Day treatment programs for personality disorders: a review

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Abstract

This paper is a modification of a chapter that will appear in the forthcoming volume: "Handbook of Personality Disorders: theory, research, and treatment," edited by W. John Livesley, PhD, MD, FRCP, published by Guildford Publications: New York, release date April 2001. The original chapter will be entitled "Partial Hospital Programs." It suggests that more partial hospitalization programs dedicated to the personality-disordered patients should become available and that more rigorous studies need to be conducted in the future, considering the main difficulties with the treatment in the day hospital, the therapeutic program to organize, the relations with the context, the staff and the families.

Key words: group, personality disorder, therapeutic program, day hospital

Partial hospitalization has been one of the most effective treatment modalities for persons suffering from personality disorders. Yet until very recently, there has been a paucity of reports on the subject in general. Two interacting reasons have been suggested for such benign neglect: a history of a lack of classificatory clarity and underutilization. The former consists of a combination of a lack of operational definitions and of a common language for communication and thus an insufficiency of the research findings. This has prevailed until a member of our team proposed a clarification that has since been adopted in the literature (Rosie, 1987). Three main categories of partial hospitalization were identified. Day hospitals proper have been serving two functions: an alternative to inpatient care or as a transitional service between inpatient and outpatient or community care (step-down units). Day care a modality characterized by offering time-unlimited maintenance and rehabilitation for patients suffering from persistent, severe and disabling illness, including personality disorders. In contrast, day treatment programs provide time-limited intensive combination of treatment, habilitation (see below) and rehabilitation to patients with relatively higher psycho-social functioning than the two other forms (Azim, 1993).
The other reason has been the historical underutilization of partial hospitalization programs, particularly in the USA, a country with the highest levels of concentration, openings and closures of day hospitals than any other. Economic factors have been proposed as the determinant agents of this phenomenon. Thus, whereas inpatient psychiatric care has traditionally been fully covered and has consumed 70 % of all mental health expenditures in the USA (Kiesler, 1982), only 20-25% of all patient charges for partial hospitalization are covered by insurance, public or private. Furthermore, the cost of partial hospitalization like that of home care and outpatient psychiatry has been subjected to co-payment by the patients and their families.

Moreover, for decades hospital administrators had no incentives to utilize innovative and less costly alternatives like partial hospitalization in favor of the more economically rewarding policies of keeping the oversupply of their beds fully occupied (Hetz, Ferman, & Cohen, 1985). This is despite the assertion that 70-90% of patients treated as inpatients may benefit from partial hospitalization (Schene & Gensons, 1986).

Clinician bias against partial hospitalization has been attributed to such factors as lack of knowledge and training and the lower level of remuneration compared to inpatient care leading to a disinclination by clinicians to refer patients and more importantly less interest in working in partial hospitalization settings. (A fuller review of interutilization is available in Piper, Rosie, Joyse & Azim, 1996).

It is perhaps instructive that the drive behind inaugurating the first modern day hospital in 1946 at the Allan Memorial Institute of Psychiatry of McGill University in Montreal was not the obvious cost effectiveness of partial hospitalization. The explicit intention of its innovator, Dr. Ewin Cameron, was to give expression to his conviction that psychiatric patients do not need to stay in bed, do not have to remain in hospital until they are well and in fact they often do not get well if we try to make them stay, and that in addition to the patient, the family unit and the general social setting are required to be attended to (Cameron, 1947). By any measure, this was revolutionary then, still is, and has hardly been heeded even today, not withstanding the advocacy for a biopsychosocial model.

The nefarious effects of the market-place morality on the utilization of partial hospitalization can be demonstrated by its reverse. There are reports from countries like Canada and the Netherlands documenting full or even over-utilization of such programs, all thanks to the grace of the social responsibility that made the Canadian and Dutch universal health care systems what they have been up until recently, (Whitelaw & Perez 1987, Schene, van Lieshout & Mastboom, 1988; Piper Rosie, Joyce; Azim 1996). There are even two reports of full utilization from the United States. In both cases funding was uncharacteristically stable and not co-payments-dependent. (Glenner & Glenner, 1989; Sternquist, 1991).

Space does not permit a review of all types of partial hospitalization. Therefore, this review will concentrate only on day treatment programs. These are well suited to intensive treatment of personality disorders. Future publications can address the other categories.

