CONFLUENCE OF PRESCRIBING AND PSYCHOTHERAPY USING DBT PRINCIPLES

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DISCLOSURE STATEMENT

□ I have no commercial financial conflicts of interest to disclose
□ I may discuss some off label use of medications as examples of treatment options

LEARNING OUTCOMES

□ Describe the biosocial model of Dialectical Behavior Therapy
□ Describe the role of the APRN as part of the DBT team.
□ Discuss common medication challenges in working with clients in DBT
□ Discuss collaborative treatment strategies involving staff and clients.

BIOSOCIAL MODEL

□ Personality disorders are complex psychopathologies that involve the interaction of biology, development, and the social environment.
□ Treatment necessarily involves intervention in all of these areas.
□ Pharmacologic agents act on neurophysiologic mechanisms only, i.e., are not specific to DSM diagnoses

BIOSOCIAL MODEL CON’T

□ Pharmacologic treatment requires a collaborative relationship with the client and working together as a team.
□ Brain creates the mind; the mind activates the brain. Therefore mindfulness is essential in treatment.
□ Neural integration permits mindfulness and self-regulation.

BASIC ASSUMPTIONS

□ Clients are doing the best they can
□ Clients want to improve
□ Clients need to do better, try harder, and be more motivated to change
□ Clients may not have caused all their problems, but they have to solve them anyway
BASIC ASSUMPTIONS CON'T

- The lives of suicidal, borderline individuals are unbearable as they are currently being lived
- Clients must learn new behaviors in all relevant contexts
- Clients cannot fail in therapy
- Therapists treating clients with borderline disorder need support

ESSENTIAL ELEMENTS

- Weekly individual therapy sessions for about 1 hr
- Weekly group skills training sessions for 2 1/2 hrs
- Skills coaching via telephone or other electronic means as needed by the client to manage in vivo situations
- Team consultation to the therapist to maintain treatment fidelity and adherence

PRINCIPLES OF DBT

- The client must attend group and individual therapy consistently
- Suicidal and self-harm behaviors are problems to be solved and are of the highest treatment priority
- The therapist agrees to make every reasonable effort to provide competent treatment
- The therapist makes explicit the boundaries of the therapeutic relationship and maintains these

ESSENTIAL ELEMENTS

- Core Mindfulness
- Distress Tolerance
- Emotion Regulation
- Interpersonal Effectiveness
- Self-Management

FUNCTIONS OF TREATMENT

- Structuring the environment
- Enhancing the client's capabilities through skill building
- Generalizing the skills to the life of the client
- Improving client motivation
- Enhancing the capabilities and improving the motivation of the staff

BEHAVIOR CHAIN ANALYSIS

- What exactly is the major PROBLEM BEHAVIOR that I am analyzing?
- What things in myself and my environment made me VULNERABLE?
- What PROMPTING EVENT in the environment started me on the chain to my problem behavior?
- What were the LINKS IN THE CHAIN (Actions, Body Sensations, Cognitions, Feelings & Events)
CHAIN ANALYSIS CON'T

- What exactly were the CONSEQUENCES in the environment? In myself?
- Ways to reduce my VULNERABILITY in the future
- Ways to prevent the PRECIPITATING EVENT from happening again:
- What HARM did my problem behavior cause?
- Plans to REPAIR, CORRECT, and OVER-CORRECT the harm

ROLE OF THE APRN

- Trained DBT therapist
- Prescriber
- Therapist & prescriber
  - Power differential with prescription pad?
  - Establishing collaboration with client
- Consultant to team
- Receives consultation
- Health promotion

PRACTICE BCA

PHARMACOLOGICAL PRINCIPLES

- Medications treat the brain, not the diagnosis
  - Symptom focused
  - Targeting medications to behaviors
- Eliciting client commitment
- Addressing therapy interfering behavior
- Addressing personal hypersensitivities
- Collaboration, not coercion

