Treatment and management of personality disorder in high secure hospitals

John Hodge assesses the changing role of the high secure hospitals.

Introduction

People with personality disorders are admitted to the three high secure hospitals in England and Wales under the 1983 *Mental Health Act*, category of 'Psychopathic Disorder'. The three hospitals are Ashworth Hospital, near Liverpool (formerly Moss Side and Park Lane Hospitals); Broadmoor Hospital in Crowthorne, Berkshire and Rampton Hospital in Nottinghamshire. While some personality disordered offenders are admitted to medium secure units, the majority currently detained in health care settings are in the high secure hospitals.

While the hospitals have been admitting and offering treatment to personality disordered offenders for many years, the development of services to these patients has been very slow and only relatively recently have there been concerted attempts to create specialised units for these patients. The main cause of this tardiness in developing services has been the lack of a clear conceptual framework in which to understand the personality disordered and formulate their problems. For example, although the 1983 *Mental Health Act* stipulated that personality disordered offenders be treatable before they were admitted to healthcare settings, there was no criteria laid down at the time for treatability and there is little consensus even now as to what this involves. As a result, many patients who seemed treatable for whatever reason on admission, have proved to be less responsive to whatever treatments were available, and have become stuck in the system.

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Treatment - a brief history

There has been a consensus for some time that personality disorder does not respond well to the biological treatments currently available. As a result the majority of personality disordered patients in high secure hospitals have at sometime or other been referred to psychological services. Although, in the main, psychologists believe that they have a lot to offer to these clients, their assessment and treatment has tended to be very individualised, and very often focused on the offence behaviour rather than on the personality disorder per se. Although individual approaches vary, most psychologists would generally adopt a problem-solving approach based on a functional analysis of the index offence and deal with personality disorder issues as they arose within that framework. At the same time, the bulk of research on personality disorder in high secure hospitals, until relatively recently, tended to wrestle with the conceptual problems regarding the nature of personality disorder rather than generating treatment options or evaluating the treatment which was taking place (Blackburn, 1975). This phase of individualised treatments co-existing with academic research was perhaps inevitable given the relatively low priority these patients had on the medical and political agendas at that time.

In the last ten to fifteen years, however, there has been a considerable increase in research interest in developing not only our understanding of personality disorder but also in developing strategies for treatment and intervention. The focus of this research has been on people with personality disorder in the community but it shows considerable promise for development for use with personality disordered offenders (Beck et al, 1990 Linehan, 1993, etc.). In this same period, there has been dramatic progress in developing treatment programmes for different offender groups, (e.g. sex offenders, violent offenders etc.) and on the assessment of risk (Marshall, et al, 1993; etc.)

In the high secure hospitals, there has been a gradual recognition that the special needs of personality disordered patients need to be addressed more systematically and this is beginning to be reflected in treatment. In the three high secure hospitals, these developments have taken slightly different courses. Also, although the earliest approach at Broadmoor is now nearly twenty years old, I think it is still safe to say that all three hospitals are still at an early stage in the development of services to these patients.

In Broadmoor Hospital, Mednip Ward (which later became Woodstock Ward) was set up to cater for young male personality disordered patients. A treatment model was developed based around an integration of psychodynamic and behavioural treatments. Delivery was based around a mixture of group, individual, and milieu therapies. The overall aim within this ward was to prepare patients for discharge to less secure settings. This particular service has developed slowly over a considerable period of time and has generated a rich series of publications as people have described and evaluated the work being done (Grounds, et al, 1987)

In Rampton Hospital, a Psychological Treatment Unit was developed in 1993. The initial concept of this unit was to provide a consistent therapeutic milieu in which offence-related and personal therapy could be offered. The unit opened as a single small ward with a maximum of twelve patients and, as a result, initial teething problems could be contained while the management and treatment processes on the ward were established. The Unit has now developed into a three-ward unit called the PD Service, and the treatment model has developed from its original, fairly loose concept towards one embracing the concepts of Dialectic Behaviour Therapy and Cognitive

Behaviour Therapy. At the present time, the predominant treatment in the service is structured group therapy, with individual work occurring outside the groups. Evaluation of the treatment programme is yet in its early stages, but shows promise (Hughes, et al, 1997).

In Ashworth, the Personality Disorder Unit was set up in 1994 and consists of six wards housing all the PD patients in Ashworth. The Unit was set up with very positive aims which was to *develop a more therapeutic ethos* for patients in Ashworth, following the Blom-Cooper Enquiry. However, there was no clear therapeutic model adopted at the early stages of the PDU. The management problems suffered by the Unit eventually led to the Fallon Inquiry, where one criticism was the lack of foresight and planning for the management problems that would be likely in dealing with such a large group of personality disorder patients.

