

Psychotherapy of Personality Disorders

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Although personality disorders are often regarded as “untreatable” by third-party payers, there is actually a growing empirical literature suggesting that Axis II conditions may be eminently treatable by psychotherapy. This literature is critically reviewed, the implications for length of treatment are discussed, and cost-effectiveness issues are examined.

(The Journal of Psychotherapy Practice and Research 2000; 9:1-6)

Psychoanalysis and psychoanalytic therapy have long been used in the treatment of patients with personality disorders (PDs). The seminal work of Wilhelm Reich¹ on analysis of the patient’s “character armor” laid the groundwork for this approach. More recently, other forms of psychotherapy have been widely used to treat PDs. Research has been slow to catch up with clinical practice, but in the last 20 years behavior therapy, cognitive therapy, supportive therapy, and short-term and long-term psychoanalytic/psychodynamic therapy have all been studied, and the results of these studies have given psychotherapists everywhere reason to feel cautiously optimistic about treating long-standing and complex character pathology.

Some managed care companies are still reluctant to cover psychotherapy for PDs. At the same time, mental health professionals have become increasingly aware that these conditions are extraordinarily costly in terms of utilization of medical services, violence, suicide, and psychiatric hospitalization.² It has also been widely recognized that PDs are not as intransigent to change as we once thought. In addition to the psychotherapy studies, other research has demonstrated that some Axis II disorders are variable over time and are influenced by significant life events such as achievements and new relationships.³⁻⁵ In this review, I summarize the major psychotherapy research on personality disorders that has appeared during the past two decades and comment on its implications for generalized treatment planning.

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The studies identified were located through a MEDLINE search and a review of relevant bibliographies.

CONTROLLED STUDIES

Much of the research on the psychotherapy of PDs has not employed randomization and control groups, partly because of the difficulties in obtaining funding for such studies and partly because the extended nature of many of the therapies leads to formidable design problems (e.g., difficulty in finding suitable control subjects; significant dropout rates; and the effect of intervening life events during the clinical trial). Nevertheless, several controlled studies have been reported in the literature.

Linehan et al.⁶ randomly assigned 44 patients with borderline personality disorder (BPD) to dialectical behavior therapy (DBT) or to “treatment as usual,” which consisted of “hit-or-miss” treatment in the community. The patients receiving DBT had once-weekly group and once-weekly individual therapy. The individual therapy focused on correction of cognitions; the group meetings taught the patients behavioral coping skills. At the end of 1 year, the group that was treated with DBT had a median of 1.5 acts of self-mutilation in a 12-month period compared with 9 in the control group. Also, the episodes of self-mutilation were less severe than those in the control group. There was a dramatic reduction in hospital days as a result of DBT, with the treatment group needing only 8.46 days of hospitalization in the entire year compared with 38.86 days in the control group. In a subsequent report,⁷ the investigators also determined that DBT subjects had lower anger scores and showed improvements in social adjustment.

Controlled studies of psychodynamic therapy for borderline personality disorder have also begun to appear. An Australian study initially used a “pre/post” design to follow 30 patients with DSM-III-R borderline personality disorder prospectively.⁸ The patients were first identified and followed for 12 months prior to receiving treatment. The same patients then received twice-weekly psychodynamic therapy influenced by the ideas of Winnicott and Kohut for another 12 months. Although the therapy was not manualized, the training therapists were intensively supervised. After termination of the therapy, the same patients were followed for an additional 12 months. Substantial and enduring improvements were observed. Among the statistically significant changes were the following:

1. Prior to therapy, the patients were absent from work an average of 4.7 months per year; following the therapy, the average had declined to 1.37 months per year.
2. The number of self-harm episodes after the therapy was one-fourth the level of the pre-treatment rates.
3. The number of visits to medical professionals dropped to one-seventh of the pre-treatment rates after the psychotherapy.
4. The average time spent as an inpatient decreased by half.
5. The number of hospital admissions decreased by 59% after the therapy.

