

# The Longer-term Clinical Outcomes of a DBT-informed Residential Therapeutic Community; An Evaluation and Reunion

Mark McFetridge and Julia Coakes

*ABSTRACT: A new synthesis of therapeutic interventions (dialectical behaviour therapy within a therapeutic community) developed from the growing evidence of positive outcomes for these apparently distinct approaches for people with the complex difficulties currently considered to represent a borderline personality disorder. All clients who joined between 2000 and 2007 completed a brief self-report measure and gave information about their experience of therapy. With the questionnaire, they received an invitation to a reunion group/day to further share and discuss their experience. Participants were women from across the UK with a history of severe self-harm and self-defeating behaviour. People responding to postal contact included those who left without completing the therapy programme. Responders were indistinguishable from those who did not respond on a range of indices. However, there was a clear difference between those women who completed the programme and those who had not at a mean follow-up period of five years. Those completing therapy had highly significant reductions on the CORE-OM in contrast to those not completing, who did not improve on this measure. Further qualitative analysis of written and verbal responses using interpretative phenomenological analysis indicated three major themes concerning change for clients: changes in sense of identity, changes in life, and changes in thinking. The longer-term changes in individuals that may be attributable to participating in a DBT-informed therapeutic community are explored.*

## Introduction

Dialectical behaviour therapy (DBT) (Linehan, 1993) and the therapeutic community (TC) (Kennard & Haigh, 2009) are employed as clinical approaches for people with the range of affective and interpersonal difficulties that meet current diagnostic criteria for borderline personality disorder (BPD) (American Psychological Association, 1994). These individuals typically report sudden, intense emotional experience that is slow to subside. This can often result in external attempts to modulate overwhelming arousal, e.g. self-harm or substance

---

Mark McFetridge and Julia Coakes are at The Retreat, York, UK.  
Email: [mmcfetridge@theretreatyork.org.uk](mailto:mmcfetridge@theretreatyork.org.uk)

*therapeutic communities, 31, 4, winter 2010*  
© The Author(s)

misuse, or internal emotional strategies, e.g. dissociative states. People also report repeating patterns of difficult relationships with others, which may be related to their experience of alternating between intense feelings of love, sadness, shame, and fears of rejection and abandonment.

These individuals frequently report a history of traumatic experience, particularly childhood sexual abuse (Herman, 1994), likely to have had an adverse effect on psychological and interpersonal development, and their capacity to emotionally self-regulate. Not all individuals diagnosed with BPD report a history of sexual abuse, however; and not all who have this history develop BPD. Classen, Pain, Field and Woods (2006) proposed a distinction between individuals with BPD based on the severity of their traumatic experience and childhood attachment patterns. They suggested the subgroup that had more chronic experiences of childhood trauma within a disorganised attachment (termed 'post-traumatic personality disorder-disorganised') had a different range of problems (including more interpersonal problems) from those with a disorganised attachment pattern reporting less severe abuse. These authors considered a disorganised attachment pattern to be the underlying pathology in people with BPD.

Linehan (1993) theorised that the inter- and intrapersonal difficulties of an individual with BPD are primarily due to emotion dysregulation, in turn a result of the complex interaction between biology and learning derived from an early invalidating environment.

## **Therapeutic communities**

The TC approach has a heritage stretching back many years. The underpinning theory and practice of Group Analysis initially emerged from pragmatic attempts to provide therapy for an overwhelming number of psychological casualties of the Second World War (see Campling & Haigh (1999) for a history of the TC).

An early form of TC may have preceded this in the relational approach to therapy termed 'Moral treatment', developed from the fundamental values of the Quakers and practised at the Retreat in York from 1796 (see Borthwick et al., 2001). Modern TCs share many of the characteristics and assumptions of Moral treatment, including an emphasis on equality and social responsibility, and an assumption that therapeutic changes result from living and learning together as a community. TCs have increasingly provided therapy for those who meet diagnostic criteria for Personality Disorders (PDs). There is evidence of the clinical and economic effectiveness of TCs for these clients (Lees, Manning & Rawlings, 2003), and a Randomised Control Trial (RCT) of a TC is underway. The TC can be considered less a treatment approach of itself, but more a flexible container for other specific treatments. TCs have traditionally been married to specific treatments from within the psychodynamic school; however, there is no reason this cannot be extended to more recent cognitive behavioural modalities.

