

Cognitive Behavior Treatment of Personality Disorders

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Abstract: Findings reviewed in this article show that CBT should be included in treatment guidelines for Personality disorders. CBT in particular has been found to be superior to control conditions, equally effective as other active psychological treatments, with treatment effects that are often maintained in the long run, conferring resistance to relapse. Moreover, CBT is as effective as pharmacotherapy in the acute treatment of mild to moderate Personality Disorders and, either as monotherapy or combined with medication, CBT is associated with better long-term outcome compared with pharmacotherapy alone. Furthermore, CBT and PA have shown promise in treating patients with complex psychological disorders characterized by mood problems, often with comorbid personality problems. CBT is accepted by many PD patients as a viable and preferred treatment. Finally, although studies suggest that effects of long term CBT may be achieved somewhat slower compared with other forms of psychotherapy as well as medication in the acute treatment of Personality Disorders, it appears to be more clinically effective and perhaps more cost effective in the long run, particularly for chronically ill PD patients. As noted, these conclusions need to be interpreted within the context of important limitations. Compared with other treatments, the evidence base for CBT in Personality Disorders remains relatively small, despite a respectable research tradition supporting Cognitive assumptions with regard to the causation of PD. In this context, the growing evidence for the efficacy and effectiveness of long term CBT is promising. Overall, it is clear that the future of the treatment of PD may lie in a combined disorder- and person-centered, tailored-made approach, which takes into account, particularly in chronic PD, the broader interpersonal context and life history of the individual. It is clear that CBT have an important role to play in this respect.

Keywords: CBT, Interventions, Personality Disorders, Psychotherapy

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I. Introduction

For nearly 50 years, cognitive behavioral therapy (CBT) has claimed higher scientific authority among the vast legion of psychotherapy approaches as a result of having more research demonstrate its effectiveness than any other therapeutic method. This article reviews the key theoretical assumptions of CBT (Cognitive Behavior Treatment) for personality disorders and summarizes findings concerning the efficacy and effectiveness of these interventions alone and in combination with pharmacotherapy in adults, children, and adolescents. Issues of suitability and acceptability are also discussed as well insights into the mutative factors in these treatments. We close this article with a summary and implications for future research and treatment guidelines.

SPECIFICITY OF THE COGNITIVE BEHAVIORAL APPROACH: COMMON AND SPECIFIC FACTORS IN COGNITIVE BEHAVIOR TREATMENTS OF PERSONALITY DISORDERS

Meta-analyses have identified very few, if any, differences in the efficacy of bona fide therapeutic interventions which were equally effective for treating certain conditions in adults, [1] [2] including personality disorders but CBT was found to be superior in treating most disorders [3]. This may be because the effects of these treatments are only in part related to specific techniques. Other factors may account for a larger portion of the variance in treatment outcome; it has been estimated that only 15% is predicted by specific techniques, 30% by common factors (e.g., providing support), 15% by expectancy and placebo effects, and 35% to 40% by extra therapeutic effects (e.g., spontaneous remission, positive events or changes). Moreover, it has been difficult to find differences among treatments because most studies have focused on symptom remission in brief, highly structured, and manualized interventions. Furthermore, most randomized, controlled trials (RCTs) have only had power to investigate non inferiority compared with other active treatments and thus may be unable to detect meaningful differences between treatments. Research focusing on outcomes broader than symptom remission, as well as long term effects, may be more promising as discussed below.

Cognitive Behavior Specific Features

Notwithstanding the many common features of treatments for personality disorder as, all types of psychotherapy aim to improve perceptions of and responses to social and environmental triggers. [4][5], studies do show important differences between cognitive behavior therapy and other treatments. For instance, relative to psychodynamic therapy, essential tenets of CBT treatment include:

- An evolving cognitive conceptualization of the client
- A strong therapeutic relationship
- Collaboration and active participation by therapist and client
- A goal orientation
- An initial focus on the present
- An emphasis on education, skill acquisition, and self-help assignments to shorten the length of treatment and prevent relapse
- Structured sessions
- Follow up assignments
- A variety of techniques from many psychotherapeutic modalities to produce an enduring change in cognition, behavior, and mood [6]

