Reflections on the Therapeutic Journey: Uncovering the Layers

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Abstract Personality disorders are present in approximately 9–14% of the general population. These behaviors are pervasive and emit distress and agony in a wide variety of life's areas, thus taking a call for a well-formulated therapeutic paradigm. Life carrying shades of interpersonal conflicts, impulsivity, heightened emotionality with underlying maladaptive perceptions often acts as a medium of distress for not only themselves but significant others as well. This in turn influences the therapeutic sessions with them. The present paper describes in detail the therapists' journey with patients with personality disorders, as to how their unrealistic demands, expectations, cognitive errors often color the therapeutic relationship. The paper further moves to describe the barriers especially to mention the personality characteristics, viz stubbornness, unwillingness to change, unrealistic expectation of instant improvement, and difficulty to openness. It acts as a hindrance further shifting the therapeutic goals, thus putting an abrupt end to the therapeutic journey. Issues of counter-transference including difficulty in handling manipulative behavior, therapists' own emotional burnout, and inability to handle the covert threats have also been mentioned. Thus, taking a cue from the barriers, urgent need is required to formulate practical evidence-based therapeutic interventions for such patients keeping in view the cultural settings.

Keywords Personality disorders · Therapy · Counter-transference

Personality disorder as pervasive and inflexible patterns of inner experience and distorted perceptions accounts for approximately one-third of the patients presenting in the mental health setting. Borderline personality disorder and antisocial

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personality outnumber all other categories. Newspapers, digital and other forms of media are flooded with incidences involving provocative behavior, intense anger outbursts, deceit, blackmail, all discreetly hinting toward personality distortions. These may have remained undiagnosed or passed off as major behavioral issue. People meeting diagnostic criteria for personality traits present themselves at mediation centers of family courts, reality shows on television, at criminal justice systems, often making headlines for exhibition of extreme behavior, for instance, altercation with a person of national importance and stalking leading media personality, forgery, coercive polygamous relationships, etc.

Characteristic features of PD usually emerge during adolescence or early adulthood, tend to remain stable over time, and often lead to serious distress or functional impairment for the individual. These behaviors are pervasive and cause distress and impairment across a range of personal, social, and occupational situations or in other important areas of individual functioning. Sharan (2010) in his review article found that the rates of personality disorder were higher in special populations such as university students, criminals, patients with substance use disorder, and patients who attempted suicide. Personality disorders when left undetected can cause difficulty in initiation and maintenance of treatment. Because the traits of PD tend to be stable over the time, these disorders have been considered not consistent with treatment; however, many treatment modalities including CBT, DBT, TFP, and medication are available. Intense anger outbursts, provoking reactions in others, being aggressive and manipulative, and using their charms as maneuvers for controlling others all act as hindrances to the therapeutic protocol. They leave the therapist feeling helpless, frustrated, and irritable. Patient's disordered personality often builds barriers in the therapists' mind, making interaction difficulty prone. The barriers interestingly are unavoidable often playing hide and seek, instilling fear, anxiety, and uncertainty of the outcome in the therapist.

Gunderson et al. (1989) evaluated reasons reported by patients who dropped out from treatment in a specialist program for PD. Dropouts had a less satisfactory therapeutic relationship; they felt more criticized by the staff, did not perceive that they were given enough support by their family, and appeared less motivated from the beginning of the treatment. Blount, King, and Menzies (2002) found that difficulties in changing dysfunctional coping mechanisms, external unfavorable circumstances like pressure from their family and problems with the staff as reasons for dropouts.

The present paper attempts to highlight the experiences and conclusions derived out of the journey with the patients with personality disorder reporting at our mental health setting named Nur Manzil Psychiatric Centre. This hospital has been a pioneer in mental health care since the 1950s, attracting patients from all corners of the Indian subcontinent. We encountered sizeable number of patients with maladaptive personality traits. Working with them using our preexisting therapeutic skills not only afforded us with greater understanding of the dynamics but also threw up with myriad of challenges. This work is an attempt to disseminate our experiences and gain newer insights from peers to overcome the bottlenecks in the therapeutic journey. The journey of obstacles is divided into four perspectives:

therapists' perspectives, patient reflection, caregiver/significant others, and dilemma with considerable overlap within four areas.