Goals of Treatment

In contrast to day hospitalization and day care, day treatment programs provide an intensive combination of time-limited treatment, habilitation and rehabilitation to personality disordered patients whose levels of social functioning, impulse control, quality of object relations (Azim, Duncan 1990), psychological mindedness, and motivation for change, are commensurate to the rigors of the modality. The availability of external social support also plays a crucial role in terms of adherence and outcome. The goal of treatment is to help a patient to attain a syndromal

remission. This involves symptom relief, the acquisition of insight, and positive changes in life functioning. Habilitation is a concept that is rarely addressed in the psychiatric literature. The Oxford English Dictionary defines "habilitation (also abilitation) as the action of enabling or endowing with ability or fitness; capacitation, qualification." Habilitation plays a particularly significant role in the care of personality disorders because of early and persistent nature of the patterns that characterize these disorders. Successful habilitation can be revealed when a patient who is reporting what sounds like a de novo experience e.g. a sense of liberation, peace of mind, less reactivity, and freedom from compulsivity and impulsivity; the patient is asked when this was felt last and the answer is a categorical never. In short, habilitation leads to a never before experienced sense of mastery over one's being and self-control. Significantly, this is usually ushered by a salutary process of grieving over what could have been but never was, and mourning the sense of wasting of one's life. Besides treatment and habilitation, rehabilitation is also, an ingredient of day treatment programs that is designed to help the patients achieve a functional remission: accept the reality of the disorder, adapt to its consequences, and achieve optimal social functioning.

An important aspect of rehabilitation for many patients in day treatment is the emphasis on and availability of treatment for co-morbid substance abuse. A study of the prevalence of substance abuse in 137 inpatients with a DSM-III borderline personality disorder diagnosis was 67% (Dulit, Fyer, Haas, Sullivan & Frances, 1990). A more recent study found that close to 60% of persons diagnosed with substance use disorders also suffer from personality disorders (Skodal, Oldham, Gallaher, 1999). Considering the secretiveness and the tendency to minimize if not to resort to denial by patients of both sets of disorders, the above figures should be considered as conservative. Substance abuse disorders have to be addressed simultaneously or prior to admission because the continued use of substances compromises the effectiveness of pharmacotherapy and the ability to benefit from group work. These patients possess a penchant for attributing their substance abuse disorders to the comorbid psychiatric disorders and press for receiving treatment only for the latter, which need to be firmly declined.

The characteristics of a highly structured day treatment program have been detailed in Azim (1993), and Piper, Rosie, Joyce, Azim (1996). Such a program usually incorporates the tenets of therapeutic community, group dynamics, psychodynamics, family dynamics, organizational dynamics, general systems theory and biological psychiatry. Over thirty years of personal experience in organizing, developing and leading day treatment programs in Montreal, Edmonton and now in Vancouver, as well as presenting, observing and consulting had taught me what will follow.

Like the other two types of partial hospitalization, the length of stay can distinguish day treatment programs. Whereas day hospitals offer a brief stay to resolve a critical phase, and day care offers a time-unlimited contract, day treatment programs stipulate a time limit, be it the same for all patients or individually tailored. Decades of experience taught us that eighteen-week duration is optimal for significant relief of

symptoms, improved social adjustment, and acquisition of insight. Furthermore our research findings support this conclusion.

Conceptual Issues

Tom Main (1946) coined the term therapeutic community. It was the result of his experience as an army psychiatrist during WWII. He noticed wide variations in the sickness rates between battalions under similar combat conditions. He came to the conclusion that differences in the culture and the quality of human relations in each battalion were the determining factors (Main, 1975). Following the war, psychiatrists like Main, Bion and Jones applied their observations and war experiences to the organization of psychiatric units for veterans and ex-prisoners of war. Their new techniques were sometimes referred to as milieu therapy. A social anthropologist, Robert Rapoport studied the Social Rehabilitation Clinic established in 1946 by Jones (Rapoport, 1980). He delineated four principles as the cornerstones of the approach: democratization, permissiveness, communalism and reality confrontation. Each concept has gone through periods of misunderstanding and misapplication on the road to its transformation into modern usage. Thus democratization is now reflected in the deliberate flattening of the hierarchy amongst the staff and between the staff and the patient population. Permissiveness now entails therapeutic tolerance for the expression of affects, thoughts and actions considered to be deviant by social standards. Communalism denotes the highly structured group interaction nature of the programs. Reality-confrontation has evolved into an environment of inquiry and sharing of feedback.