One possible learning point from the outcomes of the different service developments in the three Special Hospitals might be that an effective approach probably requires a small start and a carefully planned development. Where problems did emerge in the services, they could much more be contained in a small service than in one that was trying to deal with large numbers of PD patients at the same time. This philosophy may be unattractive to Ministers who have a political agenda for public safety and who wish to see an approach in dealing with the problem of personality disorder, and in particular personality disordered offenders once and for all. However, this group of patients has demonstrated their ability to challenge conventional management and treatment. We must learn from the lessons from the past. So what in fact is the problem they present?

What is personality disorder?

Personality disorder is probably the most complex and heterogeneous problem in mental health. Despite its being recognised now for over 150 years, there has been little progress up until fairly recently in either our understanding of the problem or indeed in our management of the problem. Although it is clear to almost everyone who comes into contact with PD offenders that they are suffering from some form of mental disorder, there has been no consensus as to the nature of that mental disorder; there has been no consensus as to where it might best be managed; and there has been no consensus as to who is best equipped to manage it. People with PD in the prison systems generally cause the more challenging management problems and prisons are often *quite enthusiastic to transfer them* to healthcare settings. People with PD in healthcare settings also cause management problems and where there is a lack of any obvious effective treatment, healthcare workers often take the view that they would be best returning to prison.

Personality disorder has been bedevilled by a lack of professional consensus on its nature. It does not easily fit in with medical concepts of 'mental illness' while, there is little link with personality theory in academic psychology. The diagnostic systems used provide no help in determining treatment. To make things worse, we keep inventing new terms like 'Severe Personality Disorder', which simply add to the conceptual morass. Our lack of an understanding of the nature of PD has also led to a lack of research on effective treatment, since treatment processes are usually based on some theoretical understanding of the problem.

It is my view that some of our current diagnostic systems do not help. These diagnostic systems were meant only to be descriptive and designed to be atheoretical. They make no statement about the development of personality disorders and do not contribute much to our understanding of their nature. The lack of theoretical base in DSM-IV and ICD-10 leads to problems in developing effective treatments or therapies linked to the diagnosis. In addition to that, they are not very reliable. It has been suggested that on average someone with PD can meet the diagnostic criteria for three-and-a-half different disorders. However, the major problem, is that since they are part of a diagnostic system, they are commonly used to explain the behaviours they describe. In other words, someone gets a diagnosis because of the behaviour they display. However, once the label is applied, the behaviour is then 'explained' by the diagnosis. This circular *causality does not progress our* knowledge in any way and contributes a great deal both to the stigmatisation of people with PD, and to the philosophy of therapeutic nihilism. This superficial sophistication in our description of personality disorders may be one of the major barriers to our developing an understanding of them.

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It cannot be denied that the diagnostic systems provide a shorthand for describing people who have similar clusters of problematic behaviour. However, there seems to be little use made of specific diagnoses in service provision. At the present time, the trend is to put together people with undifferentiated personality disorders into the developing services. With one exception, specific diagnosis is unrelated to the treatments offered. The one exception, of course, is borderline personality disorder. Here, a number of treatment approaches have been developed to specifically address this particular group (e.g. Dialectic Behaviour Therapy; (Linehan, 1994) and Schema-focused Cognitive Therapy; (Young, 1990)). There are probably a number of reasons why this particular group should be separated out and targeted. In general borderline personality disorder patients are the most obviously distressed by their mental disorder. There is also considerable and growing evidence of some of the reasons for that distress being based on trauma and abuse. Indeed there is a school of thought which would suggest that a diagnosis of borderline PD is the same as having a diagnosis of Post-traumatic Stress Disorder. However, there has been no similar focus of attention on any of the other personality disorders nor any real evidence developed that the current differentiation of personality disorder is of value in developing treatment packages.

Personality disorder - a personal view

Where there has been a great deal of research attention over the last ten years to our understanding and treatment of PD, putting it into the context of the decades of research on other mental health problems, it is still very much in its infancy. However, there are a number of themes emerging which, I think, make it possible to conceptualise personality disorder in other ways than diagnostic systems. I would not claim that the conceptualisation I am about to suggest is either comprehensive or even very well developed at this point. However, it may offer a different perspective on the usual 'mad or bad' dichotomy that is often applied to these patients.

I believe there is now sufficient evidence to support a view that personality disorder can be seen as an acquired developmental disorder leading to emotional and interpersonal disability. I am suggesting that it is an acquired developmental disorder because I think there is now sufficient evidence that events happening during the development of vulnerable people may pre-dispose them more to developing a personality disorder at a later stage. I am suggesting a disability rather than an illness model because in most cases we are dealing with a chronic problem that is likely to respond only partially to treatment.

