IN-PATIENT HOSPITAL-BASED PSYCHOSOCIAL TREATMENT OF BORDERLINE PERSONALITY DISORDER: A SYSTEMATIC REVIEW OF RATIONALE AND EVIDENCE-BASE

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Summary

Object: A systematic historical and current review of the clinical and research evidence concerning the inpatient treatment approach to borderline personality disorder (BPD), which includes the therapeutic community and the psychoanalytic hospital models.

Method: A PsychINFO, MEDLINE and manual search to identify and select relevant scientific clinical and research-based articles on the subject.

Results: The in-patient model constituted an innovative break-away from outdated traditional psychiatric practices and raised hopes and enthusiasm for a more human, enlightened and therapeutic approach to chronic and enduring mental conditions such as borderline personality disorder. Concerning the state of the evidence-base, on average results from research studies show that a relatively high percentage of BPD improves following treatment. However, methodological shortcomings and the lack of either randomised-controlled trials or comparative studies with partial hospitalisation or out-patient specialist models limit robust conclusions concerning the overall effectiveness of the model.

Conclusions: Although the long-term institutional model has served a valuable function in the treatment of BPD, its practice is in marked decline due to changes in society, mental-health delivery policies and current psychiatric culture.

Key Words: Borderline Personality Disorder - Inpatient Treatment Approach - Therapeutic Community - Psychoanalytic Hospital Models

Declaration of interest: Dr. Chiesa has been working in a psychotherapy hospital 23 years

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In this paper I will outline developments that have occurred over several decades in the hospital-based treatment of severe personality disorder, and in particular borderline personality disorder. Taking a historical approach I will review the residential psychosocial approaches to this condition and the clinical rationale upon which they are based, by placing them in their cultural and socio-economic context. Developments in service organization and delivery of psychiatric treatment, based on a changing socio-political and cultural context, will be presented and discussed. This paper will include a review of the main studies carried out to evaluate the effectiveness of the hospital-based approach and an attempt to link the theoretical underpinnings of institutional treatment with the currently available evidence-base.

The psychoanalytic hospital

Psychoanalytic hospitals dedicated to the long-term residential treatment of emotional disorders were developed as a radical alternative to the regimes present in general psychiatric hospitals as vividly described by several authors (Barton 1959, Goffman 1961). The exposure of the dehumanising and alienating conditions, in which long-term patients were forced to live in, created two different responses. The first was the development of the anti-psychiatry movement that spearheaded the drive for the closures of the psychiatric hospital, a degrading place in which patients’ basic human right were systematically disregarded (Basaglia 1968). In order to tackle in a radical fashion the source of the dreaded ‘institutionalisation syndrome’, the vertex of treatment and management of ‘madness’ was moved from the institution into the patients’ own community. In this way the founders of anti-psychiatry attempted to tackle the deep-seated stigma attached to mental illness through the integration of patients back into their community and the removal of the toxic source of pathology, the psychiatric hospital.
The second response was the creation of alternative milieus that aimed to be therapeutic by introducing very different programmes of treatment and rehabilitation, based on different views and attitudes towards mental illness. Patients were respected and regarded as active participants to the process of treatment, which had sociotherapy, psychotherapy and social rehabilitation as cornerstones of the treatment programme.

Long-term inpatient treatment in therapeutic milieus dates back to the 1920s. The renowned psychoanalytic hospitals such as the Menninger Clinic in Topeka, Kansas and Chestnut Lodge Hospital, Rockville, near Washington DC were based on the application of psychoanalytic treatment of severely disturbed individuals within institutional settings. Thus, patients with psychosis, severe depressive conditions and borderline states were seen by medically qualified psychoanalysts in 4/5 times weekly psychoanalytic sessions, which occurred within the safe boundaries of a hospital setting that guaranteed the safety of patients between sessions. The task of the institution was to facilitate psychoanalytic treatment by providing a physical container for the patients’ disturbance. Patients were looked after in hospital units, often located within wide and leafy parkland, where a pleasant and restful milieu was provided under the watchful eyes of trained paramedical staff. If necessary, the patient’s safety was guaranteed by the use of physical restraints, the implementation of compulsory stay and the application of other physical measures (such as the use of ice packs during acute episode of psychotic agitation or suicidal depression). An administrative psychiatrist was in charge of the day-to-day running of the ward and of taking decision concerning the patient’s physical and mental management.

This model of treatment organisation developed over time. As mentioned, hospitalisation was required to enable individuals with psychotic conditions, severe narcissistic states and other severe character neurosis to receive intensive psychoanalytic psychotherapy, deemed impossible within an outpatient setting. Psychotherapy occurred within a supportive and protective hospital milieu, following the original model outlined by Simmel in Berlin (Simmel 1929). The psychiatric ward allowed the management of severe acting out, suicide intent, psychotic agitation and confusional states without the need of discontinuing psychotherapy. The role of the ward was limited to the protective function, and although a degree of structuring of the hospital environment was present and a degree of communication between ward staff and psychotherapist took place, the hospital milieu was not considered to yield substantial therapeutic effects. The strategy was designed on the basis of the belief that the individual psychotherapy was the main conduit for therapeutic change, and hospitalisation was a means to allow psychotherapy to take place (Bullard 1959, Knight 1953).