What was sometimes forgotten, often with disastrous consequences was that the major aim of these four principles was the enhanced undertaking of responsibility by all concerned: patients, as well as every level of the staff's traditional hierarchy. They were developed in part in response to the then prevailing excesses of power issues in mental hospitals. Power signifies self-serving and coercive actions over others, inevitably leading to competitive and destructive group processes. By contrast legitimate authority implies the exercise of leadership towards the achievement of collective goals (Buckley, 1967, Rosie, Azim, Piper, Joyce, 1995). However, the adoption of a laissez-faire abdication of authority and responsibility by the staff of some early experiments resulted in a pseudo-democracy where patients voted on the admission, the management and the discharge of other patients. Such practices contributed to underutilization and bias against day treatment programs and even the demise to some of these programs. Such state of affairs was epitomized in an article entitled " The patient-staff community meeting: A tea party with the mad hatter". (Klein, 1981).

Curbing the powers, while increasing the responsibilities, patients and staff alike, and the judicious exercise of the treaters' authority, are vitally important, particularly in any program designed for the treatment of patients with personality disorders. The therapists in these programs operate more generically as mental health professionals and less as members of their particular disciplines. This underscores the

organizational imperative that day treatment programs utilizing a milieu therapy approach be administratively structured as discrete self-managed programs internally responsible for budgeting, training, supervising and evaluating their staff members. This is necessary in order to diminish the negative consequences of multiple loyalties and splitting among the staff members.

The major contribution of psychoanalysis to day treatment programs has been the attention to the powerful transference-counter-transference manifestations that typically occur in these programs. As many as 30 patients and 10 staff members have been know to attend large and small therapy groups (Rosie & Azim, 1990), thus creating a multitude of transference and countertransference reactions. Patients experience positive and negative transference reactions, not only towards staff members and each other, but also towards each group, as well as towards the program as a whole, and can span the whole spectrum of transferential manifestations including but not restricted to idealization and devaluation. The role of hate in the transference and countertransference interactions in the treatment of this patient population cannot be emphasized enough (Groves, 1978; Frederickson, 1990). Utilized judiciously, the differences in each person's transference-countertransference reactions can contribute to reality testing and to a realization of the extent to which individual perceptions tend to be poignantly vicarious.

Cameron (1947) cited family dynamics and family involvement in his earliest writings on day hospitals. Some present day treatment programs, including ours, stipulate in the pre-treatment contract that the patient consents to at least one family assessment during the course of treatment. Depending on the patient's life situation this may include any and all members of the nuclear and/or extended family and any other person considered a significant other. Babes in the arms and on occasion pets are included and their non-verbal responses to the ebb and flaw of the nuances of the prevailing affects are always a source of fascination if not awe. In response to some patients' suggestions, long distance and overseas conference calls for family members who are unable to attend have been instituted successfully. At times, following the assessment, family treatment was found to be indicated and was offered concurrent with and/or at follow-up. Recommendations of psychiatric assessments and treatment for other family members are sometimes judiciously and sensitively made, and referrals arranged as indicated. One of the most rewarding aspects of the family meetings has been the astute and forthright contribution by young children as well as the benefits accrued to them, as a result of the parents' increased awareness. The inevitable defensive apprehension of the patients prior to the family meeting over the inclusion of their young is usually rendered manageable by the sharing of the anxieties before, and the relief following, the previously held family assessments of fellow patients. The goals of the family meetings have to be limited to the better understanding of the family dynamics without getting sucked into them, to provide psychoeducation and to be supportive towards all parties.

