

DIALECTICAL BEHAVIOR THERAPY

ARIZONA STATE
HOSPITAL'S EXPERIENCE
WITH INPATIENT
APPLICATION OF DBT



Do you ever?

Find yourself feeling frustrated about discussing the same patients' self-injurious behaviors over and over again at risk management meetings?



Or...do you ever?

Spend significant amounts of your time responding to, and dealing with, grievances filed by patients who meet criteria for borderline personality disorder?



Or...?

Do you spend any time thinking about, or dealing with, high staff turnover related to burnout issues that are fueled by working with extremely difficult-to-treat patients?



Or...?

Do you have any patients who will call you directly to intercede on their behalf when they disagree with decisions made by their treatment team.



Borderline Personality Disorder

Borderline personality disorder (BPD) is a chronic, debilitating biological disorder affecting the limbic system of the brain that controls emotions. People with BPD have significant difficulty with regulating their emotions.

- 2% of adults have this disorder.
- 20% present in psychiatric hospitals.
- 11% in outpatient clinics.



What is DBT?

- Cognitive-behavioral treatment developed by Marsha M. Linehan, Ph.D., director of Psychology at the University of Washington (Behavioral Technology Group)
- Treatment that is designed to help people build a life that feels more worth living
- Inpatient DBT application developed by Charles Swenson, MD, Director of Training for DBT Clinical Services



Simple Description of DBT

In a nutshell, DBT is very simple:

- create a context of validating rather than blaming the patient
- within that context, block or extinguish bad behaviors
- teach more effective behaviors
- figure out a way to make the effective behaviors so reinforcing that the patient continues the good ones and stops the bad ones.

But...it's not easy...nor is it a magical cure for BPD.



Bio-Social Theory of Development

Emotional Dysregulation



Invalidating Environment

Emotional Dysregulation

- High sensitivity to emotional stimuli
 - Immediate reactions, low threshold for reaction
- Emotional intensity
 - Extreme reactions, interferes with cognitive functions
- Slow return to emotional baseline
 - Long lasting reactions, sensitivity to next event

PLUS

Great difficulty in modulating the resulting emotions



Invalidating Environments

- Responses to events and communication of private experiences pervasively rejected as invalid
- Emotional displays and/or pain behaviors met by punishment; and escalation met by erratic, intermittent reinforcement
- Ease of problem solving and meeting goals is over-simplified

**Invalidating environments can range from those in which the biological emotional deficits are not recognized and dealt with to obviously abusive environments.*



Consequences of Invalidating Environments

The individual does not learn to:

- Label private experiences in a normal manner
- Effectively regulate emotions
- Trust inner experiences as valid responses to events
- Tolerate distress
- Solve difficult problems (those with several steps)
- Accurately express emotions
- Communicate pain effectively



Consequences of Invalidating Environments...cont'd

The Individual instead learns to:

- Respond with highly negative arousal behavior
- Form unrealistic goals and expectations
- Hold to perfectionist standards
- Actively self-invalidate and search social environment for cues about how to respond
- Oscillate between **emotional inhibition** and **extreme emotional styles**



The goals of inpatient DBT...

- Long-term goal is the elimination of the need for inpatient treatment
- During the current hospitalization – CAMP:
 - Re-establish behavioral **Control**
 - **Analyze** and address the variables prompting dangerous behaviors and hospitalizations
 - **Master** skills needed to reduce and manage crises
 - **Plan** for post-discharge situation with as much stability as possible



Some of the challenges of providing inpatient DBT...

- The closed inpatient setting can seem at times more like a battleground than a healing environment
- Behaviors that lead to hospitalization are those that cause anxiety and frustration for care-givers
- Staff want to provide a safe, well-regulated environment while “BPD behavior” can create instant disruption of the milieu and patients may seem to fight against all best efforts to help



Some of the challenges in providing inpatient DBT...cont'd

- The borderline patient typically fears being separated from attachment figures and being controlled by others; and may be “hair-triggered” by emotional stimuli. Suddenly, they face separation from significant others, control by rules and practices of a hospital system, and close daily proximity with highly distressed individuals
- Over time, staff may come to anticipate “resistance”, “manipulation”, and “hostile behavior”; while patients may come to expect mistrust, “punishment”, and “rigidity” from staff



A few advantages of the inpatient setting...

