Training Clinicians to treat BPD

A DBT training program for psychiatry residents

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Agenda

- Describe a federally funded educational program to teach DBT to psychiatry residents at Columbia University · R25MH084787
- First to describe the problem that this program addresses – BPD stigma and misconceptions about BPD among mental health providers that contribute to inadequate treatment
- Objectives of the program to address the problem
- Preliminary results and efforts to disseminate the program

5 Year Funded DBT Curriculum at Columbia

- Educational Programs of Excellence in Scientifically Validated Behavioral Treatment (R25) (Multiple PI: Brodsky and Stanley)
- Comprehensive clinical DBT training treat self-harm behaviors
- Didactic seminars related to design and conduct of psychotherapy efficacy research for the reduction of self-harm behaviors
- Comprehensive model - need to adapt to disseminate to other programs

Rationale for DBT clinical training in Psychiatry Residency programs

- Much effort toward the development and empirical testing of psychotherapy interventions designed to specifically target suicidal and NSSI behaviors
- Much less to incorporate these treatments into clinical training programs
- Psychiatrists are often on the front lines in treating BPD and suicidal behavior, including making decisions regarding hospitalization
- Psychiatrists who are trained in DBT can collaborate more effectively with psychotherapists in split treatments

Why DBT?

- Evidence base (Linehan et al 1991, 1993, 2006)
- Targets self-harm behaviors and emotional dysregulation
- Increases treatment retention
- DBT assumptions destigmatize BPD
- DBT Challenges basic judgmental assumptions about BPD
- DBT helps clinicians stay therapeutically engaged with BPD patients

The Problem

- BPD diagnosis carries a stigma among mental health professionals
- Many clinicians believe that BPD is untreatable and they choose, when they can, not to treat individuals with BPD
- Clinicians who are willing to treat individuals with BPD often experience burnout and have difficulty maintaining empathy
- Treatment retention of individuals with BPD is low due to premature dropout and/or therapist burnout
- Standard clinical training for the treatment of suicidal behaviors often leads to unnecessary hospitalization in individuals with BPD and does not include treatment for non-suicidal self injurious behaviors.

Both Patients and Clinicians contribute to the cycle of stigma

- BPD disorder presents with extreme clinical challenges – suicidal and self harm behaviors, emotional and behavioral dysregulation, dependent/hostile interpersonal style.
- BPD symptoms attributed by clinicians to willfulness and deliberate effort on part of the patient to be difficult, manipulative, demanding, bad, attention seeking.

Why is BPD stigmatized among mental health providers

- Transaction between specific aspects of BPD pathology and assumptions of Treatment as Usual
- BPD patients are high utilizers of treatment but have high dropout rates, revolving door hospitalizations and don't respond to standard levels of care
- Variability in functioning due to mood lability and dependency
- The interpersonal nature of BPD symptomatology – extremely needy and help rejecting at the same time, leading to hostility
- Biological and genetic basis for BPD is not as recognized as in Axis I disorders, and medications are not very effective in treating BPD symptoms

Treating BPD requires modifications to "psychotherapy as usual"

- Adolf Stern 1938 – made modifications to psychoanalysis to treat a "borderline group" that wasn't responding
- More "reality determined" relationship
- No extended silences
- Less emphasis on transference interpretations
- Sustenance and support
- DBT, as well as other BPD psychotherapies, incorporates these modifications

DBT Assumptions

- Patients are doing the best they can;
- Patients want to improve;
- Patients need to do better, try harder, and be more motivated to change;
- Patients may have not caused their problems but they have to solve them anyway;
- Patients' lives are unbearable as they are currently being lived;
- Patients must learn new behavior in all relevant contexts;

DBT Assumptions (con't)

- Patients cannot fail in therapy – the treatment fails;
- Therapists treating patients with BPD need support.

Objective of the DBT training

- Residents will develop non-stigmatized view of BPD which will increase empathy, and they will take more responsibility for treatment success and failure with BPD patients
- Learn effective interventions for managing self-harm behaviors
- Increased willingness and confidence to treat BPD, more effectively
- Increased understanding of evidence base for DBT

Main teaching points

- DBT assumptions about treating BPD
- Validation – explicit emphasis on valid aspects of the patient's experience and behavior
- Dialectics – synthesis of acceptance and change
- Taking a very active, directive therapeutic stance
- Psychoeducation to the diagnosis and learning skills
- Availability for between-session contact and skills coaching
- Observing natural rather than arbitrary limits with patients
- DBT consultation team for therapist support

The Program

- 12 month curriculum
- Offered as an elective to residents in either their PGY III or IV year
- Starts with 15 hour clinical intensive training in the summer