Cognitive therapy theorists and psychoanalysts conceptually agree on the notion that it is usually more productive to identify and modify “core” problems in treating personality disorders. The two perspectives differ in their views of the nature of this core structure, the difference being that the psychoanalytic perspective sees these structures as unconscious and not easily available to the patient. The cognitive perspective holds that the products of this process are largely in the realm of awareness [7] and with special strategies may be even more accessible to consciousness. This demonstrates that although the basic techniques and tenets of the approach are fairly straightforward, there are a diversity of specific treatments which have developed due to the competencies required in the specific field that can be categorized more or less as falling under the CBT umbrella, including cognitive therapy, problem-solving therapy, dialectical behavior therapy, meta-cognitive therapy, rational-emotive behavior therapy, cognitive processing therapy, mindfulness-based cognitive therapy, cognitive-behavioral analysis system of psychotherapy, and schema-focused therapy [8]. Aside from these specific techniques and tenets, a number of general assumptions, rooted in cognitive behavioral theory further define the specificity of the cognitive behavior approach to the treatment of personality disorder.

A variety of approaches to therapy are generally considered to fall within the broader domain of cognitive behavioral therapy [9].

These approaches share three assumptions:

- Cognition affects behavior
- Cognition can be monitored and altered
- Behavior change is mediated by cognitive change

Cognitive behavior approach focus on the Patient’s Internal World

First, perhaps more so than any other treatment, CBT focus on the patient’s internal world, that is, representations or cognitive affective schemas of self and others that influence our perceptions, thoughts, feelings and actions. CBT techniques emerge from a fundamental premise of cognitive-behavioral theory. The cognitive model proposes that dysfunctional thinking and unrealistic cognitive appraisals of certain life events can negatively influence feelings and behavior and that this process is reciprocal, generative of further cognitive impairment, and common to all psychological problems [10][11][12][13].

In the case of personality disorders, the main etiopathogenetic mechanisms should be related to our core beliefs, which are shaped through key developmental experiences and some of which might be based on biological predispositions [14] [15]. The CT model is mainly focused on the cold general core beliefs and the mechanisms to cope with them (e.g., intermediate beliefs in the form of evaluations, positive and negative assumptions, and rules. One can, therefore, see the issue as one of the individual’s interpretations or parenthetic views. For example, if an individual were self-focused as a result of the life experience in his or her family of origin, he or she may believe that “I am Important.” The key issue is not the idea of the individual’s importance, but how he or she completes the sentence. It may be completed in a variety of ways, each determining a different emotional, behavioral, and social outcome. I am important (therefore others should give me all that I demand).” “I am important (and I have to always do things for others to maintain my special status).” “I am important (and anyone who does not recognize and agree must be punished).” “I am important (and I will never get the special treatment that I deserve and was given to me by my early caretakers and that would be awful and unlivable)” and the like. Childhood experiences, coupled with an innate, biologically-determined disposition (some of which are discussed below), establish our initial beliefs about the world. These initial beliefs evolve into fairly stable, core beliefs that shape people’s perceptions and interpretations of subsequent experiences. And if the preconceived beliefs are faulty, distorted, or biased, leads to incorrect, irrational conclusions about the

meaning of external events (particularly interpersonal interactions) and may subsequently behave in ways that cause distress and suffering. The therapeutic focus is on considering the meaning embedded in the belief, and how it impacts an individual's adaptive functions.

Yet, CT approaches to Personality Disorder emphasize the need to understand the subjective experience of the disorder. As we discuss in more detail below, a focus on the phenomenology of Personality Disorder has not only allowed researchers from different theoretical strands to delineate different types of Personality disordered experiences.

This has also facilitated research into neurobiological [16] and social factors related to personality disorders and led to an awareness of the role of distortions in mentalization, that is, the ability to reflect on the self and others in terms of mental states, both as a cause and a consequence of personality disorders. These distortions may not only influence the course but also the treatment of this disorder.