- Increased control of contingencies and reinforcement
- More knowledge about the patient's day-to-day functioning
- Increased attendance of individual sessions and skills classes (“captive audience syndrome”)



Essential Components of DBT

1. Individual Therapy

- Hierarchy of behaviors targeted for decrease (life-threatening, therapy-interfering, serious quality-of-life interfering behaviors)
- Individual coaching in use of skills

2. Group Skills Training

- mindfulness
- distress tolerance
- interpersonal effectiveness
- emotional regulation

3. Coaching

- by individuals in environment (CMs, RNs, Crisis, etc.) as well as by individual therapist and skills trainer

4. Consultation/Supervision



Video

Video of individual session during which the therapist is helping the patient to generalize skills to a treatment planning conference (staffing).



Skills Training

The general goal of skills classes is to learn and refine skills in changing behavioral, emotional, and thinking patterns associated with problems in living that are causing misery and distress.



Video

Skills training session. Skills class during the Emotion Regulation Module that is addressing the myths about emotions that many individuals grow up with.

The goals of this module are to provide a better understanding of the roles of emotions and learning how to live more effectively with a sensitive emotional system.



Coaching to use more skillful behaviors...

- To decrease suicide crisis behaviors
- To increase the generalization of new skills
- To decrease the sense of conflict, alienation, distance from treatment providers
- To decrease behaviors likely to destroy therapy

**Must be coaching, not additional therapy time*



Video

Coaching in the environment. An example of a staff member coaching a patient to effectively manage another patients' threatening behavior. Involves the use of several skills and strategies taught in DBT.



Consultation Meetings

Weekly Consultation meetings are extremely important for 4 reasons:

1. To keep team members within the framework of DBT (e.g., maintaining the acceptance vs. change dialectic).
2. To provide support to those working with difficult BPD patients.
3. To continue learning how to effectively coach skills and to learn contextual knowledge of DBT (e.g., using DBT strategies in a variety of situations).
4. To raise awareness of, and counteract, therapy interfering behavior of team members/therapists.



You may need consultation (or at least talk to a colleague) if...

- You offer administration a bribe to transfer your patient to another unit (or hospital)
- You feel so overwhelmed that you cannot possibly think of what the DBT approach might be
- You are losing, or have lost, all hope that the patient can ever do better
- You suspect that you may be inadvertently reinforcing behaviors that you are trying to decrease
- Every Sunday you spend at least 2 hours searching the Want Ads for new career ideas



Video

- Consultation meeting video clip. An example of assisting a therapist to work more effectively with a high profile patient with extreme self-injurious behaviors.



3 Brief Case Presentations

- Entrenched BPD patients vs. “DBT admissions
- First 2 cases are examples of entrenched (long term) patients
- Third case received DBT from the day of admission



