

A Hospital Based Residential DBT Program for Adolescent Girls with Borderline Personality Disorder



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Objectives



- To describe the development of a hospital based residential program for adolescent females with borderline personality disorder (BPD).
- To describe the role and expectation of staff as it pertains to training and adherence to a treatment model.
- To highlight the need for diagnostic and outcome research.
- To discuss what has worked and what has not along the way.

A New Idea?



- Our goal was to:
 - Create a unit for adolescent girls and young women with BPD using Dialectical Behavioral Therapy (DBT) as the treatment model.
 - Integrate an existing outpatient DBT model with a residential unit.
 - Have the entire staff trained in and adhere to DBT.

Difficulties in Treating BPD Adolescents



- Suicidal threats are common.
- The work can evoke powerful transference/counter transference reactions.
- Therapy can elicit desperate dependency needs in the patient leading to abandonment fears.
- BPD adolescents can be very non-compliant with treatment and treatment recommendations.

Why Residential?



- Some adolescents have a problem simply getting out of bed or functioning in a group setting or have difficulty engaging with others.
- Sometimes the presenting behaviors are too dangerous for outpatient treatment and more structure and supervision is needed.
- Because sometimes the parents themselves are burnt out and need a break themselves.
- When the patient clearly needs a specialized treatment but such treatment is not available in their home community.

Keys to a Specialized BPD Unit



- **Identifying and then creating a team of key senior clinical staff interested in working with a BPD population.**
- **Intensively training this staff in a specific mode of treatment (in our case DBT).**
- **Establishing a continuum of staff training and in particular focusing the training on new staff hires.**

A Word About DBT



- To be adherent, DBT for adolescents should have **5 modes**:
 - Individual therapy
 - Skills training
 - Skills coaching
 - Consultation team
 - Parent training
- DBT teaches **4 skill sets**:
 - Interpersonal Effectiveness
 - Mindfulness
 - Distress Tolerance
 - Emotion Regulation

Outpatient DBT



- The outpatient DBT model is a year long treatment with patients attending 1 hour of individual therapy per week and 1-2 hours of group/skills training per week.
- Skills coaching is available by pager or cell phone 24 hours per day.
- All therapists sit on a consultation team.

Before



- BPD adolescents were treated on a general adolescent unit with a typical length of stay 10 – 14 days.
- BPD adolescents had 2 hours of skills training in a skills classroom, but had no individual DBT therapy, no skills coaching and the therapists were not on a consultation team.
- These BPD adolescents had high rates of rehospitalization after discharge.
- If skills classroom was full they were assigned to an anger-management classroom or substance abuse classroom.
- **BOTTOM LINE:** The treatment was neither focused nor specific to BPD.

Identifying Key Staff



- Expertise and familiarity with any disorder makes for easier identification of pathology and treatment recommendations.
- We were fortunate to have an established intensive outpatient DBT model developed by local clinicians.
- Our residential program would build on a history of residential treatment of BPD adolescents at McLean (Dr. Ed Shapiro - Austen Riggs- had run a program for BPD adolescents).
- Fortunate to be in a place with a long history of expertise in adult BPD with regular academic rounds.
- Agreed that we would use DBT to treat BPD and had our team attend a formal intensive DBT training.

Administrative Considerations



- We settled on a minimum 4 week length of stay, based on the efficacy of intensive outpatient model.
- Insurance limitations on lengthy treatment made ours a self-pay program as a consequence we recognize that we would exclude those who could not self-pay.
- We were fortunate to have institutional backing to address all the infrastructure needs.
- Our hope is that outcome studies will validate the utility of the treatment in reducing future hospitalizations, and that in the future insurance will cover the cost of stay.

Formal Opening



- **Opened September of 2007.**
- **8 Beds on the intensive DBT residential unit.**
- **Demand for ongoing specialized BPD treatment led to the opening of a 5 bed step-down unit (opened November 2008).**
- **Further demand led to an intensive outpatient program with a capacity for 9 patients (opened February 2009), which also caters to the needs of the local community.**

Admission Process



- Our program director completes an initial screen by telephone interview with family or referrer.
- Patient is screened out if:
 - Moderate MR
 - Active substance abuse
 - Active psychotic disorder
 - Active primary eating disorder.
- Every patient undergoes a formal initial interview to assess their commitment to the treatment.
- Patients are NOT admitted without commitment to the treatment.

Commitment Interview



- Initial interview is not a “typical” clinical interview.
- Focuses on the **HERE** and **NOW** problem from the patient’s perspective.
- Assesses their commitment to work on and address the problem.
- If the patient is admitted, a more formal clinical interview takes place.
- For example: For many parents their child cutting is a **PROBLEM**. For child however, cutting is a **SOLUTION** to the problem which is often how they feel in the moment. This approach frames and exemplifies how we think about such behaviors.