## Dialectical behaviour therapy

DBT is a relatively recent therapeutic approach, outlined in detail by Linehan (1993). It is a highly structured treatment informed by learning theory and behaviour therapy, and a systemic understanding. At the time of development, novel elements of DBT included contributions from dialectical philosophy and Zen Buddhism. DBT aims to address both the problems of people diagnosed with BPD, and the problems therapists have in sustaining therapy with these individuals. In addition to a series of skills learning modules delivered in groups to clients, there is a structured staff group (known as the 'consultation group'), which further develops therapeutic skills and attends to the feelings and behaviour of the staff team. In common with the TC approach, DBT extends systemic understanding to the staff team as a central feature of effective therapy.

An RCT undertaken by Bohus et al. (2004) compared three months' inpatient DBT with a waiting list. Thirty-nine clients with BPD received DBT whilst nineteen remained on non-specific outpatient treatment/waiting lists. Those receiving inpatient DBT reported, at four weeks post-discharge, having significantly improved in their depression, anxiety, interpersonal functioning, social adjustment, global psychopathology, and self-mutilation. The authors concluded that 42% of those receiving DBT had clinically recovered on a general measure of psychopathology. The waiting list group made no such improvements. No follow-up data were provided to examine whether these gains were maintained following discharge. Given the investment of clients, staff and health care resources to such intensive services, the issue of longer-term client gain cannot be ignored.

A further RCT undertaken by Van den Bosch, Koeter, Stijnen, Verheul and van den Brink (2005) followed up female clients diagnosed with BPD six months after DBT. Fifty-eight clients were randomly assigned to either one year of outpatient DBT ( $n=27$ ) or treatment as usual (TAU). Six months post-therapy the DBT group had sustained reductions in levels of parasuicidal and impulsive behaviours and in alcohol use compared to the TAU group. There were no such benefits for clients abusing drugs. The authors concluded that DBT appeared to have a sustained effect on some of the core symptoms of BPD, and on misuse of alcohol. They expressed caution in assuming these benefits would be sustained further without additional DBT therapy however, and noted the serious and persistent nature of the problems people experience associated with BPD.

Some researchers have however suggested there is significant remission in people diagnosed with BPD. Zannarini, Frankenburg, Hennen and Silk (2003) reported 68.8% of their sample of clients with BPD, admitted in crisis for the first time, no longer met full diagnostic criteria six years later. Zannarini et al. (2003) found the 'acute illness' symptoms including self-harm and suicidal attempts were the most likely to improve. However, two-thirds of the sample reporting the affective symptoms of chronic feelings of anger or emptiness, suspiciousness, difficulty tolerating being alone and abandonment fears still reported these six years later. There were 11 suicides (3%) among Zannarini et al.'s (2003) sample of 362 people.

Whilst increased hope of change for clients with BPD would be welcome (and no doubt therapeutic in itself), clinicians should be cautious in drawing conclusions from this and similar studies. Typically, people with BPD referred to residential services in the UK have had numerous or protracted acute psychiatric admissions and a clinical history exceeding six years since first admission. People referred to specialist residential services may therefore represent a more pathological and entrenched group.

The National Institute of Clinical Excellence (NICE) report on self-harm in July 2004 concluded 'For people who self-harm and have a diagnosis of borderline personality disorder, consideration may be given to the use of dialectical behaviour therapy.' In the absence of sufficient data at that time, particularly at follow-up, DBT remained only a suggested therapeutic approach. NICE's 2009 report on borderline PD recommended more clearly 'For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme.'

There is a need to further examine the longer-term effectiveness of therapeutic approaches for this client group, particularly those who are unlikely to remit. Some have argued such research should be practice-based evidence of 'real' and complex clients and of actual clinical services (Lucock et al., 2003) rather than data derived from randomised controlled trials.

