A review of group intervention with personality disorders

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A REVIEW OF GROUP INTERVENTION WITH PERSONALITY DISORDERS

A THESIS

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

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BY

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Abstract

The literature available informing the use of group therapy within the subset of individuals with personality disorders is vast and at times contradictory. This study outlines and synthesizes the available information for both the individual diagnoses as well as the group of personality-disordered patients as a whole. While there is extensive research for several of the diagnoses such as antisocial personality disorder and borderline personality disorder, this literature contains some major gaps in regards to several of the diagnoses. Themes found across different treatment modalities, examination of the gaps and directions for future research are discussed.
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Introduction

Personality disorders are enduring, inflexible, pervasive patterns of inner experience and behavior that deviates markedly from the expectations of the individual’s culture manifested in cognition, affectivity, interpersonal functioning and impulse control. These patterns have persisted throughout the lifetime with an onset that can be traced back to adolescence or early adulthood. These patterns consistently lead to clinically significant distress or impairment in social, occupational or other important areas of functioning (American Psychiatric Association, 2000).

Historically, the zeitgeist has suggested that individuals with personality disorders are contraindicated for group therapy (Yalom & Leszcz, 2005), however there have been certain aspects of group therapy that may be considered especially useful in the treatment of individuals with personality disorders. Some examples of this is the dilution of transferences onto the therapist due to the other available sources, as well as stimulation of multiple transferences placed onto each group member (Hummelen, Wilberg, & Karterud, 2007; Campo-Redondo & Andrade, 2000). Also, groups help to highlight maladaptive personality traits in the here-and-now, in a benign social environment (Hummelen et al., 2007; Yalom & Leszcz, 2005). All individuals with a personality disorder diagnosis find themselves struggling with healthy, adaptive interpersonal relationships, as well as having difficulty relating to others that can lead to problematic functioning socially or vocationally, as well as significant distress. The nature of group psychotherapy is that one must be able to have understanding of and functioning within a social microcosm. Group therapy interactions differ from the clients’ problematic interactions in greater society because within a group there is the possibility of greater acceptance and
understanding from group members, as well as an environment of safety for testing new ways of interaction (Leszez, 1989).

In general, there has been some support for long-term psychodynamic group therapy as an effective model for the treatment of personality disorders. One study found significant change within a population of mixed Axis II disorders on Global Assessment of Functioning Scales, Global Severity Index of the Symptom Checklist, and a version of the Inventory of Interpersonal Problems called the Circumplex of interpersonal problems (Wilberg et al., 2003). Another study found comparable results using a similar analytic group that focused on exploring intrapsychic and interpersonal events, de-emphasizing the role of the therapist, promoting the whole group in participating actively, and intervention at the group, sub-group, and individual levels (Lorentzen & Hoglend, 2004).

It has been suggested that group therapy focusing on psychoeducation and social problem solving alone has helped individuals with personality disorders work towards resolving many of the social issues fundamental to personality disorders (Huband, McMurran, Evans, & Dugan, 2007).

One group, the Thames Valley Initiative, has created a group known as the Support Training and Recovery System (STARS) that allows for individuals post-treatment to continue with their involvement within the mental health system as well as future opportunities for relational interaction experiences. This group works in many outreach areas and helps as a stepping-stone to connect these individuals back into greater society. Another role of STARS members is to provide feedback to mental health practitioners about personality disorders and their treatment. Last, it serves as an example of successful treatment to those whom they are serving (Jones & Stafford, 2007).
There has been some study of how individuals with varying levels of severity to personality dysfunction interact within group settings. Vaglum et al. (1990) found that those with severe symptoms of personality disorder felt significantly less support and saw significantly less order and organization within a milieu therapy setting. These individuals were also more likely to leave treatment early against medical advice or to be discharged early due to rule breaking.

There is support both for and against the concept that individuals with personality disorders demonstrate poor attendance and significant dropout rates (Garfield, 1994; McMurran, Huband & Oberton, 2010; Vaglum et al., 1990). Ogrodniczuk, Piper, and Joyce (2006) found that higher levels of interpersonal distress had significant affect on increasing attendance to supportive group therapy; however, there was no correlation to interpretive group therapy. Consequently, less interpersonal distress resulted in a greater number of absences.
Purpose and Method of Study

The objective of this study is to synthesize the available research about the use of group therapy in the treatment of personality disorders. Many professionals adhere to dated thinking that referral of a personality disordered client to group therapy is contraindicated; however, there is significant research which refutes this idea. This study outlines the existing information available for use of group intervention with each individual personality disorder. The method of this study is a literature review of all available research of treatment of each personality disorder through group intervention.
Literature Review