Cognitive Behavior Approaches are Person Centered

Second, cognitive behavior approaches of personality disorders are more person than disorder centered. An individual's personality is influenced by experiences, environment (surroundings, life situations) and inherited characteristics. Each of the 10 DSM-5 (and DSM-IV-TR) personality disorders is a constellation of maladaptive personality traits, rather than just one particular personality trait [17]. CBT offers several specific treatment techniques that appear to map onto the pathology of personality disorders well. For example, CBT approaches emphasize the connection between implicit, automatic thoughts and their underlying schemas, which are widely thought to be dysregulated and maladaptive in PDs. CBT approaches focus on practical goals such as skills training to address the common problem of social dysfunction in PDs, homework assignments that promote generalization of skills into regular life, and learning-based procedures designed to inhibit self-defeating or treatment-threatening behaviors common in PDs. Furthermore, because CBT is a practical and technique-based approach, it is generally amenable to selecting packages of treatment methods and augmenting treatments with other approaches to address what are often unique and complex symptom presentations in PDs. However, to test the specific utility of these CBT techniques, elements of CBT treatments that overlap with one another and with other treatments need to be identified and articulated more clearly. RCTs that have been conducted for PDs have generally shown that most well-intentioned treatments designed to treat PDs are similarly effective, and are often usually more effective than treatment as usual.

CBT approach Take a Developmental Perspective

Finally, CBT approaches have always emphasized the importance of a developmental perspective in conceptualizing and treating personality disorders, and recent research has provided dramatic support for these assumptions. For instance, the emphasis in contemporary models of personality disorders concerning the impact of early adversity on the Childhood experiences play an important role in the development of personality traits and personality disorders. Traumatic childhood experiences, such as physical, sexual, or emotional abuse and neglect, have been identified as risk factors that increase the likelihood a personality disorder may develop [18] are congruent with assumptions about the role of early developmental factors in the causation of personality disorders. Other adverse experiences in childhood may also heighten people's risk for developing features of a personality disorder. Some examples are: the death of a parent; the separation or divorce of parents; the lack of parental affection; poor family communication; a harsh and controlling parenting style; or exposure to assaultive bullying [18].

II. Theoretical Perspective

Historical developments

In the last several years, there has been a growing interest in the study and understanding of personality disorders. Patients with personality disorders have been part of the clinician's worry since the beginning of the recorded history of psychotherapy; the general psychotherapeutic literature on the treatment of personality disorders, however, has emerged more recently and is growing quickly. Cognitive psychology began in the 1950s as a reaction against behaviorism. Cognitive therapists hold that behavior can be explained by examining the contents of internal mental structures called schemata. Historically, schemata derive from work by Bartlett (1932) and Piaget (1926). Like scientific paradigms, schemata have a kind of conceptual priority that dictates the construction of the world. They decrease cognitive load but also inhibit the development of other approaches and an appreciation for other perspectives (Theodore millon). Although Beck and Ellis were among the first to use a wide array of behavioral treatment techniques, including structured in vivo homework, they have consistently emphasized the therapeutic impact of these techniques on cognitive schemata and have argued in favor of the integration of behavioral techniques into therapy within a broad framework that has some roots in prior analytic practice [19][20] they and their associates have emphasized the impact of treatment for particular types, or styles, of cognitive errors on dysfunctional self-concepts, as well as on presenting focal problems

