The Use of DBT Skills and Pharmacotherapy in the Treatment of Difficult Patients in the General Hospital

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Objectives

- Review concepts of DBT
- Look at adaptability of DBT in the general hospital setting
- Evidence for medications for the difficult psychiatric patient

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<table>
<thead>
<tr>
<th>Affiliation/Financial Interest</th>
<th>Name of Organization(s)</th>
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<tr>
<td>Grant/Research Support</td>
<td>Pfizer, Reckitt Benckiser, Astra Zeneca, Wyeth</td>
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<td>Consultant</td>
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Dealing with the difficult patient

- Osler did not have much to say
- Winnicott - 1949 paper “Hate in the Countertransference”
  - 4 types of hateful patients
    - Dependent clingers
    - Entitled demanders
    - Manipulative help-rejecters
    - Self-destructive deniers
- Koekkoek et al, 2006 review of 94 articles

What is Dialectical Behavior Therapy?

- Relies on the principles of cognitive behavior therapy and Eastern meditative philosophy to help to regulate emotions.
- Focuses on development of skills in 4 areas: mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation.
- Used primarily for psychiatric outpatients, typically about 12-18 months in duration.

Five Functions of Comprehensive Treatment

1. **Enhance capabilities**
2. **Improve motivational factors**
3. **Assure generalization to natural environment**
4. **Enhance therapist capabilities and motivation to treat effectively**
5. **Structure the environment**

Case Presentation

- Ms. R., a 35 year old woman, admitted to the hospital after an overdose of 25-650 mg acetaminophen tablets.
- Described in the ER as “angry, entitled, and uncooperative.”
- Diagnosed with “depression with borderline traits” and placed in four-point restraints.
Dialectics as Persuasion
A method of logic or argumentation by disclosing the contradictions (antithesis) in an opponent’s argument (thesis) and overcoming them (synthesis).

Concepts of Dialectical Behavioral Therapy
- The notion of dialectics involves the assumption that within any reality, there is polarity.
- Internal synthesis of previously opposing ideas can lead to resolution of internal conflict and lead to change.

Dialectical Failures
- An inability to integrate two opposing feelings, desires, or points of view.
- As a result, there is ‘splitting’ - little awareness that contradictory emotions like joy and sadness or love and hate can exist simultaneously.
Behavioral Interventions
- Natural schedule of reinforcement works well for most patients but can cause trouble for patients who struggle with emotional regulation.
- Patients may feel that the only time they will get attention is when they are in crisis.

Behavioral Interventions
- In outpatient DBT, patients are instructed to call their treaters before they are in crisis.
- If patients commits a self destructive act, no contact for 24 hours.
- Changes schedule of reinforcement from inadvertently reinforcing crisis.

Behavioral Interventions
- Emotionally dysregulated patients will tend to seek reassurance form staff; will become frantic if calls go unanswered.
- Patients may create crises to obtain attention.
- Relationship based on collaboration and respect make it more likely that the patient will act more appropriately.

Skills Teaching
- Mindfulness – the ability to have an awareness of one’s thoughts feelings and behaviors in the present.
- Interpersonal effectiveness - the process of analyzing an interpersonal situation to identify the patient’s goals for that situation.
Skills Teaching

- Emotional regulation – The identification and labeling of emotions as well as strategies to reduce vulnerability.
- Distress tolerance – Learning to bear pain skillfully through a set of strategies (journal writing and self-soothing) used to tolerate painful situations.

Use of DBT Skills for Difficult Patient-Staff Interactions

- How can patients cope better with the medical environment so that they get the care they deserve and need?
- How can staff more effectively manage difficult patients?

Step 1: Validation

- Validation allows patients and staff to be heard.
- State things from patient’s point of view (e.g. “I can see that it seems like you are suffering....)"
- Help each person express his or her side of the story.

Step 2: Use of Dialectics

- DBT emphasizes that reality is whole and can have simultaneous good and bad qualities
- Change is not all or nothing, but continuous and transactional.
- Identity is not static but dependent on interpersonal relationships.
Step 2: Use of Dialectics

- Staff need to be educated to realize that they themselves have been part of a dialectic by becoming polarized in their points of view about the patient.
- The psychiatric consultant can act as a mediator and a validator, helping staff to synthesize their view of the patient.

- Patient also needs to be validated and also understand that harmful actions are unacceptable.
- Acknowledge a reality for the patient but also a larger reality.
- Help the patient to generate new ways to cope effectively.

Step 3: Behavioral Interventions

- Important to reinforce desired behaviors and extinguish noxious behaviors.
- Emotionally dysregulated patient may create crises to receive reinforcement.
- Develop a plan with staff and patient, doing so puts trust and respect with the patient.

Step 4: Teaching DBT Skills

- Only after acute crisis has stabilized!
- Patients need to cope with not only the problem that precipitated the admission but also the medical procedures needed to address the medical problems.
- Can be used for the emotionally dysregulated patient at baseline but also the ‘well-adjusted’ patient.
**Step 4: Teaching DBT Skills**

- Brief teaching better than in-depth teaching.
- Distraction is an example - can direct emotions away from painful emotions.
- Mindfulness is another example that could be used, especially in the vignette!