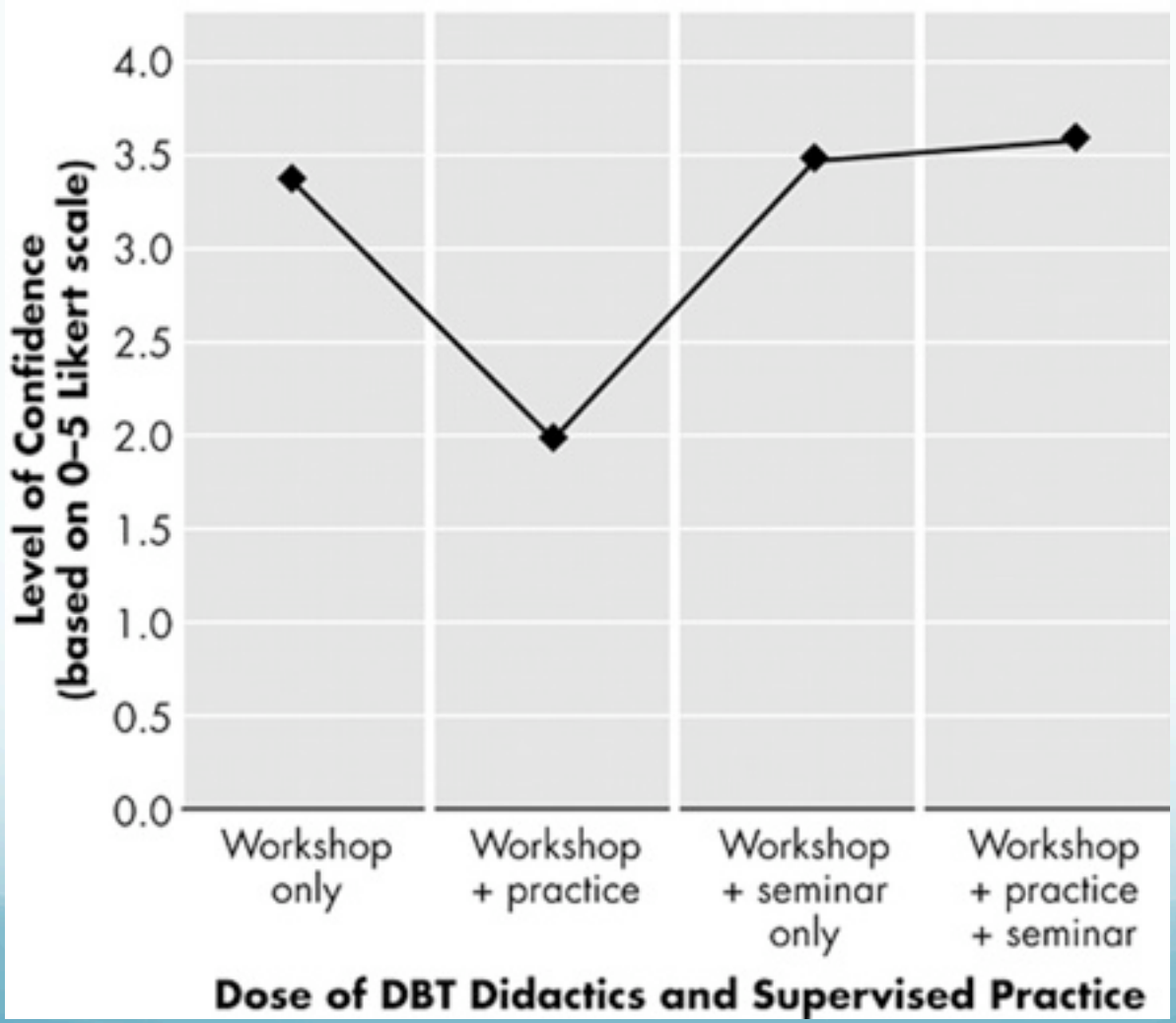
On- going clinical training

- Weekly two hour team meeting for supervision
- Residents have 1-2 individual training cases and rotate co-leadership of a DBT skills training group
- Review of individual cases
- Review of DBT skills group
- Ongoing didactics
- Periodic viewing of residents videotaped sessions and informal rating of these sessions

