

Short-Term Psychotherapy of Personality Disorders

Arnold Winston, M.D., Michael Laikin, M.D., Jerome Pollack, M.D.,
Lisa Wallner Samstag, M.A., Leigh McCullough, Ph.D., and J. Christopher Muran, Ph.D.

***Objective:** The efficacy of short-term psychotherapy has become an area of increasing interest. The primary objective of this study was to assess the results of two forms of short-term psychotherapy in patients with personality disorders. **Method:** Eighty-one patients with personality disorders were randomly assigned to brief adaptive psychotherapy, short-term dynamic psychotherapy, or a waiting list for therapy. Outcome at termination of therapy for the treatment groups and at the end of the waiting period for the waiting list group was evaluated by means of ratings of target complaints and scores on the SCL-90 and the Social Adjustment Scale. In addition, for 38 of the treated patients, target complaints were reevaluated an average of 1.5 years after treatment ended. **Results:** Patients in the two therapy conditions improved significantly on all measures in comparison with the patients on the waiting list. There was no significant difference between the results in the two therapy conditions. The waiting list period averaged approximately 15 weeks; treatment averaged 40 weeks. At follow-up, after an average of 1.5 years, target complaint ratings were not significantly different from those at the termination of therapy. **Conclusions:** These data indicate that brief adaptive psychotherapy and short-term dynamic psychotherapy are effective for patients with certain types of personality disorder and that the two therapy approaches do not differ in overall outcome.*

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Short-term psychotherapy in its various forms has become a frequently used psychotherapy (1). Along with this development there has been the increasing interest of insurance companies, funding agencies, and legislators in the efficacy of psychotherapy (2). Two recent studies using meta-analysis to address the efficacy of short-term dynamic psychotherapy (3, 4) have reported mixed results. One of the studies (3) found that it produced good results in comparison with waiting list conditions but did not produce outcomes different from those of other psychotherapies or medications. The other study (4) found short-term dynamic psychotherapy inferior to other psychotherapies. The dearth of studies of psychotherapy of personality disorders that is reflected in the two meta-analysis reports is particularly important. We previously reported a study (5) of 32 patients with personality disorders, predominately in the cluster C category of DSM-III-R, which demonstrated significant improvement of treated patients compared with control subjects.

The present study was a continuation of the past

study and provided a larger patient group. Two forms of brief therapy based on procedures specified in therapy manuals were used: short-term dynamic psychotherapy (6), based on principles developed by Davanloo (7), and brief adaptive psychotherapy (8), which was developed at Beth Israel Medical Center. These therapies lasted approximately 40 weeks, and their results were compared to those for persons who were on a waiting list for an average of 15 weeks. For ethical reasons we did not ask patients to wait longer than this for treatment. Both treatments are psychodynamically based therapies and use many of the standard brief psychotherapy techniques of Mann (9), Malan (10), Sifneos (11), and Davanloo (7). Patients were selected on the basis of the criteria for brief psychotherapy delineated by Malan (10), and careful histories were taken to determine the dynamic focus.

The two treatment conditions differed according to planned variations in technique and focus. In general, short-term dynamic psychotherapy is a more active and confrontational therapy than brief adaptive psychotherapy, although both forms of therapy are quite active and confrontational relative to standard therapeutic techniques. In short-term dynamic psychotherapy, defense, anxiety, and impulse are actively confronted, clarified, and interpreted. Short-term dynamic psychotherapy focuses on confronting defensive behavior and eliciting affect in an interpersonal context so that re-

Received Dec. 31, 1991; revisions received Dec. 11, 1992, and July 9, 1993; accepted July 29, 1993. From the Department of Psychiatry, Beth Israel Medical Center. Address reprint requests to Dr. Winston, Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th St., New York, NY 10003.

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pressed memories and ideas are fully experienced in an integrated affective and cognitive framework. Brief adaptive psychotherapy is a more cognitive therapy that focuses on the identification of the patient's major maladaptive pattern and its elucidation in past and present relationships, and especially in the patient-therapist relationship. The goal is to enable the patient to develop insight into the origins and determinants of the pattern, so as to produce more adaptive interpersonal relationships.

METHOD

The data for this study were obtained at Beth Israel Medical Center in New York City from an original group of 93 outpatients accepted between 1983 and 1988. All potential subjects completed an intake evaluation administered by a research assistant and gave informed consent for the research protocol. The inclusion criteria were the following: 1) age between 18 and 60 years, 2) evidence of at least one close personal relationship, 3) no evidence of psychosis, organic brain syndrome, or mental retardation, 4) no active DSM-III-R axis III medical diagnosis, 5) no evidence of current substance abuse, 6) no active suicidal behavior, 7) no history of violent behavior or destructive impulse control problems, and 8) no use of psychotropic medications such as neuroleptics, antidepressants, or lithium within the past year. In addition, patients had to meet the DSM-III-R criteria for an axis II personality disorder. Exclusion criteria were axis II diagnoses of paranoid, schizoid, schizotypal, narcissistic, and borderline personality disorders. Diagnoses were formulated by the interviewer using the Structured Clinical Interview for DSM-III-R (12), the Structured Clinical Interview for DSM-III-R Personality Disorders (13), or the Personality Diagnostic Questionnaire (14).