## Method

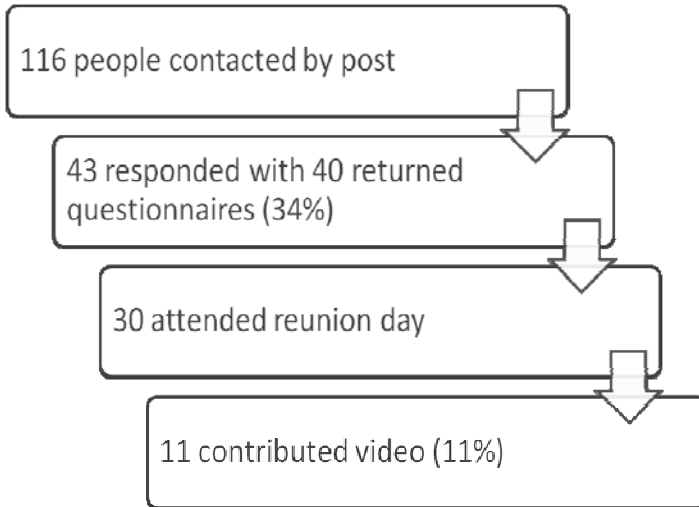
The idea of a reunion group emerged from the TC staff team discussion about clinical outcomes and research. Further consideration and the effective containment of staff team anxieties resulted in an invitation being sent to every client who had joined the programme between 2000 and 2007, irrespective of whether they completed the programme. The letter of invitation also included two questionnaires and a paid return envelope. The Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) was employed (Barkham, Gilbert, Connell, Marshall & Twigg, 2005), together with a semi-structured questionnaire. This requested details of subsequent hospital admissions, medication changes and life events, and invited an account of how life compared now with prior to joining the DBT-informed TC. Recommendations for programme improvements were also sought. Ex-clients were also informed that they would be able to make a video about their experiences and reflections of their therapy if they chose (alone or in groups), if they were able to attend the reunion day.

## Sample

Of the 116 contacted, 40 individuals (34%) returned questionnaires. The mean age of ex-clients on admission was 31.5 years ( $sd=9.8$  yrs) and ranged from 18 to 59 years. All were state-funded specialist residential referrals from England, Northern Ireland and the Channel Islands. Virtually all clients had been referred

with an Axis-II diagnosis (DSM-IV) of BPD (96%). There was a mean of 7.5 years since first psychiatric admission.

**Figure 1: Reunion group sample of a DBT-informed TC**



The majority of clients were taking psychotropic medications on referral and on joining the TC. Existing medication was maintained initially, following which there was a negotiated reduction. Over 85% of clients joined the DBT-informed TC informally; however, occasionally, clients were still formally detained on admission. All such clients committed themselves to the therapy programme following an assessment period (two weeks) and agreed to become informal residents.

The average time elapsed since leaving the programme was 60 months (range of 5–80 months).

### **Therapeutic intervention**

The typical length of residential therapy within the DBT-informed TC was eight months, with a maximum duration of twelve months. Clients received twice-weekly DBT skills training groups and weekly individual DBT diary-focused interventions. They also participated in twice-daily community meetings, twice-weekly group-analytic therapy groups and a weekly individual therapy session with a clinical psychologist (MM) or psychotherapist. Individual therapy sessions aimed to initially address any difficulties experienced within the community group, encouraging people to return and discuss this within the group. Subsequently, where appropriate, individual therapy then focused on reducing post-traumatic stress responses, known within DBT as ‘stage 2 work’.

## Staff training and supervision

The majority of staff had completed the DBT intensive training programme. To facilitate therapist adherence to DBT there was a weekly staff consultation team meeting. In addition, all staff received weekly group supervision facilitated by an external group analyst. Staff received training in group therapy and group dynamics provided by a group analyst.

## Quantitative data analysis

Ex-clients providing follow-up data (questionnaire and video) could not be distinguished as a group from those who did not provide data by age or pre-therapy CORE-OM. They did, however, receive significantly longer therapy, i.e. they were less likely to have dropped out of therapy prematurely; 62% of those providing follow-up completed planned therapy.