[21][22][23]. Aaron Beck and his associates have been particularly successful in developing cognitive therapies for a wide range of Axis I disorders, especially depression [19][24]. Because most mental disorders have cognitive symptoms, cognitive therapy provides an important avenue for treatment. In more recent years, Beck, Freeman, and associates (1990) applied the cognitive perspective to the personality disorders, describing the schemata, or core beliefs, that shape the experience and behavior of such individuals. Like other beliefs, these schemata are always available and always working to produce order from sensation. As such, they operate at a non-conscious level and give rise to "automatic thoughts," which influence emotion and behavior. In the paranoid personality, for example, core beliefs such as, "People are malicious and deceptive" lead, in actual interpersonal situations, to automatic thoughts such as, "He is trying to fool me," and "I cannot afford to believe him," which naturally leads to anger and an interpersonal posture of guardedness and hostility. In addition, Beck and associates also emphasize the importance of cognitive distortions. These are chronic and systematic errors in reasoning that promote the misinterpretation of consensual reality. The cognitive therapy model of Beck et al. (1990) is anchored to evolution and links the personality disorders to certain primeval evolutionary strategies, adaptive in moderation, but exaggerated in personality pathology. For example, the dependent personality exemplifies a "help-eliciting" strategy. Although asking for help when faced with obstacles is adaptive from both a personal and an evolutionary viewpoint, dependents make this strategy the organizing principle of their entire existence. Although these observations are still relevant clinically, traditional CBT theories of personality disorders were often over specified, lacked theoretical precision, and were too broad to be empirically tested.

III. Attachment, Mentalization, And The Neurobiology Of Personality Disorders

Attachment

Attachment theory has been largely airbrushed out of not only psychoanalytic thinking, but other clinical approaches as well. An influential way of thinking about personality disorders stems from attachment theory. This theory is credited to John Bowlby and Mary Ainsworth. Like object relations theory, attachment theory proposes that people develop internal representations of relationships through their interactions with early caregivers. These internal representations, or working models of relationships, then go on to influence: 1) personality development, 2) social interaction tendencies, 3) expectations of the world and of other people and, 4) strategies for regulating emotions. The theory separates these working models of relationships into two main categories, secure attachment and insecure attachment, according to the degree of safety and security present within the relationships represented by the models. Many of the features of insecure attachment in adulthood resemble the signs and symptoms of PD [25]. There have been numerous studies of attachment patterns in people with PDs, particularly of the DSM-IV cluster B [26] which indicate that such individuals show higher rates of insecure attachment than the general population [27]. Conversely, secure attachment is rarely associated with borderline PD (BPD) and avoidant PD (28, 29). Adults presenting a preoccupied style are more sensitive to rejection and anxiety, and are prone to histrionic, avoidant, borderline, and dependent PDs. BPD is strongly associated with preoccupied attachment in the presence of unresolved trauma (28,30,31,32,33,34). CT recognizes the cognition has preconscious (i.e. automatic), conscious and metacognitive levels (i.e. decentering and distancing; Alford & Beck, 1997).

Mentalisation

Anthony Bateman and Peter Fonagy are the founders of Mentalization-Based Treatment (MBT). There is accumulating research evidence that MBT is an effective treatment for Borderline Personality Disorder [35]. MBT originates from attachment theory. Mentalization refers to the ability to reflect upon, and to understand one's state of mind; to have insight into what one is feeling, and why. Mentalization is assumed to be an important coping skill that is necessary for effective emotional regulation. Difficulties with regulation are one of the four primary characteristics of all personality disorders. Fonagy and Bateman propose that caregivers' insightful understanding of children's experience, coupled with feedback to children about that experience, provides a useful model. Fonagy and Bateman argue that people with Borderline Personality Disorder are limited in their capacity to mentalize. Lacking this capacity, they cannot accurately recognize their own feelings and those of other people. The end result is their interpersonal relationships are negatively impacted. The capacity to mentalize is seen as an important and necessary skill one must master in order to successfully cope with intense emotions. For instance, my ability to understand exactly what I feel and why I feel it, provides me the information I need to better regulate, or simply tolerate, intense feelings. Similarly, if I have an understanding of what I want to do, and why I want to do it (i.e., my motivation), I will be better able to slow the progression of an impulsive urge to do something that is contrary to my ultimate goal. In addition, having this understanding of my feelings and motivations provides the basis for a more complete and internally consistent sense of self. Thus, the limited ability to mentalize would account for several difficulties experienced by people with Borderline Personality Disorder including: 1) impulsivity, 2) a sense of identity that is fragmented and inconsistent, and 3) poor regulation of intense emotions.