As mentioned earlier, biological methods of treatment were a mainstay of the early day hospitals. During the last decade, psychopharmacology has widened the scope of

day hospital programs making it possible to treat patients who would have been previously excluded due to the severity of their symptoms and character traits. The daily groups provide an opportunity to evaluate valuable subjective responses to different medications and to understand the interaction of psychodynamics, group dynamics and pharmacodynamics. Here again, shared experiences, encouragement and assurances by fellow patients have such inestimable an invaluable effect on the fostering, receptivity and adherence to pharmacotherapy in patients who are notorious for having difficulties in adhering to all therapeutic interventions. The intensity of the program also allows, when necessary, for the introduction of extreme dosages and unusual combinations in otherwise pharmacologically treatment-resistant cases (Geogea, 1999), such as may be required for patients who had suffered severe and persistent mixed Axis I and Axis II diagnoses e.g. symptoms of a double depression in association with varying degrees of paranoid, borderline and obsessive compulsive personality traits or disorders and substance abuse disorders. Reliance is put on SRIs for the control of the symptoms of anxiety, depression and OCD; on anti-epileptics for mood stabilization and control of aggression and anxiety; and on Trazodone and Doxepine for sleep normalization.

Program Description

Sigmund Karterud, M.D. wrote, partially based on first hand observation "John Rosie and Hassan Azim (1990) described an unusually well structured day treatment program for non-psychotic patients. Each day, Monday through Friday, started with the community meeting; which assembled about 50 patients and staff members and which lasted for an hour. The primary task of the meeting, as Rosie and Azim described it, was similar to that of small group psychotherapy:

'Dialogue is encouraged, expression of affect is supported, dreams are welcomed and emotionally laden material from other groups is introduced. Exploration of relationships within the groups in the here-and-now is commonplace. Transference interpretations are made, usually by the therapists, occasionally by patients. . . Group-as-a-whole interventions are generally restricted to those occasions when such processes are seen to be significantly affecting the group work. Individual patients are encouraged to do as much individual work as they seem to be ready for at the time.'

Another impressive aspect of that well-designed day treatment program was that its efficacy was scientifically proved by a controlled clinical trial. (Karterud, 1993)."

Description of the same program was later elaborated upon in further detail by Azim (1993) and by Piper, Rosie, Joyce and Azim (1996). The process and content of every group in the program were featured in the latter.

Staff Issues

Attention to staff issues is critical in these programs. Comprehensive day treatment programs are labor intensive. Three-to-one patient to staff ratio is desirable in view of the intensity of the program. The staff members have to be almost constantly able to negotiate the contradictions if not the paradoxes inherent in working in day treatment

programs. Thus the staff have to weigh the exercise of therapeutic tolerance against the need for limit setting; fostering closeness among the patients yet actively discouraging and interpreting the destructiveness of subgrouping; expecting the patients to share whatever they become aware of, yet censure attacking and advice-giving; being least restrictive while attending to the enhancement of safety; fostering assertiveness by all players that has to be associated with the containment of emotional explosion and adherence to mindful interactions; promoting group-as-a-whole processes and dynamics and at the same time keeping in focus the ultimate goal of treating the individual in the group; increasing the freedom of action of the individual but only in tandem with a rise in one's own responsibility; and advancing of the program cohesion while being heedful of the context in which the program is funded and the community served.

Assuming the role of a leader of such an intensive program for the treatment of personality disorders is not for the faint hearted. The leader needs to possess organizational skills and has to be well versed not only in individual, group, family and institutional dynamics but also in psychopharmacology. It is also important for the leader to be able to contain the ever-present pressures of persecutory anxiety in relation to the program's staff as well as to the powers that be. This has been found possible to accomplish by holding weekly staff - staff relations meetings. Here, the leader should model openness without burdening the staff with unnecessary self-disclosure. The leader should also make every effort to invite and encourage the staff members to express any and all grievances towards the leadership and to facilitate supportive confrontation towards each other. (O'Kelly and Azim, 1993). The overarching task of the leader has to be the meticulous maintenance of the boundary between the legitimate attention to the here and now of the work situation on the one hand and on the dangerous descent into therapy on the other. In these meetings flight into discussing patients or bringing up administrative issues has to be identified and referred back to other weekly meetings devoted to one and to the other. To the extent that staff-staff relations meetings succeed in unearthing covert staff conflicts, the incidence of patients' parallel collective disturbances is kept at bay. However, the latter are inevitable and their resolution usually requires emergency staff-staff relations meetings followed by large group meetings. (For details see Rosie, Azim, 1990; Azim, 1993; O'Kelly and Azim, 1993).

