Inpatients with personality disorders who stopped treatment had problems with the institutional culture and relationships

Chiesa M, Drahorad C, Longo S. ***Early termination of treatment in personality disorder treated in a psychotherapy hospital. Quantitative and qualitative study****. Br J Psychiatry 2000 Aug;****177****:107–11.*

QUESTION: In patients with personality disorder who stop treatment early after admission to a psychotherapy hospital, what problem areas do they identify in their hospital experience?

Design
Semistructured, indepth interviews (quantitative data were also collected, but this abstract focuses on the qualitative data).

Setting
A psychotherapy hospital in Richmond, UK.

Patients
42 patients (mean age 33 y, 74% women) who had been treated for personality disorders and had left the hospital within 14 weeks of starting treatment were invited to participate. 18 patients agreed to be interviewed.

Methods
Semistructured, indepth interviews of patients were dictated and transcribed. 3 researchers used content analysis to identify main categories. Transcripts were reviewed and scored independently by 2 raters to determine the interrater agreement ($\kappa = 0.91$).

Main findings
Patients identified problem areas in their hospital experience. These were grouped into 6 categories: institutional culture and structure, organisation of treatment, dimensions of living together in a therapeutic community, relationship with key nurse, relationship with therapist, and other. Most problems were reflected in the first 3 categories. *Institutional culture and structure:* patients felt they were misunderstood by staff, who failed to recognise fears and vulnerabilities behind problem behaviour; were left out of decision making; were excluded by staff; and faced unrealistic expectations on admission. *Treatment organisation and delivery*: patients identified that the need for privacy was not recognised and was seen as resistance to participation in treatment; group meetings were viewed as persecutory; treatment delivery was viewed as inflexible; and the treatment approaches and philosophy were vague leaving patients with unclear expectations. *Dimensions of living together in a therapeutic community*: participants identified increased responsibility on some patients to support other patients and the emergence of an anti-therapeutic subculture, which included intimidation, bullying, and backbiting from a dominant subgroup of patients. The 2 categories relating to staff indicated a lack of availability, confidentiality, and trust.

Conclusions
Patients with personality disorders who stopped treatment early identified institutional culture and structure, organisation of treatment, and their relationship with other patients as problematic. Other problems included their relationships with staff.

Source of funding: Sir Jules Thorn Charitable Trust.

For correspondence: Dr M Chiesa, Research Unit, The Cassel Hospital, 1 Ham Common, Richmond, Surrey TW10 7JF, UK. Fax +44 (0)208 332 6424.

COMMENTARY

Chiesa *et al* state that the generalisibility of their findings is low. An alternative reading is that we need to be specific about what works for whom, where, and when. In the UK, user feedback will increasingly inform local arrangements for ensuring access and for making commissioning decisions about the most appropriate, acceptable, and effective form of service provision.

This study provides a methodology for obtaining vital qualitative and quantitative information about mismatches between patient need and service provision. Significant interactions among diagnosis, socioeconomic factors, and treatment type were observed in 134 patients admitted to a therapeutic community, where 57% of patients completed treatment and 32% dropped out prematurely.

Therapeutic communities have a well defined treatment philosophy associated with evidence-based admission criteria for those likely to benefit from this form of care. Patient commitment to putting difficulties into words, and to taking responsibility for struggling with the frustration of living with others with whom one may have little in common, is essential.

Predictably, factors associated with early termination were: low levels of education, living alone, low income, absence of borderline diagnosis, and lack of ongoing support and aftercare in the community upon discharge. Since these factors are now widely recognised as being associated with failure to engage with services,[1] alternative service models, such as assertive outreach, early intervention, and home treatment are being pioneered (in the UK by the North Birmingham Mental Health Trust).

The second area of mismatch relates to the failure to recruit, retain, and provide resources for suitable staff. Work skills in therapeutic communities include the ability to identify inappropriately referred people and to develop and maintain a culture consistent with the espoused values of this approach, such as structures and processes for ensuring democratic decision making, conflict resolution, respect, safety, and trust.

User feedback from this study can help to improve standards of care by informing the development of guidelines and protocols for appropriate assessment, referral and treatment, and workforce development plans and by identifying the training needs of staff. The finding that twice as many women than men dropped out prematurely supports the emphasis which the UK government guidance places on the need to make services more responsive to the needs of women.

Hilde Rapp, MA
British Initiative for Integrative Psychotherapeutic Practice
London, UK

1 *Keys to engagement. Review of care for people with severe mental illness who are hard to engage with services.* London: The Sainsbury Centre for Mental Health, May 1998. http://www.sainsburycentre.org.uk.

Evid Based Mental Health: first published as 10.1136/ebmh.4.1.32 on 1 February 2001. Downloaded from http://ebmh.bmj.com/ on October 18, 2019 by guest. Protected by copyright.