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**ECONOMIC GRAND ROUNDS:
TREATMENT OF PERSONALITY DISORDERS
IN AN ERA OF LIMITED RESOURCES**

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Our field is at a moment of great excitement, opportunity and risk. Faced with the reality that resources for treatment have limits, a revolution in funding of mental health benefits has begun. In order to contain costs new strategies are emerging, like capitation, case rates, case management and utilization review, that closely limit or oversee treatment provided and/or ask providers to bear the financial risk of treatment. The attention of psychiatrists has been powerfully drawn to the financial arena, where the introduction of close management of benefits has introduced a sometimes dizzying array of hoops through which a clinician must leap, dragging the patient behind, in order to persuade a case manager or utilization reviewer that a particular treatment is indicated. Quality is in danger of falling by the wayside in favor of cost containment as the watchword by which clinicians practice their art.

The impact of managed care on psychiatry has the potential for positive effects through better resource management, but the turning of psychiatrists' attention away from quality to cost containment is worrisome if it means only minimal treatment will be authorized for patients. A recent Rand Corporation study of prepaid versus fee for service mental health benefits showed that depressed outpatients in prepaid plans were more likely to acquire new limitations in role or in their physical functioning than those treated in a fee for service model (1). The authors suggest that the presence of Axis II disorders may account for the finding. The shift to new reimbursement strategies is here to stay, but we ought to pay attention to the clinical consequences. One danger, which may explain some of the Rand Corporation study findings, is the way many of the new reimbursement strategies leave the patient out of the terribly important negotiations around the treatment plan and its funding. The crucial clinical and financial dialogues about treatment have increasingly been reassigned to the doctor or other clinician and case manager, without the patient's true participation. This has the potential to leave the patient in the position of being a passive recipient of treatment, rather than an active agent in it (2).

This may work fine for the treatment of medical or surgical problems, and may even work reasonably well for treatment of a number of Axis I psychiatric disorders uncomplicated by Axis II comorbidity, like major depression, when a defined syndrome is well treated with medication and/or psychotherapy. However, leaving the patient out of the negotiation process is ill advised in the treatment of Axis I disorders comorbid with personality disorders or in the treatment of pure personality disorders. After all, by definition personality disorders reflect chronic impairment in adaptive functioning in social, interpersonal and/or occupational roles. They are manifest by repeated and enduring patterns of behavior that often induce marked consternation in treaters. This consternation is usefully understood as countertransference. For the most part, personality disorders do not respond well to treatment plans based primarily on medication (3). In fact, personality disorders can be understood as involving an admixture of maladaptive traits into the identity of the patient, so that the borderline patient's impulsivity or rage proneness or fear of abandonment can scarcely be separated from the rest of their personality, unlike the depressed patient's neurovegetative symptoms. As a result, it is ill advised to leave a patient with a personality disorder out of the dialogue about treatment or to spare them from experiencing the financial tension to provide treatment within the limits of available resources, because one clear goal of treatment for these patients is enhancement of the capacity to adapt better to the reality of resource limitation.

Understanding the Clinical/Financial Interface

This point of view suggests that the most appropriate treatment approach to personality disorder patients includes interpretation of the meaning of maladaptive behaviors within a collaborative therapeutic alliance that is part of a multidisciplinary treatment approach. Certain psychodynamic concepts are crucial to understanding and working with these patients. These include the concepts of countertransference, mentioned above, and of enactment, a modern reworking of Freud's "repetition compulsion." Personality disorder patients constantly repeat and reenact scenarios from their past which reflect their core issues, as when the borderline patient

with a history of abuse repeatedly experiences revictimization in the present, including, especially importantly, in the transference. The interpretation of the meaning of these transference enactments and of the accompanying countertransference responses is central to the clinical approach to personality disorder patients described herein, regardless of whether the treatment is of long or short duration. Treatment is a collaborative endeavor with a patient who is an active agent, with responsibility for utilizing limited resources to improve his or her capacity to adapt to reality.