The therapeutic community

The concept of the therapeutic community was developed in the 1940’s by Tom Main and Maxwell Jones, later to become medical directors of the Cassel Hospital and the Henderson Hospital, respectively (Jones 1953, Main 1946). They both advocated a drastic change in the social structure typical of traditional hospitals, in the direction of greater involvement by staff and patients in treatment and administrative matters. A shift from hierarchical and basically authoritarian structural arrangements to a structure that incorporated greater democracy, permissiveness and other collaborative features defined therapeutic community settings. The traditional roles assigned to patients and staff, in which patients were seen as passively ill individuals and staff as actively knowing what was best for patients and administering treatment, changed dramatically. The flattening of the hierarchical structure gave patients a much more active role within the institution, and they were asked to participate in their own and other patients’ treatment in an atmosphere that facilitated, and valued, more open communication. The setting of the milieu created a sense of belonging to a community of people (communalism), who lived together for a period of time with the aim of facilitating frank and honest interpersonal exchanges, in the hope to heal previous traumatic and troublesome experiences in the patients’ own environment. Within a therapeutic community settings patients’ participation in the life of the hospital included an empowerment in decision making regarding new prospective patients’ selection and an active role in other decision making processes in patients’ management, for example voting in community meetings concerning possible sanctions for a patient who broke the community rules. Emphasis was on active rehabilitation as opposed to custodial practices. Maxwell Jones defined the development of a therapeutic culture as “…the accumulation through time of the attitudes, beliefs, and behaviour patterns, common to a large part of the unit. This is arrived at as the result of considerable inquiry into the nature of these attitudes and an attempt is made to modify them to meet the treatment needs of the patients. The tendency is for these cultural patterns to be most clearly established in the more stable and permanent members of the community, i.e. staff” (Jones 1976, p. 88). The creation of a therapeutic culture of enquiry within the institution allows for an ongoing examination and discussion of staff and patients’ roles and role relationships, overt and covert group dynamics and projective phantasies, interpersonal and intra-system difficulties and other institutional defensive operations. This type of culture should lead to constructive investigation concerning the functioning of the organisation, and the identification of deficiencies and flaws without blame being attached, in a way that corrective measures can take place.

Developments in the organisation of long-term hospital treatment

Following the influence of the therapeutic community movement and the findings of a systematic enquiry into the influence of institutional factors in affecting therapeutic outcome (Stanton & Schwartz 1954) greater attention was given to the complex interpersonal dynamics that occur within the institution as potential sources of therapeutic and anti-therapeutic effects. Thus the socio-therapeutic use of hospital milieu
was tapped by building increasingly sophisticated structured programmes within the hospital environment, which became more integrated with formal psychotherapy. The milieu became more structured and it required the active participation of staff and patients. A series of small and large group meetings would take place to facilitate communication, foster a sense of belonging, plan activities and empower patients who fell responsible to run aspects of the life of the institution. The frequent interactions between staff, patients and amongst the peer group were aimed at a detailed scrutiny of way of relating. Often patients’ government was set up through meetings in which rotating and elected representatives of the patients’ group met with representatives of the staff group to discuss issues of mutual interest. In this way patients felt empowered to be active in the decision making process concerning their treatment and the institution that host them. The totality of the living within the institution provided ways of working therapeutically with patients, within a cultural atmosphere of continual enquiry (Main 1989a, Norton 1992). Formal individual psychotherapy, available through individual sessions at a frequency of 2 to 4 times a week, and small group analytic sessions once to three times a week, became more integrated within the overall programme, through psychotherapists becoming members of the hospital team, rather than independent outpatient practitioners. Detailed two-way communication between sociotherapy and psychotherapy staff members allowed closer monitoring of therapeutic progress, planning and coordination of the treatment process. Other treatment modalities such as family therapy, cognitive-behavioural and supportive therapies, and art and drama therapies became also available. In many settings patients were encouraged to keep links with the external world and week-end leave was arranged as appropriate.

The way in which psychotherapy and sociotherapy are structurally arranged defines the model adopted by the institution. Rather schematically, in bipolar models the psychotherapeutic and sociotherapeutic spheres are kept separate (Janssen 1994). The roles and areas of competence of psychotherapists on one side and sociotherapeutic staff on the other are clearly defined, and the boundary between the two realms is well demarcated. Areas of clinical overlap do exist, and a degree of information is shared in staff meetings to meet basic requirements of treatment coordination. However, therapists’ contact with their patients outside sessions is limited in order to minimise intrusion into the psychoanalytically-based nature of the one-to-one relationship. The sociotherapy staff defines their role as more reality-based, setting overt goals to be achieved through the fulfillment of therapeutic tasks during the patient’s stay. The aim is to use real events and interactions to increase the patient’s awareness of problems in his functioning and of the effects of their disturbed behaviour on others.

