CHANGING THE MODALITY OF PSYCHIATRIC IMPATIENT CENTERS FROM TREATMENT AS USUAL TO DIALECTIC BEHAVIORAL THERAPY

Approved: __Susan Sebastian_____ Date: __11/29/2015_____

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A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin-Platteville

In Partial Fulfillment of the

Requirement for the Degree

Masters of Science

In

Education

Adult Education

By

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2015

Abstract

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The purpose of this paper is to implement evidence based treatment from research done at residential centers, inpatient centers, partial hospitalization, outpatient, and emergency rooms. Using research articles to reinforce the need for changing the modality of the Inpatient Centers (IC) from treatment as usual to short term Dialectic Behavioral Therapy (DBT) based treatment which will give patients the skills needed to effectively step them down to a lower level of care.

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Chapter One: Introduction

Using different therapeutic interventions from the CBT model effectively changes the modality of IC to short term therapy and skills training that assists patients with deficits of distress tolerance, emotion regulation, and interpersonal effectiveness. Using DBT forms clinical teams within the IC staff to effectively treat the patient as a team instead of individuals. This incorporates the therapeutic alliance and skills reinforcement needed to minimize the dysregulation in patients while in IC and when they discharge. When learning skills the whole team reinforces the skills in groups, individual sessions, and in the milieu. This integrated approach is effective in the patient learning and working on mastery of the skills to use during crisis situations once they leave the IC and step down to the appropriate level of therapy. Current treatment as usual in IC is not addressing the lack of skills used when there are external stimuli in the environment which leads to self harm, suicide, and continuous inpatient stays.

Statement of the Problem

The current treatment as usual in inpatient settings is ineffective for patients who admit for various life threatening behaviors to effectively step down to a lower level of care.

Delimitations of Research

The research was conducted in and through the Karman Library at the University of Wisconsin-Platteville, over ninety (90) days. Primary searches were conducted via the Internet through EBSCO host with PSYCH, Academic Search Elite and Google/Google Scholar as the primary sources. Key search topics included “DBT”, “Inpatient”, and “Meditation”.

Method of Approach

A brief review of literature that is empirically based peer reviewed journal articles about previous inpatient stays, and current outcomes of DBT under the CBT umbrella, techniques and program success with different psychiatric diagnosis. A second part of my research will be on which DBT skills work best for crisis and long term problem solving to limit the need of inpatient stays. This project is going to show how to implement DBT into an inpatient center to effectively change the effectiveness of inpatient stays. This is a theoretical paper that would require further research into the different aspects described below.

Chapter Two: REVIEW OF LITERATURE

THE EFFECTIVENESS OF INPATIENT CENTERS

Psychiatric inpatient centers are a necessary step for some patients that need a higher level of care because of patients that have skills deficits during high levels of acute environmental stressors. Patients who enter the inpatient settings have a variety of different diagnoses across Axis I and II. According to a study done by Doerfler and Moran 65% of patients that are admitted come in due to suicide risk. . (Doerfler, 2010) There are a wide variety of life event stressors with common themes of skills deficits. The following statistics are from one study done with 97 adults. These are the top life stressors that were associated with the reasons for entering the inpatient center. Following these are the distress ratings with a scale from 1 “not at all” to 5 “very much”. The following list is comprised of different stressful

events before being admitted. 38% reported a family member does something rejecting or upsetting (distress rating of 4.6), 32% quarrel with family members (distress tolerance 4.2), 22% someone in family experiences stressful events (Distress rating 4.1), 24% experienced a quarrel with other people (distress rating 4.1), 47% had financial problems (Distress rating 4.2), and 19% had a friend experience a stressful event (Distress rating 3.9). (Doerfler, 2010) This shows that there is a need for skills training utilized by inserting DBT skills of emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness.

Areas that need to be changed for a therapy centered treatment include patient admission, therapeutic alliance, suicidal assessment, and more effective groups. Through different research there is a higher probability of readmission to the IC than effectively stepping down to a lower level of care. According to a study done by Saw, Zane, and Murphy, Asian Americans had 1.2 inpatient stays, white Americans had 1.9 inpatient stays. These are all adults with criteria to warrant admission for IC. The stay averaged 10.585 days (both races). (Kim, 2014) Similarly a randomized study done by Ellis, Allen, Green, Jobes, and Nadorff found that their participants had an average of 2.8 prior psychiatric hospital stays. (Ellis, 2012) This poses a question of treatment effectiveness during an IC stay. Similarly there are other studies done that had similar outcomes of prior stays. Participants of these studies had high risk for suicide.