Cluster A

Paranoid

Paranoid personality disorder is defined as a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent across a variety of contexts. These individuals often suspect that others are exploiting, harming or deceiving them, without sufficient evidence. Preoccupation with the trustworthiness or loyalty of those around them is common, and consequently these individuals are reluctant to confide in others and are suspicious of infidelity of a spouse. These individuals often read demeaning or threatening messages in neutral or positive interactions; consistently are quick to be on the defense against insult that is not perceived by others, and persistently bears grudges. There is never sufficient justification or evidence to support these suspicions (American Psychiatric Association, 2000).

One study was available describing group treatment with paranoid personality disorder. In this study, the evening treatment program was a modality described as a group-oriented partial hospitalization program involving 18 weeks of insight oriented groups and rehabilitative sociotherapy groups for 4 hours, 5 evenings a week. Completion of this treatment episode showed to be of significant usefulness to individuals with paranoid personality disorder. This study also found that the greater the amount of work put in, and the greater the usefulness rating made by both the client and clinician (McCallum & Piper, 1999).

Schizoid

Schizoid personality disorder is characterized by detachment from social relationships, where the individual does not desire or enjoy close relationships, including sexual contact, resulting in their consistent solitary activity. These individuals often show little interest or
pleasure in any activity. Individuals with Schizoid personality disorder often appear indifferent to those around them, unconcerned with praise or criticism, and often seem cold, detached and indifferent in affect (American Psychiatric Association, 2000).

There is little research in the area of group psychotherapy with individuals with schizoid personality disorder. One paper suggested that individuals who participated in a 10-week process group while on the wait-list for inpatient treatment showed some self-reported decrease in symptoms. The time in the group was spent processing the upcoming inpatient experience, and orienting to the therapy experience. The authors suggest that such a group could help these individuals to prepare for the transition into a therapeutic community, specifically by allowing them to work through problems that may cause early dropout, including relational detachment. There was not, however, any formal assessment of baseline or end of treatment symptomatology (Christie & Francis, 1987).

Schizotypal

Intense discomfort with social interaction that persists even with familiarity is hallmark of schizotypal personality disorder. In addition to this intense social aversion, these individuals often display patterns of cognitive and perceptual distortions and eccentric behavior. This manifests as ideas of reference, odd beliefs or magical thinking that influence their behavior that do not follow cultural norms, unusual perceptual experiences, odd thinking and speech, suspiciousness, and constricted and inappropriate affect (American Psychiatric Association, 2000).

There is no available research addressing the treatment of schizotypal personality disorder within a group setting.
Cluster B

Antisocial

Antisocial personality disorder illustrates individuals who fail to conform to social norms and show disregard and lack of respect for the rights of others, or lawful behavior. These individuals show significant lack of remorse for their actions, and are consistently irresponsible, impulsive, deceitful, and reckless. Often, these individuals show significant irritability and aggressiveness (American Psychiatric Association, 2000).

Antisocial personality disorder is often considered the most difficult personality disorder to treat due to the assumption that these clients cannot develop or experience feelings of guilt, anxiety, foresight, and judgment. One study suggested, however, that these individuals are not incapable, but simply avoid by not allowing the development of close interpersonal relationships that would require trust and vulnerability. Maas (1996) found that within a group of women, psychodynamic group therapy helped the individuals foster a greater sense of personal identity, which aided in their ability to be empathetic towards others.

Two studies, which confirm that clients with this diagnosis can be effectively treated, examined the treatment outcomes between substances abusers with and without antisocial personality disorder. Considering alcohol and drug abuse treatment when discussing individuals with this diagnosis is important due to the high rates of co-occurring substance issues; up to 90% of antisocial personality disordered clients are substance-abusing criminal offenders. It was found that after group work in a residential treatment center, individuals with antisocial personality disorder demonstrated the same levels of treatment competition, reduced drug use and recidivism as individuals without a personality disorder diagnosis (Messina, Wish, & Nemes, 1999; Messina, Wish, Hoffman, & Nemes, 2002). These findings were reflected in
several other studies that treated individuals in residential treatment centers, including treatment groups within prisons. This modality appears to be most effective within this group (Fals-Stewart, 1992; Hesse & Pederson, 2006; McKendrick, Sullivan, Banks, & Sacks, 2010).

