

# The place of group psychotherapy in the treatment of personality disorders

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Empirical research to assist health professionals in the development of group therapy models, to guide treatment differentiation, and to enhance the understanding of group processes for patients with personality disorders is advancing slowly. Recent efforts to investigate the relationship between group process variables and outcomes are therefore valuable contributions. Important studies have been published on comprehensive treatment programmes, relying heavily on group therapies, for the more severely disturbed patients. *Curr Opin Psychiatry* 14:125–129. © 2001 Lippincott Williams & Wilkins.

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## Introduction

Group psychotherapy has been considered useful for the treatment of personality disorders for various reasons, including the following: the customary long-term format; lower cost; containment and holding potential of the groups; stimulation of multiple transferences and dilution of transferences to the therapist(s); awareness and working through of maladaptive personality traits in the here and now; and relief of the therapist's burdens through a cotherapist format and possibilities of combined group–individual treatments [1–3]. In order to construct more specific and empirically founded therapeutic guidelines, we need to differentiate between different types of group psychotherapy, different treatment contexts, different subcategories of personality disorders and different levels of personality functioning.

Recent reviews that evaluated the small but growing body of empirical research examining the outcome of psychotherapy in general for patients with personality disorders [4•–7•,8] suggest that psychotherapy may be beneficial in the areas of symptoms, dysfunctional behaviour and social adaptation, and that these benefits may be maintained after treatment. Clinical recommendations for patients with borderline personality disorder emphasize an integrated approach that involves a combination of interventions drawn from diverse psychotherapeutic approaches and schools of thought [9•,10•]. At present the evidence does not suggest superiority of one type of therapy over another. The existing studies include psychodynamic/interpersonal, cognitive–behavioural, mixed and supportive therapies. Group therapy may be conducted along all of these lines. In fact, many patients with personality disorders are treated in a group format, either in groups that are focused on symptom disorders [11–13] and in various group-based 12-step programmes that are directed at problems that often coexist with personality disorders (e.g. Alcoholics Anonymous, Narcotics Anonymous, Overeaters Anonymous, Sexaholics Anonymous [10•]), or as part of more comprehensive hospital programmes [14••,15•].

Treatment research has tended to focus on borderline personality disorder. Too little attention has been paid to the heterogeneity that the personality disorder population displays with regard to phenomenology and level of impairment, and to the consequences of this heterogeneity for treatment differentiation and level of service.

Moreover, very few empirical studies have focused specifically on group therapies [16–19]. The present review of the literature in this field from the past year focuses on the following areas: therapeutic alliance; combined treatment; dialectical behaviour therapy; inpatient and day hospital therapeutic programmes; and the development of a two-staged format for poorly functioning patients.

### Therapeutic alliance

Problems in interpersonal relations and attachment are important features of personality disorders, and may lead to poor therapeutic alliance, premature termination of treatment and poor outcome. The high dropout rates in two studies of time-limited outpatient group therapy in cluster C and B patients [17,18] led Perry [4•] to hypothesize that developing a therapeutic alliance may be a particular challenge in group psychotherapy of patients with borderline personality disorder, because shared attention puts great strain on the patients, and problems with controlling primitive rage, primitive defences and disruptive behaviours may interfere with the development of group cohesiveness.

There are great methodological problems associated with the assessment of therapeutic alliance in complex systems such as groups, which offer multiple possibilities for therapeutic relationships (i.e. to therapist(s), other group members, or the group as a whole). In the first study of therapeutic alliance in group therapy for patients with borderline personality disorder, Marziali *et al.* [20•] chose to assess alliance from the perspective of the patients' perception of the therapists' behaviour. Early (third session) and late (eighth session) therapeutic alliances were moderately positive for both interpersonal group therapy and individual dynamic therapy. For the group therapy, however, there was no significant association between early and late alliance, and only the later alliance contributed significantly to outcome at 12 and 24 months follow up. Thus, it may be that more time is needed for the alliance to be consolidated in group therapy, and that it is this later alliance that is important for predicting treatment response. Interestingly, there was no association between alliance and duration of treatment in either therapy.