According to an article written by James L. Knoll IV, MD who is the editor in Chief Emeritus of Psychiatric Times and also a professor of Psychiatry at the Sunny Upstate Medical Center in Syracuse, wrote about the problems which resulted in suicide in Psychiatric Inpatient Centers. There are over 35000 completed suicides each year of which 6% are completed in IC.

The greatest reason given by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) which is comprised of a 10 year data study is failure in clinical assessment of suicidality. According to Knoll "The failure to conduct an adequate suicide risk assessment, when necessary, deprives the psychiatrist and hospital staff of the ability to use reasonable professional judgement in determining the proper safety precautions required for the patient." This is a breakdown of not only adequate assessments, but the breakdown of a clinical team between frontline staff, nurses, and doctors. In Knoll's article he calls this a breakdown in the therapeutic alliance. Staff become judgmental when they view clients as Knoll says "manipulative, provocative, unreasonable, over-dependent, or feining." (Knoll, 2012) In one study done by Busch, Fawcett, and Jacobs, looking at 76 completed suicides done in an IC 78% denied suicidal ideations and 51% were on enhanced observation of 1:1 or 15 minute checks. (Busch KA, 2003) Knoll and JCAHO's assessment of the breakdown of the therapeutic alliance and the overconfidence of enhanced observation calls for a change in the therapeutic alliance which will be covered in the DBT for Staff section of this paper. The shift from treatment as usual to CBT will be covered in the rest of this section.

CBT OVERVIEW

CBT is the umbrella therapeutic interventions of CT, ERP, DBT, and BA fall under. The basic principle of CBT is a psychotherapy that focuses on the relationship between thoughts beliefs and behaviors that is goal-orientated and behavior focused. CBT is an empirically evidenced based therapy that is used to reduce or extinguish symptoms of a patient's mental illness. Studies show that CBT paired with psychopharmacology is more effective than psychopharmacology alone. (National Alliance on Mental Health , 2012)

DBT THEORY

The three theories behind DBT are the biosocial model, behavioral model, and dialectic philosophy. The biosocial model is a genetic predisposition to vulnerability of emotions and an invalidating environment which contributes to the suicidal ideations and self-harm in patients due to the higher baseline of emotions coupled with the lack of skills needed to bring the emotions back to the already heightened baseline and the vulnerability of external stimuli to emotion reactivity. The behavioral model identifies thoughts, emotions, and actions demonstrated by the patient. This is important in the conceptualization of a treatment plan and the continuation of the clinician's therapeutic interventions. The third aspect, DBT, is the dialectic philosophy of acceptance of where the patient is at and the push for change. Using a non-judgmental stance and describing the interactions of the patient in the IC behaviorally helps the clinician with behavioral reinforcements and punishments both positive and negative. The dialectic philosophy helps the clinician with validation of the emotion without validating the target behaviors. (Rizvi, 2013)

DBT CONSULTATION TEAM

Staff on an IC usually consist of front line staff (FLS), skills trainers (role could also be filled by therapists or psych nurses), nurses, dieticians, experiential therapists (art, music, or general ET) therapists (LCSW, LPC or equivalent, PHD), psychologists, MD (general and psychiatrists). These can be cross trained and duel positions depending on the facility and the state licensure laws. According to the JCAHO and Knoll one of the main methods of decreasing completed suicides on inpatient is implementing DBT for staff is to strengthen the breakdown in the therapeutic alliance within these positions (In DBT all of these positions are included in the team and clinician/therapist is interchangeable).

"I have come to believe that it is extraordinarily difficult to deliver effective treatment to most borderline patients without consultation or supervision. I have been amazed at how many very good therapists end up conducting ineffective therapy or making major mistakes with this patient population." – Marsha Linehan (Linehan, 1993)

Consultation team is often referred to as "therapy for the therapist." The team's role is to "help the therapist think clearly about how to conceptualize the patient, the relationship, and behavioral change in DBT theoretical terms, and how to apply the treatment skillfully." (Linehan, 1993)

This changes the dynamic of clinicians from separate entities to a cohesive team that communicates effectively with each other in a supportive role to effectively treat the patient.