The durability of these changes was confirmed with a 5-year follow-up assessment.⁹ Most of the outcome measures continued to show declines as compared to the pre-treatment rates. The only exception was that the time away from work began to increase over the 5-year follow-up period, but the investigators could not determine how much of that employment difficulty related to the recession that occurred in Sydney during that time period.

The same investigators¹⁰ subsequently published a comparison of their 30 BPD patients with a wait-list control group. The first 30 patients on the waiting list who had been waiting 12 months or longer made up the comparison group. These patients had their usual treatments during the waiting period, which included supportive therapy, crisis intervention, and cognitive therapy. The investigators then compared the results of the treated patients with those of the wait-list control subjects. Of the 30 treated patients, 30% no longer met criteria for BPD after 12 months of psychotherapy. The 30 patients on the waiting list for 1 year or more showed no change in diagnosis. The treatment group also showed a significant reduction in symptom checklist scores; the wait-list group showed no significant change on those measures. Definitive conclusions cannot be drawn from this study because randomization was not employed, the length of time before follow-up data were collected varied for the wait-list group, and different instruments to measure symptomatic improvement were used in the two groups. Nevertheless, the results are suggestive of substantial gains from the dynamic therapy that was offered.

Promising results were also found in the Halliwick day unit study by Bateman and Fonagy.¹¹ They compared 38 borderline patients in a psychoanalytically ori-

ented partial hospital program with those in a control condition. The partial hospital condition consisted of once-weekly individual psychoanalytic psychotherapy, three-times-weekly group psychoanalytic therapy, once-weekly expressive therapy informed by psychodrama techniques, weekly community meeting, meeting with a case coordinator, and medication review by a resident psychiatrist. The control treatment consisted of regular psychiatric review an average of two times per month with a senior psychiatrist, inpatient admission as appropriate, outpatient and community follow-up, no psychotherapy, and medication similar to that of the treatment group.

They found that the treatment group had a clear reduction in the proportion of the sample with suicide attempts in the previous 6 months, from 95% on admission to 5.3% at 18 months. The average length of hospitalization in the control group in the last 6 months of the study increased dramatically; in the treatment group, it remained stable at around 4 days per 6 months. Both self-reported state and trait anxiety decreased substantially in the treatment group but remained unchanged in the control group. Beck Depression Inventory scores also significantly decreased in the treatment group. There was a statistically significant decrease in severity of symptoms as measured by the Symptom Checklist-90 at 18 months.

The investigators concluded that the improvement of psychiatric symptoms and suicidal acts occurred after the first 6-month measurement, but a reduction in frequency of hospital admission and length of inpatient stay was only clear only in the last 6 months, indicating a need for longer-term treatment. They also decided that partial hospitalization with psychoanalytic therapy seems to be a promising and cheaper alternative to specialist inpatient and general psychiatric treatment.

Winston et al.¹² randomly assigned 81 patients with PDs to one of three groups: brief adaptive psychotherapy, short-term dynamic psychotherapy, or a waiting list for therapy. The therapies lasted 40 weeks and were compared with outcomes of people who were on the waiting list for 15 weeks. Forty-four percent of the patients were diagnosed as having Cluster C PDs, with another 23% diagnosed as PD Not Otherwise Specified with Cluster C features. Twenty-two percent were diagnosed with Cluster B PDs (antisocial, borderline, histrionic, narcissistic), and 4% came from Cluster A (paranoid, schizoid, schizotypal). The patients in the two therapy conditions improved significantly more

than the waiting-list patients on target complaints, symptom measures, and social adjustment. At follow-up (an average of 1.5 years), the improvements were maintained. The authors concluded that most patients with Cluster C PDs as well as some patients with Cluster B disorders, primarily histrionic patients, respond to either modality. However, the exclusion criteria in this study were broad, and therefore many patients with poor prognoses were not included.

