NATURAL HISTORY OF SEVERE SYMPTOMS IN BORDERLINE WOMEN TREATED IN AN INCEST GROUP

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ABSTRACT

In 1989 the authors described a cluster of severe symptoms in 10 women treated in a time-limited group for incest survivors who had been psychiatrically hospitalized. All had experienced multiple prior hospitalizations and multiple suicide attempts. Multiple diagnoses including borderline and affective disorders were present in the first 10 and in a replication sample. The present study explores two clinical questions raised in the treatment and follow-up of these patients: 1) Did the trauma-focused groups exacerbate severe symptoms in some patients? and 2) On long-term follow-up did group treatment lead to a greater likelihood of recovery? We used chart review to follow emergency contacts and hospitalizations through three intervals: the two years that preceded treatment, and the two years that included treatment, and a two year follow-up interval. Acute contacts actually decreased during the treatment interval and on follow-up only one group-treated patient remained severely ill and suicidal. In comparison a control group of hospitalized borderline women showed increased rather than decreased acuity in the treatment interval, but a similarly high level of pre-treatment acuity and a similar 50% likelihood of "recovery" by the follow-up interval. Better outcome for group participants was most evident when we compared the most severe cases in the two groups. The only suicide in the study sample occurred in the control group. Lack of appreciation both of the high level of baseline severity and the tendency of borderlines to respond negatively to any form of treatment contributed to our erroneous impression that group treatment exacerbated symptoms. Dissociative diagnoses were associated with poor outcome.

INTRODUCTION

In 1986, two of the authors (Goodwin and Connell) initiated a time-limited group for adult women with a history of incest who had experienced at least one prior psychiatric hospitalization.

In 1989, we described severe symptoms and severe abuse histories in the first 10 participants (Goodwin, Cheeves & Connell, 1988). All but one suffered borderline personality disorder. All had experienced multiple prior hospitalizations, multiple suicide attempts and multiple diagnoses; all were disabled. All described multimodal child abuse by multiple perpetrators. Modes of abuse included physical, sexual and emotional abuse, neglect and witnessed violence. A replication study with the next 10 group participants confirmed these patterns of severity, both in symptoms and in childhood histories (Goodwin, Connell & Cheeves, 1990). In the second study we proposed the acronym BAD FEARS as a way to list the multiple symptom complexes in these patients: Borderline disorders, Affective disorders, Dissociative symptoms, Fears (anxiety and other post-traumatic symptoms), Eating disorders, Alcoholism or other substance abuse, Revictimizations, Somatization disorders and Suicidality usually with compulsive self-mutilation.

The present study used chart review and a convenience control group to explore two clinical issues that arose during treatment of these fragile patients. First, we noted that patients often became extremely distressed during group and later self-mutilated or were hospitalized. We were concerned that trauma-focused treatment had exacerbated severe symptoms. Later as we followed these patients, we observed that many relinquished acute psychiatric symptomatology, completed individual treatment, and resumed functional work and family roles. We wondered if the trauma focus of treatment had led in the long term to a greater likelihood of recovery.

To clarify these questions, chart review data were collected both for group members and controls for three intervals: 1) the two years prior to initiating treatment; 2) the two years that encompassed the treatment (group for probands and an index hospitalization for controls) and 3) a a two-year follow-up interval.

These data, presented below, helped place our clinical questions in the context of an emerging natural history of severe symptoms which seems to include both a prolonged period of severe acuity (Carpenter, Gunderson & Strauss, 1975) and a high frequency of recovery (Stone, Stone & Hurt, 1987), regardless of treatment modality.

METHODS

Intervention

Group treatment involved the following elements: 1) two co-therapists; 2) a 12-session time-limited format with the possibility of pursuing more than one sequence; 3) 90-minute sessions held in a Mental Health Center with adequate security; 4) fewer than 6 patients per group; 5) a requirement for ongoing individual therapy; and 6) encouragement to stop therapeutic work in a particular group and resume a later sequence if sessions proved stressful. The therapeutic focus emphasized collecting information both about symptoms and childhood experiences and understanding how responses to childhood experiences influenced present symptoms and coping strategies.

