

**THE OUTCOME OF PATIENTS WITH BORDERLINE PERSONALITY
DISORDER IN A DYNAMICALLY ORIENTED
DAY HOSPITAL PROGRAM**

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1. INTRODUCTION

While the biological approach has led to considerable advances in the treatment of patients with borderline personality disorders over the last 15 years, it has not weakened the relational approaches. With the changes that have taken place in psychiatric practice in terms of cost containment (“managed care”), group therapy is becoming the treatment of choice in many programs due to its relatively good cost/benefit ratio..

On the other hand, during the last twenty five years, there has been a rebirth of milieu therapy along inpatient units , crisis centers for severe patients . Several studies, of variable methodological quality, show favorable results in borderline patients with this type of approach based on the experiences of therapeutic communities. In 2003 we organized in Bilbao a program in a day unit for a maximum of 27 patients simultaneously. In this paper we are describing the socio-demographic and clinical variables of 109 patients (64,2 % Borderline and 35,8% Non-Borderline) , during the year preceding their admission and after their discharge from a dynamically-oriented day hospital program with a 50 days average hospital stay.

2.METHODOLOGY

2.1.Patients

There were significant differences between BPD and Non-BPD. Patients with Borderline personality disorder were more frequently male ($p=0,012$), single ($p=0,000$), of a younger age ($p=0,01$), coming from dysfunctional families ($p=0,000$), occupied ($p=0,05$), with diagnostic co morbidity ($p=0,021$), having made self-harm activities and suicidal attempts ($p=0,09$) and presenting substance and alcohol abuse ($p=0,000$). ($p=0,000$)

2.2. Diagnoses

64,2 % of the patients had a Bipolar Personality Disorder diagnosis and 35,8% other Non-BPD diagnoses (5,7% Psychoses, 47,2% Anxious/Depressive, 18,9% Substance abuse and 23,6% Other Personality Disorders).

2.2. The therapeutic programs

A maximum of 27 patients were treated simultaneously, with an average age of 37,64 years and a mean stay of 50 days (22,7%: less than 1 month, 25%: more than 3 months), five days a week, four hours a day.

The two therapeutic teams included psychiatrists, psychologists, social workers, occupational therapists and psychomotor therapists, trained in individual dynamic therapy and group and family therapy

The program included : medication prescription and control of; three small verbal therapy groups (staff-patients once a week, dynamic 5 days a week, cognitive 5 days a week) and several group activities (artistic expression 2 days a week, body movement 2 days a week, relaxation once a week, daily activities 5 days a week). The multifamily group met once a week

2.3. The instruments. Several instruments were used at program admittance and at discharge:SCID (Structured Clinical Interview for DSM IV-TR), BDI (Borderline Diagnostic Inventory, Gunderson, 1992), BSI (Brief Symptoms Inventory, Lipman and

Derogatis), HS (Beck's Hopelessness Scale, STAI (State-Trait Anxiety Inventory), BDI (Beck's Depression Inventory), ERA (Questionnaire d'évaluation des relations avec les autres, Fredenrich & Zanetti, QFS (Questionnaire de Fonctionnement Social, Weber-Rouget & Zanello

3. RESULTS

3.1. Compliance

We find a lack of differences in attendance (type of discharge and length of stay) between BPD and Non BPD, contradicting our hypotheses, based in the literature, that BPD would have a more irregular attendance. In fact, the drop-out rate was smaller in BPD than in Non-BPD ($p= 0,499$) (Table 1)