McKendrick and colleagues included some additions to the traditional therapeutic community. Their focus was to reduce the amount of substance abuse, mental illness symptoms, and criminal thinking and behavior within an incarcerated population of individuals with antisocial personality disorder. Within a specialized prison setting, they implemented a therapeutic community that included steps to reduce the intensity of interpersonal interactions, as well as add some individualized aspects to the treatment plans of group members. A combination of psychoeducation, cognitive behavior techniques, and additional specialized groups for things such as conflict resolution and co-occurring disorders, as well as mandatory drug and alcohol recovery groups and anger management groups were included. It was also emphasized that the program relied on the community as a healing agent and mutual peer self-help as to work towards developing empathy and interpersonal skills (McKendrick et al., 2010).

Another study found that while individuals with antisocial personality disorder did not leave treatment by their own volition in any way that was statistically different from a control group, they were significantly more likely to be expelled from treatment due to disciplinary discharge. This suggests that individuals with this diagnosis behave in ways during group treatment that are disruptive enough to lead to discharge from treatment (Pelissier, Camp, & Motivans, 2003).

Warren and colleagues outlined further support for the usefulness of therapeutic communities and their group-oriented practices (Warren, Evans, Dolan, & Norton, 2004). This study found that individuals with antisocial personality disorder have significantly reduced
feelings and behaviors associated with impulsivity. The issues of impulsivity, fundamental to this diagnosis, often are associated with the previously mentioned rates of disciplinary discharge (Norton & Hinshelwood, 1996). A Democratic Therapeutic Community, combining multiple different types of group therapy including small group therapy, activity groups, and daily community meetings showed significant reduction in both impulsive thought and action (Warren et al., 2004).

Walker suggests that traditional group therapy practices outlined by Yalom (1992), such as working from a nondirective, exploratory style, are contraindicated for these individuals, especially if treating co-occurring substance abuse issues. He continues to assert that the lack of internal controls fundamental to this diagnosis often results in manipulative and power-thrusting social interactions, which can seriously deteriorate any therapeutic benefits of this type of group. This does not necessarily contraindicate groups themselves for these clients; the group format can help individuals experiment with and test new ways of interaction. Instead of a typical process group, groups should have a more firm structure with identified leaders, and have specific psychoeducation or intervention goals and directives. These groups should also have clearly defined and consistently enforced rules. There is also emphasis placed on the importance of two clinicians to diffuse group versus group leader dissention. All of these measure work towards preventing both intentional as well as unintentional sabotage of the group by the typical interactions of the clients, and help these individuals to better understand the impact of their emotions and behaviors both on the self and others (Walker, 1992).

There has been some research examining earlier interventions with adolescents who display patterns of behavior that are correlated with an antisocial personality disorder diagnosis in adulthood. One study suggests that behaviorally oriented group therapy within a group home
setting can help these children to relate to group leaders and peers as well as develop some capacity for empathy (Weinstock, 1979).

**Borderline**

Borderline personality disorder is characterized by a pervasive pattern of interpersonal relationships characterized by alternating between extremes of idealization and devaluation, self-image and affective instability, as well as marked impulsivity. Borderline personality disorder often is associated with recurrent suicidal behavior, gestures, or threats, as well as self-mutilating behavior (American Psychiatric Association, 2000).

Individuals with borderline personality disorder diagnoses may find that the group setting can allow them to more easily cope with the struggle between emotional closeness and distance. Also, confrontations made by other group members may be more readily accepted than if they had come from the idealized or denigrated psychotherapist. Some characteristics often seen in individuals with borderline personality disorder which group confrontation may be more readily accepted are egocentrism, isolating withdrawal, social deviance, and demandingness (Campo-Redondo & Andrade, 2000).

Another aspect of group psychotherapy, which may be specifically useful to individuals with borderline personality disorder, is that the group is itself a microcosm of the world (Campo-Redondo & Andrade, 2000). Interplay between group members pull for characteristic defensive behavior from others in the group. The group becomes a small representation of the outside world, and how others interact within that world. Not only is the behavior on display, but also what triggered the behavior, and others’ reactions to it. The group then becomes a place where individuals can safely test out new ways of interacting and gauge how others respond differently.
Due to how rich the group interaction is, each individual has many opportunities to do this (Yalom & Leszcz, 2005).

Individuals with a diagnosis of borderline personality disorder often have difficulty staying throughout the course of a group. Emotional instability, propensity for self-destructive behavior, and strong transference and countertransference reactions are all challenges that are often seen in working with people with this diagnosis (Hummelen et al., 2007). Individuals with this diagnosis also often require extensive, long-term therapy, extending upwards of 5 or more years (Hummelen et al., 2007; Valbak, 2003).