In integrative hospital models (Janssen 1986) the differentiation between formal psychotherapy and other forms of rehabilitations used in the therapeutic community becomes more blurred. The hierarchical arrangements are more flattened and the staff team interact with the patients’ group in a more homogeneous way, privileging group to individual interaction. In hospital settings that have remained faithful to the original philosophy of the therapeutic community there is no individual psychotherapy, and psychological work is carried out in small and large group settings.

Although psychotherapy hospitals and therapeutic communities treated a range of psychiatric disorders, they gradually narrowed the main focus of treatment to severe character disorders. The often intense treatment conditions of the psychotherapy hospital and the high expectations of a degree of ego-functioning within a therapeutic community setting may not suit psychotic states. In addition the relatively disappointing research findings (McGlashan 1984) and the advances in biological and community psychiatry, have relegated the indications of inpatient psychotherapy for psychotic conditions to selected cases. The treatment of psychosis seem to require specific modifications of the settings, a lowering of the emotional ward atmosphere and of staff’s expectations of positive contributions in the running of the community, which the patient may find excessive and burdensome. In contrast, it was thought that borderline states present with an acceptable level of ego-functioning that allow them to become active participants in the life of a community and contribute to an acceptable level of self-care and social interaction.

**Indication for residential treatment**

The rationale for hospital-based treatment of borderline personality disorder has been summarised by Horwitz (Horwitz 1974), later revisited by Fenton and McGlashan (1990) and by Norton and Hinshelwood (1996). In their views, the severity of self-harming behaviour and other life-threatening episodes of self-destructiveness require a level of limit setting and control that can only be found in a hospital situation. The safety and containment found in a psychotherapy hospital setting are thought to enhance the therapeutic alliance that could not be possible to achieve in an outpatient setting. The presence of a moderate to severe degree of social breakdown as shown by the inability to obtain employment, chronic maladaptive marital or family situations, social isolation and loss of interest, would require a period of rehabilitation to reconstruct one’s life. The borderline patient often has gone through repeated unsuccessful attempts at outpatient treatment and several brief hospital admissions, which create a malignant dependence on health care systems and appear to worsen the clinical picture, rather than improve it. This category of patients described as treatment-refractory character disorders pose a challenge to health care professionals and relatives, who feel increasingly helpless in the face of deteriorating symptomatic and interpersonal conditions. Often the referral for inpatient psychotherapy is initiated by them as a last resort, given the evident failure of other attempts to treatment. One benefit of residential treatment is that the patient is removed from a dysfunctional situation, and that a space can be created for a clinical reappraisal and for a plan to be devised with the aim of changing the course of the disturbance and breaking a cycle of failures. Once in hospital the patient will inevitably re-enact the cen-
terial features of his psychopathology, and the milieu becomes the holding arena in which his highly conflicntual inner object relationships and dysfunctional interpersonal patterns become manifest. The way the therapeutic community is structured and the way clinical staff respond are crucial for evaluation, scrutiny and confrontation to take place.

Evidence-base for residential treatment models

If long-term residential approaches to borderline personality disorder have a long and distinguished history, what is the status of the available scientific evidence concerning the clinical effectiveness of these intensive, time consuming and costly treatment programmes? Several naturalistic controlled and single-cohort studies have been published over the years, which yield interesting and valuable information concerning expectable rates of improvement for patients who were hospitalized for psychosocial treatment.

Early studies

Early studies concerning long-term outcome of severe personality disorder were carried out in North America at Chestnut Lodge Hospital and New York State Psychiatric Institute. These are amongst the first attempts to collect systematic outcome data on relatively large samples of BPD and other severe personality disorders that had gone through a programme of psychoanalytically-based treatment as inpatients.

McGlashan (1986) followed up retrospectively a cohort of 81 borderline patients on average 15 years after discharge (range 2-32 years) from Chestnut Lodge Hospital. He reported that two out of three borderline patients had made a moderate to substantial recovery on a number of dimensions of functioning. The recovery profile was similar to that found in the unipolar depression sample, but significantly different from the schizophrenic sample, which showed less improvement (McGlashan 1986). McGlashan also found that improvement was a function of time, with the best outcome obtained by patients who had been discharged between 10 and 19 years.

However, other studies conducted in the same decade, but with shorter follow up assessment found that improvement was significantly less marked than in the Chestnut Lodge study (see for example Pope et al. 1983).

Stone (1990) traced 502 out of 550 patients who were admitted to the Long-term unit at New York State Psychiatric Institute between 1963-1976. Of these 299 met criteria for either DSM-III BPD, Borderline Personality Organization (BPO) (Kernberg 1967) or depression with concomitant BPO. In line with McGlashan’s findings, two-thirds of patients with borderline pathology were doing either well or were recovered according to Global Assessment Scale (GAS Endicott et al. 1976) criteria, i.e. were above the 61 threshold score on the scale. Improvements were also found in other dimensions such as readmission rates, work and marital status.