In terms of the acquired developmental disorder, it is likely that some individuals are or become more vulnerable to development of PD. Such vulnerability factors might include biologically based temperamental features such as impulsivity, emotion dysregulation and low IQ. There may also be acquired vulnerability factors such as brain damage (which would depend on the extent, location and timing of the damage). Environmental

factors would include such issues as abuse and/or trauma, neglect, indifference, changes in caretakers, indulgence. There is a fair amount of literature to suggest that these environmental factors have more or less impact on individuals depending on the presence or otherwise of protective factors such as caring relationships and the opportunity to avoid and therefore incubate problems. A lack of these protective factors would therefore enhance the likelihood of the development of a personality disorder.

I would be the first to admit that this concept of PD is hardly rocket science. However, I believe it encapsulates the general direction of current psychological research. Its singular advantage is that it offers some explanation for the diversity and complexity of the problem we are dealing with. If we were to consider the range of different types of vulnerability factors, and their almost infinite possible interactions during the development of an individual, the complexity of the outcome becomes inevitable.

Considering personality disorder to be a disability rather than an illness offers us access to the different conceptual frameworks we use for supporting disabilities of all types. If we were to see our PD patients as disabled, both in their ability to regulate their emotions and also in their ability to interact with others; if this disability were viewed as a result of the interaction between personal vulnerability and maladaptive learning experiences throughout their developmental years, then this might offer a different perspective in developing appropriate services for them in the future. A disability model is also more credible than an illness model, and carries with it a different value system, which may enable staff and others to more effectively interact and deliver services.

Whatever the conceptual framework we eventually develop to understand PD, there does appear to be a number of common issues across the wide range of personality disorders which are more or less present in most people with any form of PD. Most have a very low self-esteem. Most have interpersonal problems and a very rigid thinking style and most have some form of emotional dysregulation or over regulation. (It is arguable that people with anti-social personality disorder are over-regulated emotionally rather than under-regulated as might be felt for people with borderline PD.)

The development of a conceptual framework

I said earlier that there has been a great deal of research over the last ten years on our understanding and treatment of PD. I do not propose to go into this in any detail but an overview may provide some kind of flavour of the kind of work which is going on and the considerable promise that some of this work is showing.

Marcia Linehan began to work with women who were self-harming and attempting suicide. She developed a theory of Emotion Dysregulation to explain why these women were behaving in this way and a treatment approach called Dialectic Behaviour Therapy to address the problems presented by these women. She then became aware that these women would all attract a diagnosis of borderline personality disorder. Dialectic behaviour therapy (Linehan, 1994) is now seen as one of the most promising treatments for borderline PD and is under consideration for being applied to other types of PD. The treatment provides a structured framework to conceptualise people's problems and to address these in a systematic way.

Another way of looking at PD is to examine the typical interpersonal strategies that people with PD use in interacting with other people. There has been a long tradition of work on interpersonal theory in the USA, based originally on the work of psychiatrist, Harry Stack Sullivan. This work has been relatively little known in clinical settings in this country until recently when Ron Blackburn began to integrate the work on interpersonal theory with his previous work on psychopathic disorder (Blackburn & Renwick, 1996; Blackburn, 1998). The approach offers ways of measuring people's interactions using the interpersonal circle or circumflex and to address interpersonal problems using interpersonal theory based on the work of Keisler and others in the USA (Keisler, 1983).

Attachment theory initially developed by Bowlby (1969) has also been proposed more recently as a way of conceptualising and understanding the problems of many people with PD. In essence, the argument is that people with PD develop Avoidant and/or Anxious Attachment Styles and very rarely have Secure Attachment Styles. Attachment Theory is quite strongly empirically based and it may have considerable potential for helping develop a conceptualisation of some of the problems of PD. (Adshead, 1998)

Aaron Beck (Beck et al, 1990) and Geoffrey Young (Young, 1990) have developed different versions of Schema-Focused Cognitive Behaviour Therapy in dealing with personality disorders. Beck's approach has been to postulate a number of probable schemas based on DSM-III-R Diagnostic Categories, while Young had adopted a more empirical approach of trying to identify what he calls early maladaptive schemas from a research base. Schemas are essentially core beliefs which people use to interpret their environment and guide their behaviour. Cognitive-behavioural theory postulates that in people with PD there are a number of interacting maladaptive schemas that not only lead to them misinterpreting their environment, but also to maintaining their inappropriate behaviour. Schema Focused Cognitive Therapy has developed as a therapeutic package and is now in wide use for a range of different personality disorders in a range of different settings.

