



Reasons for premature termination of dialectical behavior therapy for inpatients with borderline personality disorder



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ARTICLE INFO

Article history:

Received 29 January 2014

Received in revised form

4 June 2014

Accepted 1 July 2014

Available online 9 July 2014

Keywords:

Borderline personality disorder

Comorbidity

Inpatient treatment

Dialectical behavior therapy

Dropout

ABSTRACT

Although one of the main aims of dialectical behavior therapy (DBT) for borderline personality disorder (BPD) is to increase the retention rates, premature termination rates for DBT inpatient programs were found to be over 30%. The aim of the study was to identify the reasons for, and to analyze, patient characteristics that are associated with premature termination. We studied 541 inpatients with BPD, who were consecutively admitted for an open-door 3-month DBT inpatient treatment in Berlin, Germany. All participants completed several self-rating measures and participated in clinical interviews. Fourteen percent, who did not complete the full 84 days of assigned treatment, were expelled, mainly due to treatment-disturbing behaviors, or substance abuse or possession. Nearly 19% dropped out of treatment, mostly due to lack of motivation, arguments with others, and poor tolerance of emotional distress. Using non-parametric conditional inference trees, expulsion was associated with anorexia nervosa and alcohol abuse, whereas more than 9 suicide attempts, antisocial personality disorders, and more than 86 weeks in a psychiatric hospital were risk factors for dropout. We discussed measures and interventions that might lead to an adaptation of DBT inpatient programs. Future research should examine the symptom course and utilization of health-care services of non-completers.

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Dialectical behavior therapy (DBT; [Linehan, 1993a, 1993b](#)) for borderline personality disorder (BPD) was originally conceived on an outpatient basis, but has been adapted to the inpatient setting ([Swenson, Sanderson, Duil, & Linehan, 2001](#)). The short- and long-term effectiveness of a 3-month open-door inpatient DBT was demonstrated by various work groups ([Bohus et al., 2004](#); [Fassbinder et al., 2007](#); [Höschel, 2006](#); [Kleindienst et al., 2008](#); [Kröger, Harbeck, Armbrust, & Kliem, 2013](#); [Kröger et al., 2006](#); [Simpson et al., 2004](#)). Although one of the main aims of DBT is to increase retention rates ([Linehan, 1993a](#)), dropout rates for DBT inpatient programs were partially high, ranging from 4% to 32% ([Höschel, 2006](#); [Kleindienst et al., 2008](#); [Kröger et al., 2006, 2013](#); [Perroud, Uher, Dieben, Nicastro, & Huguelet, 2010](#); [Rüsch et al., 2008](#); [Simpson et al., 2004](#)). In addition, these rates were difficult to compare since the treatment duration was different in all relevant studies, ranging from 3 to 4 weeks for an intensive form of DBT ([Perroud et al., 2010](#)) to the 3-month standard DBT inpatient program. Moreover, dropping out was often not explicitly defined and

differed between studies. Only two of the mentioned studies clearly defined dropout as either a “discontinuation with and without physician consent and transfer” ([Kröger et al., 2013](#)) or “leaving therapy before the end of the 11th week” ([Rüsch et al., 2008](#)). Applying the latter definition to the data of the [Kröger et al. \(2013\)](#) study would increase the dropout rate of 10%, since several participants were discharged before the 3 months were over due to obligations and changes in daily life. Finally, service-initiated expulsions due to non-adherence to stipulated treatment rules (e.g., unexcused absence from treatment sessions) and participant-initiated endings (e.g., disagreement with treatment goals and techniques) were not differentiated and analyzed in previous studies.

As shown for outpatient DBT ([Priebe et al., 2012](#); [Webb & Mc Murrin, 2009](#)), participants who terminated treatment prematurely might benefit less from an inpatient treatment attempt than completers. In addition, dropping out or expulsion from an inpatient program might decrease the motivation for starting a (new) treatment afterwards, even when there is a high burden of psychological strain. Examining reasons and predictors of premature termination might indicate how the DBT inpatient program could be adapted in order to engage and retain patients in therapy. If

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providers decide to maintain the inpatient program unchanged, the cost-effectiveness might be increased by offering assessment and standard treatment only for those who do not show characteristics in the early stages of therapy that indicate premature termination.

To the best of our knowledge, however, only three studies examined factors that were associated with premature termination, using multivariate methods (Kröger et al., 2013; Perroud et al., 2010; Rüscher et al., 2008). Premature termination was associated with younger age and substance abuse disorders (Kröger et al., 2013), fewer years of education (Perroud et al., 2010), fewer lifetime suicide attempts, and higher experiential avoidance (Rüscher et al., 2008). Including several predictors in a regression analysis, as in one study (Rüscher et al., 2008) requires a larger sample size than 60 participants. In addition, individuals with specific co-occurring mental disorders (anorexia nervosa, substance abuse disorders) were excluded from this study (Bohus et al., 2004; Rüscher et al., 2008), even though those disorders might be suggested as risk factors for premature termination (Kröger et al., 2010, 2013). In brief, results need to be confirmed and expanded in further analyses, which should be based on larger sample sizes with few exclusion criteria.