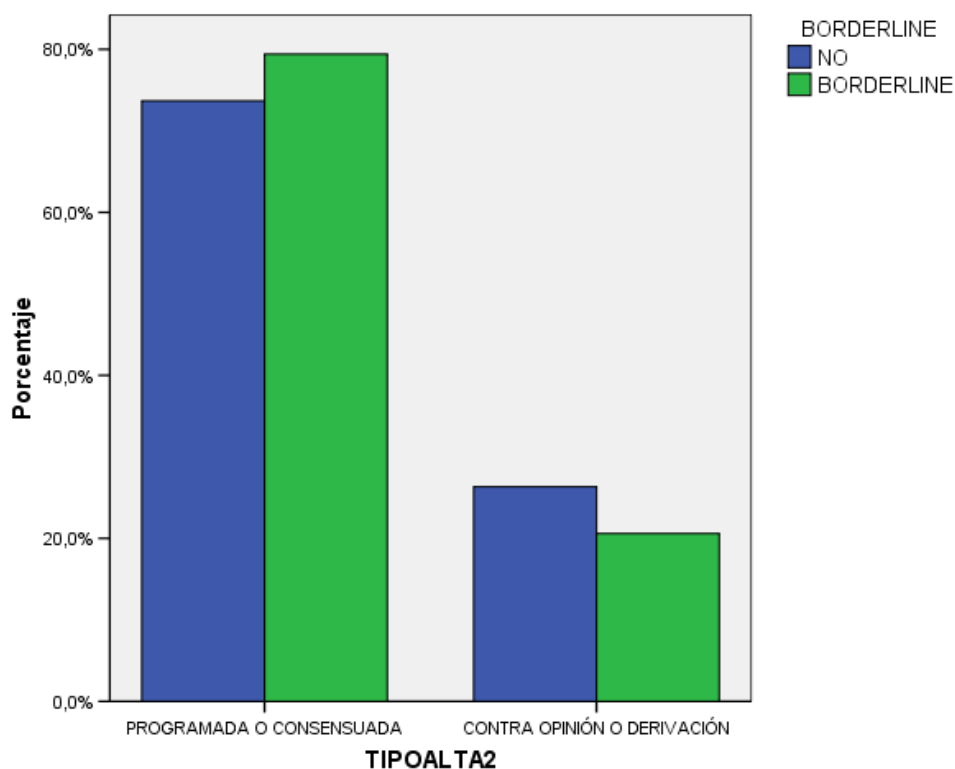


Table 1. DROP-OUT RATE

There was a statistically significant smaller drop-out rate in BPD than in Non-BPD ($p=0,499$)

3.2.Symptoms

There was an overall significantly important improvement of the symptoms without statistical differences between BPD and Non- BPD. However, in the BSI , BPD patients had a larger range in symptoms (Table 2).