Dropout percentages for individuals with borderline personality disorder range from 17 to 67%. There has also been minimal evidence to suggest that the drop out rates of individuals with personality disorders may be higher in group settings than in individual psychotherapy (Hummelen et al., 2007).

Research is lacking in determining why individuals may drop out of group therapy. One study suggests, after thorough interviews of clients with borderline personality disorder who did terminate early from a group, that there are many, complex, overlapping reasons. Many of these individuals found group therapy too distressing, citing strong negative affects being aroused, and they were not able to make use of the group. Some clients felt that they were not getting enough treatment time during the meetings. The clients in this study also suggested that they felt their relationship with the group was simply too complicated, which included conflicts with other group members and feeling that their problems were significantly more or less serious than the others (Hummelen et al., 2007).

One public sector treatment program known as Spectrum Group Treatment Program (STP) specifically targets individuals with borderline personality disorder who have a history of
unsuccessful treatment. This group combines Dialectical Behavior Therapy (DBT) skills training with experiential sessions to facilitate modeling and coping of appropriate behavior and peer support. At the end of treatment there was a significant decrease in the number of individuals who met diagnostic criteria for borderline personality disorder. There were also significantly lower levels of depression, anxiety, hopelessness, and dissociation in the group members. Over time, these individuals also endorsed using significantly more problem-focused coping and less reliance on avoidance or wishful thinking coping mechanisms (Hulbert & Thomas, 2007).

The Hummelen et al. (2007) article interviewed women who had been in groups composed entirely of members with borderline personality disorder. Other research suggests, however, that this is not the best scenario for individuals with this diagnosis seeking group treatment (Campo-Redondo & Andrade, 2000). It is also important to note, that there has been recent research around newly developed groups that are specific for people with borderline personality disorder. Obviously, these groups are composed entirely of members with this diagnosis, which historically has been seen as overwhelming and problematic.

One manualized group treatment for borderline personality disorder is a program known as Systems Training for Emotional Predictability and Problem Solving (STEPPS). This program is a 20-week treatment regime that focuses on three major components. These components are psychoeducation about borderline personality disorder, emotion management skills training, and behavioral management skills training. These components closely follow a workbook, from which the clients have activities, discussions and homework. Things such as poetry, art, and relaxation techniques are used throughout to facilitate the sessions. There is also another component of this program, in which individuals who are important within the clients’ lives are
asked to attend a 2-hour session based on psychoeducation and the best way to respond to and interact with someone with borderline personality disorder. In comparison to a control group that continued treatment as usual, individuals who were assigned to additionally partake in the STEPPS program had some significantly greater improvements. These results were seen both immediately at the end of the group, as well as 1 year after. It is important to note, however, that this program is not intended to be an individual’s sole source of psychotherapy. Clients enrolled in the program were required to also partake in individual psychotherapy (Blum et al., 2008).

Another emerging group treatment option for individuals with borderline personality disorder is an approach called Intermittent-Continuous Eclectic Therapy (ICE). This therapy is run continuously, as weekly sessions. Individuals are invited to come and join the group whenever they would like, with the stipulation that if they choose to return to the group they must attend for 10 sessions. At the end of those 10 weeks they may either stay for another 10, or choose to take a break from the meetings. This helps the clients to deal with intimacy, a central problem for borderline personality disorder. Each meeting begins unstructured, where clients may discuss whatever they would like, and is used to help the individuals enhance social skills such as empathic listening, clarification, confrontation, support, encouragement, and rationality. The second part of the session is structured like a psychoeducation class, where techniques and skills are taught for things such as handling aggression, anxiety and interpersonal relations. While still only a pilot study, there is indication that this type of therapy may be useful, and that further investigation may yield exciting new findings (Menchaca et al., 2007).

An evening treatment program, a group-oriented partial hospitalization program involving 18 weeks of insight oriented groups and rehabilitative sociotherapy groups for 4 hours, 5 evenings a week, was used to treat borderline personality disorder. This intervention resulted
in individuals with this diagnosis to endorse significant usefulness. This study also found that the greater the amount of work put in, the greater both client and clinician rated the usefulness of the program (McCallum & Piper, 1999).