It is not often easy to persuade case managers in managed care companies that personality disorder patients are worth treating. The least sophisticated points of view regard borderline and other personality disorder patients as if they were willfully choosing to be ill and could straighten out any time, or as chronic and hopeless. A more enlightened view recognizes the suffering and disability of these patients, their 5 to 10% lifetime suicide risk (4, 5) and the reasons for therapeutic optimism (4, 6-8). Clinicians must carefully steer their way through the numerous pitfalls in treatment of personality disorders in an era of resource limitation. Well meaning clinicians may unhelpfully join a patient in projecting blame onto a payor (whether parent, insurer, HMO or case manager) as if resource limitation should not exist. Other clinicians may abdicate their therapeutic role by projecting blame onto the patient for engaging in recurrently maladaptive behavior (i.e., for having a personality disorder at all) instead of getting better within the time frame “authorized.” Finally, other clinicians are in danger of blaming themselves for not having a quick fix for chronically maladaptive patterns, feeling frustrated, guilty and defeated. As a result, a treatment plan may be developed which omits the personality disorder altogether. The remainder of this column describes a strategy developed at the Austen Riggs Center for focusing on the resource limitation as an opportunity for new learning and for a patient's better adaptation to reality.

The Rate Review Committee

At the Austen Riggs Center, an up to date continuum of psychiatric treatment from inpatient through outpatient programs that specializes in psychodynamically based work with treatment resistant patients, a clinical/financial interface group called the rate review committee was formed in 1991. This group is composed of the Chief Financial Officer (CFO), the Utilization Review Coordinator, the Clinical Director (a psychiatrist with an internal focus,) and the Director of Admissions (a psychiatrist with an external boundary focus.) The task of this group is to define the clinical issues in patients' resource limitations and to help therapists bring these issues into the individual therapy through interpretation. This task is achieved by finding a way to include the patient as an active agent who feels the tension between his or her need for treatment and the limitation of resources. The intent is to provide patients an opportunity to enhance their adaptation to reality. When the tension over resource limitation is left with the provider or, for that matter, with the payor, the patient has been abandoned and put in a passive position which does nothing to enhance growth or adaptation. The functioning of the rate review committee is best illustrated by the specific clinical examples which follow:

Mr. A, a 25 year old man with a mixed personality disorder with narcissistic and dependent traits and a generalized anxiety disorder, was admitted to a thirty day treatment and evaluation program at Riggs because of overwhelming anxiety and a collapse of the ability to care for himself. This man had been the only child of an intrusively overprotective mother, who anticipated his every need, and a paranoid father, who had warned the patient not to trust anyone. The patient's father died when Mr. A was quite young. Mr. A was bright, earning bachelors and graduate degrees. As if in reaction to his mother's overprotectiveness, although born on one coast, Mr. A attended college on the other and graduate school overseas. Mr. A earned exciting overseas job opportunities, but the same pattern kept unfolding in each job. After a period of good functioning and success he would suddenly and inexplicably become overwhelmed with anxiety, then become unable to meet his own bodily needs, including forgetting to eat or use the bathroom, spending days prostrate on the floor of his apartment. When several trials of outpatient

treatment and numerous medications proved of no help, Mr. A sought admission to Riggs. The admitting doctor pointed out that the patient's symptoms of anxiety and inability to meet his own bodily needs for nourishment, sleep and excretion were like a cry for his mother once again to be there anticipating his every need. At the time of admission Mr. A was told that, when insurance benefits ended, he would likely again find it difficult to meet his own needs and might expect others to meet them for him. Mr. A had trouble grasping any significance in this prediction.

After the patient's month of insurance benefits was exhausted he had made gains, but wanted to stay in treatment for another two months. Mr. A and his therapist asked the rate review committee to provide a fee reduction for Mr. A's mother, who would pay for additional treatment. Mr. A's therapist felt that he was making progress and that this plan was clinically appropriate. The CFO, concerned about the census and eager to provide an environment in which patients could continue in longer term treatment through fee reductions, was inclined to grant the request. In the rate review committee, though, a clinician member pointed out the missed opportunity for interpretation and improvement in adaptive functioning that would come from simply granting the request. By asking the hospital to grant a fee reduction to his mother so that she could pay for his continued treatment, Mr. A was reenacting the lifelong pattern of inviting his mother's overprotective but inevitably infantilizing rescues, which deprived him of the experience of struggling to meet his own needs. Further, not only would his mother be spending some of her retirement savings to meet his needs, but the hospital would also be sacrificing for Mr. A by offering a fee reduction. The admitting doctor's prediction had come true.

It was suggested to the therapist that this be interpreted to the patient. Mr. A was reminded of the admission prediction and was advised to step down to a less expensive program that required more autonomous functioning as a way of continuing treatment, while preserving some of his mother's resources. The hospital offered a modest fee reduction appropriate to the mother's financial status. As part of the package, the patient was expected to get a job in order to

contribute toward the cost of treatment. Although he initially protested that his mother owed him more because of bad parenting, Mr. A was able to hear the interpretation. He made the appropriate moves, and found and held a job which allowed him to be an active participant in his treatment, rather than simply blaming his mother for her overprotectiveness, while demanding that she continue to meet his needs. It is now more than two years since Mr. A was discharged. He is working, self-supporting and no longer in treatment.