Finally, Trauma Theory has also developed over the last ten years or so to explain the reactions of people exposed to overwhelming and life-threatening dramatic situations (Bloom & Reichert, 1998). Studies of people with PD have shown them to be much more likely to have been exposed to trauma in their past and to suffer symptoms of Post Traumatic Stress Disorder. While much of the research on post traumatic stress disorder has been focused on people with PTSD diagnosis, there is considerable interest in its application to PD. It seems likely that many of their inappropriate beliefs and behaviours may well have had their origin in early childhood abuse and trauma (Hodge, 1992).

These conceptual frameworks, a list that I do not claim to be comprehensive, are already beginning to generate many rich ideas for the development of treatment and prevention approaches that may in the future may have considerable impact on our ability to provide services to people with PD.

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Evidence base

Unfortunately, and partially due to the fact that interest in research in PD is a relatively recent phenomenon, the evidence base for most of the treatments in current use is sparse. This places an onus on all practitioners currently involved in providing services to clients with PD in whatever setting to measure, evaluate and report on the effectiveness or otherwise of their work. In this way we could rapidly develop an evidence-base for practice.

Psychotherapy has long been used in healthcare settings for people with PD. In general this is usually dynamic psychotherapy and based on psychoanalysis or one of its derivatives. Unfortunately, despite the length of time that psychotherapy has been used in this way and despite occasional case reports of successful treatment, there is no body of evidence for the effectiveness of psychotherapy with PD.

Therapeutic communities have also been used a great deal with people with PD and are in current use. The Henderson Hospital and Grendon Prison both use a variant of therapeutic community to deal with people with PD. However,

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most therapeutic communities are highly selective of their participants and the evidence of their long-term effectiveness is unclear. There seem to be some gains while people remain resident within the therapeutic community, but less clear evidence that these gains hold after they have left.

Dialectic Behaviour Therapy is the one treatment which has been subject to a randomised control trial of its effectiveness. In a relatively small study on women who were exhibiting para-suicidal behaviour, DBT was found to lead to therapeutic improvement (Linehan et al, 1991). Unfortunately this was a small study using a fairly narrow range of subjects. At present DBT is used in a much wider range of settings and of patients than its evidence base would support, although research is being done to evaluate its effectiveness in these settings.

Schema-focused Cognitive Therapy shows a great deal of promise, but as yet no controlled clinical trials with PD patients have been published.

Interpersonal Therapy also shows a great deal of promise with PD patients but again no controlled clinical trials have been published which would demonstrate its effectiveness.

Future directions

Clearly there are a number of promising treatments beginning to emerge and our understanding of PD will develop with them. However, it seems to me far too early to commit to any one treatment or conceptual framework of PD and it is very possible that different people and/or different personality disorders (in whatever way they are eventually conceptualised) may well respond to different treatments. Given the accruing evidence that PD is akin to a long term developmental disorder, it is very likely that one component of effective treatment will depend on consistent interpersonal reactions with highly trained staff. As yet we are at a very early stage in developing the training that staff will need effectively to work with people with personality disorders.

It is clear also that there is going to be a long-term need for individually tailored treatment plans since PD is highly complex and variable. Arguably no two people with PD are sufficiently alike to respond to completely identical treatment programmes. However, this tends to be the nature of psychological treatment anyway and it may be that the bulk of treatment could be accomplished in treatment modules, the range and nature of which may vary for different people.

A 'themed' strategy

So what development strategy can we suggest on the basis of our current knowledge of PD and its treatment for the development of a Personality Disorder Service? I am not going to make any comment on whether we should be developing the service within our current institutions or whether it should be developed as a new "third way". However, I do think we have enough information to begin to make some decisions about the necessary qualities that such a service will need to have.

It is clear that there is a range of treatment initiatives currently in development, which show promise in the understanding and treatment of PD. It is far too early to discard any of these, or indeed to discard any yet to be developed. We seem to have a tendency to jump on the bandwagon of single promising solutions. At present therapeutic communities and Dialectic Behaviour Therapy seem to be the favourites. The range and complexity of personality disorder is unlikely to respond to any single solution. It may well be that different types of PD may respond to different types or combinations of treatments or that some of the current initiatives may prove superior to others. The simple fact is that we do not know yet.

On that basis, I would propose that whatever new services develop, they must contain the flexibility for different treatment approaches to be offered. Possibly this might best be done by offering different approaches in different settings so that staff can 'specialise' and become expert in the particular treatment model they offer. A range of treatments in different settings would provide the most appropriate flexibility both to evaluate what it is we are doing and also to identify what interventions show best promise with different types of personality disorder. It goes without saying that each treatment model should be properly evaluated and that a major function of any new service, however organised, will be robustly to research and continuously improve its practices. ■

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