Psychotherapy for severe personality disorder: exploring the limits of evidence based purchasing

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The growing emphasis on practising evidence based medicine has led to debate about how generalisable the findings from experimental studies are to clinical practice. Patients with severe personality disorders, who often pose difficult management problems in both primary and secondary care, illustrate the potential limits of practising evidence based medicine in the commissioning of services. The Department of Health has recently announced the development of therapeutic communities as part of providing a specialist service in England for patients with severe personality disorders (Department of Health, press release, 23 October 1997). This paper looks at the evidence for the option chosen by the department, examines alternatives, and discusses possible consequences.

What are personality disorders?

Individuals with a personality disorder show an enduring pattern of inner experience and behaviour that deviates markedly from cultural expectations. These patterns are inflexible and pervasive across a wide range of social and personal situations and lead to clinically significant distress or impairment in social, occupational, and other important areas of functioning.¹ Cluster B personality disorders (also termed "dramatic" or severe personality disorders) are one of three clusters of personality disorders. Individuals with severe personality disorders have major difficulties in establishing and maintaining adequate social relationships because of their emotional lability and impulsive behaviour. This cluster includes individuals with borderline, antisocial, histrionic, and narcissistic personality disorders.²

How big is the problem?

Establishing the prevalence of severe personality disorder in the population has been difficult because of the wide range of diagnostic criteria used.³ Drake and Vailant estimated the prevalence in the population from their sample of men as 4% with narcissistic, 2% with histrionic, and 1% with borderline personality disorders.⁴ Using standardised criteria the lifetime risk of antisocial personality disorder in the population seems to be just under 3%, with a fourfold increase in risk among men as opposed to women.⁵

Treatment

Published work on the treatment of severe personality disorders has largely been descriptive or qualitative, rather than quantitative; comparatively few studies have quantified outcomes through the use of standardised inclusion criteria,³ randomised controlled trial design, standardised outcome measures, or an adequate period of follow up. Given the chronically cyclical nature of personality disorders, follow up for at least two years is necessary to measure outcome.⁶

Summary points

Patients with severe personality disorders can pose management problems in both primary and secondary care

Much of the literature on treating these disorders has been descriptive or qualitative rather than quantitative, and there have been few randomised controlled trials

Consensus statements by expert groups have come to contradictory conclusions about the best ways to treat patients with severe personality disorders

When the decision to favour one treatment modality is made in the absence of evidence from randomised controlled trials, the development of alternative, and possibly more cost effective, approaches will be hampered

In the absence of clear findings from the scientific literature, there have been a number of initiatives by the American Psychiatric Association⁷ and the Royal Australian and New Zealand College of Psychiatrists⁸ to develop consensus statements but these statements have made contradictory recommendations.⁹ In England two commissioned, national reviews also came to different conclusions. The Reed report on forensic psychiatric services favoured the use of therapeutic communities¹⁰; the strategic review of psychotherapy recommended dialectical behavioural therapy.¹¹

Therapeutic communities

There is a long tradition of the use of therapeutic communities in the treatment of patients with severe personality disorders. Well known, comprehensive institutional programmes include the Patuxent in the United States and Herstedvester in Denmark.⁸ In England three units within the NHS offer treatment in therapeutic communities for patients with severe personality disorders: Henderson Hospital in Surrey, the Cassell Hospital in London, and Francis Dixon Lodge in Leicester. Following the recommendations of the Reed report, additional Henderson-type units have been funded in Birmingham and Salford.

Patients admitted to the Henderson Hospital usually stay for seven months, at an average cost of £23 000 (\$36 800).¹² Treatment consists of a formal daily programme of group meetings, involvement in the running of the community, and small group psychotherapy.¹²⁻¹⁴ There is, however, controversy about the effectiveness of this treatment.

Two controlled studies of a total of 372 patients reported improvement rates of 40-60% up to five years after admission, depending on whether outcome was

defined in terms of symptoms, reconviction, or psychiatric admission (table).¹²⁻¹³ However, there were a number of methodological problems such as the loss to follow up of about 70% of controls in one study¹² and of all participants in the other.¹³ In the most recent study¹³ outcome was assessed using the borderline syndrome index which could not be validated against other standardised psychiatric instruments.¹⁵ The control group of 155 individuals, moreover, represented a highly biased sample, in that they were referred to Henderson Hospital but not subsequently admitted. In all but 22 controls, this was because of non-attendance, clinical unsuitability, imprisonment, or being admitted elsewhere. These individuals were therefore a self selected group with a particularly poor prognosis.