EFFICACY AND EFFECTIVENESS OF COGNITIVE BEHAVIOUR THERAPY FOR PERSONALITY DISORDERS

Efficacy and Effectiveness of CBT Treatment in Specific Types of Personality Disorders.

Research generally supports the conclusion that CBT is an effective treatment modality for reducing symptoms and enhancing functional outcomes among patients with PDs, thereby making it a useful framework for clinicians working with patients with PD symptomatology. CBT incorporates a wide range of techniques to modify these factors, including cognitive restructuring, behavior modification, exposure, psycho education, and skills training. In addition, CBT for PDs emphasizes the importance of a supportive, collaborative and well-defined therapeutic relationship, which enhances the patient's willingness to make changes and serves as a potent source of contingency [36][37][38][39]. In sum, several aspects of CBT's conceptual framework and its technical flexibility make it appropriate to address the pervasive and diffuse impairment commonly observed among patients with PDs.

Although still scarce, research on CT for PDs has been promising. Over two decades of mostly uncontrolled case studies (cf., 13), the last decade has brought several well-designed trials of treatment for BPD [40] avoidant [41] and obsessive compulsive PDs [42]. In a randomized clinical trial (RCT) of avoidant PD patients [41] 63 individuals were assigned to cognitive behavioral therapy based on Beck's approach [or to brief dynamic therapy; both treatments consisted of 20 sessions and were manual-guided. In a published trial of CT for BPD, Brown et al. [40] treated 32 individuals weekly for one year and reported moderate improvement in all outcome measures including hopelessness, BPD symptoms, suicidal ideation, and self-injury.

Though both led to improvement (avoidance and anxiety as assessed by both independent raters and self-reports), the effect sizes for CBT were mostly large, and were uniformly larger, both immediately post-treatment and at six month follow-up. An important point made theoretically [43] and empirically [42] is the centrality of the therapy relationship in effective cognitive treatment of PDs. Indeed, greater improvement was found when early therapeutic alliance and adequate repair of therapeutic ruptures (disruptions in the therapeutic process that can be used as corrective experiences) were present [42]. Maintaining the patient's engagement is a challenge in treating PDs, for which dropout rates have often exceeded 50% [44]. Addressing this challenge is very central to two of the most innovative CBT approaches for treating PDs which are in use- Schema Focused therapy and Dialectical Behavior therapy.

Strauss and colleagues [45] conducted an open trial of treatment outcomes among outpatients with AVPD ($n = 24$) and OCPD ($n = 16$). All patients received up to 52 weekly sessions of individual CBT and were assessed before and after treatment. At follow-up, treatment gains were maintained, with 91% of the CBT group and 64% of the BDT group no longer meeting diagnostic criteria for AVPD, a statistically significant difference. In the study described above, Strauss and colleague (2006) conducted an open trial of traditional individual CBT [46]. The trial, which included 16 patients with OCPD and 24 with AVPD, attended up to 52 weekly sessions of CBT. Results indicated that 53% of patients with OCPD showed clinically significant reductions in depressive symptoms, and 83% exhibited clinically significant reductions in OCPD symptom severity. Of note, the CBT-based approach was equally effective for both disorders [45].

It appears that people with Narcissistic Personality Disorder may benefit from psychotherapy, but the data also suggests that people with this disorder are extremely likely to drop out of treatment [47] making research efforts difficult. Likewise, treatment of the Antisocial Personality Disorder has been characterized as difficult and full of pitfalls. Many experts are guarded about the prognosis for the treatment of this disorder. The general recommendation is a treatment that combines pharmacotherapy and psychotherapy, particularly cognitive-behavioral therapy [48].

