13th conference of Bridging Eastern and Western Psychiatry
Kyiv (Ukraine)
June 10th-13th 2010
Coping complex issues for Contemporary Psychiatry:
What we can treat; what we cannot treat

Residential Treatment for Eating Disorders

The "Kortenberg experience" implementation in Tuscany

Alessandro Del Debbio, MD, PhD

Dpt of Psychiatry, Versilia Hospital, Italy

psyter

Historical perspective: the experience of Pinel at Bicêtre

- A review about the consent in psychiatry begins from the hagiographic celebration: the famous liberation from chains of madmen in Bicêtre (Paris) in 1794.

  During French Revolution, for the revolutionary newspapers[1] Bicêtre, an Asylum, an hospital for mad persons, could have, amongst these crazy persons, also victims of the arbitrary power, of noble families.

- While a revolutionary leader Couthon visits the hospital, the psychiatrist in chief Philippe Pinel shows him the more agitated patients. Couthon asks Pinel: "Citizen, are you so crazy to will the liberation from chains of these animals?".

  And Pinel : "Citizen, I believe that these patients are so agitated as they have been bereaved of air and freedom".

  The same day there was the liberation from chains of 12 alienated.

[1] Gazette nationale, 12 december 1789

Historical perspective: the Retreat of York

In 1791 the english quackers, members of the religious cult "Society of Friends", were impressed for the death of a woman in a Mental Hospital, also because the psychiatrist had prohibited the visits of other cultists [1]

Samuel Tuke, nephiew of Fox, the Founder of the cult, decided to open a subscription to a fund in order to have a house for madmen. The Retreat was inaugurated in 1796. The house was "open door" and the corretional actions were employed rarely ("no restraint").

Also George Fox, the Founder, was admitted, with a follower in a correctional House of Darby, where they spent 6 months.

[1] Sewel, *The History of the Rise, Increases and Progress of Christian people*, quoted in M. Foucault: *Histoire de la Folie à l'Ăge Classique.* Gallimard, Paris, 1972

Historical perspective: the mith of Geel

• A very important mith for the Reformistic Movement in psychiatry has been the experience of Geel. In according to the tradition, Saint Dimfna, daughter of the King of Ireland, was martyrized in 600 in Geel (Belgium), for the refusal of incest of the father become mad.

• The tumb became the place for pilgrimage especially for mad persons. Sometimes these persons spent some periods in the village, helping the peasants in the work of fields.

• In the Nineteen century Geel represented a living myth: mental patients can live and work without any seclusion or restraint.

Defining a therapeutic community

- The term is usually used to describe small cohesive communities where patients (often referred to as residents) have a significant involvement in decision-making and the practicalities of running the unit (Campling, 2001)

- "A consciously designed social environment and program within a residential or day unit in which the social and group process is harnessed with therapeutic intent" (Lees et al., 1999)

- "In the therapeutic community the community is the primary therapeutic instrument" (Lees et al., 1999)

Therapeutic communities: Historical perspective

- Therapeutic community ideas have their roots in various religious and political movements; e.g., the "moral treatment" movement in the early 19th century: the importance of work, a healthy environment and warm relations.

- Therapeutic communities developed from visionary experiments between 1942 and 1948, known as the Northfield experiments (Harrison, 2000).

- The first experiment was led by Bion and was unsuccessful, in the sense that it had to close after 6 weeks.

Therapeutic communities: Historical perspective

- The psychiatrists at Northfield Hospital, facing with hundreds of psychologically traumatized soldiers, decided to focus on the unit as a whole rather than on individual problems: they structured the wards as communities, encouraging mutual support and cooperation in living

- They saw the whole community as both the patient and the instrument of treatment

- The aim was the education and training of the community in the problems of neurotic defences and interpersonal relationships

- The idea was later known as the leaving-learning experience

Therapeutic communities: Historical perspective

- After the Second World War, Thomas Main went on to become the Director of the Cassel Hospital in Surrey, which he reorganized on psychoanalytical lines to be a therapeutic community

- At the same time, Maxwell Jones developed a unit along similar lines at Mill Hill in London, helping soldiers from what was known as ‘effort syndrome’

- M.J. later became the director of a new unit at Belmont Hospital in Surrey that was renamed Henderson Hospital in 1958

Community as doctor[1]

➢ The work of a therapeutic community, four principles:

- democracy
- reality confrontation
- permissiveness
- communality

➢ The repeated cycle of oscillations:

- times of healthy functioning, when residents were well able to manage responsibility and a level of therapeutic permissiveness;
- times when high levels of disturbed behaviour meant that staff had to take a more active role

➢ This conflict between rehabilitation and psychotherapy

➢ The community as a whole and the parallel development and progress of individual residents

[1] Rapoport, R.N. (1960) *Community as Doctor*. London: Tavistock.