After the intake assessment was complete and consent was obtained, patients were randomly assigned to either the brief adaptive psychotherapy, the short-term dynamic psychotherapy, or the waiting list condition. It was understood by the waiting list patients that they would begin treatment as soon as a therapist became available.

Twenty-four therapists (11 for brief adaptive psychotherapy and 13 for short-term dynamic psychotherapy) were recruited from Beth Israel's psychiatry department. The therapist group consisted of 15 psychiatrists (five for brief adaptive psychotherapy and 10 for short-term dynamic psychotherapy), seven psychologists (five for adaptive and two for dynamic psychotherapy), and two social workers (one for each treatment modality). They were almost evenly divided with respect to sex (for adaptive therapy, six women and five men; for dynamic therapy, five women and eight men). The mean age of the whole group of therapists was 40.8 years (range=29-60); for those doing adaptive therapy, mean=42 years (SD=9), and for those doing dynamic therapy, mean=41 years (SD=10). The clinical experience of the whole therapist group averaged 11.6 years, with a distribution of less than 1 year to 33 years; for the adaptive therapy group, mean=14 years (SD=10), and for the dynamic therapy group, mean=10 years (SD=10). There were no significant differences in demographic characteristics, education, or experience between the therapists for the two kinds of treatment.

Each therapist engaged in only one kind of treatment to avoid mixing the techniques of the two therapies. The therapists treated an average of 2.2 patients (range=1-6). Training consisted of an ongoing seminar for each therapy for 1.5 hours per week, as well as individual supervision of videotaped case material for 1 hour per week. Treatment manuals were developed to help achieve uniform treatments (15, 16). All sessions were videotaped, and therapists were monitored through systematic scaled ratings of their videotaped sessions to ensure adherence to the procedures delineated in the treatment manuals (17). Two therapists were removed from the study before it began because of their inability to adhere to a technique. There were no significant differences in adherence between the therapists using brief adaptive psychotherapy and those using short-term dynamic psychotherapy. All therapists continued to attend the seminars for their respective psychotherapies to avoid drift in techniques.

The intake evaluation included the patient's completion of a social history, ratings of target complaints (18), the SCL-90-R (19), and the Social Adjustment Scale (20). The target complaint ratings, SCL-90-R, and Social Adjustment Scale were repeated 1 month after termination of treatment. Target complaints were again rated at a follow-up evaluation at least 6 months after termination. The target complaint method requires the patient to rate severity of the three main problems for which he or she is seeking treatment. The SCL-90-R measures general levels of psychiatric symptoms including depression, anxiety, hostility, and somatization as well as obsessive-compulsive and psychotic-like symptoms. For the purposes of this study, we used the global severity index of the SCL-90-R. The Social Adjustment Scale assesses social functioning in the context of work, family, and friends. All of the measures are patients' self-reports.

A multivariate analysis of covariance (MANCOVA) was conducted to test for differences among the brief adaptive psychotherapy, short-term dynamic psychotherapy, and waiting list groups. Specifically, the analysis involved a comparison of the termination scores of patients in the two treatment conditions and the scores at the end of the waiting period of patients in the waiting list condition, controlled for scores at intake. Intake assessment scores were included as the covariate in the analysis: target complaint ratings and SCL-90-R and Social Adjustment Scale scores were converted to standard z scores, with a mean of these three intake scores serving as the covariate index. Univariate F tests were used to demonstrate any differences between treatment groups on the individual measures. Target complaint scores at follow-up assessment for the brief adaptive psychotherapy and short-term dynamic psychotherapy treatment conditions were compared with the use of t tests. Differences between the treatment conditions in patient and therapist demographic variables and diagnostic categories were compared by using either chi-square or t tests.

RESULTS

Of the 93 patients accepted for treatment, 12 voluntarily dropped out of the project: four left before assignment to therapy, six dropped out of short-term dynamic psychotherapy, and two dropped out of brief adaptive psychotherapy. This resulted in a total of 81 patients in the study group. Thirty patients completed brief adaptive psychotherapy, 25 completed short-term dynamic psychotherapy, and 26 were on the waiting list for a period averaging 14.9 weeks (SD=6.2). As mentioned, ethical considerations prohibited the extension of this time period. The mean length of treatment for the 55 treated patients was 40.3 sessions (SD=8.6). The mean number of sessions for the dropouts was 7.3 (SD=8.8).