There is comparatively little literature on the evaluation of services provided within the NHS by the Cassell Hospital¹⁶ or Francis Dixon Lodge.¹⁷ Abroad, only the Patuxent programme in the United States has been evaluated in controlled follow up studies. Although initial reports suggested an improved outcome,^{8, 18-20} a later independent inquiry showed that Patuxent graduates had rates of reoffending that were equivalent to controls in the regular correctional system.²¹

Dialectical behavioural therapy

The NHS strategic review of psychotherapy in England concluded that dialectical behavioural therapy was the most effective intervention for borderline personality disorder specifically and parasuicidal behaviour generally.¹¹

Dialectical behavioural therapy was developed in the United States and is a form of "integrative" psychotherapy; it combines individual interventions with group work in behavioural skills training. There have been only small studies of the effectiveness of this approach, with a sample of only 39 women completing all stages of the research (table).²²⁻²⁴ These studies were, however, randomised controlled trials that used standardised diagnostic criteria for borderline personality disorder from the *Diagnostic and Statistical Manual of Mental Disorders*.¹ Outcome, as measured by appropriate standardised psychiatric instruments, was assessed in terms of suicidal behaviour, anger, global functioning, social adjustment, and number of psychiatric inpatient days at the end of a 12 month course of intervention and at follow up at 18 and 24 months. Follow up in both the intervention and control group was generally more complete than in the Henderson studies (table). Dialectical behavioural therapy significantly reduced the incidence of parasuicide, the medical risk of parasuicide, the number of days in hospital,

Comparison of studies of interventions for treatment of cluster B personality disorders

Criteria	Study		
	Henderson Hospital ¹² (n=235)	Henderson Hospital ¹³ (n=137)	Dialectical behavioural therapy ²²⁻²⁴ (n=39)
Standardised inclusion criteria	No	No*	Yes
Randomised controlled trial design	No†	No†	Yes
Standardised or valid measures of outcome	Yes	No	Yes
Length of follow up	3 and 5 years	1 year	2 years
Percentage of participants followed up	30% control group	25%	62%
Trained practitioners available locally	Yes	Yes	No

*On average subjects met or exceeded the cut off points on the Personality Diagnostic Questionnaire for personality disorder as described in the *Diagnostic and Statistical Manual of Mental Disorders*.

†Authors have philosophical objections to randomised controlled trials.

and dropout from treatment, and improved the social adjustment of participants.

Other psychotherapeutic interventions

Cognitive analytical therapy was developed in the United Kingdom and, like dialectical behavioural therapy, is a form of integrative therapy.²⁵ Some encouraging results have been reported using open trials but full details are not yet available, and the approach has not been evaluated using randomised controlled trials. Supportive analytical therapy has also been suggested but has not been evaluated.

Is the use of Henderson-type treatment consistent with evidence based purchasing?

None of the interventions for the treatment of severe personality disorders is entirely satisfactory. Many approaches have not been formally evaluated and among those that have, the number of study participants has been small. The only studies that have quantified outcomes through operationalised inclusion criteria, randomised controlled trial design, and standardised measures of outcome have been those evaluating dialectical behavioural therapy. Although the studies of dialectical behavioural therapy are of a comparatively small number of patients, they are methodologically more rigorous than those used to evaluate treatment at the Henderson Hospital. However, dialectical behavioural therapy was developed in the United States and there are few trained practitioners in the United Kingdom.

It is surprising that in spite of this uncertainty Henderson-type therapeutic communities are being developed as part of a £12m national initiative to promote centres of excellence. This is especially strange given that findings from randomised controlled trials favour the use of dialectical behavioural therapy, and this decision suggests that the application of evidence based purchasing to health service planning is limited. Central funding for one particular intervention may have a number of unfortunate consequences: Henderson-type units will have a competitive advantage over therapeutic communities which do not receive such ring fenced financial support, it may hamper the development of alternative provisions for outpatient care, and it may skew research away from what might possibly be more cost effective interventions.

It may be more appropriate to openly acknowledge the limits of evidence based medicine rather than rely

on flawed studies that give the illusion that evidence exists. Such studies may be used inappropriately to support decisions which are, in turn, based on grounds other than the evidence.

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- 1 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington: APA, 1994.
- 2 The Quality Assurance Project. Treatment outlines for borderline, narcissistic and histrionic personality disorders. *Aust N Z J Psychiatry* 1991; 25:392-403.
- 3 Stone MH. Long term outcome in personality disorders. *Br J Psychiatry* 1993;162:299-313.
- 4 Drake RE, Vaillant GE. A validity study of Axis II of DSM III. *Am J Psychiatry* 1985;142:553-8.
- 5 Robins LN, Tipp J, Przybeck T. Antisocial personality. In: Robins LN, Regier DA, eds. *Psychiatric disorders in America*. New York: Macmillan, 1991: 258-290.
- 6 Roth AD, Fonagy P. *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press, 1996.
- 7 Kernberg OF, Clarkin JE. *Treatment of personality disorders: scientific group on the treatment of psychiatric disorders*. Geneva: World Health Organisation, 1989.
- 8 The Quality Assurance Project. Treatment outlines for antisocial personality disorder. *Aust N Z J Psychiatry* 1991;25:541-7.
- 9 Burville P. Quality assurance project reports on the treatment of personality disorders. *Aust N Z J Psychiatry* 1991;25:311-3.
- 10 Department of Health and Home Office. *Report of the Department of Health and Home Office Working Group On Psychopathic Disorder*. London: HMSO, 1994.
- 11 NHS Executive. *NHS psychotherapy services in England: review of strategic policy*. London: Department of Health, 1996.

