Coping with Chaos: Working with Individuals with a Borderline Personality Disorder

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Objectives:

- Define how to work with Borderline Personality Disorder in a case management context.
- Describe how Dialectical Behavioral Therapy is used to decrease self- harm behaviors and decrease utilization of emergency rooms.
- Implement case management functions with persons receiving DBT, supporting and enhancing therapy.

BPD Overview: Causes, Incidence and Risk Factors

- Causes are unknown- Genetic, family and social factors are thought to play a role.
- Risk Factors:
  - Abandonment in childhood or adolescence
  - Disrupted family life
  - Poor Communication in the family
  - Sexual Abuse

  Incidence: Tends to occur more in women and among hospitalized psychiatric patients

BPD: Symptoms

- Uncertain about identity- causing interests and values to change rapidly .
- Tend to see things in extremes
- Views of people may change quickly- causing unstable relationships.
- Feelings of: abandonment, emptiness, boredom, frequent displays of inappropriate anger, impulsiveness with money, substance abuse, sexual relationships, binge eating or shoplifting, intolerance for being alone, repeated crises.
- Acts of self injury- wrist cutting or overdosing.

BPD: Treatment

- Types of individual talk therapy: Dialectical Behavioral Therapy (DBT)
- Group Therapy- can help change self-destructive behaviors
- Medications: can help with mood swings and treat depression or other disorders that may occur with this condition.
- Prognosis: Depends how severe condition is and the willingness of the individual to accept help. Gradual improvement can occur .

BPD: Suicide and self harm

- 80% of individuals with BPD have suicidal behaviors and about 4-9% commit suicide.
- Self harming behaviors: do not stem from a desire to die
  - Include: Cutting, burning, hitting, head banging, hair pulling among other harmful acts.
  - Individuals self harm to help regulate emotions, punish themselves or to express pain.
  - These individuals do not always see these behaviors as harmful.

DBT Overview

- A treatment designed specifically for individuals with self harming behaviors and many that meet the criteria for BPD.
- Empirically supported treatment.
  - Biopsychosocial Theory
- Individual and group therapy, along with phone coaching as needed.

DBT: Invalidating environment

- Invalidating environment is usually other people.
  - “Invalidating” refers to a failure to treat a person in a manner that conveys attention, respect and understanding.

- In DBT BPD arises from the transaction between emotional vulnerability and the invalidating environment.

DBT: Dialectics

- Is a complex concept that is rooted in philosophy and science.
- Involves from several assumptions:
  - Everything is connected to everything else
  - Change in constant and inevitable
  - Opposites can be integrated to form a closer approximation to the truth.
- DBT uses specific dialectical to help clients get “unstuck” from rigid ways thinking or viewing the world.

DBT: Last notes…

- Individual therapist is "in charge of treatment"- coordinate treatment with other people:
  - i.e.- Skills group leader, vocational counselor and case manager
- Case Management in DBT:
  - Task Specific
  - Time limited

RGHS - BHN Service Lines

Service Line	Affiliate	Number Served (2010)	% of Service to Community (2010)	
Children and Youth Services				
Outpatient Clinics –				
RMHC	BHN	815	16.5%	
GMHC	RGH	1405	28.5% = 44.0%	
5 School Based Health Centers	RGH	2918	n/a	
Community Based Services (RSCD, Monroe County, etc)	BHN/RGH	266	n/a	
Adult Services				
Outpatient Clinics –				
RMHC	BHN	3264	14.6%	
GMHC	RGH	2846	12.7% = 26.3%	
Case Management	BHN	599	31.8%	
Rehab/Addictions Services				
Personal Recovery Oriented Services (PROS)	RGH			
RMHC		212	14.6%	
GMHC		157	12.7% = 26.3%	
Grants – MICANet, PATH, MICA Homeless, Recovery Connections	BHN	83	n/a	
Addiction Services	RGH	917	11.1%	
Acute Services				
Inpatient - G-1	RGH	570	19.2%	
1-South	NW		100%	
ED	RGH/NW	2667	26.39%	
Consultation Services	RGH/NW	985	n/a	

BHN Org. Structure
BHN Clinical Components
BHN DBT Representation

<Handouts>

BHN Case Management Program

- Serves adult clients throughout Rochester Area - Referred through the Single Point of Access - SPOA (county wide); must be SPMI
- 214 Intensive Slots (Minimum 4 contacts/month)
- 240 Supportive Slots (Minimum 2 contacts/month)
- Shire Program – serves 30 residents
- Team of 28 case managers; manager; coordinator
- 3 case managers, 1 program coordinator, 1 therapist liaison on our DBT Team.