Significant improvements on the GAS, symptom scores and social adaptation levels were also found in a prospective 27-year outcome study of 81 BPD. A wide range of outcomes ranging from complete recovery to continued dysfunction was reported. Only 5% of the sample still retained borderline criteria for diagnosis, and the same percentage met criteria for concurrent substance abuse or depression. The suicide rate was 10% percent, confirming findings from previous studies (Paris et al. 1987, Paris & Zweig-Frank 2001).

Forty patients with severe personality disorder treated as inpatients for an average of eight months in the specialist borderline unit at New York Hospital- Cornell Medical Centre were prospectively followed up at regular intervals up to two years after discharge (Tucker et al. 1987). The results showed change from admission to follow-up in impulsivity, global functioning and social adjustment. At 1-year follow-up, subjects who had stayed as inpatient for more than 12 months were more likely to remain in outpatient psychotherapy and avoid re-hospitalisation. However, no significant difference was found between patients hospitalized for shorter or longer stays at the 2-year follow-up.

Although these studies present very interesting and rich data concerning the long-term outcome of BPD, including highlighting the high mortality rates present in these disorders, due to the length of the follow up period they give important indications concerning the natural history of the disorder, but leave the question of the evaluation of specific treatment effects still unresolved. In addition these studies were weakened by methodological problems including not clear diagnostic criteria, the often subjective nature of outcome measures and retrospective designs (Aronson 1989).

Recent literature

A number of more recent longitudinal studies have attempted to give more detailed accounts of short to medium-term outcome for severe personality disorder.

Gabbard et al. (1999) evaluated 216 (out of a possible 617) patients who were admitted to two similar intensive inpatient programmes offered by the Menninger Clinic and Harding Hospital in Ohio over a 7-year period. The median length of stay varied considerably, and the median admission to the programmes was 58 days. All patients met clinical criteria for at least one DSM-III-R personality disorder diagnosis. Patients were interviewed at intake, then at discharge and subsequently at 1-year follow-up. Results showed that on average the sample improved significantly in global assessment of mental health (GAS), in all dimensions of ego functions (Bellack’s Ego Function Scales) and in severity of psychiatric symptoms (Brief Psychiatric Rating Scale). Questions concerning the representativeness of the selected sample at follow-up, the wide variation of length of stay due to financial circumstances, a lack of information on the specific treatment received and the unclear diagnostic composition of the sample limit the conclusion concerning the effectiveness of the inpatient programme.

The Henderson group (Dolan et al. 1997) carried out a controlled longitudinal study by comparing 70 (out of a possible 228) patients admitted to the thera-

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peutic community programme with 67 non admitted patients (patients who were either considered unsuitable at assessment, or did not attend the clinical assessment procedure or had their funding for treatment refused by their local District Health Authority). The study sample met diagnostic criteria for severe personality disorder (80% were borderline). A measure of borderline core symptoms (Borderline Symptom Index) was applied at intake and at 1-year after discharge for the treated sample and 1 year after referral for the untreated group. Improvement was shown to be significantly greater in the treated sample, with 43% achieving both reliable and clinically relevant improvement compared to only 18% in the non-treatment group. Improvement was also found to be positively correlated with length of stay: those who had made clinically significant changes stayed for an average of 36 weeks compared to 21 weeks for the group who did not improve. This study shows significant clinical improvement in a group of severely personality disordered patients treated in a specialist therapeutic community setting. However, there are a number of limitations which should be borne in mind when considering these results. First, data was available for only a subset (137) of the total referrals (598) to Henderson, so selection bias is a strong possibility. Second, serious questions concerning the suitability of the chosen untreated group must be raised: patients who do not attend assessment or are refused admission by the hospital on clinical grounds are likely to belong to a poorer prognostic group than patients who are more motivated to attend assessment and are selected for specialist treatment. Also, the time difference of follow-up ratings in the two groups may be an additional source of bias.

