Interpersonal Group Psychotherapy for Borderline Personality Disorder

Treatment Outcome

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e-Book 2016 International Psychotherapy Institute

From *Interpersonal Group Psychotherapy for Borderline Personality Disorder* by Elsa Marziali and Heather Munroe-Blum

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Treatment Outcome

The merits of any newly developed treatment program must be determined through the careful appraisal of treatment results. The essential question to be answered is, What form of treatment, for what duration, produces the greatest benefits for which diagnostic group of patients? Although borderline patients comprise between 13% and 15% of psychiatric outpatients, only two treatment comparison trials have been conducted: Marsha Linehan and her colleagues' (1991) cognitive-behavioral treatment of chronically parasuicidal borderline patients, and the treatment comparison trial in which IGP was tested. Both trials used group models of intervention for the experimental treatments but differed in terms of the comparison treatment; Linehan used "treatment as usual in the community," which included any number of models of treatment (inpidual psychotherapy, day treatment, pharmacotherapy, etc.). In contrast, IGP was compared with psychodynamic inpidual psychotherapy; the intent was to choose a comparison treatment that best represented the typical form of psychotherapy offered borderline patients in psychiatric outpatient clinics. It was also thought that a psychodynamic approach to inpidual psychotherapy with borderlines would best emulate the form of treatment prescribed for borderlines in the literature (Kernberg, 1975; Waldinger & Gunderson, 1987).

Both treatment comparison trials showed positive results. Linehan et al. (1991) showed that at 12 months following assessment the patients treated with the experimental treatment (Dialectical Behavioral Therapy, DBT) had fewer parasuicidal (any intentional self-harming action) behaviors and fewer days in hospital than the control group, but the two groups did not differ on self-report measures of depression, hopelessness, reasons for living, and suicide ideation. That is, both groups improved equally on these dimensions. Of note is the fact that the groups did not differ on the proportion of parasuicides that were actual suicide attempts.

The treatment trial in which IGP was compared with inpidual psychodynamic psychotherapy showed that borderline patients benefit from both forms of treatment. Outcome was measured through patient self-reports of depression, general symptoms, social behavior, and specific behavioral problems such as the management of angry and violent behavior. When interviewed at follow-up therapists who had engaged in the IGP model of treatment reported more satisfaction with their therapeutic experiences than those in inpidual psychotherapy. The IGP therapists valued both the co-therapy and group structure of the treatment. They reported that previous anxieties that were typical when initiating a course of inpidual psychotherapy with a borderline patient were much diminished as they engaged in the IGP process. The fact that a shared state of confusion was an expected dimension of the treatment allayed many of their fears about being in a room with a

group of impulsive, demanding patients. Each IGP therapist reported that it was possible to develop empathic connections with each of the patients, even though the continuity of their empathic responses varied both within and across the therapeutic sessions. The time-limited boundary of IGP also provided both therapists and patients with a predictable, safe time frame in which to carry out their work. In contrast, the therapists who conducted the inpidual comparison treatment were often unaware as to why their patients terminated treatment; in their view the treatments had not been completed.

Follow-up interviews conducted 12 months posttreatment are reported for the three clusters of patients discussed in chapter 8. The two patients in the Impulsive Angry (IA) subgroup continued to make progress. Both felt that the most important change was that the r expectations of others had been lowered; therefore they had moderated their demands. For example, one IA patient realized that she was not very tactful and was working hard to change that. Both felt that their ability to communicate more openly and clearly had improved; they were in better control of their interactions with their children and their mates. One of the patients talked about her drive to change; she fe.t 85% of the change that was needed was in herself. The other had joined a group in a community mental health program and talked about liking the leader and how sad she felt when the group ended. She felt the t she managed her temper more effectively. Both of the IA patients knew that some things were not going to change, and when they worried about this, thoughts of self-

harm reoccurred; but neither had made any suicidal attempts. When asked about her thoughts about the IGP experience, one IA patient said that "it was a farce; everyone kept talking, but nothing was accomplished." She added that the therapists never said a word, "so what was their purpose?" She hadn't liked the group the whole time she attended. Despite this patient's negative recollections of her experiences in group, she clearly had benefited from it. Her own strong motivation to change had sustained her in the group, and despite her reluctance she had become intensely involved with the other members, and she did make some important gains. During the last few sessions of the group she had actually acknowledged that it was her participation in IGP that had helped her most despite her comments about the futility of the group at follow-up. The other patient was more ambivalent about her experience with IGP. She had liked the other group members, had felt that she could be forthright with her opinions, and had learned some things about herself; however, the group had not gone on for as long as she would have liked. She had also hoped to make enduring friendships within the group, but this had not happened.