Brief cognitive therapy approach

Cognitive therapy adheres to the basic goals of planned brief therapy, but treatment times can vary. It typically lasts from 12 to 20 weeks, with the client and therapist meeting once per week [49]. However; it can be conducted in less time, for instance, once per week for six to eight sessions. The number of sessions will depend on the nature of the problem. Carroll, K.M. suggests that Cognitive therapy can be quite successful as an option for brief therapy for several other reasons like:

- It is designed to be a short-term approach suited to the resource capabilities of many delivery systems.
- It focuses on immediate problems and is structured and goal oriented.
- It is a flexible, individualized approach that can be adapted to a wide range of clients, settings (both inpatient and outpatient), and formats, including groups.

However, due to the nature of personality disorder problems, the duration of therapy may vary.

Longer term treatment for personality disorders

Treatment for most personality disorders usually involves a long-term course of psychological therapy. Despite the frequent statements personality disorders are not treatable, there is substantial evidence that they respond to

psychotherapy. Extended therapy appears to be necessary for the full effect of the treatment. The duration of the therapy usually varies depending on the severity of the condition and other co-existing problems.

Because cognitive therapy is usually planned for comparatively short treatment times, there has not been much research to study the relative effectiveness of longer term cognitive therapy. Small body of research supports the notion that PDs may require more extended psychotherapy than Axis I conditions. Howard et al. studied the dose–effect relationship in psychotherapy and found that borderline patients take longer than other groups of psychiatric patients to show improvement in psychotherapy. Fifty percent of anxious and depressed patients improved in 8 to 13 sessions, whereas, according to clinical chart ratings, borderline patients required 26 to 52 sessions to achieve similar levels of improvement. Some patients with BPD did not show significant improvement until the second year of once-weekly treatment. Report on mental illness in Canada, 1999 comprising all age groups, observes that personality disorders were more likely to be a contributing factor rather than the main factor determining length of stay in hospital. This reflects the fact that personality disorders are associated with other conditions, such as suicidal behavior, that may need hospitalization.

In the dissertation research of Dr. Lisbeth Høke [50] 58 borderline patients were followed for up to 7 years. The BPD subjects in this study could be divided into two different groups based on their natural course. The first group (approximately half) had intermittent or inconsistent psychotherapeutic treatments; the second group had consistent psychotherapy over at least 2 years. Those who remained in a stable psychotherapy process showed greater improvement in mood functioning, a decreased need for more intensive psychiatric interventions (such as hospitalization, emergency room visits, and day treatment), decreased impulsiveness, and improved Global Assessment Scale scores. A Norwegian study [51] supported the findings that PDs may take longer to change than Axis I conditions. In this study, 48 patients were treated with dynamic psychotherapy that ranged from 9 to 53 sessions.

In a small, intensive study of 5 borderline patients successfully treated by experienced analytically oriented therapists, Waldinger and Gunderson noted that the therapists' perseverance over time was an important factor [52]. A common thread was that all the therapists had an unusually strong commitment to persist at the difficult work of therapy until a satisfactory outcome was achieved. A major finding of the study was that none of the 5 patients were manifestly diagnosable as having BPD after 4 years of treatment.

Cognitive behavior therapy and Pharmacotherapy

The evidence base of research comparing the efficacy and effectiveness of CBT, pharmacotherapy, and their combination is still relatively limited. Yet, studies in this area seem to be consistent with meta-analyses suggesting few differences in the effects of bona fide psychotherapeutic treatments and pharmacotherapy in the acute treatment of personality disorders and that psychotherapy and combined treatment are associated with better (long-term) outcome.

Component dimensions of personality, such as impulsivity or aggressiveness, have demonstrable neurobiological correlates, as shown via a variety of endocrine, electrophysiological, and neuroimaging measures [53][54][55][56][57][58][59][60][61][62][63][64][65][66]. Identifying neurobiological substrates of personality has allowed for increasingly specific pharmacotherapy. Nevertheless, improvement from effective pharmacotherapeutic interventions is often transient and/or restricted to several symptom domains. In the USA, there are no FDA-approved medications for treating personality disorders. Thus, pharmacotherapy for personality disorders remains off-label, and psychopharmacological strategies for evidence-based practices remain lacking.