A 6-year prospective controlled trial of outcome for severe personality disorder has been described by Chiesa and colleagues at the Cassel Hospital (Chiesa & Fonagy 2000). Results concerning 94 patients admitted to the Adult Unit, which were naturallyistically (according to geographical criteria) allocated to a one-stage programme (12 months inpatient hospital treatment with no follow-on treatment after discharge) and to a step-down programme (6 months inpatient stay followed by 2 years specialist psycho-social outpatient treatment) were presented in several reports. A control group of 49 matched patients with severe personality disorder was selected within the general psychiatric services at North Devon Health Care NHS Trust. This group (treatment as usual-TAU) reflected expectable outcome for this group of patients if treated with a general psychiatric approach. The patients in the three samples met criteria for on average 3 DSM-III-R personality disorder (70% were BPD) and presented with high levels of psychiatric morbidity as shown by the high number co-morbid Axis-I diagnosis, the high rates of sexual and physical abuse by care-givers and the long history of previous psychiatric treatments. Although naturallyistically selected the three comparison groups were well matched on most socio-demographic, diagnostic and other clinical variables, including severity of presentation and the only significant differences were found in marital and educational status and major depression. The samples were evaluated by trained independent researchers at 5 different time points from intake on several dimensions of functioning, including symptom severity (GSI-Symptom Checklist 90-R), social adjustment (SAS-Social Adjustment Scale), global outcome (GAS-Global Assessment Scale), self-mutilation, attempted suicide and rates of re-hospitalisation. Results reported at 24- and 36-month follow-up consistently showed that a specialist psychosocial approach is superior to a general psychiatric approach. Significant improvements were revealed in GSI, SAS and GAS in the one-stage and step-down models compared to TAU. However, results in self-mutilation, attempted suicide and re-admission to psychiatric services was mixed, with patients in the step-down programme showing significant decreases in all three variables compared to one-stage and TAU patients, who did not differ significantly (Chiesa & Fonagy 2003). Rates of Clinically Significant Change again showed consistent advantage in the step-down group compared to the other two conditions: while 51% of step-down patients were found to have significantly improved by 24 months in social adjustment, only 27% and 10% met the stringent criteria for clinically relevant change in one-stage and TAU, respectively (Chiesa et al. 2004). The findings at 6-year follow-up confirmed the superiority of the step-down model over a long-term inpatient programme, which was only marginally better than treatment as usual in a number of measures (Chiesa et al. 2005). Severe personality disorder patients exposed to a combination of medium-term therapeutic community residential treatment followed by a long-term structured outpatient psychosocial programme remained consistently improved on most of the outcome indicators used in the study. Rates of self-mutilation decreased from 50% at intake to 27% at follow-up, and attempted suicides and inpatient episodes dramatically decreased from intake to 6-year follow-up (53% vs 6% and 56% vs 9% of the cohort, respectively). In contrast, although one-stage patients showed faster rates of improvement over time than TAU in symptom severity and social and global adjustment, no significant difference with TAU was found in self-mutilation, parasuicide and inpatient episodes. This study indicates that severe personality disorder characterised by severity and chronicity of psychopathology appears to respond better to a phased approach, which combines an initial intense residential stage followed by medium intensity treatment as part of a long-term approach. The continuation psychosocial treatment in the patient’s own community allows for continuous improvement for the patients exposed to the programme four years after expected termination of treatment.

The cost-effectiveness of the three programmes was evaluated in two different reports. Health service utilisation costs in the year after discharge from treatment were compared with costs incurred in the year prior to intake (Chiesa et al. 2002). It was found that a significant reduction in health-care costs was achieved by the two specialist programmes (SDP and One-stage) compared to TAU, but greater savings were found in the SDP compared to the One-stage. A significant association between and clinical outcome in SDP and One-stage programmes, but not in TAU, further highlighted the greater cost-effectiveness of the specialist approach to SPD. A fuller economic evaluation that included a cost-offset analysis consistently pointed to advantages for the shorter residential programme fol-
lowed by community-based psychotherapeutic treatment (Beecham et al. 2005).

The non-random allocation of the samples, the difference between selective groups referred for tertiary treatment (Cassel Hospital) and a group of SDP drawn from a local community sample of patients identified and screened from consultant general psychiatrists’ caseloads, and relatively small sample sizes represent a threat to the internal validity of the study and limit generalisation to other settings.

Recent findings on large samples of severe personality disorder have given a major contribution to improving our knowledge concerning the antecedents of BPD, gender differences, co-morbidity and service utilisation patterns, as well as yielding new and surprising information on the natural course of the disorder.

A recent longitudinal study has indicated that up to 70% of borderline patients previously admitted to McLean psychiatric hospital remit from the disorder and may recover symptomatically within 6 years (Zanarini et al. 2003). Although the same authors found a marked decrease in hospitalisation rates from 79% to 33% over the last 2 years of follow-up, outpatient psychiatric utilisation and patterns of polypharmacy remained high and stable over time (Zanarini et al. 2004).

The largest study so far is the multi-centric Collaborative Longitudinal Personality Disorder Study, which recruited 668 patients with diagnosis of schizotypal, borderline, avoidant, or obsessive compulsive personality disorder and patients with major depression and no personality disorder, in four different clinical sites located in north-eastern USA (Gunderson et al. 2000). The already extensive publication output has given major contributions to the knowledge-base concerning socio-demographic features, diagnostic characteristics, service utilisation patterns and patterns of improvement in personality disorder. Shea and colleagues (2002) have reported substantial symptomatic improvements in PD with as many as 60% no longer meeting diagnostic criteria only 1-year after intake assessment, demonstrating a much greater diagnostic instability than previously indicated (Shea et al. 2002). A further report from the same group has revealed that, over three follow-up assessments significant improvement occurred in three out of the seven dimensions of psychosocial functioning for patients with major depressive disorder but only mild or no improvement overall in patients with personality disorder. This finding seems to confirm that impairment in social functioning may be an enduring component of personality disorder, less amenable to recovery than either symptomatic distress or diagnostic criteria (Skodol et al. 2005).