ADMISSION AND CONTINUOUS SUICIDE/ SELF HARM ASSESSMENTS

Linehan Risk Assessment and Management Protocol (LRAMP) is an updated version from Linehan to effectively assess for the immediacy of a patients' suicidal ideation and/or urges to self harm. This assessment along with the IC's current admission assessments will help with an adequate concise measurement of suicide risk factors. This can be used during their stay by any of the clinicians. The assessment has a page that helps the clinician with treatment actions aimed at reinforcing skills during a patient's crisis situation and helps the clinician assess and implement emergency interventions if needed. (Linehan M.M, 2009)This is then reviewed by the therapist to help with future interventions. This primary therapist individualizes the therapeutic interventions to help promote the reinforcement of skills that the patient reports as effective during a crisis situation. This document assists the clinician with debriefing after the event and highlights crisis intervention techniques used and during debriefing team can receive feedback to strengthen the team in future crises. Bringing it to the team will help with support

for the clinician and assist with education for all staff. This document is available online at http://blogs.uw.edu/brtc/files/2014/01/SSN-LRAMP-updated-9-19_2013.pdf.

MINDFULNESS FOR PATIENTS

Mindfulness is the practice of being awake focused and present in the moment or the here and now without judgement of the situation. Some of the skill sets within the DBT model for both the team and the patient is being able to observe, describe, and participate in that moment. When observing the moment the patient or team member is present and takes in what is going on around them without preconceived judgements or judgements while it is happening. The second component of observing is being able to describe the situation behaviorally without "short cuts" in explanation of the event. Suzie is by herself sitting in the chair with her legs crossed, arms crossed, with her head down instead of Suzie is isolating and curled up in the chair avoiding eye contact. This takes any judgmental words out of the description which would otherwise illicit thoughts of why she is doing it. This is helpful when making therapeutic interventions and the most effective skills for addressing the behavior. By being in the here and now patients are able to do so with mastery. The last skill that is described is participation. When participating the patient throws themselves into the activity even if self-judgmental thoughts come in. The patient then is able to be in that moment without thoughts of future or past. During the inpatient stay Mindfulness is useful for many different diagnosis and there are only a few criteria that wouldn't be susceptible to the efficacy of mindfulness based practice, including severely acute depressive patients that are unsuitable for group mindfulness. Patients that are in active psychosis, manic state bipolar patients, patients that are severe rating of being disassociated, poor insight, current or recent AODA both under the influence or during intense detox where the patient would be unable to be mindful of the current moment or physically affected, and those opposed to

treatment with no willingness to participate would fall into this category as well. It is best when mindfulness moments are practiced by team and patient during the day. If they are unable to participate and be mindful of the current moment they are removed and then during team debriefing discuss when the patient can rejoin group.

There are a few precepts to implementing the mindfulness portion of the therapeutic shift. Staff need to be intensively trained. Staff includes frontline staff, therapists, nurses, doctors, and psychologists. When the team is trained and meeting regularly the ability to talk to patients about mindfulness, continued psychoeducation, and effectively building mastery increases.

DIARY CARDS

According to Koerner's book Doing Dialectic Behavior Therapy There are multiple reasons for using a Self-Monitoring diary card. The diary card is a self-monitored diary card that is filled out once per day to assess the patients suicidality and self-harm. The next section looks at misery per day. Then with the therapists help the patient starts tracking different behaviors that they want to change with an increase or decrease. At the end of the front page of the diary card the patient rates different emotions (all of these can be modified for the individual). At the bottom it looks at the agenda of the patient, what happened, and goals for the day. The back lists skills that they used during the day in a check mark form. There are many reasons why this would help especially in an inpatient setting when meeting individually with the therapist. The therapist looks at this card each day and can help the patient notice trends in environmental stressors or events that caused an increase or decrease in their behavior that they want to change, self-harm or suicidal urges or attempts, and difference in emotion. With this laid out in front of the therapist they can talk with the patient about different skills that can be used in different

situations to assist in increasing or decreasing the behavior and the S/I or S/H associated with the event. This helps in time management of the session so both the therapist and the patient can look at the higher stressed times and what worked and what didn't which through sessions can help the patient become aware and mindful of their own reaction to different stimuli. With most patients returning to the inpatient center at least two times they lack the skills during these times in order to effectively manage the situation without crisis or at least have the skills to change the outcome of the crisis from that of inpatient to that of being uncomfortable with the tension that the situation caused. (Koerner, Doing Dialectic Behavior Therapy, 2012)