DIALECTICS

COMMON MEDICATION CHALLENGES

- Typical polypharmacy on intake:
  - Long acting & maybe short acting stimulant
  - Short acting prn and daily benzodiazepines
  - At least one and often two antipsychotics
  - Usually SRIs at high dosages
  - At least one and often two mood stabilizers
  - At least one and often two or three hypnotics
- “These will have to go. Where do you want to start”
- “Oh, no, how will I survive!”
SHIFT IN FOCUS
- Expecting the medications to do everything to ... 
- Supporting effective brain functioning to learn and use skills 
- Requires different assessment process 
  - Listening to behaviors in relation to neurophysiology 
  - Using medications to support and improve neurophysiology 
  - Separating operant behavior from biologic

TREATMENT RESISTANT DEPRESSION
- Is the diagnosis correct? Could this be bipolar disorder, borderline personality disorder? Complex PTSD 
- What are the treatment targets and the realistic expected outcomes? 
- Are all the treatment options being fully used? 
- What are the barriers to treatment?

SHIFT IN FOCUS CON'T
- May require off label use, e.g., 
  - Beta and alpha blockers for anxiety & autonomic hyperarousal 
  - GABA-ergics for anxiety and mood stabilization (e.g., lamotrigine, tiagabine, topiramate, pregabalin) 
- Addressing disordered sleep 
  - Sleep avoidance vs insomnia 
  - Use of sleep hygiene first and foremost 
  - Rule of 3's with hypnotics

RULE OUTS
- Bipolar I or II 
  - Episodes of excessive energy, not needing sleep, risk taking behaviors 
- Borderline Personality Disorder 
  - Intense sensitivity to criticism 
  - Reactive response to perceived loss or abandonment 
  - Anxious irritability and impulsivity 
  - Dysregulation of mood, emotions, behavior

MEDICATIONS OFTEN USED
- Serotonin Reuptake Inhibitors 
- Serotonin Norepinephrine Reuptake Inhibitors 
- GABAergics & Lithium 
- Serotonin Dopamine Antagonists & related drugs 
- Alpha & beta blockers 
- Goal is simplified regimen, maximize before giving up on a medication

COMORBIDITIES
- Substance abuse 
  - Illicit 
  - Prescriptions: stimulants, benzodiazepines, pain medications 
- PTSD 
- Chronic pain, especially fibromyalgia 
- Metabolic syndrome: obesity, hypertension, hyperglycemia, hyperlipidemia
AUGMENTATION STRATEGIES
- One change at a time
- Start with where the client wants the greatest change
  - Sleep, anxiety, depression
  - Clarify expectations
- Maximize dosage before adding another drug
- Adding based on neurophysiology and complimentary mechanisms of action

COMPLIMENTING STRATEGIES
- Serotonin reuptake inhibitors
- Serotonin agonists and antagonists
- Dopaminergics
  - Antagonists
  - Modulators
- Getting more out of each medication as well as less
  - Drowsiness as side effect to aid sleep
  - Mood stabilization, inhibiting impulsivity, decreasing anxiety

COMMITMENT STRATEGIES
- Instead of adherence/compliance
- Stages of Change
- Process of change
- Common DBT strategies
  - Devil’s Advocate
  - Door in the Face
  - Heart-to-Heart

PRESCRIBING RELATIONSHIP
- Establishing trust
- Repairing relationship
- Radical irreverence
- Radical acceptance
- Ending relationship

LIMITATIONS OF MEDICATIONS
- Medications can only change the neurophysiology; cannot change the environment
- Our medications are still crude in terms of mechanisms of action
  - No anti-suicide drug
  - Drug may increase risk for suicide
- We can prescribe but only the client can take the medication

REFERENCES
- Andion, O., Ferrer, M., Matali, J., & Gancedo, G. e. (2012). Effectiveness of combined individual and group dialectical behavior therapy compared to only individual dialectical behavior therapy: A preliminary study. Psychotherapy, 49 (2), 241-50.
REFERENCES CON'T


QUESTIONS & COMMENTS

- Example situations
- Developing expertise
  - Training through Behavioral Tech (http://behavioraltech.org/training/)
  - Advanced Intensive Training
- Mentorship