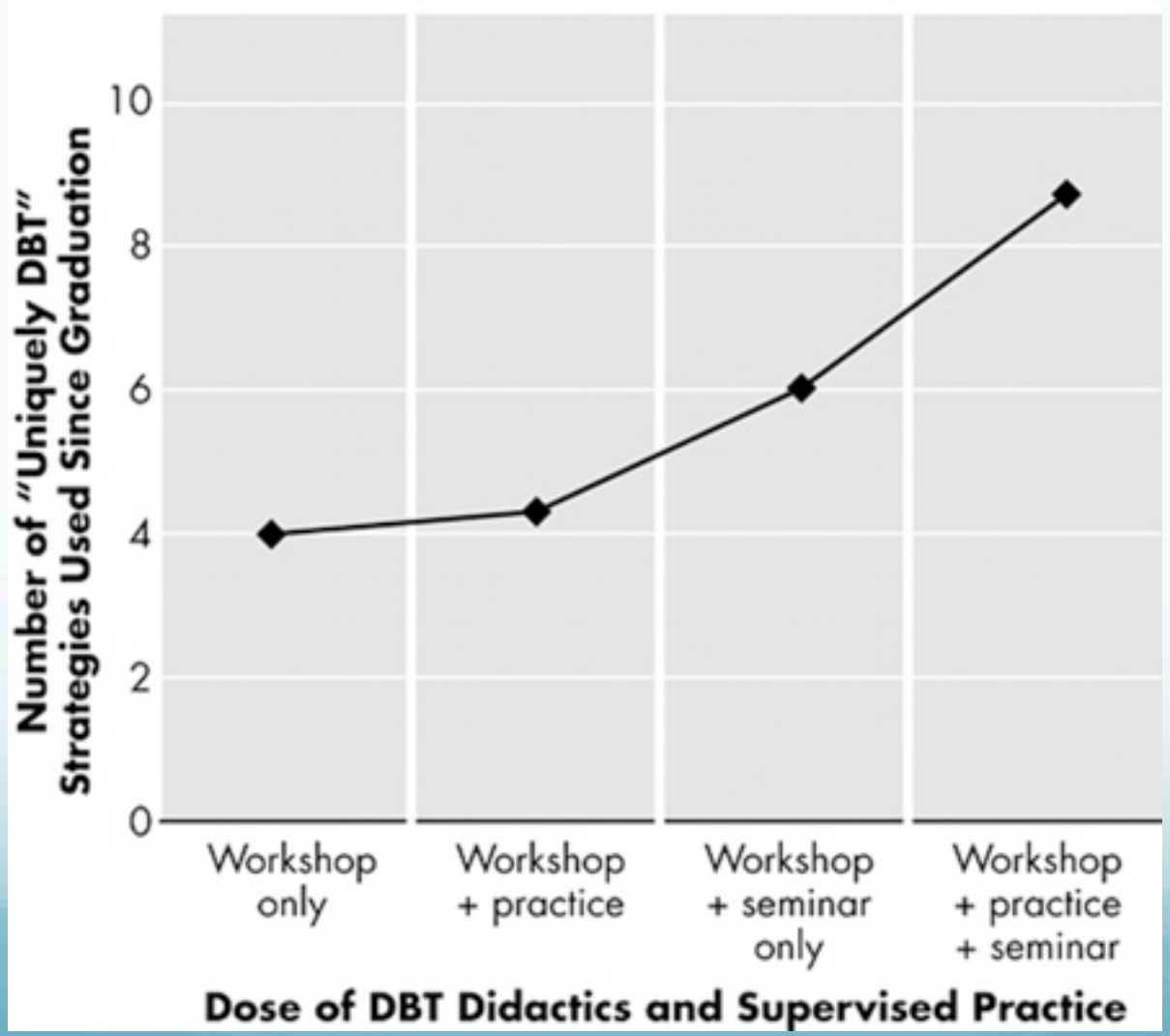
Preliminary results

- Despite the challenges, trainees report:
- Greater ability to feel empathy for and to manage negative reactions toward their BPD patients
- Developed greater confidence and effectiveness in managing suicide risk
- DBT gave them tools to understand self-destructive behavior and to intervene – skills, agenda setting, diary card, BA
- Comfort level with being available between session while observing boundaries
- Personal growth as a therapist
- More positive therapy experience – saw progress, had hope, liked their patients
- Felt supported by the DBT consultation team

Confidence to Treat Chronic SI/BPD



DBT Strategy Use by Training



Dissemination

- This curriculum has been presented at the 2011 annual AADPRT conference of psychiatry residency directors and the2012 annual conference of the American Psychiatric Association
- An article describing the curriculum, as well as an article by residents who have been through the program, is in press in Psychiatric Annals
- Book: The Dialectical Behavior Therapy Primer: How DBT informs clinical practice, by Beth S. Brodsky and Barbara Stanley, in press and publication expected in Fall 2013
- Consultation with various residency programs across the country to develop similar curricula and training
- Currently rating videotapes and conducting surveys to further evaluate this program

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