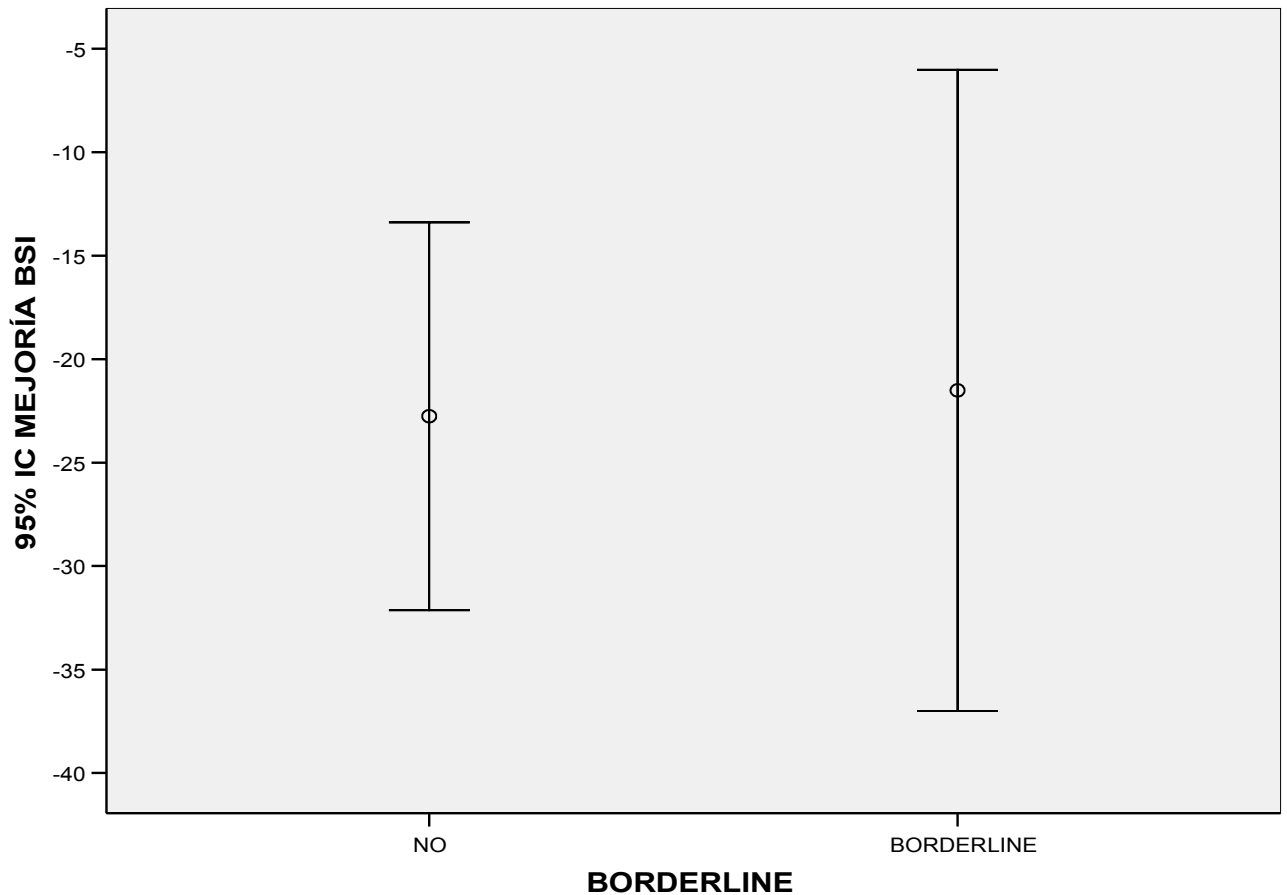


Table 2 . BSI , BPD patients had a larger range in symptoms

There was a significant improvement in the 9 factors of the BSI (Somatization, Obsessive-compulsive, Interpersonal Sensibility, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid thinking and Psychoticism)

On the other hand, some variables affected significantly the outcome of some symptoms: depression improved more in those with higher socio-economical status, higher educational level and a history of self-harm. Suicidal ideation improved more in

those who were University students . Anxiety improved more in those with a history of Substance abuse

There were also some significant differences in improvement between BPD and Non-BPD that we find difficult to interpret: BPD without co morbidity at the admission showed more improvement than Non-BPD. Non- BPD with co morbidity at the admission improved more in anxiety than BPD. On the other hand, anxiety improved more in those who had a Substance abuse history.

Depression improved more in people with higher socio-economical status, higher educational level and heavier history of self-harm. Suicidal ideation improved more in those who were University students

3.3.Global functioning

There was also an important improvement in global functioning without differences between BPD and Non-BPD in the ERA Questionnaire of relationships with others. However BPD obtained a statistically significant higher improvement than Non-BPD in the Factor 1 QFS "Daily life activities" ($P= 0,035$) (Table 3)