Research on Day Treatment Program

The early studies that appeared in the seventies shared many of the limitations mentioned under research on day hospitals. MacKenzie and Pilling (1972) conducted a prospective study of 100 consecutive patients suffering from neurotic or psychosomatic disorders in a day treatment program and reported that sixty-nine percent of the patients showed improvement in symptoms, interpersonal relations as well as work and social functioning on clinical assessments. Most maintained their gains at six months follow-up.

Subsequently a study by Dick et al (1991) reported the important finding that day treatment was more effective than outpatient care for patients with more severe anxiety and depression while the less severe cases benefited more from outpatient treatment.

More relevant to personality disorders was the study by Karterud and colleagues (1992). The program explicitly combined a therapeutic community organizational structure and a psychoanalytic object relations orientation to treat severe personality disorders. The majority of the 97 consecutive admissions were diagnosed with borderline and schizotypal personality disorder. The authors reported gains that were moderate for the former and less favorable for the latter population.

To my knowledge, the only prospective study of the outcome of a day treatment program utilizing a randomized treatment-versus-control design was reported by our team (Piper & Colleagues, 1993, 1996). The study was designed to avoid the methodological weaknesses of earlier studies including: small sample size, selection bias, lack of randomization, minimal control of variables, lack of standard outcome measures and poorly defined programs. All the patients referred to this program were asked to participate in the project, which lasted for 2 years. Ninety five percent of these patients consented to join the study. The selection criteria were long-term psychiatric problems that led to psychosocial dysfunction; ability to engage in group work; motivation for intensive therapy; and age 13 and older. Exclusion criteria were: current psychotic disorders; need for inpatient hospitalization; suicidal and homicidal threat; severe intellectual impairment; current substance abuse; and participation in another ongoing treatment. The control-condition chosen was a wait-list delay. The average waiting period to admission prior to launching the study, the delay period, and the treatment-as-usual length-of-stay in the program were all the same: eighteen weeks. Independent assessors utilized 17 outcome variables, which tapped the following areas: interpersonal functioning, psychiatric symptomatology, self-esteem, life-satisfaction, defensive functioning, and the level of the patient's treatment objectives. Subjects were then matched in pairs according of lifetime diagnosis and gender and randomly assigned to either immediate treatment or delay condition. No statistical difference in the use of medications, mostly antidepressants, was found.

Outcome variables were administered at the end of the treatment and delay periods and again at follow up point of eight months on average after completion of treatment. Eighty women and forty men comprised the 120 patients who completed the treatment and control conditions. Diagnostically 78% had lifetime diagnoses of major Depression, 60% of personality disorder and half received a combination of both.

The results showed that treated patients had attained significantly greater improvement than the control group on the following 7 variables: social dysfunction, family dysfunction; interpersonal behavior, mood level, life satisfaction, self-esteem, and individualized goals of treatment as measured by an independent assessor, while the measure of adaptive defenses approached significance. Another set of analyses revealed that compared to pre-treatment the patients showed significant improvement

in 11 variables. By contrast, at the end of the wait period, the patients showed significant improvement in only one variable (treatment objective severity as assessed by the patient). Thus there was little evidence of spontaneous remission in the control group.

At follow-up, 16 of the variables demonstrated maintenance of results while one (target severity as assessed by patients) showed further improvement. While statistical significance of results as the ones reported so far address probabilities, measuring of the magnitude of effect directly expresses the size of the effect that one variable (here treatment) has on another (here outcome). The study measured the effect size for each of the 17 outcome variables. The magnitude varied considerably from .10 to 1.96. The mean size was .71 indicating that the average treated patient exceeded about 76% of the patients in the control group. When applied only to the seven variables in which significant differences were found, the mean magnitude effect was 1.18 implying that the average treated patient surpassed 87% of the patients in the control group.

The limitations of the study include the lack of comparison with other forms of treatment and to attention-placebo activities. Another limiting factor is the fact that the program was evaluated as a whole, therefore it was not possible to determine the relative contributions of the particular components of the program. A dropout rate of 37%, comparable to findings reported in the literature, prevailed and matched patients replaced the subjects.

Together, the results are notable especially when the treatment resistant nature, the long duration, and the burden on the patients, their families, and on the social and medical systems are taken into consideration. Ninety percent of the subjects had previous psychiatric treatment and 43% had been hospitalized, all with little benefits. This study suggests that more partial hospitalization programs dedicated to the personality-disordered patients should become available and that more rigorous studies need to be conducted in the future.

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