1 Therapists' Perspective

Many a time, personality disorders go undiagnosed or recognized as simple behavioral problems in the primary health care services. They are more often labeled as bipolar, schizoaffective, mixed anxiety depression, as these are more amenable to pharmacotherapy or simpler psychosocial therapies. On the contrary, professionals may become overwhelmed by the very name "PD," thus fuelling the lack of confidence to manage them. They may consider the treatment either unapproachable or may even avoid the patient.

Another hindering perception toward effective management is the failure to take a longitudinal perspective, thus paving way for a misdiagnosis.

Often, it has been observed that working with PD patients may turn out to be emotionally taxing and exhaustive. Thompson, Ramos, and Willett (2014) suggested that clients with APD present plausible arguments in order to convince professionals there is nothing wrong with them and that they are victims of circumstances. Evans (2011) found that therapists often fall into the trap of trusting the patient with ASPD and when they realize their manipulation; embarrassment, shame, and frustration shroud their mind often making room for negative feelings. These feeling states in turn determine poor treatment outcomes (NICE, 2010).

Low morale on the part of the therapists is experienced on account of the minimal change observed in the patient's behavior. Frustration emits and burnout feeling follows. Another interesting barrier that has surfaced from our experiences is the lack of openness, secrecy, and shades of manipulation. The early formative years of patient have been colored by faulty attachment styles, thus disabling the patient to open gates of information exposure (Norton, 1996).

2 Patient Reflection

One barrier toward effective management of PD is the personality itself. Typical personality characteristics are in themselves a major block in the effective management of PD. Emotional dysregulation of borderlines, on one end to callousness and stimulus seeking in antisocial personalities on the other, to intimacy problems and restricted expressions in anxious avoidant and dependent personalities all create difficulties not only in interpersonal but also in therapeutic relations. On frequent occasions, in the backdrop of faulty attachment, personality-disordered patients present with highly unrealistic expectation for the therapist. Either he or she would be placed on the pedestal of highest authority having the magical powers to solve all problems or be judged about their credentials. The patient would oscillate

between too good or too bad. In either circumstance, therapist experiences an obstacle and if conveyed to the patient, mistrust ensues.

Defense mechanisms, a pivotal feature of personality disorder, act as roadblocks in the therapeutic journey. Projection, denial, passive aggression, reaction formation, and dissociation to name a few make the smooth functioning of therapy difficult, in turn shifting the therapeutic goals. The manipulativeness and attention-seeking characteristics interfere and increase susceptibility in violating boundaries in therapy. Patients often are seen as demanding, using conning and seduction to gain therapists' time and attention both. Subsequently, the formulated goals take a backseat while such covert behaviors demand immediate attention for proper handling.

Taking a cue from the sheer difficult childhood, non-congenial family setting, insecure attachment, patients often conceal and deliberately withhold facts from the professionals. The resultant confusion in case formulation leaves the therapist perplexed.

Secrecy coupled with rigid cognitive styles promotes intolerance for novel or alternative perspectives and viewpoints, thereby obstructing the road to recovery. Emphatic reinforcement of self-reliance and autonomy in therapy invariably converts trust into mistrust. In both AVD and BPD, rejection sensitivity threshold (a tendency to expect others to evaluate the self in a negative light) results in outright rejection of adaptive and realistic strategies (Bowles & Meyer, 2008; Adyuk et al., 2008).

The very maladaptive aspects of personality, namely self-harm behavior, irrational anger, dissociation, excessive substance use, and treatment refusal, tend to induce tectonic shifts in the therapy. Intense fear of opening pages of one's life comprising of an abusive childhood, pain-fueled memories, failed relationships, divorce/death of parents to name a few onto the therapist (who is perceived as a threatening figure) is enough a barrier to seek continual help. The fear is primarily based on the past experiences, and reliving it in the therapy sessions is often misunderstood or perceived as intolerable by the patient leading to dropouts.