Therapeutic community principles[1]

Theoretical principal	*Origin in development*	*Culture in a community*	*Structures in a community*	*Rapoport's original community themes*
Attachment	Primary bond, losses as growth	Belonging	Referral, joining, leaving	
Containment	Maternal and paternal holding	Safety	Support, rules, boundaries	Permissiveness
Communication	Play, speech, others as separate	Openness	Groups, ethos, visitors	Communalism
Involvement	Finding a place among others	Living–learning	Community meeting: agenda and structure	Reality confrontation
Agency	Establishing self as seat of action	Empowerment	Votes, decisions, seniority	Democratisation

Therapeutic community approach

"too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and a prison. Whereas the role…is that of a therapeutic community." (WHO, 1953)

"The basic premise was that for people spending a long time in hospital, the way that they lived, the work they did, their personal relationships, the regime, with its rewards and punishments, were more important for their rehabilitation than the medical treatment they might receive" (Clark, 1996)

[1] Haigh, R. (1999): The quintessence of a therapeutic community. In: *Therapeutic Communities: Past, Present and Future* (eds P. Campling & R. Haigh), pp. 246–257. London: Jessica Kingsley.

Residential treatment for eating disorders

Eating Disorder Diagnostic Criteria from DSM IV-TR

- Anorexia Nervosa
- Bulimia Nervosa
- Eating Disorder Not Otherwise Specified
- Binge Eating Disorder

Residential treatment for eating disorders

- Residential treatment for individuals with eating disorders is becoming increasingly more common

- Inpatient and day treatment units no longer are home to long-term or chronic cases,1,2 but more often serve to stabilize acute clients before a more long-term transition into less restrictive care such as outpatient or individual therapy

- In a 15-year retrospective record review of patients treated at an eating disorders program in a large metropolitan area, a decrease in inpatient average length of stay (LOS) from 149.5 days in 1984 to 23.7 days in 1998 was found (Wiseman et al., 2001)

- Residential treatment programs often require a significant financial contribution from the patient and usually involve comprehensive therapeutic resources

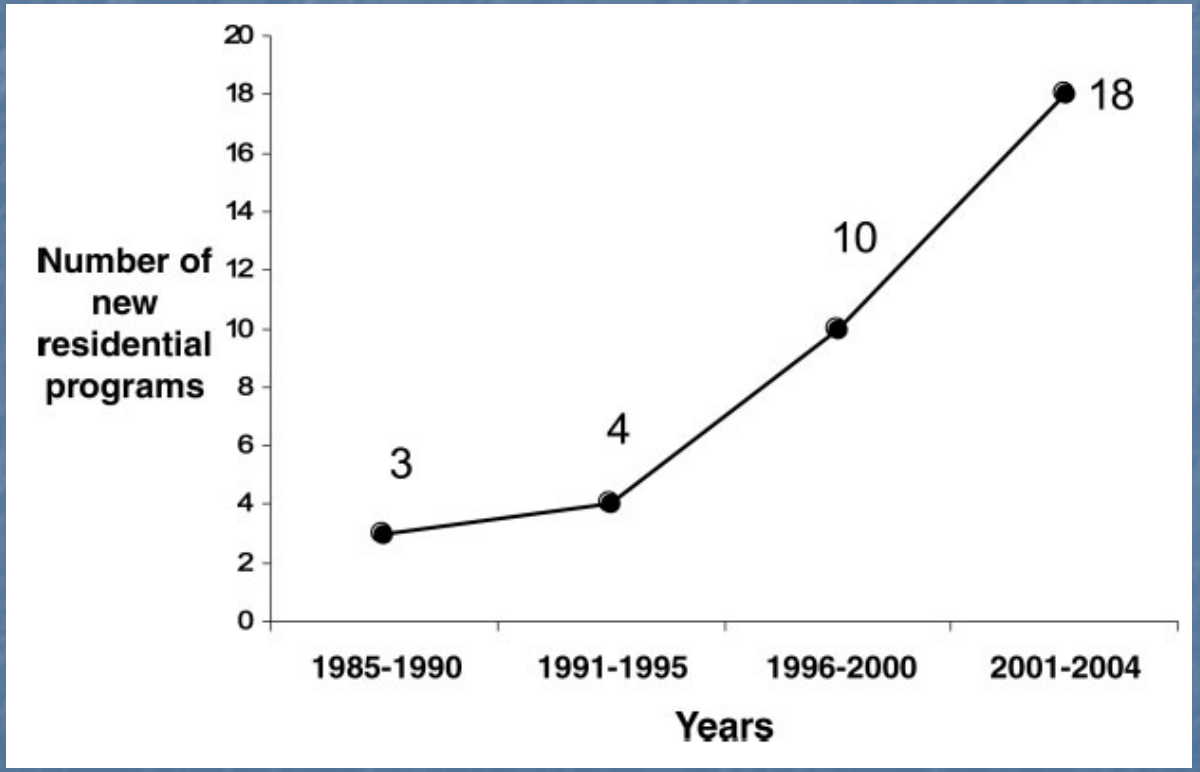
Residential treatment for eating disorders