Separate studies of avoidant personality disorder¹³⁻¹⁵ have employed brief behavioral treatments, including systematic desensitization, graduated exposure, and social skills training. In all three studies, significantly more improvement was seen in the treatment groups than in the waiting-list control groups. Stravynski et al.¹⁶ assigned 22 patients to 14 sessions of social skills training alone or social skills with the addition of cognitive techniques that challenged maladaptive beliefs. Equal and significant gains were found for both groups. One of the reasons that avoidant personality disorder, an Axis II condition with little psychodynamic tradition, has received so much study is because of its extensive overlap with social phobia. Indeed, many contend that there is little validity in distinguishing between generalized social phobia and avoidant personality disorder.¹⁷ At least two studies^{17,18} suggest that patients who are comorbid for social phobia and avoidant personality disorder do as well with behavioral treatments as social phobic patients without personality disorder. One other study¹⁹ found that patients with social phobia comorbid for avoidant personality disorder improved significantly with treatment but continued to report more severe impairment on all outcome measures than social phobic patients without avoidant personality disorder.

Some promising results for patients with antisocial personality disorder emerged from a study of opiate addicts,²⁰ in which 110 male patients with opiate addiction were randomly assigned to either paraprofessional drug counseling alone or counseling plus professional psychotherapy (either supportive-expressive or cognitive-behavioral). Those who had antisocial personality disorder made significant improvement in symptoms and employment, with reductions in drug use and illegal activity—but only if they also had a diagnosis of depression on Axis I. Antisocial personality disorder patients without depression showed little gain from psychotherapy.

LENGTH OF PSYCHOTHERAPY AND OUTCOME

As many of the studies I have reviewed suggest, most personality disorders do not lend themselves to a quick fix; “tincture of time” may be a critical ingredient. PDs involve a mixture of temperamental characteristics that are biologically based, characteristic patterns of internal object relations, particular cognitive styles, and specific defense mechanisms. These are often ingrained in the individual in such a way that the patient has little awareness of the difficulties these personality traits create for others. Hence a good deal of time is required to help the patient begin to reflect on how he or she comes across.

A small body of research supports the notion that PDs may require more extended psychotherapy than Axis I conditions. Howard et al.²¹ 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. In a subsequent study,²² the same research group examined the rapidity of change for different symptom constellations. They studied 854 psychotherapy outpatients who were in treatment with 141 psychotherapists. The orientation of the therapists was predominantly psychodynamic. Symptom checklists were administered to all patients, and the symptoms were grouped into three classes: 1) chronic distress, 2) acute distress, and 3) characterological. The typical outpatient needed about 1 year of psychotherapy to have a 75% chance of symptomatic recovery. The patients with acute symptoms showed an improvement rate of 68% to 98% after 52 weekly sessions. For those with chronic distress symptoms, the improvement rate was 60% to 86% over the same interval. When the investigators examined the patients who had characterological symptoms, however, only about 59% improved in that time interval; they therefore concluded that a longer duration of individual therapy appears to be necessary for symptoms embedded in character.

Evidence is accumulating that PD patients who can remain in a consistent, stable psychotherapy process over an extended period of time fare better than those

who get in and out of therapy on the basis of whether crises are present or absent in their lives. In the dissertation research of Dr. Lisbeth Hoke,²³ 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 study²⁴ 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. Thirty patients received an Axis I diagnosis and 15 patients had a PD; of the latter, 8 were dependent or avoidant and 7 were histrionic, narcissistic, or borderline. All patients were treated by psychoanalytically oriented psychiatrists. For those patients with PDs, the number of treatment sessions was significantly related to acquisition of insight 2 years after therapy and to overall dynamic change 4 years after therapy. There was no such correlation for patients without PDs. Significant long-term dynamic changes in patients with PDs were observed after treatments that lasted 30 sessions or more. Patients with Cluster B PDs seemed to do as well as those with PDs from Cluster C.