1) We are part of Rochester General Health System, yet our clients may participate in many different systems.

2) We work with clients in the community, where skills generalization is most needed, yet we are not the person responsible for clinical decision making.

1)We are part of a system, yet our clients may participate in many different systems.

Relates specifically to our referral source:

-SPOA is a county-wide process, with mandated “slots”

-We don’t turn people away

-While our services (case mgt) are through RGHS, therapy may be provided elsewhere

2)We work with clients in the community, where skills generalization is most needed, yet we are not the person responsible for clinical decision making.

This has to do with treatment structure – we are part of a clinical intervention, yet we do not necessarily have "clinical" degrees – psychopathology, theory and practices classes, etc.

We don't direct treatment.

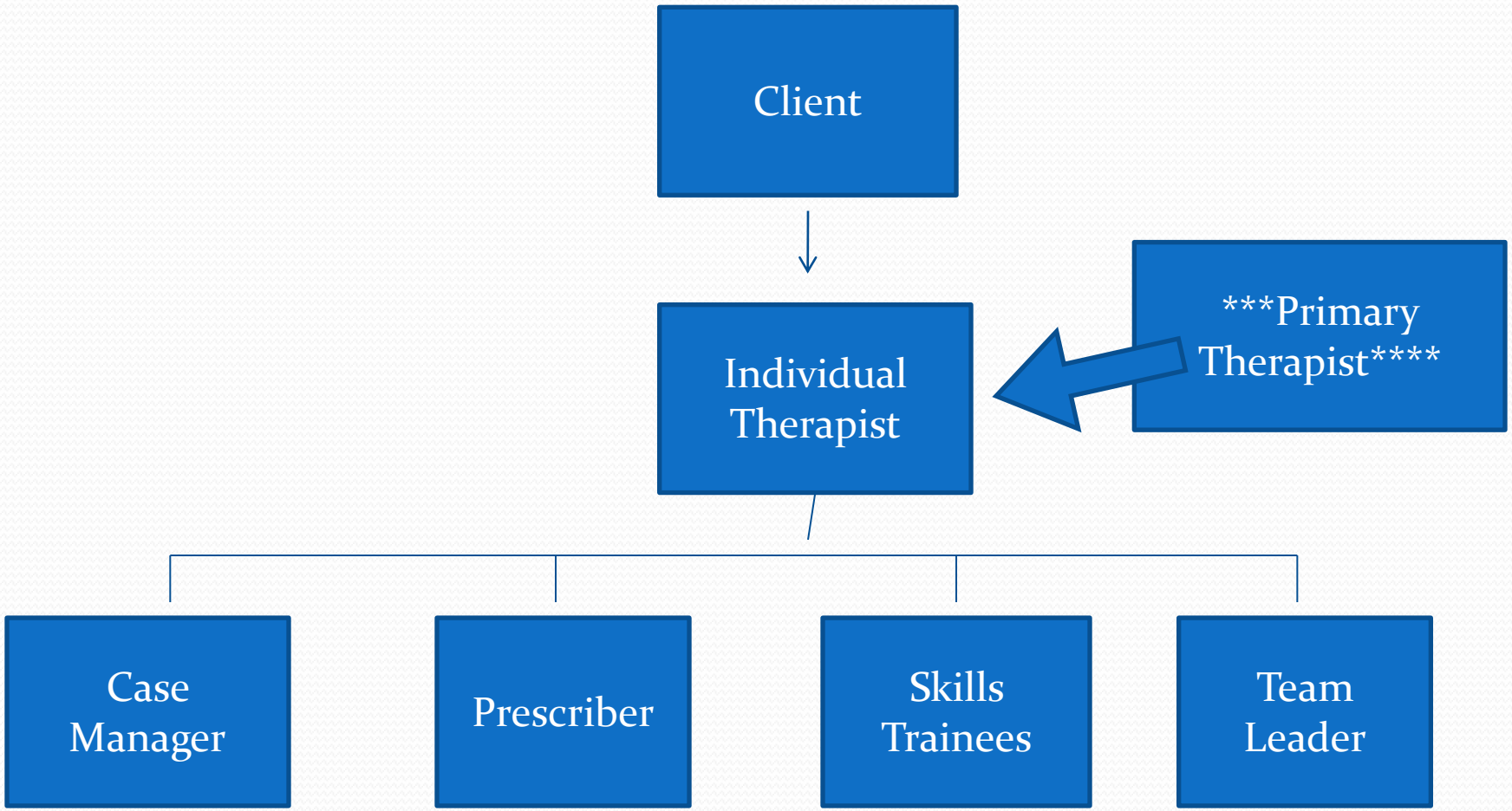
DBT Case Management Concepts:

- The function of case management is to act “in consultation to the patient” to coach and educate regarding community resources and assist with linkages only when necessary.
- The goal of case management is to be short term, task focused, assisting with tasks the client is unable to accomplish
- The primary therapist will take the lead in directing treatment (we all work for the client, but report through the therapist so that treatment is consistent and cohesive)

DBT Functions for Case Management

- ***Enhancing Capabilities***
  - This is accomplished through the individual work between the case manager and the client and at times linkage to other community based resources.
- ***Improve Motivational Factors & Assure Generalization to the Natural Environment***
  - Cheerleading & Coaching for use of existing skills (particularly distress tolerance)
- ***Structuring the Environment***
  - Case managers continue to assist clients in structuring their environment largely through their role of educators about community resources and services that may be required/desired by the client to accomplish their goals, change their situation, or improve their circumstances.

Treatment Structure



From DBT Intensive Training Manual

Our Thoughts

Despite the fact that those we work with may be part of our system or may have outside providers, we can do a better job clarifying our role as a case management provider, clarifying expectations, personal and professional limits, and our mission for **all** those we serve.

Reference:

Case Management Intervention Guidelines

&

Suicidal Statement/Behaviors Protocol for Case Managers

Purpose

- Align treatment approach
- Enhance collaboration efforts
- Clarify limits & contingencies
- Reinforces our role as a *consultant-to-the-client*.

What is the difference between how I would approach a client that is not committed to DBT (not in DBT therapy), but would still benefit from this approach and someone who is?

Our Thoughts

Certain Concepts Will Apply "Across the Board:"

- Reinforcing distress tolerance & cheerleading strategies in the field.
- Case Management Intervention Guidelines
- Reinforcing our role as a consultant-to-the-patient. (our goal for all patients, not just DBT-related, is to become more autonomous, their own case managers)

Our Thoughts

Certain facets will be more closely related to those receiving DBT therapy:

- Will attempt to assign to a DBT case manager
- Will reinforce 1st session meeting with therapist
- Will review Client Agreements (preferably at meeting with therapist)
- Will coordinate regularly with therapist to determine any role in treatment targets
- DBT Case Managers will meet monthly for Consultation Team to adhere to treatment
- Will track progress (discuss strategies to do this)

Our Thoughts

PROTOCOLS to Review:

- **Consistency and Communication with Clinical Team**
- **Case Management Intervention Guidelines**

Case Presentation from Case Management Team

Overview of Client A

Overview of Client B

Client Goals

Client A:

Living more independently

Increasing visits with her children

Client B:

Live in her own apartment

Discharge from RPC

Primary Target Hierarchy

Client A

- Decreasing self harm related to overdose
- Decrease use of ED
- Decrease suicidal thoughts
- Decrease inpatient stays (psychiatric and physical)
- Increase seeking support when in distress (before engaging in target behaviors)

As treatment progressed and commitment was gained, the following also become targeted as therapy interfering behaviors:

- "Storytelling" – ex. Her mother dying.
- Using case management visits to debrief about therapy, rather than focus on case management goals.

Primary Target Hierarchy

Client B:

- Decreasing self harm related to cutting, overdosing, hanging attempts.
- Decrease aggressive behaviors towards others.
- Decrease inpatient stays and emergency department visits.
- Increase use of skills.

Approach

Client A

- Therapist as clinical coordinator
- Commitment to treatment target behaviors
- Limits communicated and observed (therapist and case manager)

Client B

- Community protocol
- Clinical care through one community provider, case management through our system

Outcomes

Client A

- Has been able to decrease her visits to the emergency room from 250 in the past year, to one in the last 3 months (mid-June to mid-August). She has maintained housing for a couple of months consecutively. Had not reported any overdose attempts until around the time this report is being written, she did contact therapist after this attempt, but did not go to the emergency department.

Client B

- Persisted in frequent emergency department visits, court appointments, cutting behaviors, and aggressive behaviors towards others (assaulted and EMT). She was eventually admitted inpatient to Strong and then transferred to Rochester Psychiatric Center for prolonged hospitalization.

Challenges

Client A

- Initial challenge in establishing role of therapist and case manager.

Client B

- Interventions tended to be crisis-oriented.
- Roles were unclear.
- Significant reinforcement of target behaviors through environment intervening.

Questions/Comments/Thank You!