- Anyway, data concerning program composition and effectiveness are limited (Kachele et al., 2001)

- A residential summer camp for individuals with eating disorders: most were females 12-17 years of age, the average age of onset was 11.5 years, and the medical diagnosis was either severe anorexia nervosa or marked morbid obesity. (Tonkin, 1997)

- Bean et al. (2001) assessed changes in eating disorder symptom severity within a residential setting utilizing the Eating Disorder Inventory (EDI)
  - 47 females with bulimia nervosa
  - 52 females with anorexia nervosa
  - overall, there was significant improvement on eight subscales of EDI
  - *limit: lack of a control group*

Growth in residential treatment programs (1985–2004)



Frisch et al., 2006

Program demographics

- All programs offered treatment for both AN and BN
- Treatment for:

  Eating Disorder Not Otherwise Specified (EDNOS): 72.2%

  BED: 61.1%

  compulsive exercising: 44.4%

  obesity: 22.2%

- Females had greater access to residential treatment for eating disorders than males

Females were accepted for treatment in all (100%) programs, whereas males were accepted in only 22.2% of programs

- The average age treated in residential care was 22 yrs (SD=3.7), with an average age of 14 yrs – 40 yrs

Three programs restricted admission in adolescents only

Frisch et al., 2006

Program demographics

	Frequency	(%)
Type of eating disorder treated		
Anorexia nervosa	18	(100)
Bulimia nervosa	18	(100)
EDNOS	13	(72.2)
Binge eating disorder	11	(61.1)
Compulsive exercise	8	(44.4)
Obesity	4	(22.2)

	Average	(SD)
Average length of treatment		
Number of days	83	(44)

	Frequency	(%)
Types of residential staff employed		
Nonpsychiatric physicians	16	(100)
RD (registered dietician)	16	(100)
Psychiatrists	15	(93.8)
RN (registered nurse)	15	(93.8)
Administrative	14	(87.5)
Doctoral-level therapists	13	(81.3)
Master's-level therapists	12	(75.0)
MSW (master's level social worker)	11	(68.8)
Interns	11	(68.8)
Holistic staff	9	(56.3)
Teacher	8	(50.0)
Bachelor's-level social worker	6	(37.5)
Doctoral-level researcher	6	(37.5)

Frisch et al., 2006

Treatment methodology and techniques

- 89% of the programs

Cognitive-Behavioral Therapy (CBT) as the primary method of treatment

- 16.7% of the programs

Interpersonal Therapy (IPT)

- 33.3% of the programs

Dialectical-Behavioral Therapy (DBT)

Frisch et al., 2006

Treatment methodology and techniques

Traditional Group Therapies	Nontraditional Group Therapies	Individual Therapy
General	Art	Individual sessions with a doctoral or master's-level counselor, psychologist, psychiatrist, or physician
12-step	Recreational	
Process	Meditation	
Food/feelings	Experiential	
Spirituality	Yoga	
Psychoeducation	Equine	
Body image	Dance	
Nutrition	Music	
Goal setting	Journaling	
CBT	Message	
Relapse prevention		
Family		
Family systems		
Intimacy/sexuality		
Trauma		
Contract		
DBT		
Aftercare		

Note: CBT = cognitive-behavioral therapy; DBT = dialectical-behavioral therapy.

Therapy	Minutes per week per Patient
T - General	503
A - Art	262
T - 12-step	208
T - Process	206
A - Recreational	119
T - Food/feelings	85
T - Spirituality	76
A - Meditation	68
T - Psychoeducation	67
A - Experiential	56
A - Yoga	54
T - Body image	50
T - Nutrition	49
A - Equine	42
A - Dance	42
T - Goal setting	32
A - Music	30
A - Journaling	30
T - CBT	29
T - Relapse prevention	26
A - Massage	25
T - Family	22
T - Family systems	19
T - Intimacy/sexuality	18
T - trauma	18
T - Contract	17
T - DBT	13
T - Aftercare	12

Note: T = traditional; A = alternative; CBT = cognitive-behavioral therapy; DBT = dialectical-behavioral therapy.

