The efficacy of therapeutic communities in the treatment of personality disorders

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What's new?

- In the absence of evidence for the effectiveness of treatments for people with antisocial personality disorder there is growing interest in the role that 'hierarchical' TCs might play in the management of offenders with personality disorders
- Evidence from observational studies suggests that outcomes achieved through short-term and 'step-down' models of care are equivalent to or even better than those obtained with long-term residential treatment in a TC
- The website of the Association of Therapeutic Communities includes a detailed register of TCs and provides a useful resource for professionals considering referral to a TC

What are therapeutic communities?

The term 'therapeutic community' (TC) describes a complex psychosocial intervention for patients with personality disorder. TCs are cohesive groups whose members – staff and patients – participate together in daily decision-making in matters affecting group functions, and in the development and delivery of therapeutic insight to self and others. Communities encourage patients to take responsibility for their own actions, and utilize group interactions such as structured community meetings and catering working parties to explore and critique each individual's presentation, behaviour and underlying attitudes. Communities tend to be led by staff trained in psychotherapeutic approaches.

Strengths of the TC model include its ability to work within the everyday activities and discourse of patients, and the delegation of authority from staff to peer patients, who may be seen as having similar problems and so greater insight and legitimacy. Residents offer empathy and mutual support and can help each other avoid dysfunctional coping strategies, such as self-harming and substance misuse. New residents are likely to experience initial tolerance, sympathy and support, but if they do not appear to strive for change, they will subsequently experience peer pressure and, eventually, expulsion. All TCs require patients to volunteer for admission, since treatment is, by its nature, participatory. Until relatively recently, most TCs were full-time residential facilities, with residents facing a difficult transition to ordinary life at discharge. There are approximately 65 TCs in the UK affiliated to the Association of Therapeutic Communities.[1]

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History and structure

The modern TC movement traces it origins to residential programmes aiming to rehabilitate traumatized military casualties of the Second World War. Rapoport's ethnographic study[2] of the pioneering Henderson Hospital, in Sutton, UK, identified four essential principles of the TC:

- democratization
- permissiveness
- communalism
- reality confrontation.

Residents concede the authority of the community, exercised through democratic voting, and the group provides a tolerant setting in which residents express and work through their own difficulties and those of other community members.

More recently, Haigh[3] identified five universal qualities of a modern TC:

- attachment (sense of belonging)
- containment (safety)
- communication (openness)
- involvement (participation)
- agency (empowerment).

There are three different types of TC (Figure 1), but all tend to be relatively structured. This is because sustaining democracy, and avoiding the dominance of the most assertive, demands a framework for conduct which can deliver equality and continuity, preventing community breakdown as people enter and leave.

Suitability for treatment

TCs serve a diverse client group. Limited research (see below) has made it difficult to be certain who the patients being treated in TCs are, and which respond best to this type of treatment (Figure 2).

'Personality-disordered' best describes the typical patient, but referral criteria for TCs have avoided the medical model, instead emphasizing, for example, dysfunctionality in relationships and employment, distress caused to self and others, dysfunctional coping strategies and experience of abuse. Since treatment is voluntary, many communities accept self-referrals, in which a personal account of the difficulties experienced by the sufferer or

Three types of therapeutic community

Democratic therapeutic community
Within fixed guidelines, decisions (e.g. who to accept, who to expel, day-to-day running of the community) are made by democratic voting; staff have similar voting rights to residents (see Figure 2)

'Hierarchical' secure prison community
Staff have custodial authority over residents, as in a secure prison TC

'Concept' therapeutic community
Substance misuse programme (possibly for offenders). Regulations and restrictions (e.g. about substance avoidance) limit democratic decision-making

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his family takes precedence over a clinical diagnosis. TC staff use the discourse of psychotherapy rather than that of mainstream psychiatry, tending to reject the use of diagnostic categories and pharmacological remedies. The current government emphasis on finding and funding treatments for personality disorder may give practitioners of mainstream psychiatry a greater incentive to develop relationships with TC practitioners.

It is a requirement of most TCs that referred patients are of at least average intelligence and do not have major psychiatric illnesses; and that residents sign up to a 'contract' of rules (commonly these are: no sex between residents, no alcohol unless sanctioned by the community, no drugs unless prescribed, no aggression, and attendance at specified sessions). The penalties imposed for contravening these rules, and the extent to which the community will try to dissuade a person from discharging her- or himself, are other variables among TCs.

Recent calls for services for personality-disordered patients[4] and offenders with dangerous and severe personality disorder (DSPD; see also pages 23–5) have revived interest in commissioning TCs, but TCs continue to suffer from low referral numbers and high levels of attrition in both community and forensic settings.[5] Campbell's review[6] of HMP Grendon found only 25 prisoners on the waiting list for a 230-place service, with only 19% of patients meeting their treatment aims at the end of treatment, and many choosing to return prematurely to mainstream prison. Early exit from TCs is a major problem for referrers, who feel that time spent on referring and motivating their patients is wasted if they leave the service prematurely.

A qualitative and quantitative exploration[7] among premature drop-outs from treatment from the Cassel Hospital TC in Richmond, UK, found that ex-patients had left for a number of reasons:

- unrealistic expectations of staff
- inflexible routines that patients could not change
- lack of privacy
- too much responsibility for other patients
- a subculture of intimidation.

The study raises questions about the relativity of a phrase such as 'democratic', but the providers' willingness to publish the findings suggests a real intention to tackle these issues. The researchers found that those with high occupational status and borderline personality disorder pathology were more likely to stay in treatment, raising additional questions about the suitability of the existing TC model to treat all social classes, ethnic groups and personality clusters. Diversity among people in TC treatment is a neglected area for research.[8]

Distinctions between therapeutic communities

TCs have variable criteria: some permit residents to continue established drug treatments (aimed at mood stabilization, reduction in aggression or affective disorders); others believe psychotropic drug treatments are incompatible with psychodynamic techniques. Some TCs require a drug- or drink-free period before entry, while others ('concept' TCs) incorporate elements of a 12-step addiction recovery programme and are designed to support the rehabilitation of those with substance misuse problems. Some have tertiary funding status (with places effectively funded for any referrals accepted by the service), while others depend on private subscription or health authority funding. Some TCs offer induction and follow-up services or support groups, others actively discourage ongoing contact after discharge because it may foster dependence.

Suitability of patients for treatment in a democratic therapeutic community

Suitable

- Patients with borderline personality disorder (BPD) commonly suffer affective (depressive and anxious) symptoms for which they may consult a GP; they may also resort to self-harm, substance misuse and eating disorders which bring them into contact with medical services. BPD patients may well constitute the core client group of the TC
- Patients with an anxious or obsessive personality type (Cluster C) may also be amenable to TC treatment if their behaviour is sufficiently controlled to permit them to live in a community context

Unsuitable

- Individuals who exhibit severely antisocial traits would generally be excluded from TCs (except in prison settings) because of the risk they may represent to others. In the UK, HMP Grendon has since 1960 offered secure TC treatment to a population with severe antisocial disorders, and takes voluntary referrals from convicted offenders serving a custodial sentence of at least 2 years[4]
- Treatment in a TC is unlikely to be sought out or tolerated by people with schizoid and paranoid personality types (Cluster A personality disorders)

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