Dr. Villalba introduces the Integrated Therapies Program at Butler

New program expands Butler's partial hospitalization programs

BY MARY KORR
RIMJ MANAGING EDITOR

BUTLER HOSPITAL/CNE

Dr. Rendueles Villalba II is a Clinical Associate Professor of Psychiatry and Human Behavior at the Alpert Medical School.

PROVIDENCE – In September, Dr. Rendueles Villalba II arrived at Butler Hospital to direct its new Integrated Therapies Program offered within a partial hospital setting. Three other partial hospital programs are already in place; this latest addition provides an existential and interpersonal psychotherapeutic approach to treating patients in crisis or who have reached an impasse in their outpatient treatment.

Patients attend a combination of tailored individual and group therapy and educational sessions for six hours each day over a compressed period of treatment. The average time in the program is five days, but sometimes can extend to several weeks. Patients range in age from 17 to 80-plus.

"The program is a hybrid between inpatient and outpatient care," Dr. Villalba said. 'Our patients receive all the services of an inpatient facility, but they go home in the evening. We have found that patients attending the partial hospitalization program are often more ready and capable to engage in in-depth psychotherapy than their inpatient counterparts. So when the custodial role of an inpatient service is unnecessary, an acute care partial hospital program like ours can offer a more elective, empowering, psychotherapeutically advantageous alternative."

Previous to his arrival at Butler, Dr. Villalba directed Rhode Island Hospital's partial hospital program for 17 years. He trained at both Cornell and Dartmouth in psychiatry and neuropsychiatry. He leads an interdisciplinary team which includes psychiatrists, social workers, mental health counselors, a program manager and a service utilization reviewer. His partial hospital practice includes an extensive quantitative outcome measurement protocol, which has received national recognition.

In an interview with RIMJ, he elaborated on his chosen field and the new program.

Q. What led you into psychiatry as a specialty?

A. Psychiatry presents a compelling challenge to wrestle with the ever mysterious relationship between the mental and the physical. Part science, part art, part applied philosophy, it is arguably the most intimate form of medicine. To do it well requires a presence of mind in the healer that becomes its own reward. I believe I am a far more enlightened human being for having shared in the inner lives of my patients. It is deeply gratifying to help a person grow emotionally and existentially.

Q. Your program is held within a partial hospital setting. Is that a relatively new concept?

A. It actually dates back to the 1940s, when it was first conceived of in Russia. I don't believe it caught on here in America till the 1960s and '70s. Butler Hospital has one of the oldest partial hospital programs in the country, of which there are about 700.

Q. Are the third-party payers willing to pay for this?

A. Yes. It is a less expensive alternative to inpatient care. Everybody wins – insurance company pays less, patients get a more intensive psychotherapy experience and families get to have mom or dad at home with them at night.

Q. Who are candidates for this program?

A. The vast majority of our patients present with mood or anxiety disorders. Many have been suicidal, or are experiencing some other crisis – debilitating grief, trauma related symptoms, a psychotic break, panic over a destabilizing life transition.

In addition to crises, we see patients who have reached an impasse in their outpatient treatment. An outpatient clinician may seek a second opinion about diagnosis or wish to try a more evocative psychotherapy intervention for a patient that seems "stuck." What makes us unique is our focus on existential and interpersonal therapy. The Integrated Therapies Program combines these particular approaches because we have found them to reciprocally reinforce each other. The existential content amplifies the experiential learning of interpersonal therapy.

Q. Can you elaborate on the meaning of existential therapy?

A. A simple answer to this tough question is a focus on the concept of time – how we live in time or how we live with the limits of time – the ticking clock. Commonly we push our finiteness out of our routine awareness – largely to function in our day-to-day lives without paralyzing fear or grief. In this way, death becomes a taboo rarely addressed, even in medicine. The existentialist will tell you this is a profound disservice. This "denial" of death leads to frankly dishonest living that will move toward the mundane or toward hollow heroics. These in turn, will produce crises of meaning of their own right, ultimately landing a person in a deeper dilemma than what the denial presumably meant to spare them. Denial of this sort causes great harm to everyone. Think of it as a type of self-inflicted blindness, and think of all the preventable bad things that happen in our world because of this blindness. Healthy awareness of mortality humbles us, clarifies priorities, frees us of trivial worry, orients us towards an empathic awareness of the vulnerability we all share, peeks our hunger for meaningful experience, prods us to work toward the common good.