Levy, Meehan, Weber, Reynoso, and Clarkin (2005) suggested that individuals with an avoidant attachment pattern may be at risk for dropping out of treatment because they are not fully committed or attached with the therapist. They may perceive that psychotherapy may emotionally unravel them. In contrast, individuals with preoccupied attachment may drop out of treatment after perceived abandonment such as emergency cancelations, scheduled vacations, and even waiting for phone calls to be returned.

Mcaleavey, Castonguay, and Goldfried (2014) found 27.5% of patients reported fear of being exposed and associated emotional reactions as perceived barriers to treatment. Pessimism about therapy, for instance, taking cues from failures and disappointments with past therapy, colors the notions of the present times. Many a time, patient feels that his or her distress is not sufficiently understood or addressed. Patients report no substantial improvement or change in their fears and cognition; little do they realize that change lies in their hands. Lack of trust as identified by Martens (2004) in the therapeutic relationship as a contributing factor to poor

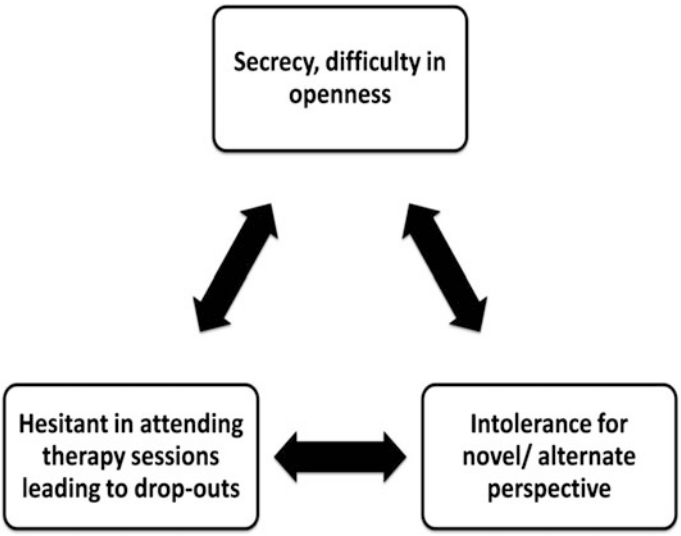

Fig. 1 Diagram represents varying reasons for dropout from the therapy program

treatment outcomes especially in ASPD and maybe perpetuated by mutual distrust between clinician and client. This barrier contributes to the stigma of client with ASPD and increased therapeutic pessimism (Selkin, 2002). Thus, therapy which is assumed to be an intimate, emotionally charged, especially a nurturing relationship may get influenced by the transference factors. Bradley, Heim, and Westen (2005) reported various dimensions of transference that are correlated with adult attachment styles and PD clusters (Fig. 1) exhibits our observations during the therapy sessions.

3 Caregivers' Perspective

Family has a major role to play in treatment in India. Strong bonding, empathy, and trust are foundation stones for family ties. Thus, a close-knit family also serves an important function toward the rehabilitation of the patient. Unrealistic expectation toward psychotherapy lurks not only in the patient's mind but also in the caregiver as well. The thought of an "instant improvement" through a single session of counseling is often encountered in the mental health settings, discounting the fact that psychotherapy and counseling are a long-drawn process of unveiling and resolving conflicts. On other occasions, the parents and caregivers tend to violate the boundaries themselves by making frequent frantic calls for knowing the recovery status. Their own personality makeup serves as a barrier. In cases of BPD, the caregivers are themselves trapped in the FOG (fear, obligation, and guilt) cycle,