The number of group sessions utilized by a single patient ranged from one to forty; in seven patients there was ongoing consultation between group and individual therapists; six patients contacted the group therapists in the follow-up period and were interviewed; eight completed questionnaires about symptoms and lifetime violence history.

Chart Review for Group Participants

Chart review for group participants collected 1) lifetime severity indicators and 2) acuity indicators for pre-treatment, treatment, and follow-up intervals.

Lifetime severity indicators included total number of psychiatric hospitalizations, age at first hospitalization, and presence of a life-threatening suicide attempt.

Acuity indicators for each time interval included: 1) number of emergency visits; 2) number of hospitalizations; 3) days of psychiatric hospitalization; and 4) months of outpatient therapy (any month was counted in which at least one outpatient contact was logged).

The index hospital was a large public teaching facility which provided both general medical and psychiatric services. In these analyses we do not distinguish medical from psychiatric contacts. For example, an overdose leading to a medical emergency visit, a medical hospitalization, a psychiatric emergency visit, and a psychiatric hospitalization was tabulated as two emergency visits and two hospitalizations.

Records from other institutions or outside therapists were present or alluded to in some charts; however, these data were incomplete and inconsistent, and we did not tabulate them. All patients were receiving medications during the study interval, but we did not tabulate this either.

"Total acute contacts" refers to the sum of emergency visits and hospitalizations in the index institution in a particular interval.

"Low acuity" is defined as four or fewer acute contacts for a patient in a two-year interval; "moderate acuity" refers to patients with five to nine acute contacts over two years, and a "high acuity" is defined as 10 or more acute contacts. "Acute contacts per year per patient" is a self-explanatory calculation devised to maintain comparability despite the changes in denominator as patients were lost in the follow-up period.

CONTROLS

Controls were a convenience sample of 10 women with a primary or secondary diagnosis of borderline personality disorder hospitalized in the institution in the same year that the group began.

This sample had originally been chart reviewed for two related purposes: 1) to determine whether other hospitalized borderlines met the high severity criteria found in incest group members; and 2) to determine the frequency with which child abuse histories were charted on inpatient units.

Nineteen (about 10%) of the 194 patients admitted to one of the index institution's psychiatric teaching wards during 1986 were discharged with a primary or secondary diagnosis of borderline. For the present study, we excluded the five males in this sample and the two women who appeared in this sample but who later participated in the incest group. We included as controls the remaining 8 white females (all women in the incest group were white) and the two black women in the sample who had a secondary diagnosis (for comparability with the probands, all of whom had at least dual diagnoses).

Although the presence of two probands in the original control group argues some comparability, the results of the earlier study indicated that hospitalized borderlines had lower severity and less data available about childhood abuse. In that study we generated chart review indicators of the BAD FEARS or severe symptoms; all probands produced at least six indicators while only two of the ten women included as controls had that many indicators of severe syndrome status. Only eight of the ten controls showed charted information on childhood abuse or neglect; two described physical and sexual abuse (the same two who showed severe symptoms); one physical and emotional abuse; one emotional abuse with parental alcoholism; and three said a parent had been psychotic. Of the two incest group members who appeared in the inpatient sample, only one had child abuse experiences charted.

RESULTS

Severity Measures in Probands and Controls

The 10 probands were white women ranging in age from 20 to 44 with a median age of 28. All had three or more prior hospitalizations and all had made life threatening prior suicide attempts. Number of lifetime hospitalizations ranged from three to 13 with a median of 10. Age at first hospitalization ranged from 13 to 28 with a median of 21. Duration of illness (calculated as the years between first psychiatric hospitalization and entry into treatment) ranged from one to 18 years with a median of eight years. Nine had a borderline diagnosis. The tenth was diagnosed as having a mixed

personality disorder with dependent features. All had a coexisting affective diagnosis. Seven had eating disorders and seven gave addiction histories. All gave histories of physical and sexual abuse in addition to other types of abuse and neglect.