Q. How do you broach this concept within the context of the patient setting?

A. Here's an example. A woman in her late 30s came to our program with a depression brought on by a break-up with her boyfriend. For five years she had engaged in a cycle of repeated break-ups and reunions with the same man. She was both sad and angry that she could not seem to rise above this trap. When she was with "Joe" she could only think of her freedom, as she found him overbearing and abusive. However, as soon as she left him a crushing fear of isolation would take over and she would rush right back. While painfully aware of feeling angry, she was confused as to why or with whom. At first, she thought she was angry with Joe for "manipulating" her. Then she would get angry with herself for letting him have this control over her. It was obvious in her mind, that this was a reflection of her self-perpetuating low self-esteem that she should "settle" for such a dysfunctional and frankly unloving relationship. However, as we explored how she was living in time (or its limits), she discovered a deeper source of grief and anger. For as long as she could remember, she had dreamed of being a mother. Still childless at the age of 35 and mindful of her "ticking clock," she suddenly appreciated how sad and angry she was for being cheated of her dream. This awareness helped her to find the conviction to not fritter any further time in her current relationship and to act more decisively toward a path that would make her dream of motherhood a more likely possibility. So, while she came to the program hoping for a "cure" of her depression or at least some of its symptoms, what she ultimately went home with was a deeper understanding of what really mattered to her and the courage to act accordingly. She came to see her depression as a call of her conscience to align her life with her core values.

Q. Have you done studies which show evidence of success in this approach?

A. We have collected outcome data on our patients for many years. We have examined over 10,000 admissions and seen substantial improvement in depression, anxiety, and suicidal risk. One study of sexually traumatized patients with PTSD and depression also found that our program helps to correct an exaggerated external locus of control – the feeling that chance or other people are in more control of your life than you yourself are. A person who has been victimized commonly has an

externalized locus of control. This is one of the sad consequences of trauma. To achieve an improvement in this area is very rewarding.

Q. In your years in practice, do you see it's more and more urgent to have programs like this today?

A. Psychiatry is growing in its needs and demands. The World Health Organization reports that incidents of depression are rising worldwide. It's the most prevalent medical problem throughout the world. This epidemic likely has to do with the profound changes underway in our global society. In the last few years in America alone, a spike in suicide correlates with the downturn in our economy. Poverty, unemployment, and war are obvious sources of adversity. But even things that many of us consider positive, such as technological advancement, can have very damaging unintended consequences. Take the invention of the cell phone for instance. Some would say this thing isolates us as much as it connects us. Think of all the face-to-face conversations that don't happen, that are texted and tweeted away because this is a more "efficient" form of communication. When we need a friend to "be there," do we really want them to arrive as a Facebook "like?" We are at risk of trading-in the actual for the virtual. People used to play in bowling leagues. Now they play video games.

Q. So we should put aside our mobile devices and bowl to feel better?

A. Yes, but not alone – with a friend!

Q. In your view, what is the trajectory in dealing with mental health issues in the 21st century?

A. We are making headway in understanding the biological foundations of mental illness and how psychotherapy works. Psychiatric outcome research is showing that the best results are produced when care is delivered by an empathic clinician, mindful of the therapeutic alliance, and who is skilled at making use of a patient's readiness to change. ❖ www.butler.org/itp

Rhode Island Medical Journal Submissions

The Rhode Island Medical Journal is a peer-reviewed, electronic, monthly publication, owned and published by the Rhode Island Medical Society for more than a century and a half. It is indexed in PubMed within 48 hours of publication. The authors or articles must be Rhode Island-based. Editors welcome submissions in the following categories:

CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports.

Maximum length: 2000 words and 20 references.

PDFs or Jpegs (300 dpis) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

CREATIVE CLINICIAN

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6.

PDFs or JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text.

POINT OF VIEW

The writer shares a perspective on any issue facing clinicians (eg, ethics, health care policy, patient issues, or personal perspectives). Maximum length: 600 words.

ADVANCES IN PHARMACOLOGY

Authors discuss new treatments. Maximum length: 1000 words.

ADVANCES IN LABORATORY MEDICINE

Authors discuss a new laboratory technique. Maximum length: 1000 words.

IMAGES IN MEDICINE

Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 400 words.

Contact information

Editor-in-chief
Joseph H. Friedman
joseph_friedman@brown.edu

Managing editor
Mary Korr
mkorr@rimed.org