The mean age of the 81 patients who completed the study was 40.8 years (range=23-61 years). Table 1 shows other demographic data on the three groups of patients (brief adaptive psychotherapy, short-term dynamic psychotherapy, and waiting list). They were comparable in terms of age, marital status, and level of education, but the percentage of women in the treatment groups was significantly higher than that in the waiting list group.

Table 1 also shows the distribution of axis I and axis II diagnoses among the three groups. There were no significant differences in diagnosis between the treatment groups and the waiting list group. The patients who dropped out of the study were similar to the treated patients in both demographic characteristics and diagnosis, although no formal analyses were conducted because of the small number of dropouts.

TABLE 1. Demographic Characteristics and DSM-III-R Diagnoses of Subjects Receiving Brief Adaptive Psychotherapy or Short-Term Dynamic Psychotherapy and Subjects on a Waiting List for Therapy

Variable	Treatment Group							
	Brief Adaptive Psychotherapy (N=30)		Short-Term Dynamic Psychotherapy (N=25)		Waiting List Group (N=26)		Total Study Group (N=81)	
	N	%	N	%	N	%	N	%
Sex								
Female	23	77	17	68	8	31 ^a	48	59
Male	7	23	8	32	18	69	33	41
Marital status								
Never married	12	40	10	40	7	27	29	36
Married	11	37	7	28	9	35	27	33
Divorced/widowed	7	23	8	32	10	38	25	31
Education level								
Junior high school	0	0	0	0	1	4	1	1
High school	3	10	5	20	7	27	15	19
College	12	40	5	20	10	38	27	33
Graduate school	13	43	15	60	7	27	35	43
Missing data	2	7	0	0	1	4	3	4
DSM-III-R diagnosis								
Axis I								
Dysthymia	4	13	7	28	8	31	19	23
Major depression	2	7	2	8	0	0	4	5
Cyclothymia	0	0	0	0	1	4	1	1
Adjustment disorder with depressed mood	0	0	1	4	0	0	1	1
Adjustment disorder not otherwise specified	1	3	1	4	0	0	2	3
Generalized anxiety disorder	0	0	4	16	2	8	6	7
Phobias	2	7	0	0	0	0	2	3
Panic disorder without agoraphobia	0	0	0	0	2	8	2	3
Psychosexual dysfunction	2	7	0	0	0	0	2	3
Bulimia	0	0	0	0	1	4	1	1
V codes	1	3	2	8	1	4	4	5
None	18	60	8	32	11	42	37	46
Axis II								
Cluster C personality disorders	11	37	11	44	14	54	36	44
Cluster B personality disorders	6	20	4	16	8	31	18	22
Cluster A personality disorders	0	0	2	8	1	4	3	4
Personality disorder not otherwise specified, with cluster C features	10	33	6	24	3	12	19	23
Personality disorder not otherwise specified, with cluster B features	1	3	0	0	0	0	1	1
Personality disorder not otherwise specified, with cluster C and B features	2	7	2	8	0	0	4	5

^aSignificant difference between the treatment groups and the waiting list group ($\chi^2=13.00$, $df=2$, $p<0.01$).

Results of the MANCOVA presented in table 2 indicated a significant difference among the two treatment conditions and the waiting list condition. Post hoc analyses showed that only the treatment groups evidenced significant change on the outcome measures (multivariate $F=12.75$, $df=3, 75$, $p<0.001$), and there was no significant difference between them. Univariate analyses yielded significant differences on each of the three outcome measures: target complaints, SCL-90-R global severity index scores, and Social Adjustment Scale scores (table 2).

Thirty-eight patients were available for follow-up target complaint ratings from 6 months to 4.5 years after the completion of treatment (mean=1.5 years, $SD=1.1$). At follow-up assessment, the mean target complaint rating for the brief adaptive psychotherapy patients ($N=19$ of 30) was 5.44 ($SD=3.06$), and that of the short-term dynamic psychotherapy patients ($N=19$

of 25) was 5.42 ($SD=2.63$), a nonsignificant difference. Although these ratings were an improvement over the ratings of target complaints at the termination of treatment, these differences were also not significant.

Because of the significant difference in distribution of the sexes between the treatment groups and the waiting list group, a comparison of termination scores by sex, controlling for scores at intake, was done. There was no significant difference between the scores for men and the scores for women.