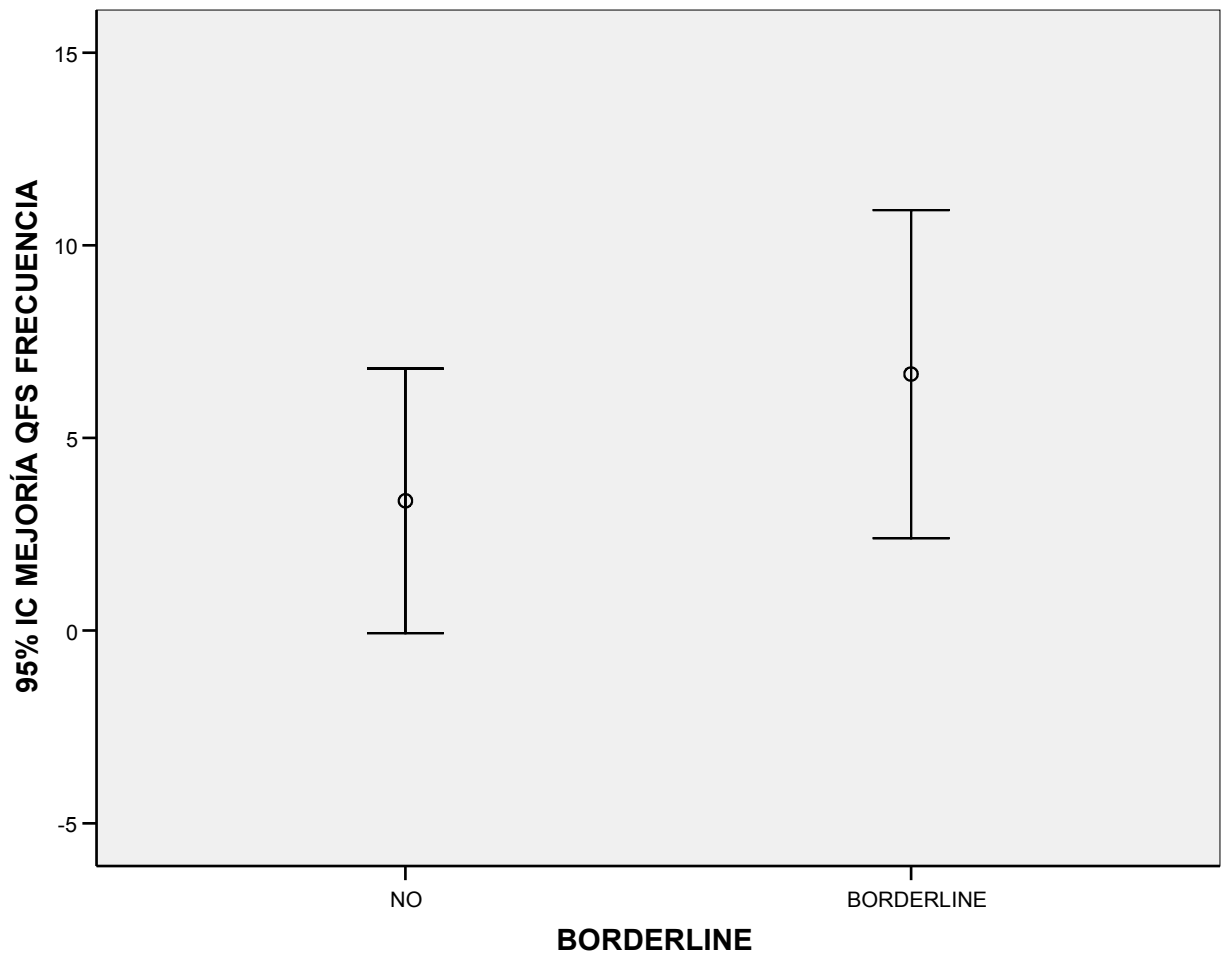


Table 3. BPD obtained a statistically significant higher improvement than Non-BPD in the Factor 1 QFS "Daily life activities" (P= 0,035)

4.DISCUSION

4.1. Overall results: The limits of "evidence based" studies

The program we have presented in this article is one of the group therapy programs we have developed over the past 30 years, involving many severe patients,

with an orientation towards community therapy, in a dozen different care units (short-stay units in general hospitals, rehabilitation units, and day hospitals) in Spain and in Switzerland .

These programs (we have named “decaffeinated therapeutic communities”) include, as a minimum: a “medium size” daily group, bringing together patients and staff; a patients “small group”, with a dynamic orientation, but with occasional cognitive-behavioral techniques; and several group activities (“group work”, in a Foulkian sense). The use of multifamily groups is a significant component of this type of programs.

This article shows important improvements in symptoms and global functioning after the program discharge. BPD patients showed, on the other hand, a non-expected good compliance. The evaluation we are currently doing in the 6, 12 and 18 months follow-up will tell us more about the medium term interest of our model.