Ms. B was a 52 year old divorced woman with recurrent major depression, a borderline personality disorder and a history of severe and recurrent sexual abuse. As a young child she was sexually abused by a clergyman and a family member. Her mother did not believe Ms. B when she reported this. The patient married quite young as a means of escape from home. Her husband was sexually demeaning and physically and emotionally abusive. On one occasion early in the marriage the patient was raped, then told her husband, who beat her up, protesting that it must have happened because she wanted it to. The patient eventually left the marriage and completed college. She was able to function marginally as a human service worker in part because of an enduring, stable relationship with a lover. When the patient developed a physical illness, the relationship with her lover began to fail. Ms. B began a spiral of self-destructive and suicidal behavior with multiple short-term hospitalizations. Eventually Ms. B made a highly lethal suicide attempt by an overdose in the woods, surviving only because she was found accidentally by hunters. Ms. B was referred to Riggs for treatment.

In addition to a borderline personality disorder, a post-traumatic stress disorder and recurrent major depression, Ms. B manifested brief paranoid delusional episodes. She was particularly fearful of men and had difficulty interacting with male patients or providers. Ms. B's treatment was followed closely by an enlightened case management company which supported treatment at the Center for a number of months as the patient made gradual gains, but with frequent setbacks heralded by transient paranoid episodes. After extended treatment, though, a new case manager imposed a retroactive denial of months of benefits and insisted on discharge. The Center's CFO

was prepared to recommend discharge, feeling that the treatment had unraveled financially. The therapist felt strongly that the patient was making gains, urging the rate review committee to offer free treatment because the patient would be unable to function in outpatient treatment alone. The Utilization Review Coordinator noted the patient met criteria for continued treatment in at least a partial or residential level of care.

In rate review committee discussions it was noted that Ms. B was being treated as if too fragile to be an active agent in dealing with her predicament. It was recommended that the therapist include the patient in discussions, treating her as someone who had the ultimate stake in the resolution of this financial crisis in the treatment. It was also noted to the trainee therapist that the sudden and arbitrary termination of benefits was another instance of abuse of the patient. When the therapist reframed and interpreted the situation as the patient's predicament, Ms. B spontaneously noted that this sudden retroactive denial felt like the kind of abuse that she was determined not to put up with again. Ms. B felt she had gained enough in treatment to see the way she repeatedly passively submitted to revictimization, and was determined not to let this happen again. Ms. B decided that, if necessary, she would hire an attorney to fight the denial of benefits. With the support and help of the rate review committee, a detailed appeal letter was written to the case management company by the therapist and patient. The letter presented a careful explanation to the case management company of how the sudden retroactive denial of benefits was inevitably and realistically experienced by the patient as another episode of abuse, enacting her core dynamic paradigm. During the extended appeal process the rate review committee agreed to carry the financial risk of Ms. B's ongoing treatment because she had no resources beyond her insurance. The case management company psychiatrist who reviewed the appeal agreed with the Center's treatment plan and reversed the retroactive denial of benefits. More than a year later, Ms. B has been discharged and is functioning well in outpatient treatment still supported by the case management company.

Conclusions

These examples illustrate clinical instances in which the rate review committee was able to identify the latent clinical enactment buried in the manifest financial issues that emerged in each case. In each case an effort was made to bring the patient into the process in a way that [1] encourages the patient to experience the tension of the financial difficulty, while [2] interpreting the underlying enactment in a way that helps the patient discover meaning in his or her life situation, take ownership of the treatment, exercise authority and adapt better to reality. The rate review committee approach need not be applied by a committee, although this may be helpful within institutions. Our experience suggests that once introduced to the concepts involved, most clinicians can develop the capacity to include this approach in their work with patients.

The meaning of issues buried in the clinical financial interface is too important to allow to become invisible in a changing health care reimbursement system. We must not let patients be excluded from the opportunity to grapple with the way issues related to resource limitation may represent enactments of underlying clinical issues. Use of the approach described here with outpatients, as well as with patients in residential or hospital settings, offers them an opportunity to grapple with the determinants of these problems in a way that can lead to resolution, growth and better adaptation to reality.

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