Notably, 75% of the CLPDS were recruited as outpatients, and for those who had inpatient treatment, the nature and length of the residential treatment applied to these patients was not well defined. In addition these naturalistic studies do not include systematic monitoring of treatment protocols, which might allow us to distinguish the natural course of the disorder from the benefits derived from treatment. Moreover the extent of the representativeness of these longitudinal community samples recruited on the basis of meeting Axis-II criteria is debatable, when compared to the chronic ‘treatment resistant’ cases that are generally the focus of treatment efforts.

In an elegant outcome study, Vermote and his team studied prospectively for two years 70 personality disordered patients consecutively admitted for up to a year to the inpatient psychoanalytically-informed treatment programme at the University Centre Kortenberg near Brussels (Vermote 2005). Outcome measures were applied three-monthly from intake through to discharge and at 3- and 12-month post-discharge follow-up. Significant improvements over time were found in the areas of general symptoms, anxiety, depression, self-harm and personality-related dimensions. By computing a global measure of outcome and through a sophisticated statistical procedure, four trajectories of improvement based on patients’ initial levels of severity of presentation were identified. The group of more severely disturbed patients (16% of the sample) started to make significant and sustained improvement only during the follow-up period. The low severity group (9%) does not show improvement over the 2-year period, while in the medium severity group (75% of the sample) two different trajectories of good and poor outcome were observable. Features of avoidant, schizoid, paranoid and narcissistic features and other measures of introversion seemed to predict good outcome, while more marked borderline and anaclitic features and experiences of sexual abuse predicted poor outcome in this group.

In addition, measures of psychic change were obtained through the Felt Safety Scale, the Differentiation Relatedness Scale and the Reflective Functioning Scale. Significant changes in all three dimensions were apparent by 24-month follow-up. Significant associations were found between measures of internal changes and external changes (symptoms), suggesting that a close relationship between structural change and symptomatic improvement.

In a recent meta-analytic study Leichsenring and Leibing have shown that both cognitive and psychoanalytically-based approaches have shown a satisfactory degree of effectiveness in the treatment of personality disorder (Leichsenring & Leibing, 2003). They found that large effect sizes of 1.46 (range: 1.08 for self-report measures to 1.79 for rater-based measures) and 1.00 (range: 1.20 for self-report measures to 0.87 for rater-based measures) for psychodynamic therapies and cognitive therapies, respectively.

**Discussion**

The birth and maturation of the psychotherapy hospital and of the therapeutic community have given an important contribution to the treatment of refractory severe personality disorder and other psychiatric conditions. The theoretical framework and the therapeutic culture characteristic of these institutions have hailed a new era of psychiatric institutional work that has inspired generations of psychiatrists and other mental health workers, and has contributed to the rehabilitation of psychiatry from the horrors of the old institutional and custodial approaches to mental illness. Although these models enjoyed a long period of growth and popularity and influenced the work of a large number of psychiatric, rehabilitative and other residential centres, in the last two decades we have witnessed
a progressive decline of the relevance and influence of the inpatient psychotherapy model worldwide. The number of inpatient facilities offering this type of treatment has dramatically reduced, particularly in English-speaking countries. Amongst the casualties we find pioneering institutions like the Menninger Clinic and Chestnut Lodge Hospital, and in the US, the only surviving institution offering long-term inpatient psychotherapy is the Austen Riggs Centre. In the UK several therapeutic communities have been closed and even the short-term future of historic state-funded centres like the Cassel Hospital and Henderson Hospital is far from ensured. Likewise, Australia and New Zealand have seen a marked decrease in the provision of residential psychotherapy units. The political changes within the various national health systems have had a profound effect on the level of service provision of this treatment model. The introduction of market-driven reforms in the UK and the managed-care model in the US, have contributed to treatment cost considerations to become central to health-care provision (Pollock 2004). As a result relatively expensive residential tertiary referral facilities that involve longer-term treatment have been struggling to survive in the current climate (Schimmel 1997). As a report from Henderson Hospital shows, financial considerations seem to have superseded clinical indications as the major driving force when considering service provision from tertiary psychotherapy services (Dolan et al. 1994). These changed circumstances have left these centres vulnerable to a substantial drop in referrals, and unless circumstances change they may face extinction. In the US third-party payers no longer reimburse inpatient admissions longer than four weeks for personality disorder, and as a result long-term hospital-based treatment for personality disorders is no longer considered as a realistic option. Attitudes within psychiatry have also changed, and in the absence of unambiguous empirical evidence of effectiveness and cost-effectiveness, general psychiatry has been distancing from considering inpatient psychosocial treatment as a treatment of choice, but for the most disturbed and treatment refractory personality disordered patient. In addition, advances in biological psychiatry and improvements in community care have contributed to marginalise therapeutic community treatment. The establishment of less costly modes of psychosocial and psychotherapeutic treatments carried out in day-patient or and outpatient settings have further impinged on what once was the almost exclusive territory of the therapeutic community. As well as being less expensive, these models have shown to be effective approaches to borderline personality disorder (Bateman & Fonagy 2001, Verheul et al. 2003, Wilberg et al. 1998).