The three patients in the Dependent subgroup varied in their responses to IGP. One patient was enormously positive about her experience with the other group members and the therapists. She had never previously been in group psychotherapy and at the onset of IGP had been skeptical about what could be accomplished. However, she felt that she had gained considerable

control over her anger toward family members who had disappointed her so much in the past. She now expected less and felt that as a result she was often surprised when unexpected support and affection was forthcoming from them. She had still not found the ideal mate but was hopeful that she would. Although she was working, she was not satisfied with her job, but she was looking to find something more suitable.

A second patient in the D subgroup felt that the group had been helpful because she now felt good about herself. However, she was still unemployed and worried that living on welfare might become a permanent way of existing. She met with friends regularly and managed her daily responsibilities well. She did tend to go to bars too much but did not feel that she resorted to drinking to alleviate anxiety and depression as she had in the past.

The pseudo-competent patient from the Dependent subgroup who had dropped out of IGP had participated in a day treatment program for about 3 months but had not found it helpful; she felt especially negative toward the psychiatrist who had initially recommended the referral to the program and had refused his recommendation for intensive inpidual psychotherapy. Following the experience with the day treatment program the patient learned about a special program for suicidal patients at a hospital in another city. She applied and was admitted for an intensive 2-week program. She felt she had

benefited; she learned that her emotional reactions and depressions were connected to her patterns of intense involvement with men who always disappointed her. Although the patient reported that she was not depressed, her affect during the follow-up interview was flat. She talked about trying to control her emotions by taking "one thing at a time." She was involved in various exercise classes, went swimming, and walked a lot. She was also taking better care of her appearance and was getting positive feedback from her employer and co-workers. However, when asked about friends and family, it appeared that the patient did not have many close relationships and had not found the ideal mate. When asked about the IGP group she felt that "it had been good in a sense" but did not know if it had helped much because she never felt accepted by either the therapists or the other group members. Her admission to hospital when she left the group had been a repetition of what had been happening to her in the 3 years prior to attending the group; when she became depressed and suicidal, hospitalization seemed to be the only answer. She felt that the group she had attended during the intensive 2-week treatment program had been more useful because the leaders focused on suicidal behaviors. She felt that she needed to deal with "concrete issues" and that the IGP experience had not helped her with that. The patient's leaving the group was understandable. Her need for attention and her need to control the group had not been well-managed. Although the patient had made some gains from the IGP experience and from subsequent treatments, at follow-up she

appeared fragile and in need of more therapy. She was "hanging on" and managing but still longing to develop an intimate relationship with a man.

The male patient in the Substance Abuse (SA) subgroup reported that he was doing well and had never been as happy. He said, "I'm a different person; people used to have power over me, especially women. Now they don't. I just do what I want." He was dating a woman whom he felt was different from the women who had disappointed him in the past and was hopeful that things would work out for them. He didn't need to be taken care of so much as before and as a result had lowered his expectations of others. He had not attended AA meetings since beginning IGP. He did not miss the meetings and had not resumed drinking. However, it appeared that he had become "addicted" to bingo, which he played most nights of the week. He did not feel that he was a chronic gambler; he controlled how much he spent on the bingo and often won enough money to pay for the games. He liked the socializing at the bingo games and had come to know some of the regulars. He had found a part-time job as a clerk in the office of a friend's business. He earned enough to maintain himself in a small apartment, although he lived a frugal existence. The patient continued to take antidepressant medication. Sometimes he thought about "going off of it" but was afraid of "sliding back." The only therapeutic contacts he had were regular appointments with a psychiatrist to monitor his medication. In response to questions about his experience in the IGP group, the patient said that he had found it very helpful.