We have not been able to make randomized controlled trial of our programs the results since the research designs were always “naturalistic”..

The treatments efficacy assessment is presently acquiring growing importance for psychiatric practice. "Empirically Supported Treatments" are proposed through useful techniques such as randomised controlled trials, the meta-analysis, the "Consumer Reports" studies and the Cochrane collaboration systematic reviews. However, they also have important biases such as the gaps in interpreting the available evidence, the neglect of individual patient uniqueness and the high artificiality of the settings.

The results of some evidence based programs of this kind that have been evaluated are rather optimistic. A Cochrane Review concludes that home care crisis treatment, coupled with an ongoing home care package, ‘is a viable and acceptable way of treating people with serious mental illnesses’. Another Cochrane Review compared day hospital versus outpatient care for severe psychiatric disorders, and found that there was evidence from one trial suggesting that day treatment programs were superior to continuing outpatient care in terms of improving psychiatric symptoms. However, on the contrary, another Cochrane review did not find any randomized trial evaluating the effects of non-medical day center care for people with severe mental illness.

A recent *Cochrane Review* by concludes that, although some of the problems frequently encountered by people with borderline personality disorder may be amenable to talking/behavioural treatments, all therapies remain experimental and the studies are too few and small to inspire full confidence in their results.

These frustrating conclusion highlights other limits of “empirically supported psychological treatments” with BPD: they have not been effectively disseminated to the mental health professionals; they are not readily available to the public who requires them; and they have only a remote resemblance to what goes on in actual clinical practice.

But, how to overcome these difficulties?. Many authors emphasise the need to overcome the problems of rigid manuals and to avoid forcing clinicians to adhere to theories and practices that are outside their interest. Most proclaim the need of naturalistic psychotherapy studies.

The “evidence-based” movement has appeared in psychiatry as a research method . It is, however, also a powerful socio-political endeavour. It has, last but not least, important ethical implications since moral neutrality is a myth when referring to the incompatible ethical positions inherent in clinical and research practices.

4.2. The programs effect on the treatment environments.

Group Psychotherapy is a basic therapeutic resource in psychiatric care. In our experiences some specific groups produce important attitudinal and clinical changes . Most importantly groups improve the quality of psychiatric programs by the creation of a better climate in the wards .

In a research, we compared, by means of Moos’ Ward Atmosphere Questionnaire , the atmosphere in 200 psychiatric wards (both in general and psychiatric hospitals) in Spain. The ratings of the personnel in the wards where a group program was used showed significantly higher scores on some items such as “support”, “interpersonal orientation”, and less “control”. The ratings of the patients were higher on “spontaneity”, “autonomy” and “support”.

In short-stay psychiatric units, the patients have to deal with a high degree of stress, arising from short stays, acute symptomatology, auto- and hetero-aggression, rapid turnover of patients, and limited space. Group analysis, with its particular emphasis on the 'here and now' and on inter-member cohesiveness, has shown itself to be, in our experience, a useful stabilising ('buffer') tool, through fostering involvement and support and allowing a controlled expression of anger and aggressiveness.

The patients-staff group is the key element, from the standpoint of its creation of a good ward atmosphere and through the information it provides to patients. The other groups also give the patient orientation and emotional support. All this has enabled us to decrease the dosages of medication required and to create an agreeable atmosphere in the sessions, as well as lowered the number of incidents (e.g., aggression, suicide attempts, and runaways). The tensions in the therapeutic teams have diminished and incoming nursing personnel notice how their previous fears and apprehensions diminish.

In this kind of settings it is assumed that the staff should play an «alter familia» role that would enable the patients a “corrective emotional experience ». However, various difficulties arise in the team coming from real problems and from projective identifications that clients put on the staff members. Conductors frequently feel compelled to act transferentially as if they were moved by the projections of the patients. Tensions arises in the team while its members essay to become an adequate continent, a «loving therapeutic team», able to take on the needs of the clients and avoid having to assume the difficulties of the staff members.