Beyond what are undoubtedly unfavourable external developments within society and the political-economic climate within psychiatry and healthcare in general, we need to consider the extent to which problems and contradictions within the therapeutic community movement may have contributed to its decline.

I would like to start by considering the degree of fit between the theoretical postulates and the evidence that may confirm or contradict them. To what extent the ideal found in therapeutic community principles coincide with actual practices? What are the complexi-

ties and problems in the application of individual psychoanalytic psychotherapy within a group-based therapeutic community setting? Does the intense and complex milieu of the inpatient setting carry danger of iatrogenic effects for some borderline patients, with negative consequences concerning prognosis?

Most of the literature of residential psychoanalytically-based treatment seems skewed towards emphasising the positive aspect of these programmes, and very little is to be found concerning the possible negative effects of hospital-based treatment. Yet, in one of his least-known papers, Tom Main, the founder of the therapeutic community, conveyed his view that ‘for patients needing psychotherapy, [long-term] hospitalisation usually carries more dangers than benefits [my italics]’ and that the request for hospitalisation should be considered itself as a symptom (Main 1989b). He felt that the dangers of regression inherent in long-term hospital treatment couldn’t be outweighed even with the most vigorous psychosocial programme, and that the patient should be discharged as soon as he is ready for outpatient therapy. This paper, written in 1958 remained unpublished until 1989. As described by various authors, a difficulty inherent in inpatient psychotherapy centres upon the role of the individual therapist and its relationships with the rest of the team. The delicate balance essentially required between therapeutic and administrative tasks is often upset by the patients’ severe pathology and or interpersonal difficulties between sociotherapy and psychotherapy staff. When this balance is upset deep splits in the therapeutic team may occur. Ploye vividly described the escalating ‘bad sequence’ that can be triggered within the inpatient setting, which inevitably leads to negative outcome (Ploye 1977). The difference in tasks and conceptualisation between the sociotherapeutic sphere, aimed at supporting the patient’s ego driven activities, and the psychotherapeutic sphere, aimed at understanding unconscious conflicts and hence fostering a degree of regression, may lead to therapeutic inconsistencies and conflict with each other (Gordon & Beresin 1983). The high drop-out rates sometimes reported in therapeutic community settings, often higher than those reported in day or outpatient programmes, are at odds with the notion of a uniquely containing and holding environment (Blount et al. 2002; Chiesa et al. 2000). The intense nature of interpersonal relationships and the continuous scrutiny to which patients are subjected may have negative as well as therapeutic consequences. The atmosphere of the twenty-four hours a day therapy for residents can easily escalate to an emotional ‘pressure cooker’ (Clark 1977), which may become unbearable for some patients, who may feel acutely persecuted and claustrophobic. Acting-out may then become a means, may be the only means of discharging tension and of escaping the torrid atmosphere of a place that the patients has lost its containing function.

The evidence-base for therapeutic community and inpatient psychotherapy units indicates that between forty and seventy-five percent of patients benefit from this approach, a highly successful rate if we keep in mind that we are dealing with a treatment-refractory population. However, critics point to the methodological difficulties present in these naturalistic studies, including the lack of random allocation of samples and
the loss of subjects over time due to selective attrition that may skew the study sample in the direction of positive outcome (Howard et al. 1986). The almost insurmountable obstacles to RCT design in such settings include the long-term nature of treatment, the wide catchment areas from which patients are referred, ethical considerations of keeping patients in a no treatment or placebo-like condition for a considerable time, the necessary complexity inherent in RCT design, the concerns over the need to standarised procedures, the recruitment and continuing cooperation of clinical staff to the trial and the securing of sufficient funding (White & Walden 2000). It has also to be borne in mind that RCT methodology has been criticised on several grounds, including the tight laboratory-like procedures that do not reflect how a particular treatment is applied in actual clinical practice, hence reducing the external validity of the findings (Slade & Priebe 2001). Besides, the RCT paradigm may not best fit the parameters of psychodynamic psychotherapy (Chiesa & Fonagy 1999). A recent study has revealed that the average results found in naturalistic and observational studies were remarkably similar to those of the randomised controlled trials that assessed the same intervention (Concato et al. 2000). These findings showing that well-designed observational studies do not appear to overestimate the treatment effects of the condition under evaluation are a challenge to the traditional way in which the quality of evidence based on research design in clinical research is hierarchically set.