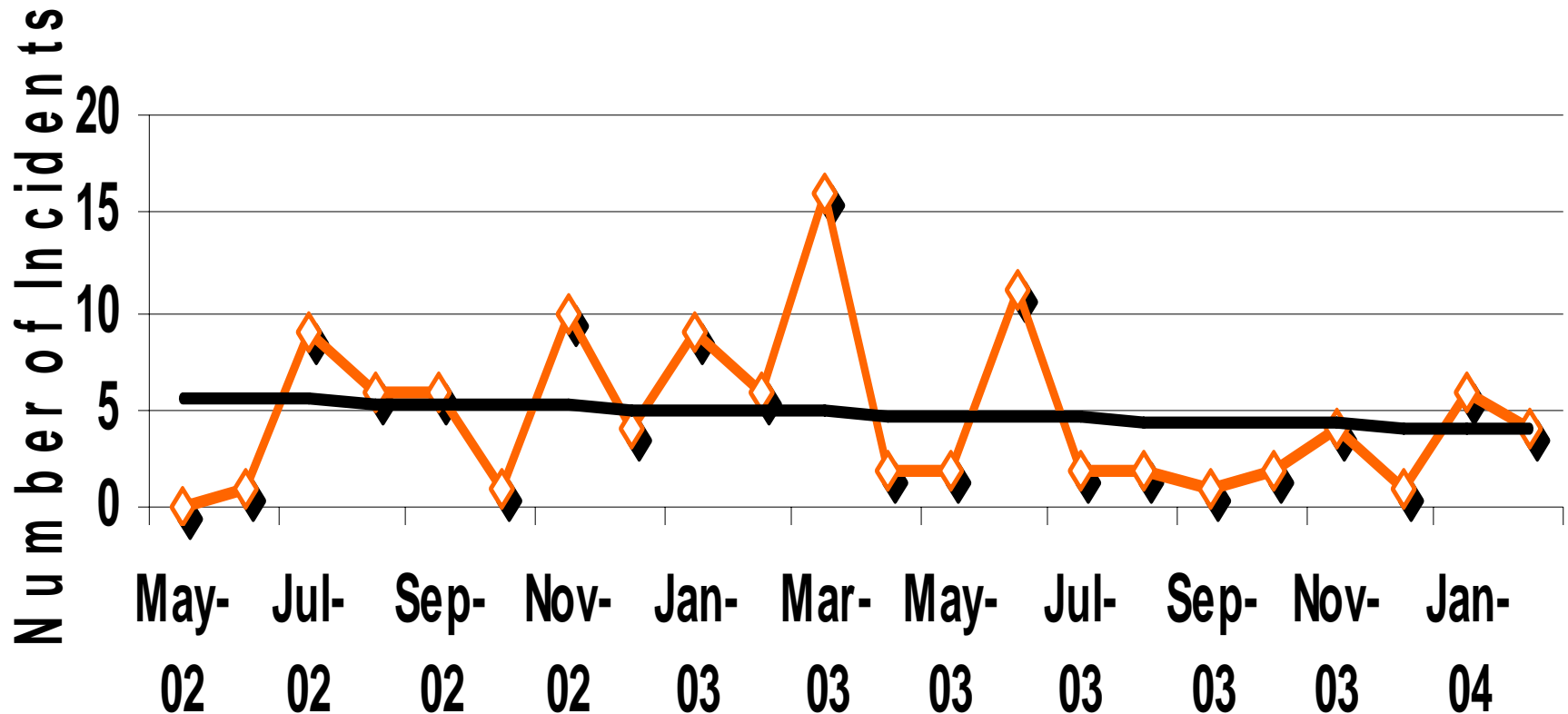
Case Presentation #1 - TK

- TK is a 30 year old Caucasian woman admitted in 2002
- Extreme self-injurious behavior (swallowing objects) in response to anger and sadness...also very reinforced by going for medical treatment
- Good example of analyzing factors leading up to problem behaviors, reinforcement, teamwork and persistence.
- Discharged in October 2004 to family in NY and continues to solve problems without resorting to self injury (discharge included coordination with outpatient DBT program in NY)