Of the controls eight were white and two were black. They ranged in age from 23 to 40 with a median of 35. Nine had three or more hospitalizations prior to the treatment interval but only four had made a life-threatening suicide attempt. Number of lifetime hospitalizations ranged from 0 to 22 with a median of five. Age at first hospitalization ranged from 15 to 34 with a median of 27. Duration of illness ranged from 0 to 19 years with a median of 9.5. All had borderline diagnoses. Six had a coexisting major affective disorder. Two had eating disorders and one gave an addiction history. Two had no Axis I diagnoses at all. Only two gave histories of combined physical and sexual abuse; six others had other types of adverse childhood experiences.

Although lifetime chart review indicated lower acuity in controls, when we looked only at the pre-treatment interval, five controls and four probands were at high or moderate levels of acuity.

In summary probands tended to differ from controls, as follows:

1. They were younger.
2. They had a younger age of onset of psychiatric symptoms
3. They had more previous hospitalizations.
4. A higher percentage had made life-threatening suicide attempts.
5. A higher percentage had multiple diagnoses.

In some areas the two groups were quite comparable. About half in both groups had moderate or high acuity in the pre-treatment interval, and both groups had a median duration of illness of eight to ten years.

Acuity of Probands in the Pre-Treatment, Treatment and Follow-up Intervals

For group participants, total acute contacts declined at each interval, with 59 contacts logged pre-treatment, 51 during treatment and 18 post-treatment (See Table 1). Emergency visits declined more steadily than hospitalizations, going from 37 to 28 to 12 while hospitalizations went from 22 to 23 to six. Days in hospital changed from 383 to 155 to 411, but a single patient accounted for 410 days of hospitalization in the last interval.

Only one group participant was lost to follow-up; she had entered the group with a diagnosis of fugue state and fuged again one year into the treatment interval.

Looking case-by-case rather than at group data, we found that four patients had more than doubled their acute contacts during the treatment period; in two the increases took them into the moderate and high acuity ranges while the other two remained in the low acuity range.

Nine probands had some acute contact both in the pre-treatment and treatment intervals (eight were hospitalized in each of those intervals). In the follow-up interval only four had acute contacts and three of those patients had low acuity, logging a total of four contacts for the following complaints: anxiety attack, pelvic pain related to pelvic inflammatory disease, nausea diagnosed as secondary to hepatitis, and elective surgery to repair ear damage secondary to physical abuse. Only one proband remained acutely ill and chronically suicidal. This woman had high acuity throughout and was diagnosed as having multiple personality disorder in the treatment interval. She accounted for five of the six hospitalizations, 410 of the 411 hospital days and nine of the 12 emergency visits logged by the probands in the follow-up interval. Chart review, interviews and consultation indicated a great deal of conflict between inpatient and outpatient therapists regarding her dissociative disorder diagnosis. This may have exacerbated acuity. Her 410 days hospitalized in a two-year interval was the highest seen in either probands or controls. The next highest was 155 days per interval logged respectively by one proband and one control.

Of the three probands diagnosed with a dissociative disorder, one fugued and was lost to follow-up, one remained acutely ill and one (diagnosed as having multiple personality in the pre-treatment interval) was the most ill of the three patients still showing low acuity at follow-up.

Five probands had attained zero acuity at follow-up

TABLE 1
Acuity Measures for Group Participants in Pre-Treatment, Treatment and Post Treatment Intervals.*

	Total Acute Contacts	Emergency Visits	Hospitalizations	Days in Hospital
Pre-Treatment	59	37	22	383
Treatment	51	28	23	155
Post-Treatment	18	12	6	411

**One patient was lost to follow-up in the treatment interval.*

although four had logged outpatient visits in that two-year interval. Of these five patients, two had low acuity both in pre-treatment and treatment intervals despite a prior history of life-threatening overdoses. Both pursued greater than 24 months of outpatient treatment with termination and both resumed jobs. Both remained well at follow-up despite major stresses: one had married and one had been diagnosed as having a life-threatening physical illness. A third patient had moderate acuity pre-treatment which increased to high acuity in the treatment intervals with physical fights, psychotic symptoms, medication toxicity and somatic symptoms. She was stabilized in a home health care program but remained disabled for work. Two had high acuity with 18 and 22 contacts in the pre-treatment interval due to multiple life-threatening suicide attempts. Both completed 24 or more months of psychotherapy with termination and resumed jobs.