The majority of psychopharmacological research on personality disorders has focused on borderline personality disorder (BPD). In the most recent treatment guidelines for BPD, the American Psychiatric Association (APA, 2001), acknowledges that 'pharmacotherapy has an important adjunctive role', along with 'extended psychotherapy to attain and maintain lasting improvement in personality, interpersonal problems, and overall functioning'. Similarly, others have described psychopharmacological treatment of BPD as resulting only in 'a mild degree of symptom relief' [67]. Moreover, there remains a dearth of evidence-based medication treatments for other personality disorders. Although evidence-based psychotherapy remains an integral part of treatment, Axis II psychopathology is increasingly conceptualized according to neurobiological substrates that correspond to specific psychopharmacological strategies. NICE recommends that antipsychotic or sedative medication such as benzodiazepines should only be used for short-term crisis management or treatment of comorbid conditions in dissociative or emotionally unstable personality disorder [68]. Also more research is needed in that current evidence suggests that brief CBT is as effective as pharmacotherapy for mild to moderate personality disorders and that combined treatment is more effective and cost effective.

COGNITIVE BEHAVIOR THERAPY IN CHILDREN AND ADOLESCENTS

Disorder of personality in adolescence is a complex concept. On the one hand, it may be hard to distinguish personality pathology from normal developmental impermanence and instability. A developmental perspective demands that we keep an open mind about pathology trajectories, and balance resilience against vulnerability factors [69]. On the other hand, a small subgroup of young people do seem to present with emerging psychopathology that resembles adult personality disorder, where early diagnosis is likely to lead to early interventions and thus improve prognosis. The challenge lies in getting the formulation right. In adolescence, this 'transaction' between Axis I and Axis II disorders is likely to be more pronounced, such that each makes the other more likely to develop, and both suggest a vulnerable psychological self-regulating system [70].

There is evidence that suggests it is the mother's 'mindedness' about the child that affects the way in which the child develops an emotional language and theory of mind that are part of their personality structure [71]. Support for the parents is therefore an important aspect of helping young people with emerging personality pathology. In addition, parents of children with conduct or hyperactivity problems are likely to have significant personality pathology themselves [72][73][74][75]. The most die-hard genetic reductionist must accept that if personality problems are largely genetic, then both the genes and the environment come from the parents. If a child has, for example, callous and unempathic traits, then at least one of the parents probably does too, with potentially dire effects on the caregiving milieu in which the child grows up.

Dialectical behavior therapy (DBT) a cognitive behavioral treatment developed by Marsha Linehan has been adapted for a wide range of clinical populations, including adolescents. Programmes offering DBT to adolescents have been adapted in a number of ways, but no one version has been shown to be superior. There is preliminary evidence to support an adapted version of DBT with adolescents who meet criteria for borderline personality disorder [76]. Adolescent DBT (DBT-A) differs from adult DBT in that it is designed to be delivered over fewer sessions (24 sessions over 12 weeks, compared with typically weekly sessions over 12 months for adults), includes parents in the therapy programme, places a greater emphasis on the family, and focuses on teaching a smaller number of skills. The language used is adapted to be more appropriate for an adolescent [76]. Involvement of the family or carers in skills training is common to many of these adaptations. Teaching other family members skills can enable them to act as skills coaches to generalize these skills in young person's everyday environment. Although individuals are encouraged to work towards changing their own environment during DBT, it is recognized that adolescents may not always have the autonomy to affect these. Rathus & Miller (2002) found that adolescents engaging in DBT were admitted to hospital less often, had higher rates of treatment completions, reduction in suicidal ideation and symptoms of borderline personality disorder when compared with treatment as usual. There was a significant reduction in behavioral incidents when DBT was used on an adolescent in-patient unit, when compared with a unit run on psychodynamically oriented principles [77]. James *et al* [78] offered DBT to a community sample of adolescents in the 'looked after' system (i.e., in the care of the Local Authority). The authors found a significant reduction in self-report depression scores (Beck Depression Inventory), hopelessness (Beck Hopelessness Scale) and episodes of self-harm. Dialectical behavior therapy has also been shown to have some positive effects in female juvenile rehabilitation settings [79].