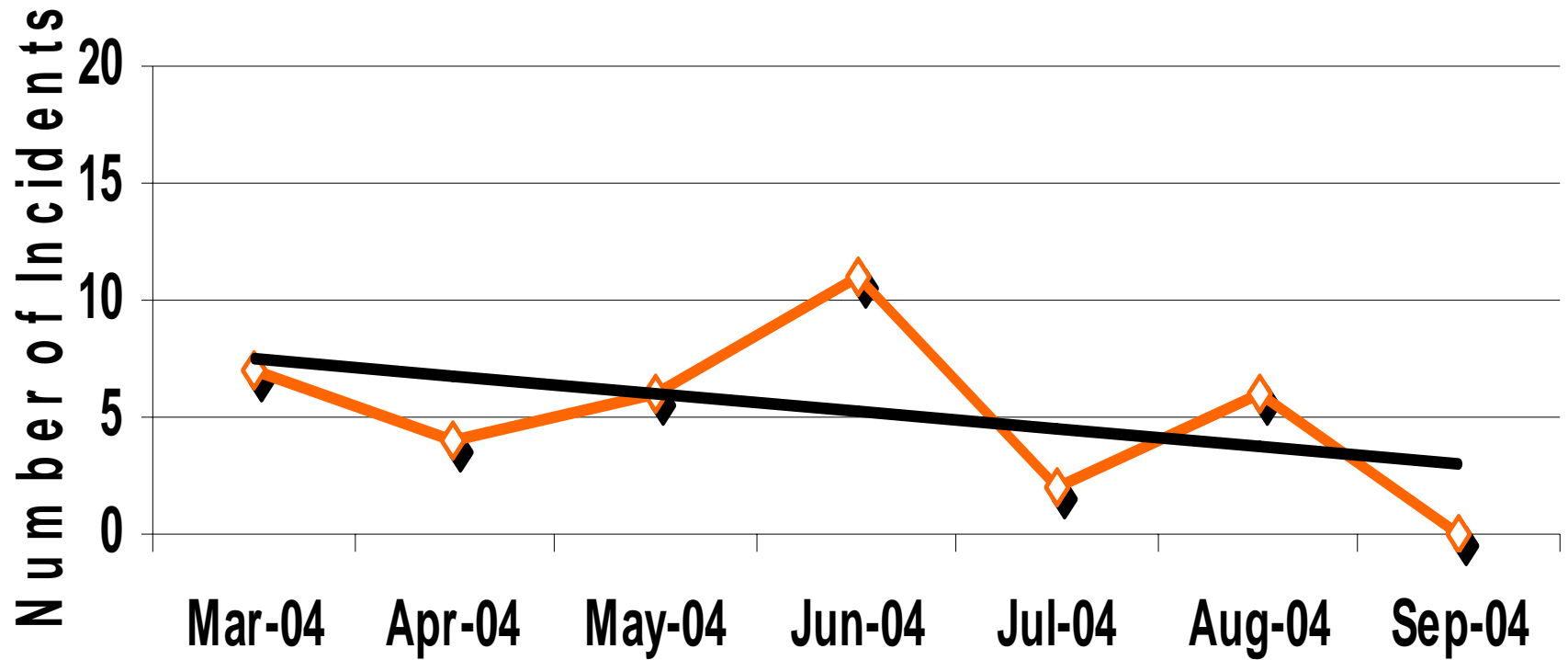
TK Before DBT

Incidents Prior to DBT Training



TK after DBT

Incidents After DBT Training



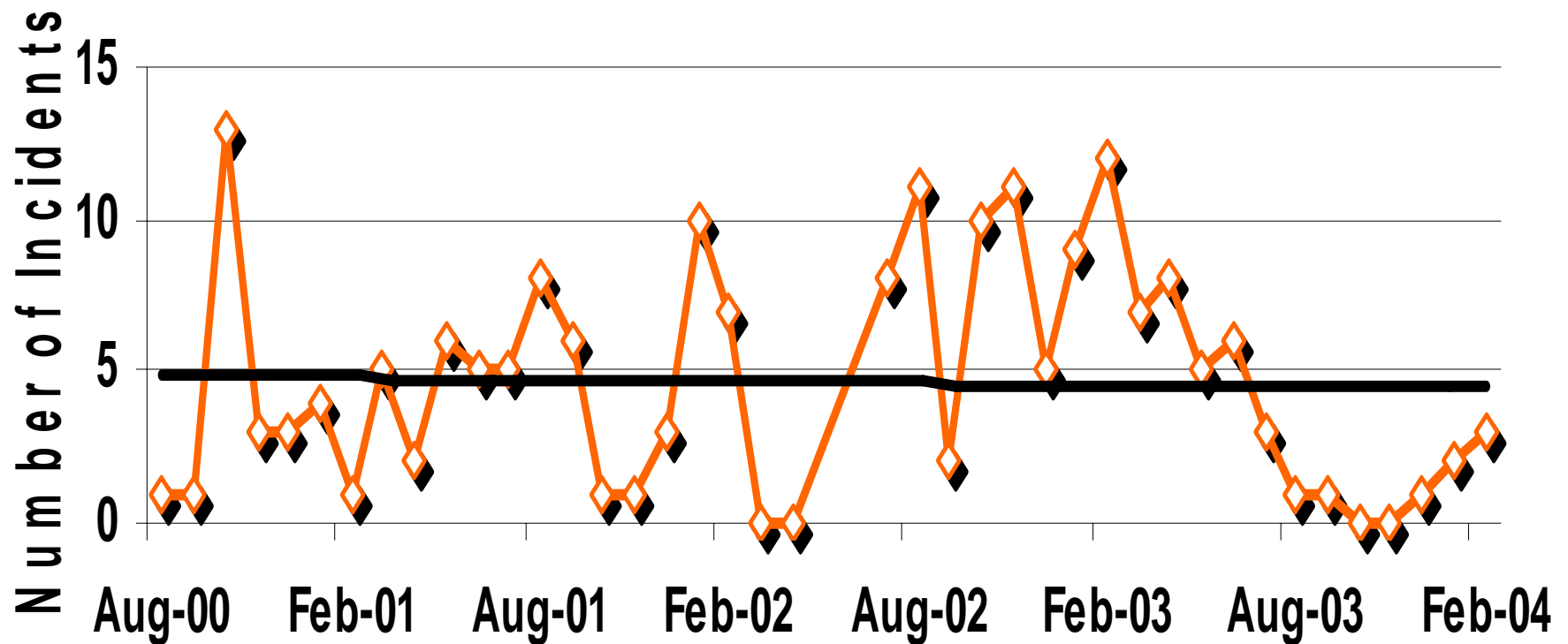
Case Presentation #2 - JR

- JR is a 31-year-old Caucasian woman admitted in 2000
- In some type of institution or placement since the age of 15
- History of physical and sexual abuse
- Her behavior strongly influenced the atmosphere of the living units she was in
- Good example of “entrenched BPD patient” and how persistence pays off