Although he had been in AA groups for many years, he had not learned things about himself until he attended the IGP group. He was comfortable with the other patients and had learned a lot from them; he also valued being able to help them. He talked about the therapists; he felt secure with them, and because of them "the group was done really well." His only regret was that the group had not lasted long enough; more sessions would have helped and "maybe the others wouldn't have had to go for more treatment." He viewed his experience in the group as advancing a positive therapeutic continuum that had been initiated during his hospitalization just prior to joining the group. He was motivated to continue the work of therapy and thus from the onset of the group was positively disposed to change despite the other patients' reluctance to join in the work of the group.

The other SA patient had gained more control over her angry reactions when men in her life disappointed her. Although she continued to search for the ideal mate, she was more cautious about engaging in new relationships with men. She was still successful at her job but had not altered her drinking and drug-taking habits. The patient felt that the group had been helpful but that she possibly had not given it a chance because she had found it difficult to involve herself in the group. She had learned a lot by listening to the other group members.

These brief vignettes of the follow-up contacts with three patient

subgroups describe the quality and quantity of change in important domains of the patients' lives. For example, for the male SA patient, the group experience extended the therapeutic work initiated previously. In contrast, the pseudo-competent patient from the Dependent subgroup continued to need attention, and her flat affect at follow-up was symptomatic of how hard she was trying to maintain control in the face of unmet needs. She had made some gains, and possibly her experience in the IGP group helped her better manage the intensive 2-week experience in the group that focused on the management of suicidal behavior. The other two patients from the Dependent subgroup had made significant changes in their lives. The patients from the IA subgroup had made important gains, as for example achieving increased control over angry reactions. However, one of the patients denied that the group contributed to her increased self-control, despite evidence to the contrary.

For borderline patients, IGP is more cost-effective than open-ended inpidual psychodynamic psychotherapy. Even with a co-therapy group model of treatment, patient-therapist contact time is considerably reduced. Typically, seven patients were treated in each group, for 30 sessions by two therapists—an equivalent of 90 hours (1 and *Vi* hours per session x 30 sessions x 2 therapists), which compares favorably with 210 contact hours if the same 7 patients were treated by inpidual therapists for 30 sessions. In addition to the cost benefits, general outpatient psychiatric services that

develop group models of intervention such as IGP could help allay therapists' frequent "allergic" reactions when confronted with the prospects of treating borderline patients. In tandem, the "bad press" that accompanies BPD patients might be tempered. This viewpoint is stressed by Vaillant (1992) in the title of a recent article "The beginning of wisdom is never calling a patient a borderline." Vaillant argues that the borderline label often reflects the clinician's subjective response rather than diagnostic accuracy; thus, in any encounter with borderline patients, therapists' attitudes influence both their perceptions and management of this group of patients. The IGP model of treatment pays special attention to therapists' subjective reactions and endorses the view that patients with BPD share a universal need for care, respect, and empathic response. When these elements are provided in a therapeutic context, the patients' abilities to make choices and to control their destinies are enhanced.

Integration of Etiologic, Diagnostic, and Intervention Hypotheses

All approaches to the treatment of BPD patients assume links between specific etiologic hypotheses, unique diagnostic dimensions, and well - defined therapeutic principles and strategies. In designing and testing IGP, each of these domains of the disorder and its treatment focused or, understanding the complex phenomena that define the nature and function of interpersonal relationships. Thus, developmental antecedents that contribute

to information processing about self-other relationship schemas in an interpersonal space influenced by strong emotions (either positively or negatively valenced) were linked to salient diagnostic dimensions. These included the borderline patients' chronic problems in establishing and maintaining caring relationships, their confusion about their own and others' motivations and emotions, and the use of impulsive, self-destructive behaviors in response to repeated disappointments and frustrations with important people in their lives. The IGP model of treatment directly addresses the etiologic and diagnostic hypotheses about the meanings of borderline patients' views of themselves and others, including therapists. The therapists are trained to monitor the meanings of group member interactions within the context of the patients' expectations of the therapists. Their therapeutic responses are focused on avoiding the replication of negative interpersonal transactions so typical of the histories of borderline patients. The ultimate goal of IGP is to help the patients to achieve altered and more benign representations of themselves in relation to others.