Integrated cognitive-evolutionary therapy models combine both group work and individual work. The groups were run from an interpersonal motivational systems theory emphasizing here-and-now interactions; however, there are cognitive-behavioral homework aspects as well as some psychoeducation. Participants with the addition of the group to their individual treatment showed significantly greater improvements on Global Assessment of Function, Behavioral and Symptoms Identification Scale-32, and Quality of Life Index, as well as reduction of self-harm and substance use than participants who received individual treatment alone (Ivaldi, Fassone, Rocchi, & Mantione, 2007).

Another modality that has demonstrated significant improvements in borderline personality disorder symptoms is Schema-Focused therapy. This manualized intervention requires 30 weekly sessions, and combines emotional awareness training, psychoeducation, distress management training and schema change work. At the end of the treatment 94% of the individuals who attended the group in addition to their individual therapy no longer met criteria for borderline personality disorder, compared to 16% of the control group which received individual treatment alone (Farrell, Shaw, & Webber, 2009).

Dialectical Behavior therapy groups have also been compared to standard group therapy in treatment of borderline personality disorder symptoms. It has been shown to be significantly more effective in retaining participants and reducing general psychiatric symptoms as well as improving symptoms of depression, anxiety, irritability, anger, and affect instability (Soler et al., 2009).
Warren and colleagues demonstrated the usefulness of therapeutic communities and their group-oriented practices. This study found that individuals with borderline personality disorder significantly reduced feelings and behaviors associated with impulsivity. A Democratic Therapeutic Community, combining multiple different types of group therapy including small group therapy, activity groups, and daily community meetings showed significant reduction in both impulsive thought and action (Warren et al., 2004).

Issues of impulsivity manifested as disordered eating, specifically episodes of binging and purging, were successfully treated within a group of women with borderline personality disorder with the use of long-term group-analytic psychotherapy. It was also suggested that the addition of cognitive and psychoeducational elements would likely enhance these findings (Valbak, 2001; Valbak, 2003).

Self-injurious behaviors due to issues with emotional regulation and avoidance of the current experience are often seen in individuals with borderline personality disorder. A group intervention targeting this self-harm behavior in women with borderline personality disorder was created to teach more adaptive ways of responding to emotions. The major basis for this group is Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) with elements of Dialectical Behavior Therapy (Linehan, 1993), Emotion-Focused Therapy (Greenberg, 2002), and traditional behavior therapy. Psychoeducation is combined with in-group exercises and homework assignments. This treatment modality has been shown to be significantly effective in reducing self-harm behavior, experiential avoidance, depression, anxiety, and stress as well as positive affects on ability to regulate emotions (Gratz & Gunderson, 2006).
**Histrionic**

Histrionic personality disorder defines individuals who find it necessary to attention seek excessively, to the point where the individual is uncomfortable with situations in which they are not the center of attention. Intense, but shallow and rapidly shifting emotional expression is also characteristic. These individuals often use their physical appearance to draw attention and use inappropriately sexually seductive or provocative behavior in their interactions. Those with histrionic personality disorder usually demonstrate significant theatricality and exaggeration, often considers relationships to be more intimate than they actually are, and are easily influenced by those around them (American Psychiatric Association, 2000).

There is no available research addressing the treatment of Histrionic personality disorder within a group setting.

**Narcissistic**

Lack of empathy, need for admiration, and intense grandiosity are key diagnostic criteria for Narcissistic personality disorder. These individuals have an exaggerated sense of self-importance and spend much time fantasizing success, power, brilliance, beauty, and love. Often individuals will only associate with those they see as of high-importance as they view themselves, however interpersonally they are arrogant, haughty, exploitative, and display unwarranted entitlement.

There is no available research addressing the treatment of narcissistic personality disorder within a group setting.
Cluster C

Avoidant

Avoidant Personality Disorder is characterized by a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. These individuals will avoid activities that require social interaction unless certain of being liked. These individuals demonstrate intense fear of criticism, disapproval and rejection, and view themselves as inadequate, socially inept, personally unappealing, and inferior (American Psychiatric Association, 2000).

Research has demonstrated individuals with an avoidant personality disorder diagnoses can make significant improvement when compared to a wait-list control when treated with a short-term group treatment program (Alden, 1989). The group outlined by Alden consists of therapeutic processing of fears and avoidant patterns, making cognitive shifts from attending to fear-related anxious thoughts to behavioral action, graduated exposure to anxiety producing situations, progressive relaxation techniques, and interpersonal skill training. It is important to note that while these individuals did make significant improvements, they were not functioning at the level of a normative comparison sample post-treatment.