Frisch et al., 2006

Research involvement and production

Of the programs currently conducting treatment outcome studies:

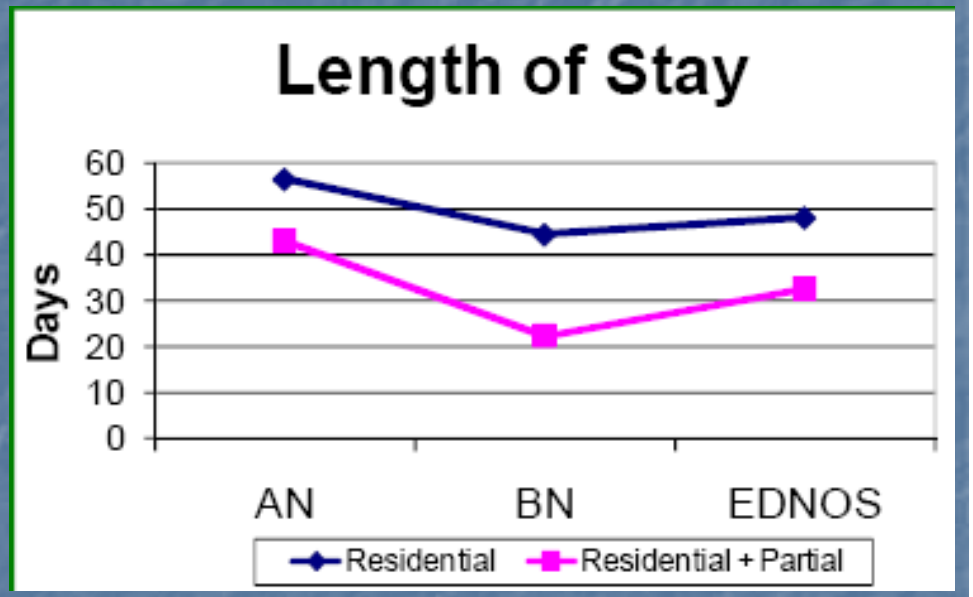
- 100% reported treatment outcomes studies, showing positive changes, ≤ 12 months post-treatment
- 50% of all residential programs reported conducting treatment outcome research for a minimum of 3 yrs
- 25% of all programs reported conducting research from 3 to 5 yrs
- 25% reported conducting research for the last 6-10 yrs

Frisch et al., 2006

Outcomes of Residential Treatment for Female Adolescents with an Eating Disorder

- An open-door residential treatment facility for females ages 13-23 with EDs
80 partecipants

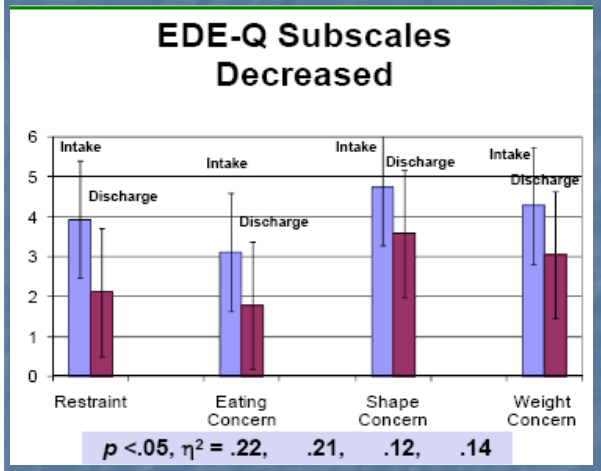
- Treatment is multi-disciplinary
  - group therapy,
  - family therapy,
  - psychopharmacology,
  - medical management,
  - nutritional counseling,
  - expressive therapy