Despite various conceptualizations of therapeutic alliance, there appears to be a general consensus that the working alliance captures a collaborative element of the patient–therapist relationship. McCallum and Piper [21•] conducted a study of relatively well-functioning patients with paranoid, dependent and borderline disorders in a group-orientated evening treatment programme. Those investigators defined 'work' as the degree to which patients contributed to exploring their own and other patients' problems in psychodynamic therapy groups,

with special emphasis on the patients' contribution to their own difficulties. That study suggested that work was essential for outcome. Psychological mindedness, conceptualized as the ability to identify intrapsychic components and to relate them to a person's difficulty, was independent of the type of personality disorder, but had some ability to predict work. Psychological mindedness may therefore be a candidate variable regarding selection for psychodynamic group therapy.

When group therapy is part of more comprehensive treatment programmes it may be difficult to evaluate which parts of the programme are crucial for therapeutic alliance. In-depth interviews with personality disordered patients who dropped out from two inpatient programmes [22•] suggested that nonproblematic relationships with individual therapists or primary nurses may not protect against premature termination when the patients experience other aspects of the treatment culture more negatively.

### Combined treatment

The clinical and theoretical literature on group therapy, in a pure sense, in patients with personality disorders stems to a large extent from the psychodynamic or group analytic tradition, and is mainly focused on borderline personality disorder, or the less precise concept of 'the difficult patient'. This trend has continued in the literature published during the past year [23•–26•].

The questions regarding whether some patients with severe personality disorders need combined individual and group therapy, or preparatory treatment before entering outpatient group therapy to 'learn therapy' and develop a good enough therapeutic alliance are of great clinical importance and deserve systematic scrutiny. However, the literature continues to be of a narrative clinical nature. Faced with intense transference reactions and projections in groups, some patients will need the assistance of a safe attachment to an individual therapist to prevent ego disintegration [26•]. When the individual and group therapist are different persons, the need for collaboration is paramount. However, clinical experience suggests that combined therapy with the same therapist does not always prevent splitting mechanisms.

The possible influence of group composition (i.e. diagnostically homogeneous versus heterogeneous groups) on the need for combined treatment is unclear. It has been argued that homogeneous groups with patients with borderline personality disorder may enhance primitive processes in groups to degrees that can be difficult to control, thus hampering the development of a sufficiently safe environment for fragile patients. According to clinical experience, patients with schizo-

phrenia do not fare well in groups that include patients with severe personality disorders. Clinical experience suggest that patients with severe personality disorders do better in groups with better functioning patients (without personality disorders), but there is yet no empirical evidence for this [10•,25•,26•].

### **Dialectical behaviour therapy**

A particular kind of combined therapy is the Dialectical Behaviour Therapy developed by Linehan *et al.* [27], which comprises weekly outpatient individual therapy and skills training groups, combined with extensive therapist availability through extrasession phone calls, and a therapist consultation team that meets regularly. The evidence of a positive effect of Dialectical Behaviour Therapy stems from clinical trials of parasuicidal patients with borderline personality disorder, which is supported by small studies with less rigorous designs [7•]. There is promising data on the adaption of Dialectical Behaviour Therapy to inpatient and forensic settings. The treatment may be particularly effective for the reduction of self-destructive behaviours associated with borderline personality disorder, or other dysfunctional behaviours that are intended to regulate overwhelming emotions. It is still not clear which parts of the treatment model are effective. However, a small study [7•] indicated that the group skills training part of the Dialectical Behaviour Therapy was not effective as an additive treatment to ongoing non-Dialectical Behaviour individual therapy.

Recently, a small randomized study [28•] suggested that active outreach Dialectical Behaviour Therapy specifically targeting substance abuse may be effective in reducing drug use in drug-dependent borderline patients, known as ‘very difficult to treat’ patients. Bohus *et al.* [29•] took a first step in exploring the idea that the course of therapy for borderline patients may be accelerated and improved by Dialectical Behaviour Therapy in an inpatient setting as an initial treatment before outpatient Dialectical Behaviour Therapy. In a naturalistic pilot study, those investigators found significant reduction in symptoms and parasuicidal acts during 3 months of inpatient Dialectical Behaviour Therapy treatment. A further interesting extension of the applicability of Dialectical Behaviour Therapy was introduced by Hoffman *et al.* [30•]. Aware of a possible predictive value of family communication on outcome in patients with borderline personality disorder [31], those investigators described a multifamily group model for Dialectical Behaviour Therapy–family skills training.