Post groups in therapeutic communities are of great help to avoid severe emotional difficulties arising in these professionals.

These different groups constitute a network for group analysis, which is favorable to the harmonious communication between the different services. This systemic vision of the Mental Health system is conducive to easier, quicker detection of problems and conflicts inside the institutions. All of these elements furnish the input which feeds “healthy anticipatory paranoia” , which is so indispensable to managing these organizations.

SUMMARY

INTRODUCTIONThe authors have organized in 2003 a naturalistic programs in Bilbao for a maximum of 27 patients simultaneously. They describe in this paper the socio-demographic and clinical variables of 109 patients (64,2 % Borderline and 35,8% Non-Borderline) , during the year preceding their admission and after their discharge from a dynamically-oriented day hospital programme with an average hospital stay of 50 days.

METHODOLOGY. Several instruments were used at the time of the admittance and at the discharge from the program:SCID (Structured Clinical Interview for DSM IV-TR), BDI (Borderline Diagnostic Inventory), BSI (Brief Symptoms Inventory, HS (Beck's Hopelessness Scale, STAI (State-Trait Anxiety Inventory), BDI (Beck's Depression Inventory), ERA (Questionnaire d'évaluation des relations avec les autres, Fredenrich & Zanetti), QFS (Questionnaire de Fonctionnement Social, Weber-Rouget & Zanello)

RESULTS. The authors find a lack of differences in attendance (type of discharge and length of stay) between BPD and Non BPD, contradicting our hypotheses, based in the literature, that BPD would have a more irregular attendance. In fact, the drop-out rate was smaller in BPD than in Non-BPD ($p= 0,499$). There was a significantly important improvement of the symptoms whithout statistical differences between BPD and Non- BPD. However, in the BSI , BPD patients had a larger range in symptoms. Some variables affected significantly the outcome of some symptoms: depression improved more in those with higher socio-economical status, higher educational level and a history of self-harm. There was also an important improvement in global functioning without differences between BPD and Non-BPD in the ERA Questionnaire of relationships with others. However BPD obtained a statistically significant higher improvement than Non-BPD in the Factor 1 QFS "Daily life activities" ($P= 0,035$).

The authors support the need for more naturalistic studies and, based on their experience, they favour eclectic, brief, dynamic, day hospital approaches with heterogeneous patients as an optimal emergency approach for people with BPD

RESUMEN

INTRODUCCIÓN: Los autores organizaron en Bilbao en 2003 una unidad de día para pacientes graves (64,2 % con TLP y 35,8% con otros diagnósticos) que se ocupa de un máximo de 27 pacientes simultáneamente repartidos en dos programas, con una duración media de 50 días.

METODOLOGÍA. En un reciente estudio “naturalístico” comparan diversas variables de los pacientes al inicio del tratamiento, en el año anterior y en el momento del alta con diversos instrumentos: SCID (Structured Clinical Interview for DSM IV-TR), BDI (Borderline Diagnostic Inventory), BSI (Brief Symptoms Inventory, HS (Beck’s Hopelessness Scale, STAI (State-Trait Anxiety Inventory), BDI (Beck’s Depression Inventory), ERA (Questionnaire d’évaluation des relations avec les autres, Fredenrich & Zanetti), QFS (Questionnaire de Fonctionnement Social, Weber-Rouget & Zanello)

RESULTADOS. En contra de lo que se había predicho, los pacientes con TRLP tuvieron un cumplimiento terapéutico semejante a los no TLP e incluso el porcentaje de abandonos fue menor. Desde el punto de vista sintomatológico las mejorías fueron importantes sin diferencias entre los dos grupos, aunque el rango era mayor en los que presentaban TLP. La mejoría en el funcionamiento social fue también semejante, aunque los que tenían TLPO mejoraron más en las actividades de la vida diaria. Ante estos datos alentadores consideramos que las aproximaciones basadas en unidades de día con programas breves, intensivos, dinámicos (o eclécticos) son una indicación excelente para los pacientes con TLP.

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