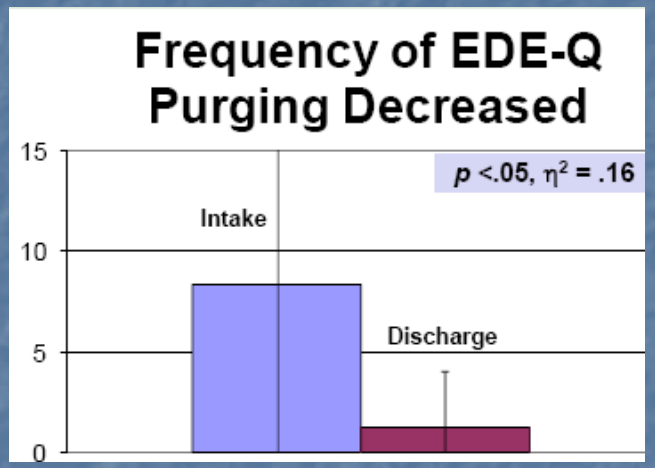


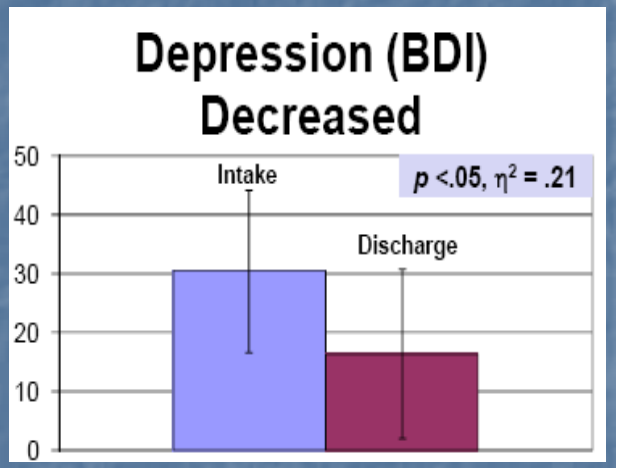
- Procedures (Baseline assessment, 2 weeks, 4 weeks, and discharge)
SCID-IV
Eating Disorder Examination Questionnaire 4.0 [EDE-Q],
Beck Depression Inventory-II [BDI-II],
Quality of Life Enjoyment and Satisfaction Questionnaire [QLESQ])
% expected body weight (EBW),
length of stay, reason for discharge, and readmissions to this facility

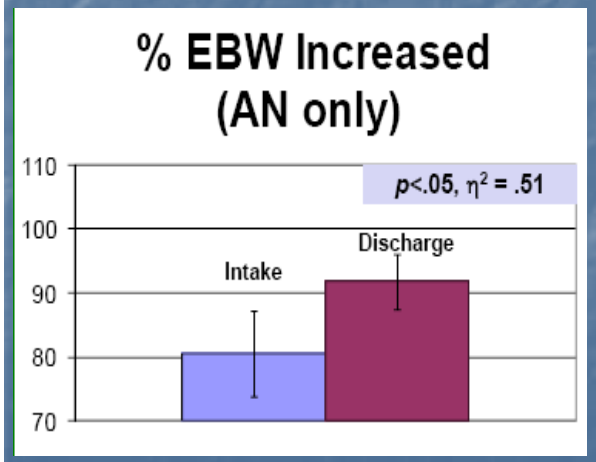
Delinsky et al., 2006

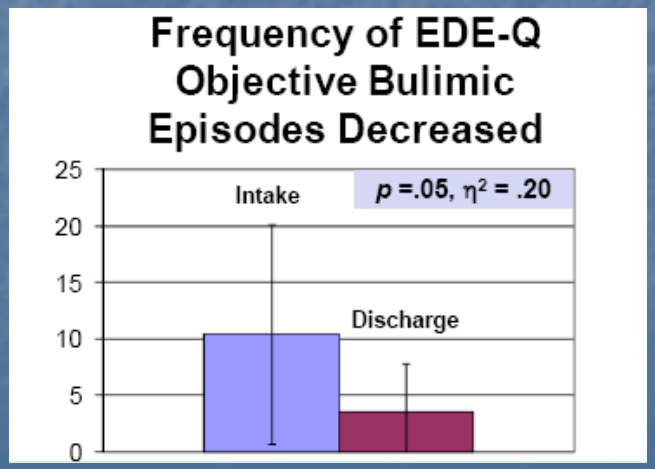
Outcomes of Residential Treatment for Female Adolescents with an Eating Disorder

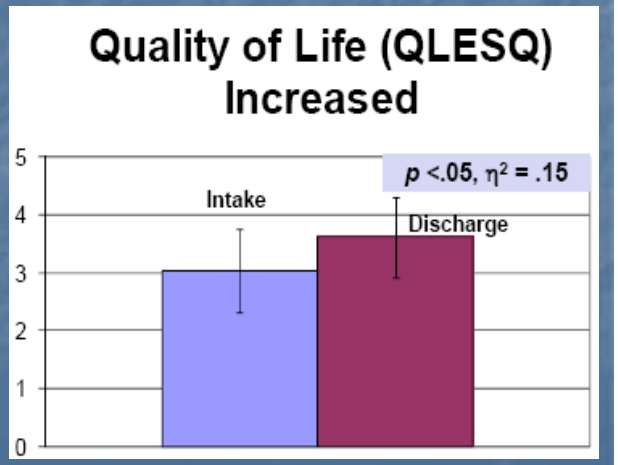












Delinsky et al., 2006