Pre-therapy (assessment) and post-therapy CORE-OM scores were compared for ex-clients who had completed therapy, and those who had left prematurely. T-tests were used to assess the statistical significance of differences between subgroups and time points. Distributions of the CORE-OM scores are presented in 'box and whisker' plots in Figure 2. The central box represents 50% of the distribution, with the median (average) score at its centre, and the remaining 50% being represented by the outer lines ('whiskers'). Any outliers are represented by a single point.

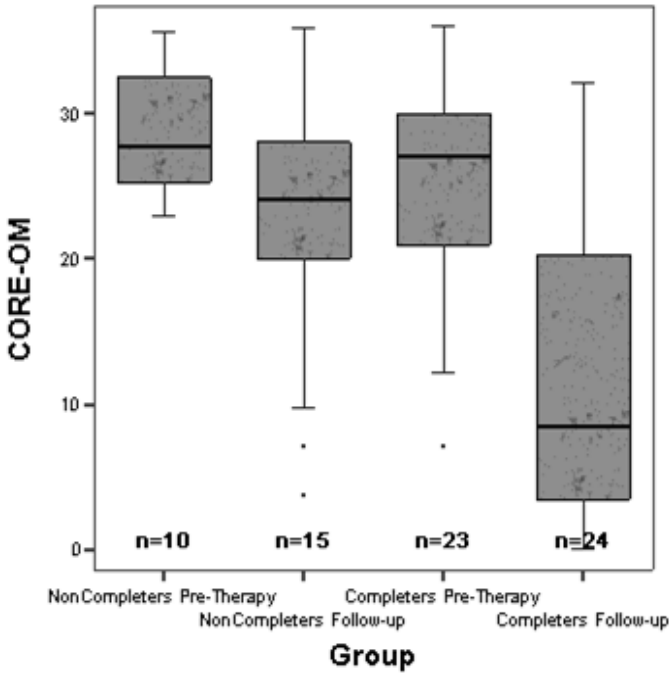
## Quantitative results

There were highly significant reductions in the CORE-OM scores of ex-clients who completed therapy on follow-up ( $t=5.59$   $df=22$   $p=.0001$ ). The CORE-OM scores of ex-clients who completed therapy were significantly lower than those of ex-clients who had not completed the programme ( $t=3.16$   $df=37$   $p=.003$ ).

There were no significant differences between the two groups at pre-therapy, and no significant change in the CORE-OM at follow-up of those ex-clients who did not complete the programme.

Those people completing the DBT-informed TC programme reported fewer subsequent admissions to psychiatric hospital and fewer psychotropic medications (mean number of meds=1.08/1.5) than those who did not complete therapy.

**Figure 2: CORE-OM for clients completing/not completing therapy at pre-therapy and follow-up (updated CORE scoring system x10)**



### Qualitative data analysis

Video recordings were anonymised and transcribed. The qualitative data from both the video and semi-structured questionnaires were analysed using Interpretive Phenomenological Analysis (IPA) (Conrad, 1987). This was considered the most appropriate method of analysis as it is traditionally used to explore the insider’s perspective and focuses on the participant’s view of the world. IPA is grounded in a phenomenological approach and as such is concerned with the personal perceptions or accounts of experience. It does not seek to provide an objective statement of truth. This analysis was conducted by the author (JC) who has received training in, and undertaken doctoral research employing IPA. The validity of these interpretations was further explored using a suitable triangulation approach. In order to enable this, two ex-clients were trained to use IPA and then independently analysed the data. The themes they discovered were compared to those determined by the author. There was 100% agreement between staff and ex-client researchers on all themes. Themes identified represent the end product of this process.