Avoidant personality disorder does not differ significantly in treatment outcomes from Social Phobia when both are treated with Heimberg’s (1991) group therapy (Hope, Herbert, & White, 1995). This is a treatment program that integrates role-playing exposure to feared situations within the group as well as in vivo exposure outside the group via homework assignments; cognitive restructuring is also a key piece to this treatment modality (Heimberg, 1991). There is further support that avoidant personality disorder is responsive to treatment created for social phobia, as individuals with both diagnoses made equal gains after a behavioral
psychotherapy group specific for public speaking anxiety which facilitated the use of psychoeducation and exposure therapy both within group and *in vivo*. This study found that following this group, those with avoidant personality disorder demonstrated reductions in overall fear of criticism and rejection, a key factor of avoidant personality disorder (Hoffman, Newman, Becker, Taylor, & Roth, 1995).

There is debate as to whether the addition of social skills building to behavioral exposure increases the effectiveness of treatment. While many treatments reduce avoidance and anxiety of social situations, it is theorized that this does not address the ability to function effectively in social situations (Stravynsk, Arbel, Lachance, & Todorov, 2000). Stravynsk, Lesage, Marcouiller, & Elie (1989) found that when the order of treatment modalities (social skill building and group discussion) was switched, there was ultimately no significant difference between the groups. It is important to consider, however, that both groups received both treatment modalities, and both groups saw significant improvement (Stravynsk et al., 1989).

One study examining the usefulness of social skills training did find significant improvement in measures of avoidance and anxiety after social skills training consisting of a graduated hierarchy of behavioral modification, modeling by the therapist, and role rehearsal, as well as feedback from the therapist and group. This study also found no significant difference in results between conducting this training within a clinical setting (where only the clinician and clients are present) or in public with the opportunity for clients to interact with strangers (Stravynsk, Belisle, Marcouiller, Lavallee, & Elie, 1994).

A 4-day intensive group treatment program outlined by Renneberg, Goldstein, Phillips, and Chambless (1990) theorized that the level of anxiety within the group of clients with avoidant personality disorder is so high that it would be more effective to begin treatment with
relaxation training and systematic desensitization opposed to the social skills training and behavioral training that is seen in other treatments. This study found that overall there was reliable and clinically significant change, most notably in fear of negative evaluation. The authors suggest that the 32 hours of treatment given to these clients demonstrates the ability of the treatment methods to produce desired results; however, they assert that more treatment hours across a longer period of time will likely produce greater results.

One study examined the effectiveness of social skills training versus social skills training in addition to cognitive modification in both group and individual settings. Stravynski, Marks, and Yule (1982) found that social skills training in combination with cognitive modification did not demonstrate significantly different results than social skills training alone, nor were there significant differences between outcomes of those treated within a group versus individually.

Eikenaes, Gude, & Hoffart (2006) indicate that individuals with avoidant personality disorder need significant time to acclimatize to group settings to be able to participate fully in therapy. This study found that an effective treatment modality for treatment of avoidant personality disorder is wilderness therapy; constant exposure to interactive social situations can help these individuals to become more comfortable with relying on and associating with others (Eikenas et al., 2006). Another core symptom to avoidant personality disorder is the reluctance to move outside daily routines (American Psychiatric Association, 2000). Wilderness therapy also exposes individuals to a variety of new experiences. This type of group treatment modality was found to be equal in effectiveness as typical inpatient group treatment. Metacognitive interpersonal therapy (MIT) is a therapy used for treatment of personality disorders which focuses on improving deficits in metacognition, the ability to understand mental states and think about thinking, as well as help to create new interpersonal representations to replace maladaptive
ones (Dimaggio et al., 2007; Fiore, Dimaggio, Nicolo, Semerari, & Carcione, 2008). The authors cite the ability for a group to provide feedback about demonstrated issues in metacognition, pointing out inconsistencies to others in the group.

**Dependent**

Those with dependent personality disorder demonstrate excessive need to be taken care of by others. This manifests in submissiveness, clinging behavior, and fear of separation. Often, these individuals find it difficult to do anything without the support and approval of others, often delegating major responsibility of their life to those around them. A strong desire for approval and liking can drive these individuals to avoid disagreement, or initiate projects. The intense fear of being alone and unable to care for oneself is characteristic of dependent personality disorder, leaving individuals to feel helpless without a relationship, and become preoccupied with fears of being left (American Psychiatric Association, 2000).