**Other skills might utilize interpersonal effectiveness** (What is it that you want to accomplish when you are interacting with staff?)

- Or learn emotion regulation, to put a name to emotions and how to modulate them before they get out of control.

**Warnings!**

- This is not one stop shopping!
- Skills need significant time and repetition.
- Patient needs to feel validated before skills can be learned!

**Teaching the Staff**

- Staff on general medical floors have little experience with psychiatrically ill patients.
- Important to provide basic psychoeducation in terms of personality disorders and countertransference.
- Can also teach staff about effective communication
- Part of the liaison in consultation/liaison psychiatry.
Teaching the Staff

- Can also use DBT skills with staff as well, using dialectics.
- Frame problems for staff that emphasizes effectiveness, rather than complete compliance.
- Help staff develop understanding of the patient’s difficulties.

Teaching the Staff

- Encourage staff to empathize with the patient.
- Encourage the staff to empathize with each other.

Teaching the Staff

- When all else fails, radical acceptance can be useful.
- Does not imply liking of painful situation.

Summary

- Validate the experience of both patient and treaters.
- Introduce idea of dialectics to staff and patients to reduce splitting.
- Identify/implement reasonable behavioral interventions.
- Teaching skills.
Benefits

- Potential improvement of medical care
- Reduction of staff distress
- Relief of suffering
- Long term cost effectiveness

Pharmacotherapy

Treatments for BPD: Paul Soloff, MD


Medications Algorithm & Rules

- Target specific problem area
  - Cognitive/perceptual
  - Affective
  - Impulsive dyscontrol
- Strong empirical support
- Safe
- Act rapidly

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Patients, n</th>
<th>Length of Study</th>
<th>Study Medications</th>
<th>Results</th>
<th>Limitations/weaknesses</th>
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<tbody>
<tr>
<td>Soloff et al. [31]</td>
<td>Inpatient</td>
<td>108</td>
<td>5 weeks</td>
<td>Haloperidol (4 mg per day) vs phenelzine (60 mg per day) vs placebo</td>
<td>Phenelzine &gt; placebo &gt; haloperidol in most measured outcomes; no clear efficacy seen during continuation phase [32]</td>
<td>Majority of patients had combined BPD and schizotypal personality disorder, similar to Goldberg et al. [18]; type II error possibly accounts for loss of continued efficacy [32]</td>
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<tr>
<td>De la Fuente [22]</td>
<td>Inpatient</td>
<td>20</td>
<td>30.9 days (mean)</td>
<td>Carbamazepine vs placebo</td>
<td>No significant positive effects found</td>
<td>Negative trial</td>
</tr>
<tr>
<td>Salzman et al. [28*]</td>
<td>Outpatient</td>
<td>22</td>
<td>13 weeks</td>
<td>Fluoxetine (40 mg per day) vs placebo</td>
<td>Fluoxetine superior to placebo in overall distress and anger in the axis I-free population</td>
<td>High placebo responsiveness rate; did not use intent-to-treat analysis of the original 27 participants</td>
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<tr>
<td>Hollander et al. [30]</td>
<td>Outpatient</td>
<td>16</td>
<td>10 weeks</td>
<td>Divalproex sodium vs placebo</td>
<td>Divalproex sodium superior to placebo in global symptom severity, functioning, aggression, and depression</td>
<td>High drop-out rate; differences in intent-to-treat analysis not significant</td>
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<td>Zanarini and Frankenburg [26*]</td>
<td>Outpatient</td>
<td>28 women</td>
<td>6 months</td>
<td>Olanzapine vs placebo</td>
<td>Olanzapine superior to placebo in self-reported Symptom Checklist-90 “core” BPD symptoms</td>
<td>Only nine subjects completed the entire 6-month trial; eight completers were in the olanzapine group, indicating differential dropout rates; only moderately ill women were included</td>
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<tr>
<td>Rinne et al. [29*]</td>
<td>Outpatient</td>
<td>38 women</td>
<td>24 weeks (6 weeks double-blind)</td>
<td>Fluvoxamine (150 mg per day during 6 week double-blind period) vs placebo</td>
<td>Fluvoxamine superior to placebo in mood shifts (but not impulsivity or aggression)</td>
<td>Sample size may have caused power to be too low, leading to non-significant results</td>
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<tr>
<td>Zanarini and Frankenburg [23*]</td>
<td>Outpatient</td>
<td>30 women</td>
<td>8 weeks</td>
<td>Ethyl-eicosapentaenoic acid (1 g per day) vs placebo</td>
<td>Ethyl-eicosapentaenoic acid superior to placebo in aggression and depression outcomes, 10% completion rate</td>
<td>Similar selection bias to Zanarini and Frankenburg [26*]; only moderately ill women were included</td>
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BPD--borderline personality disorder.
Antidepressants / anger (Mercer et al. 2009)
Mood Stabilizers / depression

Consensus By Experts on Pharmacotherapy for BPD
- No “magic bullet” medication for BPD patients
- Soloff’s algorithm is method of choice where drugs target domain of dysfunction.
- Pharmacotherapy alone is insufficient to treat BPD; must be combined with psychosocial treatment.
- Pharmacological treatment of people with BPD is not based on good evidence from trials and it is arguable that future use of medication should be from within randomised trials (Binks 2006)