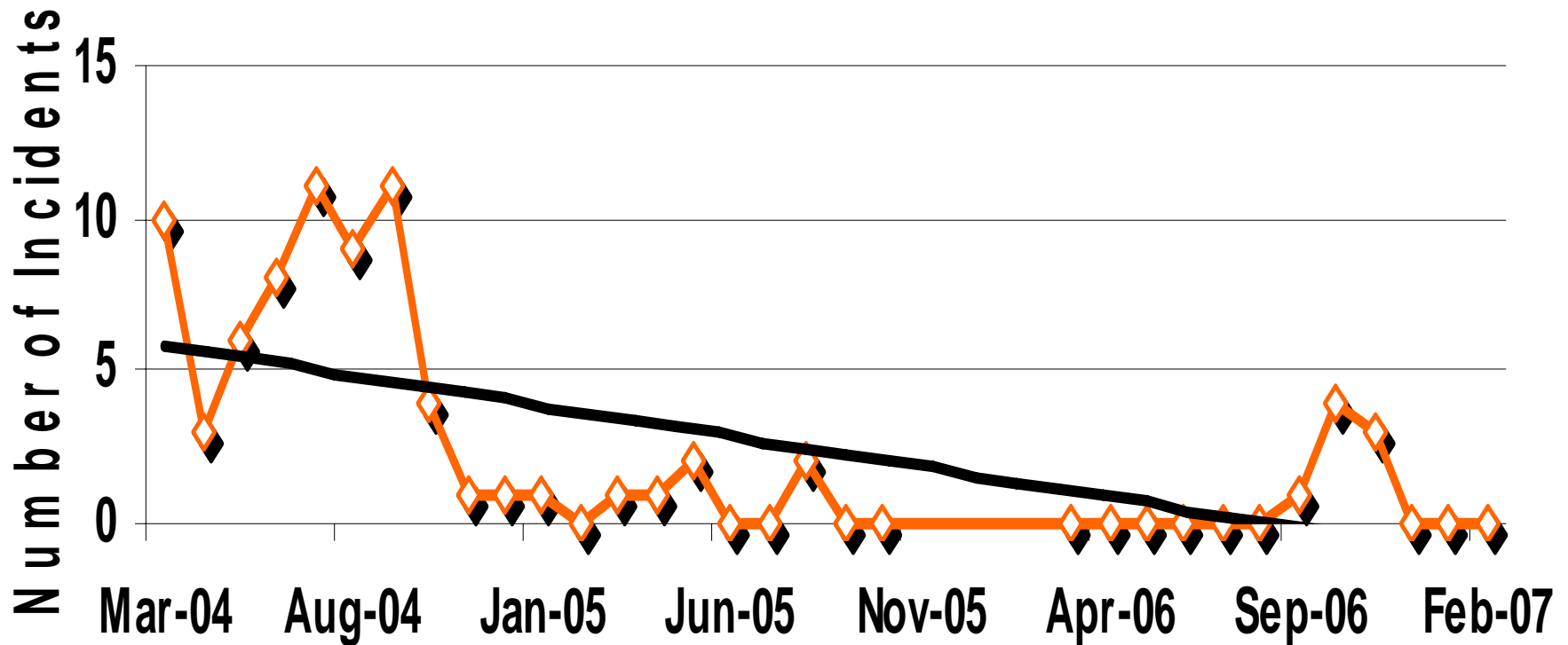
JR Before DBT

Incidents Prior to DBT Training



JR After DBT

Incidents After DBT Training



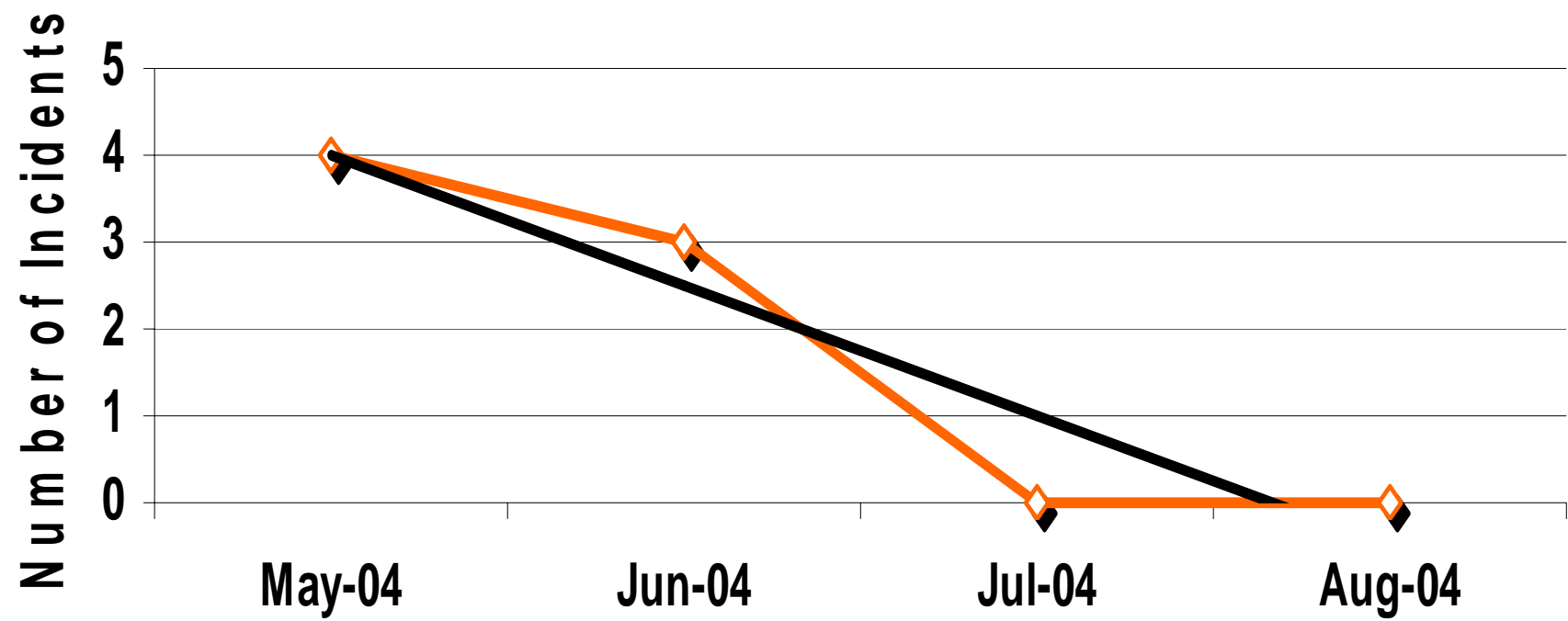
Case Presentation #3 - RC

- RC is a 33 year old woman admitted May of 2004
- History of 3 previous hospitalizations at AzSH and history of frequent self-injurious and assaultive behaviors
- Good example of implementing DBT on the day of admission
- Smooth transition back to outpatient DBT team in Southwestern Arizona



