2003, assessed the participants' self-harming and damaging impulsive behavior, such as gambling and substance abuse, using the Borderline Personality Disorder Severity Index. After seven months of therapy, DBT-treated participants more successfully reduced suicide attempts, self-mutilating and self-damaging behaviors than those who received treatment as usual. Additionally, DBT patients were nearly twice as likely to stay in therapy.

Linehan, (2000) [4], shows that DBT can be learned and applied effectively by teams.

Changing thecore beliefs

While DBT emphasizes emotional regulation, CT, as applied by practitioners such as Beck, 1990, the director of the Beck Institute for Cognitive Therapy and Research, also conceptualize all 10 personality disorders as dysfunctional core beliefs about the self, others and the world. The cognitive therapist helps people with these disorders learn to identify and change these core beliefs. This is most often accomplished by weekly sessions with a trained therapist.

According to Beck, a person with BPD, for example, may believe "I'm defective, helpless, vulnerable and bad. ""Everything that they do, everything that happens, ends up maintaining these beliefs," says Beck. "If they don't give money to a homeless person, they think they are bad. If they do, they think they should have given more. "To root out such dysfunctional beliefs, CT practitioners often must help patients revisit and reinterpret early-childhood experiences.

For example, a person may have picked up the belief, "I'm inadequate," because his parents had assigned him responsibilities he was not developmentally ready for. "Perhaps he was asked to take care of his younger siblings, and, not unreasonably, he failed," says Beck.

Beck and other CT practitioners ask clients to move beyond thinking of such events as proof of inadequacy and instead explore alternative meanings. Ideally, the patient comes to understand the underpinnings of dysfunctional core beliefs and works to change them. However, says Beck, problems can emerge if a patient interrupts that process by applying his or her dysfunctional beliefs to therapy itself.

"Axis I patients often come to therapy believing 'I can trust my therapist, this is going to work,'" says Beck. "Axis II [personality disorder] patients may think things like 'I can't trust my therapist, she might hurt me,' or 'If I listen to my therapist it will show how weak I am and how strong she is. '"To counteract such dysfunctional thinking, therapists should be ready to help patients examine dysfunctional beliefs about the therapist or therapy. Preliminary trials of cognitive therapy for BPD lend support to Beck's theory. In one such study in press at the *Journal of Personality Disorders*, conducted by Gregory K. Brown, and his colleagues at the University of Pennsylvania, 32 people with BPD benefited from cognitive therapy sessions conducted weekly over one year. "Their borderline symptoms came down significantly after a year of therapy," says Brown. At follow-up, 55 percent of the participants no longer met diagnostic criteria for BPD, he adds.

Researchers hope promising treatments for BPD may lead to clinical advances for the other nine personality disorders. In addition to identifying dysfunctional beliefs of those with BPD, Beck has found typical beliefs for the other personality disorders. For example, the person with antisocial PD believes other people are potentially exploitative and develops the maladaptive strategy of exploiting others first, she says. While pilot studies have been promising, cognitive

therapy has not yet been shown as an effective therapy for personality disorders other than BPD.

"It's too early to report results," says Lynch, who is conducting the study, "but we are in the process of writing up a manual on how to alter DBT for personality disorders other than borderline."

A provocative new study by Rick Nauert, (2014), suggests a new therapy approach is an improved method to treat a broad range of personality disorders.

Researchers believe schematherapy, a technique popular in Europe, is cost-effective and delivers better outcomes for a wide range of personality disorders including avoidant, obsessive-compulsive, dependent, paranoid, histrionic, and narcissistic conditions. A large scale randomized control trial demonstrating the value of the intervention has been recently published in the *American Journal of Psychiatry*. Schema therapy resulted in a higher rate of recovery, greater declines in depression, and greater increases in general and social functioning and had a lower dropout rate. The results also suggest schema therapy is more cost-effective, achieving these results in a total of 50 sessions, and that it can be readily implemented in regular clinical settings. Traditionally, schema therapy has been used for the treatment of borderline personality disorder. Three major outcome studies have shown that use of this technique on patients with Borderline Personality Disorder can aid full recovery across the complete range of symptoms.

In these studies, researchers found the technique to be twice as effective as a popular alternative, Transference Focused Psychotherapy. The current study extends these findings by including a broad range of understudied personality disorders, and suggests that schema therapy is the most effective means currently available to alleviate the high societal and personal costs of these prevalent disorders. While rapidly gaining popularity in Europe, schema therapy is virtually unknown in the United States.