BEHAVIORAL CHAIN ANALYSIS

The Behavioral Chain Analysis (BCA) is an intrigue part of DBT and with the IC. The BCA is used when a patient reports or engages in a target behavior. This helps build insight not only of the problem behavior but also what initiated the behavior, the vulnerability factors that contributed to the behavior, what the patient felt emotionally, how it affected people/environments, what skills could be used instead of the target behavior, and how to repair, correct, and over correct the satiation. This is a helpful tool for the patient as they have to look at what they did and what they could have done instead. Using a BCA upon admission (if they are able to) helps formulate a treatment program and help with case formulation. This can be used for any behavior that is exhibited by the patient. It is not a punishment and should be used for psychoeducation, pattern formulation, and skills enforcement. (Koerner, Doing Dialectic Behavior Therapy, 2012)

SKILLS GROUPS

Skills group is the most essential aspect to implement in the IC. There are many different skills in the DBT Skills Training Handouts and Worksheets by Marsha M. Linehan. There is also a DBT skills Training Manual for the Skills Trainer. The Handouts and Worksheets book should be given to each patient guided and directed by the therapist. The following is a sample of what skills should be taught at an IC.

MINDFULNESS

The main point as stated in the training manual is to reduce suffering and increase happiness or to experience the here and now for what it is without judgements. (See previous section on Mindfulness)

DISTRESS Tolerance

According to the Training Manual the goal of Distress tolerance is to get through a crisis without making things worse. Crisis situations are, by definition, short term. These are skills to only get through the crisis and are not a lifestyle. This will assist with patients when they return to their community or lower level of care by teaching short term skills to survive the crisis without ending up back in inpatient.

EMOTION REGULATION

The manual States that the overall goal of emotion regulation is to reduce emotional suffering not to get rid of the emotion. This will teach skills that they can use when they are experiencing dysregulated emotions due to vulnerability factors and environmental stressors.

INTERPERSONAL EFFECTIVENESS

The goal of this skill is for the patients to learn how to interact with others with the outcomes they want (their goal) without losing their self-respect or building more tension between themselves and the other person. This skill is important to teach being able to effectively ask for something they want, observe and describe their own limits, or explaining what they are feeling and effectively ask for help.

The goals of each of the skills are brought right out of the DBT Skills Training Manual (Linehan M. , 2015)

These skills would be taught in a continuous rotation as to be covered every week. Mindfulness is to be put into the daily schedule multiple times a day. Staff will be trained on each of these skills to be able to coach and reinforce these skills throughout their stay. If a resident will only be there for a few days the therapist will create individual skills training for the patient from the treatment planning after intake.

DISCHARGE

The patient will work with the therapist, treatment team and family if applicable to ensure a proper step down of care to minimize readmitance into the IC. The patient will be given skills worksheets and suplimental material to assist resident with their transition out of the inpatient center. Goals sheets and coping cards will be made throughout the stay and given to the patient at discharge.

SUMMARY

Inpatient Centers are ineffective at teaching skills to avoid, manage, or tolerate crisis situations. Using these skills that have been proven to reduce self-harm and suicidal ideations in patients will help the patient effectively step down to a lower level of care. Implimenting DBT

consultation team and DBT skills to the staff will help with the therapeutic alliance between staff and the patient and help with formulating treatment in a team aspect which will help with limiting the suicides in inpatient centers. Propperly assessing S/I and S/H at admission and utillizing the LARP will help with limiting the possibility of minimizing suicide urges. Skills groups will give the patient the education and tools to be able to talk to others and effectively ask for what they want without creating a crisis situation or if one arises they are able to survive it skillfully. There are other treatments within the CBT umbrella that would be utilized by the Therapists and treatment team per patient need.

CONCLUSION

Based on the research done in different psychiatric and hospital settings the need for therapeutic change is necessary. This paper is based on theory and my hope is that this paper highlights the need for further research. The 65% of people that come in to inpatient centers due to suicide risk have ineffective skills to tolerate the stress associated with their current situations stated above. With the skills group teaching how to regulate emotions, tolerating distress, being in the present moment without judgement, and learning how to effectively commuicate with interpersonal effectiveness skills that have been effective on other psychiatric settings in theory will be effective on a short term inpatient setting. With the proper training to mileu staff, therapists, and medical doctors there can be a positive change of therapy in inpatient centers. There is lack of published data to prove the efficacy of this setting short term and would have to be extensively tracked which is hard to do when some patients come in and leave within a week and the complete set up can prove effective even in the short stay. This therapy will work best in

general inpatient center while other therapy techniques will be effective on certain specialty units.

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