SUITABILITY AND ACCEPTABILITY OF CBT

Research generally supports the conclusion that CBT is an effective treatment modality for reducing symptoms and enhancing functional outcomes among patients with PDs, thereby making it a useful framework for clinicians working with patients with PD symptomatology. Dixon-Gordon, Turner, & Chapman, 2011 [80] reviewed 33 randomized controlled trials (RCTs) of psychotherapies for PDs. In a mixed PD study on the effectiveness of day treatment programs that combined CBT with psychodynamic strategies, Cluster A (schizoid, paranoid, and schizotypal) patients demonstrated significant decreases in symptom intensity and increases in functioning, although their improvement was not as great as BPD and cluster C (avoidant, dependent, and obsessive-compulsive) patients). They reviewed multiple studies where CBT was efficacious and concluded that psychotherapies are efficacious for personality disorders. Matusiewicz, Hopwood, Banducci, & Lejuez, 2010, reviewed article on CBT for different PDs. CBT for BPD is the most studied PD and suggests CBT as an effective treatment [81]. For Avoidant Personality Disorder (AVPD), group CBT resulted in significant reductions in anxiety, depression, and symptomatic behavior (e.g., fewer irrational beliefs, less social isolation; exposure was the main active ingredient. Individual CBT with a focus on cognitions and beliefs was also shown to be effective for AVPD. CBT was equally effective for Obsessive Compulsive Personality Disorder (OCPD) as AVPD in one study. For Antisocial Personality Disorder, CBT led to equivalent improvement to treatment as usual (TAU). CBT is able to reduce symptoms and dysfunction for patients with mixed or complex personality pathology.

A review of PD research from 2003 to 2006 cited a meta-analysis which concluded more studies were needed, especially for CBT [82]. Overall; psychotherapies (both CBT and dynamic) are a key element of

effective treatment. In another meta-analysis study on CBT and psychodynamic treatments for PDs, it is seen overall, CBT had a large effect size in the treatment of PDs [83]. CBT was mainly categorized as a useful treatment for AVPD [84]. Sanislow & McGlashan, 1998, Psychological treatments were found to be effective for PDs despite short treatment durations [85]. Emmelkamp observes Patients in the CBT group demonstrated greater improvement than those in the BDT and waitlist groups. Muran, Safran, Samstag, & Winston found that CBT and BRT were favored for improving the patient's perception of their problems, and CBT was favored over STD for interpersonal problems [86]. CBT found to be an effective treatment for AVPD [87]. CBT was found to be superior to IPT in several studies. Gordon, Salkovskis, & Bream, suggests that those with comorbid OCPD had higher levels of OCD severity at intake, but demonstrated greater treatment gains, and had similar post-treatment symptom severity as those without OCPD [88].

Lis & Myhr, analyzed data on patients who sought treatment at a CBT center wherein a greater percentage of Borderline patients demonstrated significant improvement compared to the OCPD and no PD groups [89]. According to Nordahl et al., 2016, CBT was superior to all groups (including CBT with paroxetine) at a 12-month follow-up. Patients with PDs demonstrated significant decreases in anxiety and depression after CBT compared to standard care [90]. For Fournier et al., 2008 those with PDs who responded to CBT maintained improvement, while those who responded to antidepressants and were then given a placebo largely relapsed [91]. There is a clear need, however, to develop and evaluate CBT in order to provide specific and more unambiguous treatment recommendations with particular relevance for understudied PDs.

IV. Conclusion

As there are evidences for the efficacy and effectiveness of psychological treatments derived from other psychotherapies CBT should act as a platform for psychotherapy integration, also preparing for integration with other non-psychological treatments (i.e., pharmacotherapy) when they are evidence based. A multilevel analysis of the CBT outcomes (e.g., including the neurobiological level) is important for an integration between psychological and pharmacological treatments, although, taking the state of pharmacotherapy reviewed here into account, at this time the psychological treatments are the first-line interventions for personality disorders.

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