## Qualitative results

Figure 3: Superordinate and subordinate themes

Superordinate theme	Subordinate theme	Example quotes
Changes in sense of identity	Pride and self-respect	'I enjoy being who I am and where I am.'
	Increased awareness of impact on others	'You actually consider the impact it has on other people.'
	Being responsible in own life	'I'm responsible as much as anyone else for the way my life ended up going.'
	Toleration of aloneness	'In fact I do loads of things on my own, and in a way I feel that one small action liberated me.'
	Having feelings	'[It] allowed me my feelings and emotions, good or bad.'
	Self-acceptance	'Allowed me to ... live with myself and the world.'
	Optimism for their future	'We can now walk out into life [and] ... look forward and enjoy.'
Changes in life	It's saved my life	'I really think without the programme I wouldn't be alive.'
	Being able to cope with life differently	'Being more able to cope with the sh** life throws up.'
	A job or education	'I now work full-time as a college secretary and study part-time.'
	Relationships - starting, ending and trusting	'I have a better relationship with my parents.' 'I have an amazing relationship with my nurse and psychologist - we can now talk!'
	More physical complaints	'Deterioration in physical health.'
Changes in thinking	Knowledge of own problems	'Gave me an insight to what goes on in your head.'
	Knowing you can talk about problems	'Being able to say to people I need support.'
	Self regulation/ inhibition of impulses	'I am now more in control of my self-harm ... my attitude has changed.'

Ex-clients provided a wealth of data that is not usually available. It is important to note how qualitative themes mirror the changes seen in the quantitative data, but also add to it. Of particular interest was an increase in physical problems noticed by a number of clients. Whether this is a change of focus from mental health to physical health or represents physical vulnerabilities in the client group is unclear.

A further significant part of the qualitative data-gathering process was the clients' description of the process of change. It was described by the majority of those involved as a very difficult and painful process, as well as being useful. Examples of quotes on this subject include: 'I have faced my demons, felt the pain and now I am a long way down the road to recovery,' 'Very traumatic challenging process but very necessary.' These experiences are important to consider when examining the premature leaving of therapy, but are also potentially helpful in preparing new clients for the therapy ahead in the DBT-informed TC.

## Discussion

The quantitative and qualitative data presented support the effectiveness of a DBT-informed residential TC for clients previously diagnosed as having a BPD. Gains were evident at long-term follow-up at an average of five years following completion of therapy.

As the study lacks a true randomised control group, conclusions should be drawn with a degree of caution. There is growing evidence of the therapeutic benefit of both DBT and TCs for people receiving a diagnosis of BPD. However, DBT has been criticised for producing only behavioural change (reductions in self-harm and suicidal acts) rather than personality change. It might be anticipated that a comprehensive DBT programme within the framework of a TC that emphasises living together and learning from peer relationships would be effective in facilitating more fundamental changes. Qualitative data presented suggest changes in clients' sense of identity, in important aspects of their life and relationships, and in ways of thinking in addition to any behavioural change. However, further data are required to fully examine changes in personality functioning and diagnosis as a consequence of the DBT-informed TC.

Whilst these individuals would appear to have benefitted, it is possible that ex-clients could have derived even greater benefit from a different therapy programme. This could only be examined by comparing clients who had been randomly assigned to alternative therapies. However, this methodological approach may have its own limitations, as 'what works for whom' could (still) be key to maximising therapeutic effectiveness in service provision. It is possible that those who left the DBT-informed TC prematurely are those who are less likely to benefit from this form of therapy. There is some qualitative and quantitative evidence from this sample to support this possibility.

The assumption that trauma memories need to be directly processed via exposure in individual therapy could be usefully examined in relation to overall therapy gains and fundamental positive change. The relationship between outcome, clients' trauma histories and whether this was addressed during therapy

would be interesting to explore further. As many clients have a complex array of factors contributing to their clinical and life difficulties, it is possible that complex post-traumatic responses may be ameliorated indirectly, e.g. through developing an adaptive sense of control in one's life rather than one based on self-directed violence. Further exploration of this and other areas discussed is warranted.

Particular limitations of this study include the small sample of ex-clients and a restricted range of outcome measures; a longitudinal study incorporating a range of measures with clients over the period of a decade would be informative.

## Conclusions

An intensive group-based inpatient therapy programme utilising DBT within a TC was effective in reducing psychological symptomatology in people diagnosed with BPD. Improvements were evident at a mean follow-up period of five years following completion of therapy. Ex-clients also reported more fundamental improvements in their thinking/impulse control, life and relationships, and sense of identity.