The IGP model of treatment replicates many of the strategies advocated by other clinicians who in their work with borderline patients have modified traditional psychoanalytic techniques. In the IGP approach the patients' perceptions of their life circumstances, past and current, are affirmed by the therapists. Initially in therapy there is no other reality but that represented by each patient in the group; that is, whatever the confusions and distortions

present in the group, the task for the therapists is not aimed at providing reality-orienting interpretations or clarifications but, rather, at attempting to understand the message being conveyed to them. How are the therapists being perceived? What is being expected of them? Will they be vulnerable to the expression of strong emotions? Can they tolerate the confusion and ambiguity? When the patients' motivations are well understood, the therapists avoid the pitfall of reinforcing for the patients their worst fears about rejection and abandonment. When the patients' expectations are not understood, then the risk of therapeutic derailment is heightened. Because IGP describes "markers" for recognizing when the patient-therapist process is in trouble, the therapists detect when a derailment has occurred, and they take steps to shift the process back on course. The strong emphasis on understanding the types and functions of therapeutic derailments is a unique feature of IGP. The time-limited, group format, and co-therapist model also provide a parsimonious approach to the treatment of borderline personality when typically long-term, intensive inpidual psychoanalytic psychotherapy has been considered the optimal treatment of choice. Finally, therapist satisfaction in treating borderlines using IGI' is an important feature of the potential utility of this model of treatment in general outpatient psychotherapy clinics.

The Management of Therapeutic Derailment

An important feature of IGP is the management of therapeutic derailment. Experienced clinicians can distinguish when a therapy is proceeding well from when it is faltering; however clinicians are less likely to identify the point in the interaction that signaled the risk of derailment. Through close observation of the group processes during each IGP group conducted in the comparison trial it was possible to identify "markers" that alerted the therapists that the interaction was either "stuck" or progressing rapidly toward a derailment. That is, when the therapists were unable to decipher the meanings of the patients' expectations of them, their interventions and the patients' subsequent responses demonstrated that the patients were at risk of having their most negative expectations confirmed. In descriptive terms, inpidual patient "stories" ceased to be expanded by the input of other group members. The stories became circular or "died," and the atmosphere in the group became infused with large doses of anxiety, hopelessness, and/or rage. The duration of any derailment depended on the progression from a "stuck" discourse to the expression of despair or rage by most of the group members. Another important feature of the derailment process was the effect of its adequate management on the progress of the treatment. When the therapists acknowledged that they did not have the answers and demonstrated that they could not fulfill the patients' expectations of rescue, the patients shifted to problem-solving talk and to the task of relinquishing expectations that could not be fulfilled. This process of

letting go of unrealistic hopes was especially evident during the terminating phase of each group; the patients contrasted gains that had been made with a discussion of problems that persisted. This "summing-up" process illustrated the degree to which inpidual self-control had been achieved; each patient reflected on his or her independent capacities for managing future interpersonal crises.

We learned from our experiences with implementing IGP within the context of a large clinical trial that the whole treatment team is vulnerable to inappropriate subjective reactions to inpidual patient behaviors or to group interactions in the course of carrying out the treatment. As indicated, the pseudo-competent patient presented special challenges to the therapeutic team. We learned that because these patients are in fact competent in controlling the group process, the therapists are at risk of engaging in a therapeutic-skills competition. The therapists' accompanying anxiety and anger are understandable. We observed that under these conditions it was especially important for the consultant to acknowledge her or his own subjective reactions to the process. Linehan has also identified a similar borderline patient type which she describes as "the apparently competent woman" (Linehan, 1993). It may be that in any treatment program for patients with borderline personality disorder, therapists need to be alerted to the potential effect on the process of those patients who defend against their own vulnerabilities by functioning in a controlling and competent manner. If

this behavior is responded to in a counter defensive manner as was the case in one of the IGP groups discussed in chapter 8, these so called pseudo competent patients will experience failed outcomes.