RC - DBT Began At Admission

Incidents After DBT Training



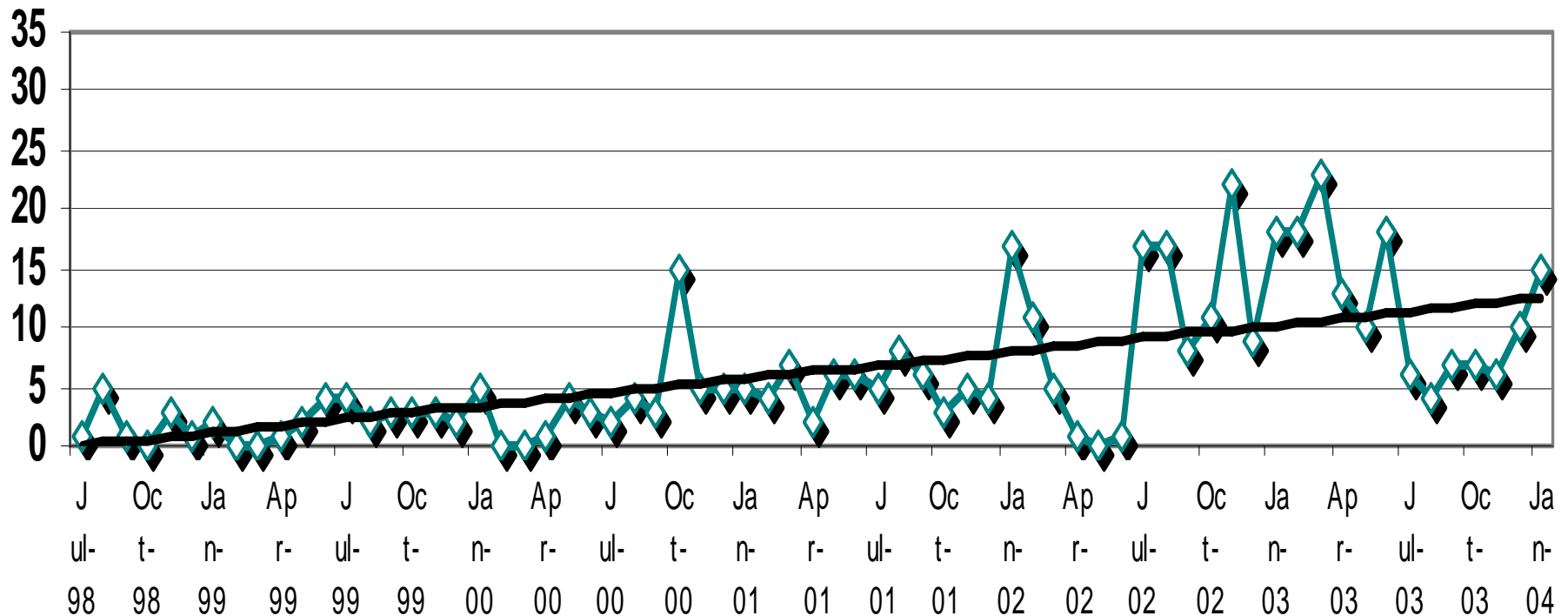
Who says DBT works?

- **Linehan et al, and other studies – when compared to “treatment-as-usual”, DBT does better at:**
 - Decreasing therapy drop-out
 - Decreasing suicidal and self-injurious behaviors
 - Decreasing medical severity of self injuries
 - Decreasing co-occurring substance abuse
- **Results of ComCare DBT project (n=37 and included some former ASH patients)**
 - 66% decrease in use of inpatient and 24-hour crisis residential beds
 - 25% decrease in claims, including cost of providing DBT



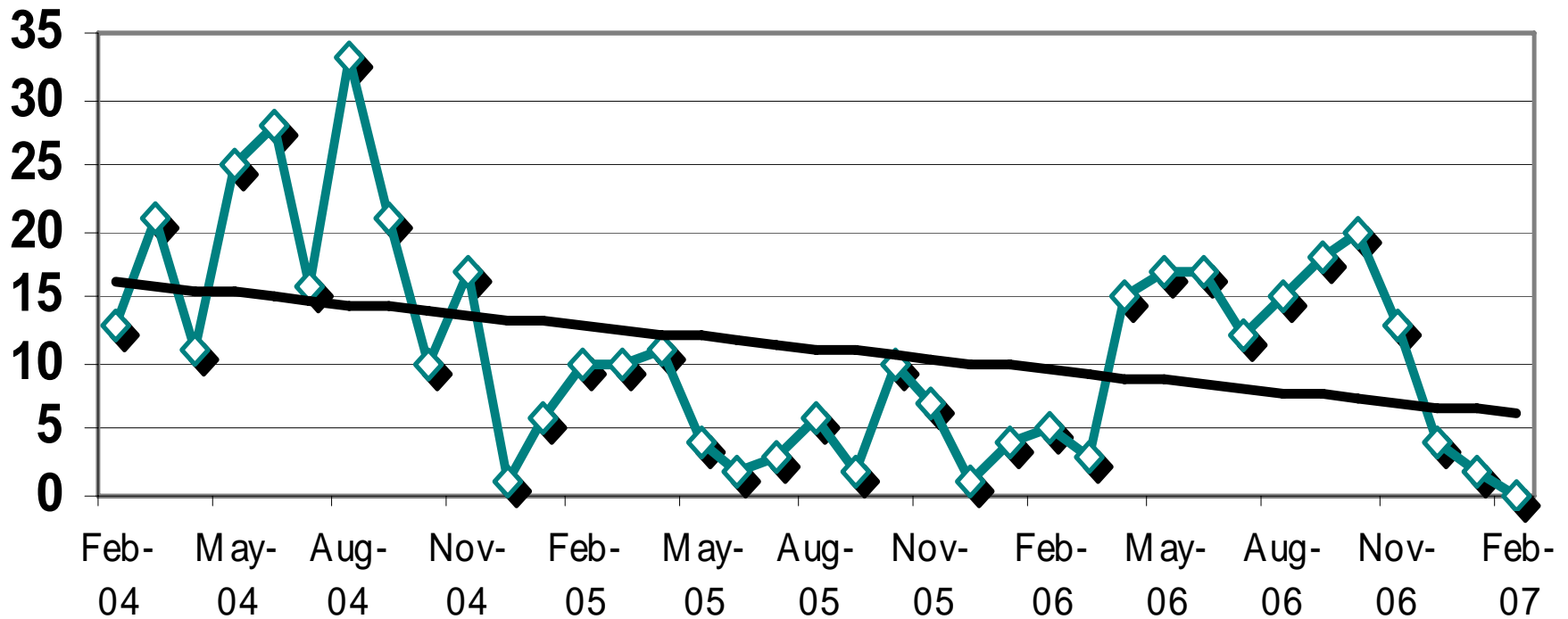
Self-Harming Incidents for DBT Patients at Arizona State Hospital...Pre-DBT