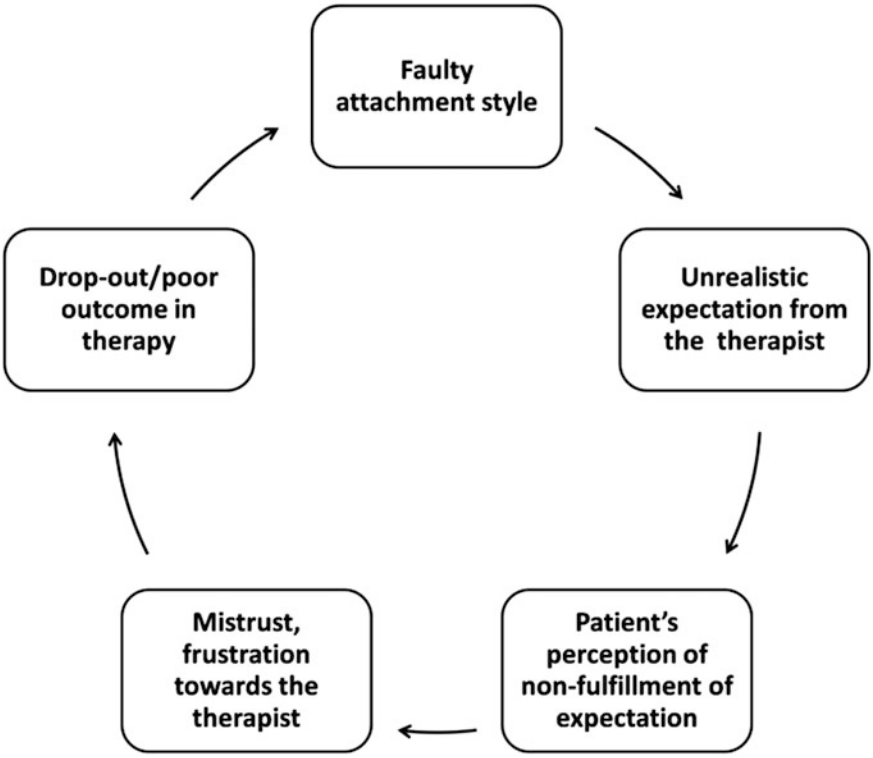

Fig. 2 Diagram represents the cycle of events from faulty cohesion in therapy

getting overwhelmed about the slow progress in patient's behavior toward improvement (Fig. 2).

Probing questions about the patient's conflicts, inner thought, state of mind by the caregiver also compels the therapist to enter a state of dilemma to divulge the information or not. On the one end, divulging would mean breach of trust while on the other end, a necessary step to corroborate the facts. Dilemma in the form of what and how much to share still prevails.

We have also observed that parents/guardians' own interaction and communication styles with each other, conflicts, cognitive errors, pattern of anger expressions, and coping styles also influence the therapy session. Resorting to criticism-laden detailing of problems adds more mistrust to the already shaky therapy ties.

4 "Other" Dilemma

Apart from the above-mentioned pitfalls and barriers, there is yet another set of factors that cast a shadow of doubt on the treatment outcome. Paucity of trained professionals in the vicinity of patient's residential setting serves as major setback. Geographical distance and non-availability of adequate transportation facility to therapy center come in the way of timely scheduling of appointment. Coupled with financial constraints, these factors not only add to the emotional burden of the personality-disordered patients and their caregivers but also pose as an impediment in gauging of appropriate and timely therapeutic progress.

5 Conclusion

Varying reflections emerge through our therapeutic journey. Firstly, either personality disorder appears masked or camouflaged by other symptoms and that personality traits get overlooked, leading to partial recovery.

Secondly, free association facilitates better understanding of the conflicts not only in the context of the various chapters of the patient's life but also toward long-term resolution of the same.

Thirdly, it is pivotal to psychoeducate both the patient and caregiver about the defenses for maintenance of trusting therapeutic relationship. Need for openness not only clears clouds of doubt but also paves way for better recovery.

Last but not least, the therapist needs to engage in periodic reality check of his/her own problem-solving skills in order to strategically deal with this emotionally volatile population.

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