The aims of the current study are therefore (1) to identify reasons for both types of premature terminations (i.e., expulsion and dropout) separately, and (2) to analyze patient characteristics that might be associated with both types. Premature termination in this study was defined as not completing the full 84 days of assigned treatment. We distinguished between those who were expelled from treatment due to violations of signed treatment contracts from those who decided to leave treatment before the planned discharge. Following the suggestions of previous researchers (Barrett et al., 2008; McMurrin, Huband, & Overton, 2010), we used data of a large consecutive sample of inpatients admitted to a 3-month DBT program. In addition, we conducted a multivariate analysis using non-parametric conditional inference trees (Hothorn, Hornik, & Zeileis, 2006) in order to consider the possible interactions between included characteristics without any assumptions regarding the distribution. Based on previous studies (Kröger et al., 2010, 2013; Perroud et al., 2010; Rüscher et al., 2008), we hypothesized that younger age, fewer years of education, fewer lifetime suicide attempts, and substance abuse, as well as eating disorders, predict both types of premature termination.

Method

Participants

The participants were admitted consecutively to an inpatient unit of psychiatry and psychotherapy from September 2001 to February 2012. As the Berlin area has a well-developed network of outpatient DBT facilities (www.borderline-netzwerk-berlin.de), only those BPD patients who could not be integrated into an outpatient setting due to severity of illness (i.e., severity of BPD symptoms, comorbidity, low social functioning) were admitted for inpatient DBT. The only exclusion criteria were: a) age under 18 years ($n = 7$), b) severe mental retardation ($IQ < 70$; $n = 14$), dementia ($n = 1$) or acute symptoms of schizophrenia ($n = 12$), or c) current intoxication on the day of admission ($n = 25$). Other mental disorders were not excluded. This study was performed in accordance with the declaration of Helsinki. Written informed consent was obtained from each patient at admission.

Procedure and assessments

The following three-stage assessment procedure was undertaken to assess BPD and other mental disorders: (1) All those

interested in the treatment were invited to the outpatient clinic, where they were screened for BPD criteria, their medical history was obtained, and they were provided information about the DBT inpatient treatment. Those who met a probable BPD diagnosis were advised to contact the DBT inpatients' unit to schedule an admission date. The waiting time between the outpatient assessment and admission lasted about 6 months (range: 4–9 months). (2) During the first two weeks of the inpatient stay, the German versions of the *Mini International Neuropsychiatric Interview* (MINI; Sheehan et al., 1998) and the module for BPD of the *Structured Clinical Interview for DSM-IV Axis I Disorders* (SKID-II; Fydrich, Renneberg, Schmitz, & Wittchen, 1997) were used for assessing mental disorders, antisocial personality disorder (ASPD), and BPD. Master-level research assistants had been instructed in the administration and scoring of these instruments in a 3-week on-the-job training. They had to rate interviews of at least 10 patients, which had previously been conducted by a trained interviewer. Prior to data collection, they had to interview at least two patients and their results had to achieve a high level of agreement (at least $\kappa = .80$ for each MINI section) with those of a trained psychiatrist. The inter-rater reliability coefficient was $\kappa = .82$ for the BPD diagnosis. All the information (e.g., anamnesis, clinical observation of the therapeutic team) was taken into account for assessing the diagnostic criteria. In order to validate, complete, and adjust their results, the research assistants conducted SCID-II guided interviews with the patients' significant others. (3) In accordance with the LEAD-standard (Spitzer, 1983), interviewers met regularly with a trained psychiatrist or a certified psychotherapist to discuss the results of their diagnoses. If there were any doubts about the scoring of any diagnostic criteria, a trained psychologist or psychiatrist tested whether the participants met the criteria in question. Finally, all data derived from the diagnostic assessment tool were checked by a senior psychiatrist.

Measures

The anamnesis consisted of 26 questions about the patient and his or her problems. Data were saved in the electronic medical record system. All participants completed self-rating measures that were administered either before or after the interviews. The following measures were used: *Borderline Symptom List* (BSL-95; Bohus et al., 2007), *Beck Depression Inventory* (BDI; Hautzinger, Bailer, Worrall, & Keller, 1995), and *Dissociative Symptom Questionnaire* (FDS; *Fragebogen zu dissoziativen Symptomen*; Freyberger et al., 1998). In the present study, Cronbach's α s amounted to .98 for the BSL-95, .86 for the BDI, and .95 for the FDS. After analyzing the data, each participant was given written feedback and a recommendation for treatment planning.

Therapists and treatment

The multidisciplinary teams consisted of varying numbers of therapists during that ten-year time period, including at least two certified DBT therapists (max. five), two certified DBT co-therapists (max. five), and two DBT therapists in advanced training (max. five). In addition, the teams also intermittently included physicians in training as specialists for psychiatry and psychotherapy, as well as psychotherapists in training. Furthermore, the team consistently included social education workers, physical therapists, and occupational therapists, who possessed basic knowledge of DBT through in-house and external training programs. The team discussed the individual patients on a daily basis. Moreover, the team and the team leader met once a week with each patient to address the patient's needs, modify techniques, and determine how to overcome obstacles. The team was supervised once a week (2 h) by the second author (S.R.), who is a state-recognized supervisor for

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