An evening treatment program, a group-oriented partial hospitalization program involving 18 weeks of insight oriented groups and rehabilitative sociotherapy groups for 4 hours, 5 evenings a week, resulted in individuals with dependent personality disorder reported that they found the program to be significantly helpful with the skills being useful outside of treatment. It is important to note that this study also found that the greater the individual’s psychological mindedness, the greater the amount of work put in, and the greater the usefulness rating made by both the client and clinician (McCallum & Piper, 1999).

**Obsessive-Compulsive**

Those with Obsessive-compulsive personality disorder are preoccupied with perfection, order and control. These individuals will compromise flexibility, openness, and efficiency. Rules, lists, and schedules are of foremost importance. While driving these individuals to work
without leisure, perfectionism is sought to the point that it ultimately interferes with the completion of the task, and delegation is avoided unless it is certain standards can be met. These individuals are often scrupulous and inflexible about morality, ethics, and values to over-conscientiousness, and are seen as rigid and stubborn (American Psychiatric Association, 2000).

It is suggested that when working with clients who demonstrate obsessive-compulsive tendencies within their personalities, it can be useful for them to witness and interact within the environment of the group due to its ability to demonstrate patterns of interaction that can be less rigid as individual work may be. There is less predictability as to what interactions may occur due to the multiple sources of interaction. Aspects of a group such as the need to be able to share control as well as adapt flexibly to multiple others offers the chance for individuals with obsessive-compulsive personality disorder more opportunities to work on issues of rigidity which are core to obsessive-compulsive personality disorder. Also, these clients can gain opportunities to practice new patterns within a safe environment where they can view reactions and consequences of others within the group doing the same, as well as have a wider variety of interpersonal stimuli to interact with and be affected by. A group can help these clients witness their own problematic behaviors reflected in other group members, which can allow for them to develop greater understanding of their own interactions. Individuals with obsessive-compulsive personality disorder often struggle with intellectualization of issues; a group’s ability to illicit problematic interactions can help bring the client into a more action oriented state of therapy work versus intellectual rumination (Salzman, 1985).

The hoarding behaviors that are often seen in association with obsessive-compulsive tendencies have been successfully treated with time-limited group cognitive behavioral treatment. This treatment modality included psychoeducation, cognitive strategies to reduce
hoarding beliefs, insight into emotional states, and emotional connection to possessions, motivational enhancement strategies, organizing and decision-making involving possessions, behavioral reinforcement, identifying barriers, replacement of maladaptive behaviors, exposure to sorting and discarding, reducing excessive acquisition, discussing the involvement of family or friends, coping with improvement, maintaining gains and preventing relapse. Many of these ideas could be adapted to other areas of obsessive-compulsive personality (Muroff et al., 2009).

Metacognitive interpersonal therapy (MIT) has also been shown to have some effectiveness in the treatment of obsessive-compulsive personality disorder. It may be helpful for the group to aid those with OCPD to examine their symptoms and issues with metacognition (Fiore et al., 2008).
Discussion

Group therapy is a modality that has been both thoroughly studied and overlooked in the treatment of personality disorders. The overall scarcity of research in the area indicates that there is still much to be explored. It appears that this is a topic that is just beginning to emerge in research and practice. As the widespread views of using this modality with this population begin to shift from avoidance to acceptance, more specialized and targeted group treatments for personality disorders are developed.

It is repeatedly suggested throughout this literature that it is important for clinicians to fully understand the nuances of a personality disorder symptomatology to be able to work with these clients in a group setting. Each disorder has specific relational issues that can pose problems within the inherently social setting of group psychotherapy. It is also important, however, for clinicians to avoid the dated concept that group work with personality disorder clients is contraindicated, impossible, or too difficult to try. A clinician who fully understands the issues associated with personality disorder diagnoses can work to structure and move the group in ways that creatively and effectively addresses the issues that may interfere with traditional group therapy.

It is also important to consider the reasons why clients with personality disorders struggle within groups and terminate early. The concept of tailoring the structure, content, and process of group therapy to align with the problematic or barrier creating behaviors of the clients appears to be key in moving forward with group practice. A thorough understanding of the aspects of both group dynamics and interpersonal relating which these individuals find problematic can further lead to groups better suited for their needs.
Those involved in the development of the ICE program understood that a key problem with borderline personality disorder clients in groups is that they have difficulty with intimacy. Giving the clients the ability to leave and return to therapy as needed allows them to monitor their own closeness, while still feeling a part of the group. Also, this allows them to try out new skills on their own out in the world, yet they can still return for maintenance as needed. In the STEPPS program, important people in the clients’ lives are incorporated into the therapy. Interpersonal interactions can be hugely problematic for clients with all personality disorder diagnoses. It is logical that usefulness can be found in incorporating into therapy the individuals with whom the client has the most relational interaction. These are the individuals with whom the client is testing the new interactions learned within the group. Awareness of the therapy and attempted changes can allow these individuals to aid the client through the therapeutic process.