What sets schematherapy apart from all the other major treatments for personality disorders, including treatments like Dialectical Behavioral Therapy, is its use of limited reparenting. This involves the therapist doing more to directly meet the early core emotional needs of the patient. Limited reparenting is organized around modes, or parts of the self. The therapist works to get past modes like the Detached Protector and Punitive Parent Mode to reach the Vulnerable Child Mode. Direct access to the Vulnerable Child is the key to the therapist being able to meet these needs and is the cornerstone of treatment. All the major alternatives involve the therapist talking to the adult patient about their vulnerabilities and thus are more focused on adult to adult interactions.

Schema therapy focuses on direct contact between the therapist and this vulnerable or child part of the self. This sets a very different tone to the treatment; one that patients respond readily to and that is believed to be the reason for the unusually low dropout rate. The adult side of the patient is gradually brought in as it becomes healthy enough to take over for the therapist. Personality disorders are common (3-15 percent of the general population) and are associated with high personal suffering for those with the disorder and for those in their life. They also result in high societal costs. Psychotherapy is considered the primary treatment for personality disorders though research into its effectiveness with this population is still in its infancy.

In one study, schema therapy was compared with Clarification-Oriented Psychotherapy (a variation on client-centered therapy developed specifically for personality disorders) and “treatmentasusual” (TAU). TAU consisted of the typical treatment provided for these patients and consisted primarily of insight-oriented psychotherapy by highly experienced psychotherapists. Patients receiving schema therapy showed statistically significant greater improvement in recovery from personality disorders. Based on the primary outcome measure, roughly 80 percent recovered in schema therapy, 60 percent in Clarification-Oriented Psychotherapy, and 50 percent in TAU. The dropout rate was also lowest among the patients receiving schema therapy, suggesting it is more readily accepted by patients. All measures were made three years after treatment started.

The study design is noteworthy in that it compares two specialized treatments (schema therapy and Clarification-Oriented Psychotherapy) and treatment as usual, thus pointing out differences in therapies and perhaps providing suggestions about their “active ingredients. ”This was a large, multi-site study (323 patients in 12 Dutch mental health institutes).

Schema therapy was delivered weekly for 40 sessions in the first year and then with 10 booster sessions in the second year. Clarification-Oriented Psychotherapy and TAU were weekly with an open ended number of sessions. Schema therapy is a relatively new approach developed by Dr. Jeffrey Young of Columbia University in large part explicitly to treat personality disorders. It is an integrative psychotherapy drawing on CBT, Gestalt, and psychoanalytic psychotherapies to create a unique, structured therapy with a cohesive model of etiology and treatment. This present study investigated typical treatment settings rather than rare expert, highly structured, specialized situations. The therapists using schema therapy in the study were not experts in the technique.

In fact, they were therapists already employed in Dutch community mental health centers who expressed interest in schema therapy, received four days of training, and then peer supervision throughout the study (as well as yearly expert supervision). This study suggests that schema therapy can realistically be implemented effectively in typical therapy settings. An important additional finding of this study is that therapists trained in schema therapy by actively practicing techniques in their training sessions and receiving immediate feedback did significantly better than therapists trained in schema therapy primarily by readings, lecture, and video examples of techniques.

Schema therapy has spread quickly around the world, yet its adoption in the United States lags far behind other countries. Researchers believe the new study will inform patients and professionals on the benefits of the new technique.

Despite the divergences of their approaches, many psychologists agree that while treating personality disorders is not easy, it isn't impossible. "That personality disorders are not treatable was a myth that occurred because there was very little empirical research [on treatments]," says Lynch. "As more studies get published, we will see that start to change."

References

1 Beck AT, Freedman A. Cognitive therapy of personality disorders. New York: Guilford, 1990.

2 Davison SE. Principles of managing patients with personality disorder. Advances in Psychiatric Treatment. 2002; 8(1):1–9. doi:10.1192/apt.8.1.1
3 Leichsenring F, Leibing E. The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. American Journal of Psychiatry. 2003; 160(7):1223-1232.
4 Linehan MM. The empirical basis of dialectical behavior therapy: Development of new treatments versus evaluation of existing treatments. Clinical Psychology: Science and Practice. 2000; (1):113-119.
5 McVey D, Murphy N. (eds.) Treating Personality Disorder: Creating Robust Services for People with Complex Mental Health Needs, 2010, ISBN 0-203-84115-8.
6 Rick N. New Therapy shows for Personality Disorders, 2011.
7 Scheel KR. The empirical basis of dialectical behavior therapy: Summary, critique, and implications. Clinical Psychology-Science & Practice. 2000; 7(1):68-86.
8 Verheul R, Van Den Bosch LM, Koeter MW, De Ridder MA, Stijnen T, Van Den Brink W. Dialectical behavior therapy for women with borderline personality disorder: 12-month, randomized clinical trial in The Netherlands. British Journal of Psychiatry. 2003; 182:135-40.