In a small, intensive study of 5 borderline patients successfully treated by experienced analytically oriented therapists, Waldinger and Gunderson²⁵ noted that the therapists' perseverance over time was an important factor. 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.

DISCUSSION

It has long been known that the presence of comorbidity on Axis II complicates the treatment of Axis I conditions. Only recently, however, has treatment research been systematically applied to PDs. The studies re-

viewed in this article reflect the fact that research on the psychotherapy of PDs is in a very early stage of development. Many studies are confounded by a lack of randomization and controls, associated inpatient treatment, the presence of Axis I conditions, the possibility that maturational processes or life events may be responsible for part of the changes measured, and the use of medications along with the psychotherapy. Moreover, some PDs, notably those in Cluster A, have hardly been studied at all, largely because patients with Cluster A PDs infrequently seek out psychotherapy or psychoanalysis. In a study of 100 patients applying for psychoanalysis at the Columbia Psychoanalytic Center, only 4 were diagnosed by the Personality Disorder Examination²⁶ with paranoid PD, 1 with schizoid PD, and none with schizotypal PD.²⁷

Despite the limitations of many of the studies reviewed, we are now at a point where several tentative conclusions can be reached. Some of the major symptoms of avoidant PD can be effectively addressed by use of social skills training and cognitive-behavioral techniques. Depressed antisocial patients with opiate addiction may be far more treatable by psychotherapy than was previously thought. BPD patients who received once-weekly individual and once-weekly group treatment following the dialectical behavior therapy model appeared to have reduced severity and frequency of parasuicidal behavior and a reduced need for hospitalization. Internal feeling states of hopelessness and despair may show little improvement, but interpersonal relatedness may change for the better.

Psychodynamic psychotherapy also appears to be highly effective for borderline personality disorder, especially when combined with an overall partial hospital program. A psychodynamic approach seems to alter some of the internal feeling states of depression that are untouched by DBT.

In an era of managed care, it is incumbent on clinicians who treat PDs to make a strong cost-effectiveness argument for the treatments they prescribe. With patients who suffer from severe PDs, such as BPD, there is a substantial medical morbidity, work disability, and need for hospitalization, all of which can be quite costly. If regular outpatient therapy is not provided for these patients, they will appear in emergency rooms, in the

offices of other medical specialists, and in psychiatric hospitals. They are a highly treatment-seeking population and will one way or another find access to the health care delivery system.

Both the studies by Linehan et al.⁶ and Stevenson and Meares⁸ demonstrate that providing extended psychotherapy of 1 year or longer for patients with BPD is highly cost-effective. Because the patients in the former study used only 8.46 hospital days per year compared with 38.86 for control subjects, and also had much less self-mutilation, the research group calculated that regular psychotherapy saved \$10,000 per patient per year.²⁸

Similar conclusions can be reached from the Stevenson and Meares 1992 study,⁸ in which the use of hospitalization was cut by half after psychotherapy. Savings can also be calculated in the reduced number of visits to medical professionals, the decreased number of self-harm episodes, and the impressive reduction in work disability.²⁹ When Stevenson and Meares³⁰ looked at the cost of hospital admissions for the 30 patients for the year before their psychotherapy, they calculated that hospital treatment alone cost \$684,346 in Australian dollars, with a range of \$0 to \$143,756 per patient. The cost of hospital admissions for the year after treatment was \$41,424, with a range of \$0 to \$12,333 per patient. The average decrease in cost per patient was \$21,431 over 12 months. The average cost of therapy per patient was \$13,000, representing a savings per patient of \$8,431. Although cost savings were not calculated for the Halliwick day unit study,¹¹ the figure suggested similar savings were made in that setting.

SUMMARY

Despite the frequent statements from insurance and managed care companies that 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. Medications may be helpful adjuncts to the psychotherapy with some personality disorders. Moreover, although intensive and extended psychotherapy may be expensive, in the long run it is highly cost-effective because it reduces inpatient stays and other costs.

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