Before DBT Implementation



Self-Harming Incidents for DBT Patients at Arizona State Hospital...Post-DBT

After DBT Implementation



Lessons learned...

- Administrative support is essential
- Attend to commitment of all stakeholders (Nursing, Medical Staff, Social Workers, Rehab, Patient)
- Training and support for staff at all levels but especially “line staff”
- Apply DBT strategies in almost all situations
- Persist and consult with your team when feeling discouraged



Administrative Support

- Funding to hire staff, develop program, facilitate inter-departmental communication
- Two week intensive training provided by Behavioral Tech (the continuing technical support is invaluable)
 - ✓ Initial training for AzSH DBT team: Program Manager, two psychiatrists, psychologist, social worker, RN, and a psych tech)
 - ✓ A team of 5 “line staff” and 2 DBT team members attended a 2-day training on teaching skills classes



Commitment/DBT Agreements

- People are more likely to do what they have agreed to do (don't assume you have commitment)
- 100% staff “buy-in” is nice but not essential or realistic
- Consistency is nice but not needed for treatment to be effective
- AzSH has developed a DBT Agreement Form for Patients/Therapists/Unit Team Members to sign



Patients' DBT Agreements

- To meet weekly with the DBT therapist
- To attend skills training classes when scheduled
- To work toward decreasing suicidal behaviors
- To work on decreasing behaviors that interfere with therapy
- Will not miss 4 consecutive individual therapy or skills training classes



DBT Therapists' Agreements

- To make every reasonable effort to conduct therapy as competently as possible
- To adhere to standard ethical guidelines and professional codes
- To communicate with patients and their teams concerning the possibility of termination of DBT, because of a patient's behavior, in time for changes to be made and to assist the patient in making the needed changes in behavior
- To participate in ongoing, weekly DBT consultation/supervision meetings



Referring Treatment Team Agreements

- To support patients' participation in the DBT program by tying privilege levels to attendance and effort in individual therapy and skills classes (participation rate of 80% for skills classes and individual sessions will be required for privilege level increase)
- Members of the treatment team will attend weekly DBT consultation meetings, whenever possible
- To learn and provide, to the best of our ability, competent coaching in the four areas of DBT skills as presented in the skills training manual
- The individual DBT therapist will be considered a key member of the treatment team and will be included in treatment planning conferences, if at all possible



Staff Training

- 12 to 15 hour initial training
- Additional training is a planned part of weekly consultation meetings
- Providing modeling in the milieu...”guerilla consultation”



Coordination with Community Agencies

- Arizona DBT Task Force
- Introductory (3 day) training open to all providers free of charge
- “Meticulous and flexible” discharge planning
- Applying the DBT strategies to ourselves and our partners in the system



Program Development

- Currently have DBT program on three treatment units
- Working with Forensic Program to develop programming for patients in the Post-Trial GEI Program



Steps to Implementation

1. Make the investment to provide intensive DBT training with BTG (<http://behavioraltech.org>)
2. Attend to orienting and getting commitment from internal stakeholders
3. Plan to provide all 4 components
4. Develop and provide training for all staff involved
5. Persist (it's difficult but it works)



Questions/Discussion

Thanks for inviting us to speak and...
feel free to contact Steve Bolte or Dr.
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questions.