The positive findings in the several naturalistic studies previously reviewed also do not answer the important question whether the inpatient treatment is necessary to account for the observed changes. In the absence of a comparison with specialist day-patient (Piper et al. 1994) and out-patient treatment programmes (Clarkin et al. 2001), we are not in a position to assert with certainty that the inpatient component is uniquely responsible for the improvement found in borderline personality disorder. In addition, in absence of systematic process-outcome studies, we are in no position to determine what aspects of inpatient treatment are responsible for outcome. For example we do not know to what extent formal psychotherapy as opposed to the sociotherapy/therapeutic community input and at what degree of intensity, they are necessary to achieve improvement. In addition, a further confounding factor lays in the differential use of psychotropic medication done by the different institutions: some, like Henderson do not admit patients on medication, while for others, like Austen Riggs, medication is an important factor in the overall treatment approach.

Our own study found no evidence of a relationship between intensity and length of in-patient treatment input with positive outcome (dose-response relationship) in our personality disordered group. This may be an indication that long-term residential stay has both therapeutic and iatrogenic effects, and it is the combination of the two that was reflected in the outcome for the long-term inpatient group. Due to the nature of their psychopathology, a number of severely personality disordered individuals are more susceptible to the counter-therapeutic elements present in long-term hospital-based interventions. It has been reported that they may respond to the intensity of inpatient treatment conditions either with acute persecutory and clausrophobic reactions (Chiesa et al. 2003) and drop-out of treatment. Another sub-group may become adhesively dependent and assume a compliant attitude by learning rapidly to adapt to the practical aspects of the inpatient milieu (Bell 1997, Fonagy & Target 2000). The strengthening of the ‘as-if’ aspects of these patients’ personality prevents real change from occurring, and they will inevitably face considerable difficulties when returning to live in the external community following discharge from hospital.

Gunderson concludes that, in his experience, these states of regressive dependency or paranoid combative-ness fostered by the in-patient environment become highly resistant to analysis and interpretation because of the continuous gratification derived from being in a hospital setting (Gunderson 2001). The emotionally intense environment of the therapeutic community setting in long term inpatient care may unwittingly have a negative effect on the already flawed mechanisms of affect regulation and on the social cognitive capacities in BPD. However, shorter hospital stay in medium intensity therapeutic community milieu may yield long-term beneficial effects if followed by the provision of post-discharge care in the form of intensive psychotherapy and psychosocial support in the community, which gives the BPD patient the opportunity for ongoing psychological and psychosocial work for acquiring the capacities necessary for independent functioning in an external social milieu (Chiesa 2005).

Finally, it needs to be emphasised that questions concerning the suitability of current diagnostic systems for the definition of BPD have been raised by several authors, who think that a dimensional approach would be more valid to reflect the complexity of clinical presentation than the current DSM-IV or ICD-10 categorial system (Livesley & Jang 2000; Westen & Shedler 1999a, 1999b).

Conclusions

The long-term institutional model based on psychoanalytically-informed and therapeutic community principles has served a valuable function in the treatment of BPD and other severe personality disorder. However, its practice is in marked decline due to societal changes, shifts in mental-health delivery policies and in the current psychiatric culture, which favours community-based treatment, and by the research evidence that has shown the effectiveness of models of shorter hospital stay, partial hospitalisation programmes and specialist outpatient treatments.

References


"Every once in a very long while in our field, a clinical innovation is introduced that profoundly improves patient care. Marsha Linehan's development of a cognitive-behavioral approach to borderline personality disorder is such a rare innovation... Her techniques are clear, teachable, and learnable, and make good common sense to the therapist and the patient. Dr. Linehan's methods have greatly improved my treatment of borderline individuals and my teaching of others in how best to understand and treat these patients."—Allen Frances, MD. "Marsha Linehan's the sleep phenotype of Borderline Personality Disorder: A systematic review and meta-analysis. Article. Feb 2017. Objective: Little is known about the psychosocial functioning of adolescents with borderline personality disorder (BPD). The main objective of this paper is to compare the psychosocial functioning of a group of adolescents with BPD to a group of psychiatrically healthy adolescents. Methods: The present cross-sectional study included 104 adolescent inpatients with BPD, compared with 60 age-matched psychiatrically healthy comparison subjects. Validity, utility and acceptability of borderline personality disorder diagnosis in childhood and adolescence: Survey of psychiatrists. Article. Jan 2011. M. Griffiths. Borderline Personality Disorder. The key deficits, as opposed to descriptive characteristics, associated with BPD are normally thought to include impulsiveness, difficulty in managing emotions, and difficulties in relationships. It has been suggested that these vulnerabilities in part arise out of problems with mentalization, that is a limited ability to perceive mental states in self and others accurately. They may also be linked to problems. It is quite likely that high levels of arousal following traumatic experience contribute to suppressing the functioning of the frontal areas of the brain that normally underpin mentalization. In effect, an interdependent process between environmental..."