Treatment for the 'untreatable'
Despite the difficult-to-treat reputation of personality disorders, clinical trials of treatments show promise.

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Up to 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.

While people with PDs 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, PhD, assistant professor of psychology at Duke University and the Duke University Medical Center. "And this includes therapists."

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.

However, hope is on the horizon as researchers begin the search for effective treatments, says Lynch. 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, researchers say.

Still, psychologists seeking to treat the other nine personality disorders face a paucity of existing research, Lynch says. He posits that 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: 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, according to Lynch.

Getting emotions under control

People with the most-studied of the disorders, BPD, 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 M. Linehan, PhD, a psychology professor at the University of Washington, has developed DBT, 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, she says.

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.
At the same time, cautions Linehan, 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* (Vol. 182, No. 1), 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, PhD, 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.

This study, says Linehan, shows that DBT can be learned and applied effectively by teams other than her own, she explains.

**Changing core beliefs**

While DBT emphasizes emotional regulation, CT, as applied by practitioners such as Judith Beck, PhD, the director of the Beck Institute for Cognitive Therapy and Research in Bala Cynwyd, Pa., 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, says Beck. 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, says Beck.

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, says Beck.

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, PhD, 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.

**Beyond BPD**

Promising treatments for BPD may lead to clinical advances for the other nine personality disorders, researchers hope.

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. The same goes for dialectical behavior therapy, though one study applying DBT to other personality disorders is in its fourth year.
"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."

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."

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