The Importance of Training

The IGP model of treatment was designed and tested in a treatment comparison trial with stringent criteria to ensure that therapists were adequately trained to apply the study treatments reliably. The same rigorous training criteria should be used for initiating the IGP model of treatment in any clinical setting. As stated, only therapists who have experience in treating borderline patients inpidually and who also have experience with group psychotherapy should be trained to use IGP. Because IGP specifically addresses a group of severe personality disorders patients who are at high risk of harming themselves, it is not a treatment that can be practiced by inexperienced therapists. Because much emphasis is placed on understanding the therapists' subjective reactions to patients in the context of the inordinate amount of confusion generated in group sessions, therapists who are trained in IGP must be prepared to examine openly their inpidual subjective reactions. Only through this careful self-monitoring is it possible for the therapists to understand their own contributions to the interaction. During the training, the aim is to establish a collegial environment in which the risk of criticism is low and the opportunity for learning is high.

Application of IGP in Clinical Settings

Although IGP was tested on patients with a BPD diagnosis, it is expected that the treatment model might be equally suitable and effective with groups of patients who do not share the same personality d: s- order but share similar levels of severity. For example, a mixed-diagnosis group could include patients with borderline, narcissistic, dependent, and obsessive personality disorders. The aim would be to choose patients with similar interpersonal problems, but who might present differently. However, the same inclusion-exclusion criteria discussed in chapter 2 should apply. It is also important to use a standardized screening device such as the SCID (Spitzer, Williams, & Gibbon, 1987) to check the reliability of the Axis II diagnoses. The actual effectiveness of IGP with a mixed group of personality disorders would need to be tested.

For the treatment comparison trial, the IGP model of treatment consisted of 30 sessions; however, each patient was in contact with the project 3 to 4 months prior to beginning treatment. Because randomization to treatments was used, a pool of 16 to 20 qualifying patients was accumulated prior to each wave of assignment to treatment; that is, each patient had equal chance of being assigned to either treatment. During the waiting pretreatment period, each patient was in continual contact with the research assistant who scheduled a number of appointments for the completion of the

study measures and maintained regular telephone contact with each patient to keep them informed about when treatment might begin. These research contacts no doubt functioned as supplementary treatment sessions, especially as the research assistant was trained to use strategies that paralleled those used in the IGP model of treatment. Thus, to assess the effects of IGP it is important 1o factor into the treatment time the additional 3 to 4 months of pretreatment research contacts. In a clinical setting a pretreatment time interval will be necessary in order to screen a sufficient number of patients for assignment to an IGP group, depending on the rate of referral of suitable patients. To replicate the duration of patient contact used in the treatment comparison trial it is recommended that the number of group sessions be extended from 30 to 45. Alternately, patients could be offered 1 year of treatment but would receive approximately 45 sessions because of holiday and vacation breaks. An extended time frame for the treatment might also be more beneficial for those patients who had greater difficulty engaging in the group process. Even when the group treatment is extended, it would still be more cost effective as compared to the same number of inpidual psychotherapy sessions for each patient.

Between 30% and 40% of patients dropped out of treatment within the first five group sessions. Reduction of this high dropout rate might be controlled through brief weekly inpidual contacts with each patient during the initial phase of treatment. Budman (1989) instituted this practice during a

study of patients with personality disorders treated with group psychotherapy. The inpidual sessions were especially useful for the borderline patients and markedly reduced the dropout rate (personal communication). Within the IGP context it would be important to establish a priori a specific structure and duration for the inpidual sessions. Both therapists would meet with each patient, and the technical strategies used in IGP could be replicated in the inpidual sessions. This would include communicating to each patient at the time of referral to IGP that, in addition to the pregroup session, a specific number of inpidual sessions are available to each patient if she or he wishes to use them.

The limitations of the IGP model of treatment include the following:

1. It is not any more effective for substance abusing borderline patients than any other form of treatment. Until these patients are able to exercise some control over their addictions, such as attending AA meetings, they are less likely to benefit from any form of psychotherapy.