In four of these five cases of recovery both patient and psychiatrist felt there had been a positive response to medications.

Comparison of Acuity and Outcome in Probands and Controls

The 10 Control women showed slightly higher rates of acuity in the pre-treatment interval (3.3 acute contacts per patient year versus 3.0 acute contacts per patient year in probands). They also logged more outpatient months in the index institution than did probands (108 for controls versus 28 for probands), indicating that their treatment was more concentrated in the index institutions.

Excess acuity in controls was also observed in the treatment and follow-up intervals (See Table 2.) The difference attained significance only during the treatment interval when controls averaged 4.5 acute contacts per year and group members logged 2.7. Comparison of total acute contacts yielded a chi square of 8.94 with P less than .01.

One control suicided one year into the treatment interval. A second control moved away at the beginning of the follow-up interval.

Despite these dropouts and the very long hospitalization described in one proband, controls outstripped probands in total days in hospital over the 6 years, logging 1026 days as compared to 949 for probands. Controls also utilized more months of outpatient therapy over the 6 years with 297 months versus 233 in probands. Only in the follow-up interval did probands outstrip controls in outpatient utilization, 103 months to 70 months. The control patient who suicided logged only five months of outpatient therapy, the second lowest in this group.

Looking at individual patterns we find that five controls more than doubled their acute contacts in the treatment interval; two of these remained at low acuity levels despite the increase, one entered the moderate range and two entered the high acuity range.

Overall, eight of 10 controls were hospitalized pre-treatment. All were hospitalized during the treatment interval (this was a requirement for their being defined as controls).

TABLE 2
Total Acute Contacts in Probands and Controls During Pre-Treatment, Treatment and Follow-up Intervals.*

	Probands		Controls	
	Total Per Year	***Rate Per Patient**	**Total Per Year**	***Rate Per Patient**
Pre-Treatment	59	(3.0)	66	(3.3)
Treatment	51	(2.7)	86	(4.5)
Follow-Up	18	(1.0)	30	(1.9)

**Rates are based on a denominator of 10 for both groups pre-treatment, 9.5 for both groups during treatment, and 9 probands and 8 controls during follow-up.*

TABLE 3
Outcome in High Severity* Probands and Controls

	Probands	Controls
Number	4	4
Dead	0	1
Ill	1	2
Well	3	1

**High severity is defined as presence of a major affective diagnosis, a history of suicide attempt and moderate or high acuity in the pre-treatment interval.*

Eight had emergency contacts pre-treatment and 10 during the treatment interval.

In the post-treatment interval, two patients remained quite ill. One logged seven hospitalizations and 16 emergency visits, the other three hospitalizations and three emergency contacts. Both remained acutely suicidal. As mentioned, another patient had died by suicide in the treatment interval. One patient remained at a low level of acuity. A fifth patient moved and was lost to follow-up.

Of the two controls who told inpatient staff about sexual abuse in childhood, one suicided and one is the most acutely ill patient at follow-up. These were the only two patients who met severe syndrome criteria on the chart review study. The sexually abused control still alive but ill was scored as having dissociative symptoms on chart review because of voices described as inside her head and problems with finding possessions that she could not remember having purchased. Both controls with eating disorders also had poor outcomes; one was the control who suicided and the other was the second most ill control at follow-up.

Five controls had attained zero acuity at follow-up. Two had low acuity throughout and had never made a suicide attempt. Two others had low acuity pre-treatment which increased to moderate and severe levels during treatment. Both had made life threatening suicide attempts in the past. The fifth patient had maximal acuity pre-treatment but had never made a life-threatening suicide attempt. She was the only patient of the 20 to log 72 months of outpatient treatment over the six-year study interval. One focus of her treatment concerned her feelings about her own mother's psychosis, which had resulted in numerous foster care placements for the patient in childhood. The patient wanted to be a better parent to her own children.