- 12 Dolan B. *Perspectives on Henderson Hospital*. Sutton: Henderson Hospital, 1996.
- 13 Dolan B, Warren F, Norton K. Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *Br J Psychiatry* 1997;171:274-9.
- 14 Dolan B, Evans C, Norton K. Funding treatment of offender patients with severe personality disorder: do financial considerations trump clinical need? *J Forensic Psychiatry* 1994;5:263-74.
- 15 Marlowe MJ, O'Neill-Byrne K, Lowe-Ponsford F, Watson JP. The borderline syndrome index: a validation study using the personality assessment schedule. *Br J Psychiatry* 1996;168:72-5.
- 16 Coombe P. The Cassell Hospital, London. *Aust N Z J Psychiatry* 1996; 30:672-80.
- 17 Davies S, Campling P. Does every district need a therapeutic community [abstract]? In: *Proceedings of the Annual Meeting of the Royal College of Psychiatrists*, 1997. London: RCP, 1997:23.
- 18 Hodges EF. Crime prevention by the indeterminate sentence law. *Am J Psychiatry* 1971;128:291-5.
- 19 Carney FL. The indeterminate sentence at Patuxent. *Crime and Delinquency* 1974;20:135-43.
- 20 Carney FL. Treatment of the aggressive patient. In: Madden DJ, Lion JR, eds. *Rage, hate, assault and other forms of violence*. New York: Spectrum, 1976.
- 21 Gordon RA. A critique of the evaluation of Patuxent institution with particular attention to the issues of dangerousness and recidivism. *Bulletin of the American Academy of Psychiatry and Law* 1977;5:210-55.
- 22 Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. Cognitive-behavioural treatment for chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 1991;48:1060-4.
- 23 Linehan MM, Heard HL, Armstrong HE. Naturalistic follow-up of a behavioural treatment for chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 1993;50:971-4.
- 24 Linehan MM, Heard HL, Armstrong HE. Interpersonal outcome of cognitive behavioural treatment for chronically suicidal borderline patients. *Am J Psychiatry* 1994;151:1771-6.
- 25 Ryle A. *Cognitive-analytical therapy: active participation in change*. Chichester: John Wiley, 1990.

Commentary: Mix of perspectives needed in purchasing of care

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Kisely is right to question the Department of Health's decision to fund expensive therapeutic community programmes. Clinicians from these hospitals have worked for years at great public expense but without any serious scrutiny of the efficacy, effectiveness, and cost of their favourite techniques. It is all very well for them to declare philosophical objections to randomised controlled trials. But nowadays taxpayers are voicing their own philosophical objections to giving money to doctors who won't even try to show that they are spending it wisely. Psychotherapists at the Henderson Hospital have finally realised that the world does not owe them a living and have investigated outcomes for their patients after treatment¹ but Kisely shows that their data are of insufficient quality to inform funding decisions.

Overall, however, Kisely's paper is a disappointment. As is so often the case with the evidence based medicine approach, it will be of little help to clinicians who take on the care of these most difficult patients—those with severe personality disorders. Kisely's summary of operational diagnostic criteria does not convey the dismay that people with severe personality disorders cause in medical, social work, and penal settings nor the strains that they create in professional relationships. I will never forget trying to maintain the morale of a weeping psychiatric nurse who had reached the end of her tether when a furious consultant anaesthetist held her to blame for a potential clinical disaster. One of my patients had just had two thumb tacks and a broken thermometer removed from her bladder and a battery smeared with superglue removed from her rectum. God knows how it happened but when she woke up from the operation (her hundredth—at least—in the past three years), she

smiled to reveal thumb tacks in her mouth. I was near to tears myself when staff from State Hospital refused to take her because they treat people who are a danger to others, not those who harm themselves. They congratulated our ward team on good work over the past year and predicted that things would settle in a couple of decades when the patient matured.

It is not only clinicians who face near impossible decisions about these patients. Directors of public health have to deal with police, judges, social workers, distressed relatives, and members of parliament demanding that "something must be done" when every one of their local psychiatrists has refused to get involved with a chaotic patient with a personality disorder. It will not be enough to reply that "the NHS strategic review of psychotherapy concluded that dialectical behavioural therapy was the most effective intervention for borderline personality disorder specifically and parasuicidal behaviour generally."

Kisely's paper is a valuable discussion of some of the shortcomings in our knowledge of what if anything can be done to help these patients. However, it is only a first step. There is no way that he explores the limits of evidence based purchasing as promised in the title of his paper. Purchasing care for patients with personality disorders—or any complicated medical problem—requires a mixture of clinical and administrative perspectives as well the useful but (let's face it) ever so modest methods which have recently been claimed as their own by the evidence based medicine movement.

- 1 Dolan B, Norton K. Audit and survival: specialist inpatient psychotherapy in the National Health Service. In: Davenhill R, Patrick MR eds. *Rethinking clinical audit: the case of psychotherapy services in the NHS*. London: Routledge, 1998.