2. Patients who protect themselves from acknowledging their own scarred images of self by adopting pseudo-competent roles in any therapeutic situation may benefit less from a model of treatment such as IGP that is based on the premise that patients are competent and that their view of the world is to be affirmed. Pseudo-competent patients have all of the "right" answers and provide them in liberal doses for the other group members but in so doing avoid acknowledging

their own vulnerabilities. These patients may need longer therapies to repeatedly test expectations of others and to be reassured that they will not be punished or abandoned when they forgo the competent stance and reveal their painful life experiences. If the IGP time boundaries were extended to 1 year, the pseudo-competent patient might have a better opportunity to relinquish this interpersonal pattern of behavior in favor of alternate strategies for engaging with significant others.

3. Even though all patients made moderate to notable gains, a small number chose to continue therapeutic work in inpidual psychotherapy. By their own reports the patients felt that their experiences in the group had helped them to make better use of the subsequent inpidual therapy sessions. In these instances IGP functioned both as a vehicle for change and as a support for continuing in inpidual psychotherapy. In this regard the group was especially effective for those patients who had previously had repeated failures in inpidual treatment.

4. The IGP model does not include other family members in the treatment paradigm. Some borderline patients could benefit from both marital and family forms of treatment (Shapiro, Shapiro, Zinner, and Berkowitz, 1977). Some might need support in accessing services from community social welfare agencies. Others could benefit from a trial of psychotropic drugs, especially when they meet criteria for Axis I affective disorders. Thus, for some borderline patients a multimodel approach to treatment (Waldinger, 1992) may be the most

beneficial, and IGP would be but one factor contributing to change.

Summary

In many respects the IGP treatment model is not dissimilar from other forms of dynamic group psychotherapy. The unique difference is that much of the work of the group is focused on recognizing and mourning the loss of the wished-for fantasies imbedded in interpersonal relations. Historically, when these fantasized wishes were frustrated and the borderline patient responded with impulsive, self-destructive behaviors, the mourning process and the accompanying pain was circumvented. In IGP, the fantasized wishes are expressed and measured against the reality of each patient's personal life situation. Each patient has the opportunity to give and receive empathic understanding for the shared losses of the hopes and expectations that cannot be realized. It is the successful management of this process within the context of IGP that advances the therapeutic work. The therapists are inevitably the targets for much of the anxiety and frustration that accompany the relinquishing of unattainable wishes. However, when mourning has been accomplished, reduction in the quantity and intensity of debilitating behaviors is the outcome. Thus, the progress made by patients in their capacities to mourn the past within the process of IGP is measured in terms of changes in the concrete behaviors of everyday living, such as improved and

more stable living arrangements, stable employment, and a more predictable and satisfying social life, including improved relations with intimate others.

In summary there is no evidence as yet to suggest that any one approach to the treatment of BPD is more effective than any other. As reported, both the Linehan, Armstrong, Suarez, Allmon, & Heard (1991) study and the treatment comparison trial that tested IGP showed that BPD patients improve in all forms of treatment. Linehan's model of treatment targets parasuicidal behavior and patients treated with DBT show fewer parasuicidal behaviors than the comparison group. The results of both comparison trials showed that there were lower dropout rates when compared with rates of dropout for BPD patients treated in general psychiatric services.

It may be that ultimately the most effective and parsimonious model is a staged approach that combines different models of treatment. Borderline personality disorder patients with extensive histories of impulsive and self-destructive behaviors coupled with no fruitful work experience may need either the structure, support, and direction of an educational behavioral approach such as Linehan's (1993) or the neutrality and affirmation of the IGP approach in order to achieve control over these behaviors. Once this is accomplished, inpidual dynamic psychotherapy may add depth and stability to inpidual patient changes in behavior and understanding of self. Future research could add useful information about the optimal match of patient

profile and treatment strategy. As illustrated, subgroups of the borderline disorder exist. It may be that any matching program will need to take into account the differences across subgroups to formulate treatment plans that respond best to the needs of patients in each subgroup. The uniqueness of each patient's contribution to the treatment encounter will show us the way.