DISCUSSION

These findings indicate that active, short-term dynamic psychotherapy leads to significant improvement in patients with DSM-III-R cluster C personality disorders, as well as some patients with cluster B disorders

TABLE 2. Scores on Outcome Measures Before and After Treatment of Subjects Receiving Brief Adaptive Psychotherapy or Short-Term Dynamic Psychotherapy and Before and After the Waiting Period for Subjects on a Waiting List for Therapy

Measure	Treatment Group								Waiting List Group (N=26)				Analysis of Variance ^c
	Brief Adaptive Psychotherapy (N=30) ^a				Short-Term Dynamic Psychotherapy (N=25) ^b				Before Waiting Period		After Waiting Period		
	Before Treatment		After Treatment		Before Treatment		After Treatment		Mean	SD	Mean	SD	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Target complaint rating	9.80	1.51	6.93	2.56	9.54	1.40	5.77	2.90	10.63	1.47	9.57	2.04	F=17.36, df=2, 77, p<0.001
SCL-90-R global severity index score	42.38	7.72	35.83	6.12	44.04	10.08	38.92	7.19	46.23	7.37	44.15	7.18	F=8.27, df=2, 77, p<0.001
Social Adjustment Scale score	2.07	0.46	1.70	0.21	2.22	0.35	1.85	0.33	2.21	0.46	2.05	0.48	F=4.32, df=2, 77, p<0.05

^aMultivariate F=26.27, df=1, 78, p<0.0001.

^bMultivariate F=17.74, df=1, 78, p<0.001.

^cMultivariate F=7.00, df=6, 148, p<0.001.

(primarily, histrionic personality disorder). The further finding that this improvement was maintained over the course of an average follow-up period of 1.5 years is a major step in validating the efficacy of brief dynamic psychotherapy for this group of patients. The waiting time for the waiting list subjects averaged approximately 15 weeks, while the two therapy groups had an average of approximately 40 sessions on a once-a-week basis. Certainly, it would have been better to have a 40-week waiting period for comparison. However, our policy has been to assign patients randomly to the different psychotherapies as openings arise, and we felt that we could not ethically ask patients to wait more than 15 weeks. In addition, we found that many patients placed on a waiting list would seek treatment elsewhere rather than wait. Other studies of brief psychotherapy have had waiting periods of 3–5 months and somewhat shorter psychotherapies (3). This appears to be the maximum period that one can realistically and ethically expect patients to wait for treatment.

Our finding of no significant differences in outcome between the two treatments is not surprising and is in keeping with other psychotherapy outcome findings (21, 22). This finding may be due to a number of factors, such as similarities in certain techniques, lack of a homogeneous patient group, use of structured manuals (standardized treatments), and the type of outcome assessment used. There was a difference in the rate of dropouts, with more occurring in the short-term dynamic psychotherapy condition. However, this difference was not statistically significant.

With regard to technique, the two treatments share a number of characteristics. Both are psychodynamically based and place a strong emphasis on interpersonal behavior. However, short-term dynamic psychotherapy pursues affect, while brief adaptive psychotherapy is a more cognitive treatment. We have documented this difference in the treatments, as well as a number of other differences, such as activity level, addressing defense and impulse, and confrontation, which are all significantly greater in short-term dynamic psychotherapy

(5). Despite these differences, the fact that both are interpersonal psychodynamic therapies may be more important. However, it should be noted that even therapies that are very different (e.g., dynamic and behavioral) (23) also tend to produce similar results.

The lack of homogeneity of the patients may be more responsible for our not finding differences between therapies. It may be that one therapy is better with certain patients and worse with others, while another therapy produces the opposite results. These differences would tend to cancel out one another and lead to similar overall results. The task of finding homogeneous groups of patients is formidable (24) because of the huge number of possible patient variables. In this study we treated patients with primarily cluster C personality disorders. This is a heterogeneous patient population. In a pilot study (25) we reported that short-term dynamic psychotherapy produced better results than brief adaptive psychotherapy in patients with an obsessional personality style, while brief adaptive psychotherapy had better results in patients with a histrionic personality style. It should be noted that the idea for this pilot study was theory driven, using short-term dynamic psychotherapy, with its focus on affect, for patients with difficulties in the expression of affect, as opposed to brief adaptive psychotherapy, which might be a better treatment for patients with cognitive problems. Further research efforts along these lines may lead to uncovering different outcomes with various psychotherapies.

An individual approach in which treatment is tailored to the specific problems of a given patient, as opposed to strict adherence to a treatment manual, has been suggested by several writers (26, 27). This strategy might help prevent a rigid, manual-based type of treatment that would obscure differences between therapies. In our study, patients were assessed and treated by the same person, and treatment plans were individually adjusted within the limits of each type of treatment, so that rigid adherence to rules for conducting therapy did not appear to be responsible for the similar outcome results. However, we did not individualize outcome as-

assessment or make it theory dependent. Future studies should attempt to develop additional outcome measures that are both individualized and theory driven.

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