Despite the relatively small numbers of participants, this study demonstrates the association between qualitative and quantitative outcome data and the utility of this combined approach to exploring clinical outcomes in TCs. Given the nature of the likely therapeutic agent in TCs, it is suggested this combined data strategy should be employed in future studies. In addition, the structure of a reunion group is a particularly appropriate method for TCs.

Longitudinal studies combined with longer-term follow-up intervals are important in assessing clinical outcomes in people diagnosed with PDs, and in TCs in particular. Substantial clinical change in recovery, beyond symptom improvement, can only become evident if it is enquired upon.

## Acknowledgements

The authors are grateful to Sarah Hardy and Katie Galvin for their assistance, and to Prof. Chris Leach for his statistical assistance.

## References

- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of mental disorders* (4<sup>th</sup> ed.). Washington, DC: APA.
- Barkham, M., Gilbert, N., Connell, J., Marshall, C. and Twigg, E. (2005). Suitability and utility of the CORE-OM and CORE-A for assessing severity of presenting problems in psychological therapy services based in primary and secondary care settings. *British Journal of Psychiatry*, 186, 239–246.
- Bohus, M., Haaf, B., Simms, T., Limberger, M.F., Schmahl, C., Unckel, C., Lieb, K. and Linehan, M. (2004). Effectiveness of inpatient dialectical behavioral therapy

- for borderline personality disorder: a controlled trial. *Behaviour Research and Therapy*, 42(5), 487-499.
- Borthwick, A., Holman, C., Kennard, D., McFetridge, M., Messruther, K. and Wilkes, J. (2001). The relevance of moral therapy to contemporary mental health care. *Journal of Mental Health*, 10(4), 427-439.
- Campling, P. and Haigh, R. (Eds.) (1999). *Therapeutic Communities; Past, Present and Future*. London: Jessica Kingsley.
- Classen, C., Pain, C., Field, N. and Woods, P. (2006). Posttraumatic Personality Disorder: A Reformulation of Complex Posttraumatic Stress Disorder and Borderline Personality Disorder. *Psychiatric Clinics of North America*, 29, 87-112.
- Conrad, P. (1987). The experience of illness: recent and new directions. *Research in the Sociology of Health Care*, 6, 1-31.
- Dolan, B., Warren, F. and Norton, K. (1997). Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry*, 171, 274-279.
- Herman, J. (1994). *Trauma and Recovery; from domestic abuse to political terror*. Pandora.
- Kennard, D. and Haigh, R. (2009). Therapeutic Communities. In M. Gelder (Ed.) *The New Oxford Textbook of Psychiatry (2nd ed.)* (Chap 6.3.9; pp. 142-148). Oxford: Oxford University Press.
- Lees, J., Manning, N. and Rawlings, B. (2004). A Culture of Enquiry: Research Evidence and the Therapeutic Community. *Psychiatric Quarterly*, 75(3), 279-294.
- Linehan, M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: The Guilford Press.
- Lucock, M., Leach, C., Iveson, S., Lynch, K., Horsefield, C. and Hall, P. (2003). A Systematic Approach to Practice-Based Evidence in a Psychological Therapies Service. *Clinical Psychology and Psychotherapy*, 10, 389-399.
- National Institute of Clinical Excellence (2004). Self-harm - The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. *NICE Clinical Guideline*, 16.
- National Institute for Health and Clinical Excellence (2009). Borderline Personality Disorder: treatment and management. *NICE Clinical Guideline*, 78.
- Van den Bosch, L., Koeter, M., Stijnen, T., Verheul, R. and van den Brink, W. (2005). Sustained efficacy of dialectical behaviour therapy for borderline personality disorder. *Behaviour Research and Therapy*, 43, 1231-1241.
- Zannarini, M., Frankenburg, F., Hennen, J. and Silk, K. (2003). The Longitudinal Course of Borderline Psychopathology: Six-Year Prospective Follow-up of the Phenomenology of Borderline Personality Disorder. *American Journal of Psychiatry*, 160, 274-283.