Demographics



- **Total Number of Patients: 85**
- **Gender: All female**
- **Previously Hospitalized: 78 (91%)**
- **Multiple Hospitalizations: 69 (81%)**
- **Adopted: 18 (21%)**
- **Age Range 13-23**
 - 12-13 – 3 (4%) patients
 - 14-15 – 13 (15%)
 - 16-17 – 32 (37%)
 - 18-19 – 29 (34%)
 - 20+ -- 8 (10%)

Our Typical Patient



- **Has a history of treatment resistance.**
 - Multiple hospitalizations
 - Multiple therapists
 - Multiple medication trials including many failed trials
- **Has a history of chronic and unrelenting suicidal ideation with multiple suicide attempts.**
- **Has a history of significant non-suicidal self-injury.**
- **Has a history of comorbidity with other Axis I, II and III conditions as well as problems in the family system and school attendance problems.**

Family Sacrifice



- Not covered by insurance.
- Often make heroic efforts to help their child.
- Self-pay can imply affluence but many are not affluent and this is worsened by the current economy.
- Many families have used 401ks, 529 or other college tuition plans, 2nd mortgages or borrow from relatives.

Staffing - Clinicians



- Length of stay is 4 week minimum but average length of stay is 6 weeks (range 4 weeks - 3 months).
- Clinicians
 - 3 Psychologists (each carries a maximum of 3 cases).
 - 1 Psychiatrist.
 - 1 Nurse.
 - 1 Expressive art therapist.
 - (2 other Psychologists who run groups and family training).
 - 2 DBT trained Social Workers from other units carry cases when the psychologists have full case loads.

Staffing - Milieu



- **Milieu Staff**
 - 1 Skills classroom teacher.
 - Evenings: 1 staff per 3 patients.
 - Overnight: 2 staff per unit.
 - All attend consultation team.
 - All attend 2 hours of DBT training once per week.

The Clinical Week - Patients



Adolescents attend:

- A DBT skills instruction and acquisition class for a total of 10 hours per week.
- Core mindfulness 3 hours per week.
- Individual therapy 2 hours per week.
- 10 hours of “experiential” groups including community meetings, relational dilemmas, solution analysis etc.
- Proctored DBT homework time every evening.
- Five hours in the fitness center or of active walking around the campus focusing on the importance of exercise on well-being.

The Clinical Week - Parents



Parents attend:

- One 2 hour long parent skills group per week.
- Weekly family meetings as indicated.
- Have access to the parents' skills coach.

Milieu Staff



- Provide in-vivo skills coaching.
- Co-lead the experiential groups.
- Attend consultation team two hours per week.
- Attend two hours of DBT training weekly run by a certified DBT trainer.
- Practice DBT skills with the adolescents and each other.

Integrating Research



- We are admittedly fortunate to have established BPD researchers: Mary Zanarini and John Gunderson on campus.
- We are currently examining the validity and stability of BPD symptoms and the diagnosis in adolescents under the age of 18.
- 31/33 (93%) of BPD adolescents admitted to the unit under age 18 have agreed to participate in the research.
- We will eventually want to look at treatment outcomes and changes in brain function.

Running into Trouble



- We have less success in adolescents with active eating disorders – food itself can be a trigger.
- Soon after we opened we took two adolescents who appeared to have BPD but whose cutting behavior was secondary to psychosis . These two did not respond well to the scrutiny of behavior that DBT demands.
- We admitted an adolescent who was still actively craving and seeking drugs who did not do well as she would go on pass and buy OTC drugs.

Difficulty Getting Aftercare



- It is difficult to find DBT in many parts of the country and many adolescents want to continue in DBT.
 - 70% go home
 - 15% move to the step down unit
 - 5% go to another long term residential unit
 - 10% move to Boston (ongoing treatment and go to local schools).
- We sometimes discharge patients to CBT and therapists of other orientations willing to use the material in our work books.
- The difficulty in finding aftercare led to the development of our step-down unit and intensive outpatient program.

Establishing a Similar Program



- Institutional support can help facilitate the infrastructure and training needs and costs of such a program.
- Commitment to work with BPD adolescents and using an empirically validated system of care is essential.
- Research into other validated treatments for BPD should be undertaken in adolescent populations.
- Ongoing training is mandatory.

Bottom Line



- **Despite the challenges, given the number of adolescents suffering from BPD and related disorders more specialized programs are needed if we are to meet the needs of this underserved population.**