### **Inpatient and day hospital treatment programmes**

In contemporary Western societies there is little controversy regarding the need for acute psychiatric

hospitalization when patients with personality disorders undergo severe suicidal and psychotic crises. Intermediate and long-term inpatient treatments are more controversial because of the high costs and lack of empirical studies proving their effectiveness. Units that offer such treatments are typically influenced by therapeutic community principles with a strong emphasis on group therapies. The Menninger Clinic (Topeka, USA) and the Cassel Hospital (London, UK) are outstanding representatives of this tradition, and their research reports last year are highly recommended for detailed readings.

Gabbard *et al.* [32•] studied 216 personality disordered patients treated at the Menninger Clinic and the Harding Hospital (Worthington, Ohio), using a prospective and naturalistic design that included a 1-year follow up. Median treatment duration was 58 days. The results showed substantial positive changes from admission to discharge, and a further improvement during the follow-up period for global functioning, ego functioning, suicide and substance abuse risk, and a decline in several psychiatric symptoms. Despite several shortcomings of that study, the authors concluded that ‘... patients with severe personality disorders appear to benefit from intensive inpatient treatment ...’ and that the study ‘... showed no evidence that hospital treatment is in some way regressive or dependency promoting ...’ The study lends some empirical support to the positive effects of intermediate-term inpatient treatment for (well-educated) personality disordered patients with a low level of global functioning. The role of group psychotherapy in such treatment programmes is substantial, although it is practically impossible to determine its specific effects. However, we would like to have seen the data analyzed according to variations in duration of stay. When some patients stay as long as nearly 3 years (1014 days), we cannot fully agree with those investigators’ conclusion regarding regression and dependency need. Is there any optimal treatment time for such inpatient treatment? For example, should important objectives be defined as restoring capabilities to benefit from less intense outpatient treatment?

These questions were addressed by Chiesa and Fonagy [15•] in a nonrandomized, prospective study including 90 patients (70% borderline personality disorder), comparing a one-stage 12-month inpatient programme and a two-stage programme consisting of 6 months of hospitalization followed by 12–18 months of group psychotherapy and concurrent community outreach nursing, both provided by the Cassel Hospital staff. The patients in the two-stage sample did significantly better at 6 months and 12 months on global and social functioning than did the one-stage patients. With some reservations concerning design and generalizability, the

data from that study favour a limited inpatient treatment duration, followed by a second prolonged phase of (group) psychotherapy and psychosocial support. In two separate studies, Chiesa and coworkers [22•,33•] explored the high dropout rate (47%) from this treatment and the predictive value of hospital adjustment.

However, one may ask whether inpatient hospitalization is necessary in the first stage, or at all. Would partial hospitalization be sufficient? Unfortunately, no studies have compared specialized inpatient and day hospital treatment programmes for patients with severe personality disorders. However, Bateman and Fonagy [14••] provided a strong argument in favour of the cheaper day treatment programme format through their randomized controlled trial. In that study psychoanalytically orientated partial hospitalization (until 18 months) was compared with treatment as usual for a sample of 38 very disturbed and socially malfunctioning borderline patients. This long-term attachment-inspired day treatment proved to be superior to 'treatment as usual' on a wide range of symptoms and behaviours. The specialized treatment was followed up by outpatient group psychotherapy twice a week.

### Toward a two-staged format for poorly functioning patients?

Adding the research of Wilberg *et al.* [19,34,35•] investigating a treatment programme consisting of time limited group orientated day treatment followed by long-term outpatient group therapy, there appears to be a contemporary trend toward the construction of two-staged treatment programmes that rely heavily on group therapies for the more severe spectrum of personality disorders. There is a challenge to define more precisely specific objectives for the first stage and to define appropriate treatment models (inpatient, day patient, Dialectical Behaviour Therapy) according to levels of functioning [36•]. With regard to the second stage, several research groups are currently investigating the effects of outpatient group psychotherapy after termination from hospital-based treatment programmes. We look forward to seeing the results of these studies.

### Conclusion

Several outstanding contributions last year [14••,15•,29•,32•] dealt with treatment needs of the more severe spectrum of personality disorders. Group therapies are indispensable ingredients of treatment programmes that address those needs. The study of Bateman and Fonagy [14••] is particularly impressive with respect to design, severity of illness and treatment results. However, studies on long-term group psychotherapy for personality disorders are lacking. There is still too little research to guide us in deciding which patients will benefit most from group psychotherapy,

which patients need combined treatment, and for whom group psychotherapy is a useful adjuvant. The literature published during the past year on therapeutic alliance, psychological mindedness and combined therapy have implications for these questions.

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  - of outstanding interest
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