The theme of useful therapeutic communities was repeated across several diagnoses. All of these communities combined milieu and group therapy, structuring the community and the interventions to fit the specific problems for the diagnosis. A community created within the prison setting outlined the issues for prisoners with antisocial personality disorder. A group intervention was added to address each issue. This is a setting, however, where individuals were required to remain within a structured community. Not all individuals with personality disorders would be able to devote a substantial amount of time to treatment; specifically one that was in a setting removed from family and work.

Issues of cost to clients are also important to consider. Group therapy is typically a more cost effective way of treatment; however, this may not necessarily be the case for individuals entering into a group treatment modality such as an extensive therapeutic community program. Nevertheless, there are significant costs to be considered if the client is not treated. Some of
these diagnoses are associated with repeated encounters with the legal and medical systems, both of which can cost both the individual and the taxpayer. Individual treatment for personality disorders can last years. There is some promise, however, in the concept that these therapeutic communities do not necessarily have to reflect a prison or inpatient atmosphere. One treatment modality found significant usefulness in only partial-hospitalization; the individuals spent 4 hours, 5 evenings a week for 18 weeks in treatment.

Several specific areas of tailored clinical focus repeated across diagnoses and treatment modalities. One of these themes was the concept of a benign social environment. Social interaction difficulties are key to all personality disorder diagnoses; thus, it is logical that there would be concern about the social aspects of the group. It was consistently repeated that the group allows for these individuals to witness a reflection of themselves, their behavior, and how it affects others through interacting with peers. It provides a place where most of the individuals present share many of the same struggles and anxieties. This environment also allows individuals to experiment with newly learned behaviors and ways of interaction with a greater sense of safety than in the general public.

Another area of repetition was the addition of psychoeducational pieces to the therapy. It seemed most treatment modalities found significant use in informing the clients about the etiology, maintenance, and presentation of the disorder. There was little information to support the usefulness of this as an intervention however, as no study directly looked at its effect on symptoms.

There were a variety of issues regarding the validity of some of these studies. Many of the older or more dynamically oriented interventions lacked information on the actual treatment process and failed to provide assessment measures beyond self-report or report of the clinician.
Also, many studies lacked a comparison control group, or were significantly vague about what type of therapy the control group actual received.

In regards to future research, it is of foremost importance to begin with the diagnoses that completely lack current information. It can be speculated that the lack of attention in these areas could be associated with the difficulty of addressing the specific inherent difficulties of these particular diagnoses. For example, the intense social inhibition associated with some of the Cluster A disorders may make it more difficult to develop any interactions (to use in build upon and learn from) within the group. In contrast, borderline personality disorder, a disorder characterized by highly unstable and intense social interactions, still has social interaction intrinsic to its diagnosis. Group intervention may be easier to adapt to a group of individuals who interact ineffectively rather than avoid interaction at all.

There has been a general shift in the field, however, about the treatment of many personality disorders with a group modality. Borderline personality disorder for example has multiple new manualized treatments of promising effectiveness. There are many symptoms of borderline personality disorder that were once thought of as immune from group success, however, examining these issues and addressing them with the structure of the group has proven to be useful and successful. It can be speculated, then, that the same mindset could be applied to all personality disorder diagnoses with possible success. The intense social inhibition of Cluster A could be creatively addressed with changes in group size, familiarity with the group leader, or as a first step into social interaction after progress made in individual therapy.

While there is promise to the idea of groups created for individual personality disorders, one barrier to their development is the prevalence of individuals with these disorders. Location of the treatment setting, as well as the specific diagnosis being treated can result in a very small
number of individuals interested in that specific type of treatment. This leads to the question of
groups consisting of individuals with varying diagnoses. Some studies have researched these
types of groups; however, they did not review effectiveness by diagnosis. It is possible that the
groups were significantly effective for some, while not for others. The development of treatment
groups for the individualized personality disorders could be useful to clinicians who would like
to do group work with individuals with personality disorders, but struggle to recruit enough
clients of any one diagnosis. If the clinician is aware of the techniques that work best with each,
then those techniques could be combined to work with a combined group.
References


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