Comparison of Outcome in High Severity Probands and Controls

We also compared outcome in probands and controls focusing only on individuals with high severity. We defined high severity as the presence of a major affective diagnosis in addition to borderline, a history of at least one life-threatening suicide attempt, and moderate or high acuity in the pre-treatment interval. Four patients in each group met these criteria. Three of the high severity probands attained zero acuity at follow-up, one was still quite ill. Only one of the high severity controls achieved zero acuity. Two were still quite ill at follow-up and one had died by suicide.

DISCUSSION

Problems with the Study

There are obvious problems with these data. The study sample is quite small. The controls are a convenience sample, known only by chart review (as opposed to the much richer clinical data available for probands). Controls are different from probands in age and severity. There is a great deal of missing data as only contacts at the index institution were tabulated.

The authors have tried to address these problems in two ways. First we present the data descriptively without trying to make statistical inferences which would overstep the data. Secondly, we tried to think through the problems, many of which tended to bias against finding a positive effect of group treatment in probands. Probands were younger. We noted that all five women under 30 in the combined study group did poorly. The four who were probands failed to reach zero acuity and the one who was a control suicided. Probands had higher severity. Also they were less attached to the institution pre-treatment and might have been drawn into greater institutional contacts through their entry to the group, thus leading to increased acute contacts in the treatment and post-treatment intervals.

A design problem that biased towards a false finding of better outcome in probands was the requirement that controls be hospitalized, which made their treatment condition also a measure of poor outcome. However, baseline rates of hospitalization were high (eight in the pre-treatment interval for both groups); and eight probands were hospitalized during the treatment interval. Even if 10 acute contacts are subtracted from the controls during the treatment interval, their acuity during treatment remains higher than found in probands with a chi square value of 4.9 and P still less than .05. A more serious problem with using standard treatment as a comparison is that controls did not share in the extra attention and hopefulness associated with participating in a research project.

Applying the Results to Clinical Questions

Does incest group treatment in this format exacerbate severe symptoms? These data do not support this observation. For group participants, acute contacts actually decreased during the treatment interval, while that of controls increased. Although four group members showed increased acuity during treatment, five controls showed similar increases. The one completed suicide occurred during the treatment interval but in a control. Contrary to expectation, acuity was significantly higher during the treatment interval among controls than in group participants.

In retrospect, our concern about exacerbation can be understood as follows: 1) We underestimated the high pre-treatment levels of acuity in these patients. 2) We failed to appreciate the importance of negative reactions to treatment in borderlines which were observed in controls as well as group participants. This subject is much discussed in the literature (Kernberg, 1984). 3) There may be a prolonged phase of high acuity in the natural history of this syndrome that occupies about four years of the time course regardless of treatment.

New questions are raised by the finding that contrary to expectation, the treatment focus on child abuse was associated with decreased acuity. It may be that the negative responses to treatment in borderlines are made more intelligible and workable when they can be understood in the light of earlier childhood trauma and patients' concerns about repeated abandonment or abuse.

Does a specific psychotherapy focus on child abuse favor recovery? Perhaps. Five patients in each group had attained zero acuity by the follow-up interval. However, when we looked

only at the four patients in each group with the highest severity; three in the intervention group were "well" while only one with standard treatment had improved to that level and another control had died.

There was some evidence both in probands and controls that those with dissociative disorders in addition to borderline and mood disorders remained ill longer.

We could not rule out a specific focus on child abuse in the psychotherapy of controls. Indeed in the recovered control for whom records were most complete, this was documented as a therapeutic focus.

CONCLUSION

The group of psychiatric patients defined in this and previous studies show high utilization of inpatient and emergency services, high risk for completed suicide and prolonged course, especially when dissociation complicates borderline and mood disorders. However, about half recover in terms of reaching zero acuity levels despite continued use of outpatient treatment.

This study on group treatment, like a previous study on screening (Goodwin, Attias, McCarty, et al., in press), showed no evidence that a carefully designed focus on child abuse exacerbated acuity. Indeed a favorable outcome for group intervention was most demonstrable when we looked only at those patients with the highest severity, patients who might be screened out of trauma-focused therapy if one assumed that such a focus would exacerbate symptoms. More data are needed about this high-risk group of patients. ■

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