STIMULUS HANDOUT FOR CAP QUESTIONS

2023
MOCK MCQ
EXAM

NB: one or two of the tables or figures are not as sharp as would be ideal - best we could do with the source material.

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CAP Question 1 (20 marks)

"Skills for pills": The dialectical-behavioural therapy skills training reduces polypharmacy in borderline personality disorder

Joaquim Soler, Elisabet Casellas-Pujol, et al, Acta Psychiatrica Scandinavica, Jan 2022

Abstract

Objective: Polypharmacy and overprescription of off-label medications are common in patients with borderline personality disorder (BPD). The aim of the present naturalistic study was to explore whether the skills training module of dialectical-behavioural therapy (DBT) can reduce polypharmacy in these patients in routine clinical practice.

Methods: Retrospective, observational study of 377 patients with a primary diagnosis of BPD consecutively admitted to the BPD outpatient unit from 2010 through 2020. All patients were invited to participate in the DBT skills training module (DBT-ST). DBT-ST participants (n = 182) were compared with a control group who did not participate in DBT-ST (n = 195). Pre-post intervention changes in medication load and use of antidepressants, benzodiazepines, mood stabilizers, and antipsychotics were evaluated.

Results: At baseline, most patients (84.4%) were taking at least one medication and 46.9% were on polypharmacy. Compared to controls, patients in the DBT-ST group presented a significant reduction in the number of medications (2.67–1.95 vs. 2.16–2.19; $p < 0.001$), medication load (4.25–3.05 vs. 3.45–3.48; $p < 0.001$), use of benzodiazepines (54.4%–27.5% vs. 40%–40.5%; $p < 0.001$), mood stabilizers (43.4%–33% vs. 36.4%–39.5%; $p < 0.001$), and antipsychotics (36.3%–29.1% vs. 34.4%–36.9%; $p < 0.001$).

Conclusions: These findings suggest that patients with BPD can benefit from the DBT-ST module, which may reduce the medication load, particularly of sedatives. The results suggest that DBT-ST may be useful to treat overmedication in patients with BPD and could help to promote "deprescription" in clinical practice**.**

(Excerpt from Material and Methods:)

Data were retrospectively collected from 377 patients diagnosed with BPD and admitted to the outpatient BPD unit at the Department of Psychiatry at the *Hospital de la Santa Creu i Sant Pau*… Compared with general mental health center, the BPD Unit offers: reliable confirmation of BPD diagnosis with validated instruments, greater accessibility to the unit, emergency attention in crisis, higher frequency and duration of visits, therapeutic team with specific experience and sensitivity for BPD, family care, psychoeducation of disorder, general management and non- harmful strategies, and, finally, supervision of pharmacological treatment avoiding the excessive use of medication.

(Excerpt from Materials and Methods)

The DIB-R is an instrument designed to diagnose BPD and to assess the severity of the disorder within the last 2 years. The Spanish version has demonstrated good internal consistency (Cronbach's alpha, 0.89; sensitivity, 0.81; and specificity, 0.94).

(Excerpt from Psychotherapeutic intervention – Control group:)

Although these individuals did not receive any specific psychotherapeutic intervention for BPD compared with general mental health services, they valued the higher frequency of psychiatric visits, attention in crisis, family care, and greater experience and sensitivity in the management of BPD. These follow- up visits also include supervision of pharmacological treatment avoiding, if possible, the excessive use of medications, as recommended by all clinical guidelines. They also received non- harmful strategies based on the *Handbook of Good Psychiatric Management for Borderline Personality Disorder*.

Table 1

Variables	Total sample (377)	DBT-ST (182)	Control group (195)	χ^2	t	p
Age, mean (SD)	30.51 (8.5)	30.92 (8.0)	30.14 (9.0)			n. s
Females, *n* (%)	336 (89.1%)	168 (92.3%)	168 (86.2%)			n. s
Married/stable couple, *n* (%)	140 (37.1%)	68 (37.4%)	72 (36.9%)			n. s
Employed, *n* (%)	138 (36.6%)	72 (39.6%)	66 (33.8%)			n. s
Comorbidities						
Axis I comorbidity	266 (70.6%)	133 (73.1%)	133 (68.2%)			n. s
Affective disorders	87 (23.1%)	47 (25.8%)	40 (20.5%)			
Anxiety disorders	54 (14.3%)	26 (14.3%)	28 (14.4%)			
Eating disorders	116 (30.8%)	61 (33.5%)	55 (28.2%)			
Substance use disorders	133 (35.3%)	62 (34.1%)	71 (36.4%)			
DIB-R total score, mean (SD)	7.24 (1.2)	7.46 (1.2)	7.05 (1.2)		−3.27	0.001
Pharmacological treatment						
Medications, mean (SD)	2.41 (1.7)	2.67 (1.7)	2.16 (1.7)		−2.00	0.003
0	59 (15.6%)	18 (9.9%)	41 (21.0%)			
1	67 (17.8%)	35 (19.2%)	32 (16.4%)			
2	74 (19.6%)	32 (17.6%)	42 (21.5%)			
3	85 (22.5%)	45 (24.7%)	40 (20.5%)			
4	48 (12.7%)	25 (13.7%)	23 (11.8%)			
≥5	44 (11.7%)	27 (14.8%)	17 (8.6%)			
Polypharmacy	177 (46.9%)	97 (53.3%)	80 (41%)	5.69		0.017
Antidepressants	271 (71.9%)	142 (78.0%)	129 (66.2%)	6.56		0.014
Benzodiazepines	177 (46.9%)	99 (54.4%)	78 (40.0%)	7.83		0.005
Mood stabilizers	150 (39.8%)	79 (43.4%)	71 (36.4%)			n. s
Antipsychotics	133 (35.3%)	66 (36.3%)	67 (34.4%)			n. s
Medication load, mean (SD)	3.83 (2.9)	4.25 (2.8)	3.45 (2.8)		−2.75	0.006
Sedation load, mean (SD)	2.24 (2.1)	2.49 (2.1)	2.01 (2.0)		−2.28	0.023

Abbreviations: DIB-R, Revised Diagnostic Interview for Borderlines; n. s., not significant; SD, standard deviation.

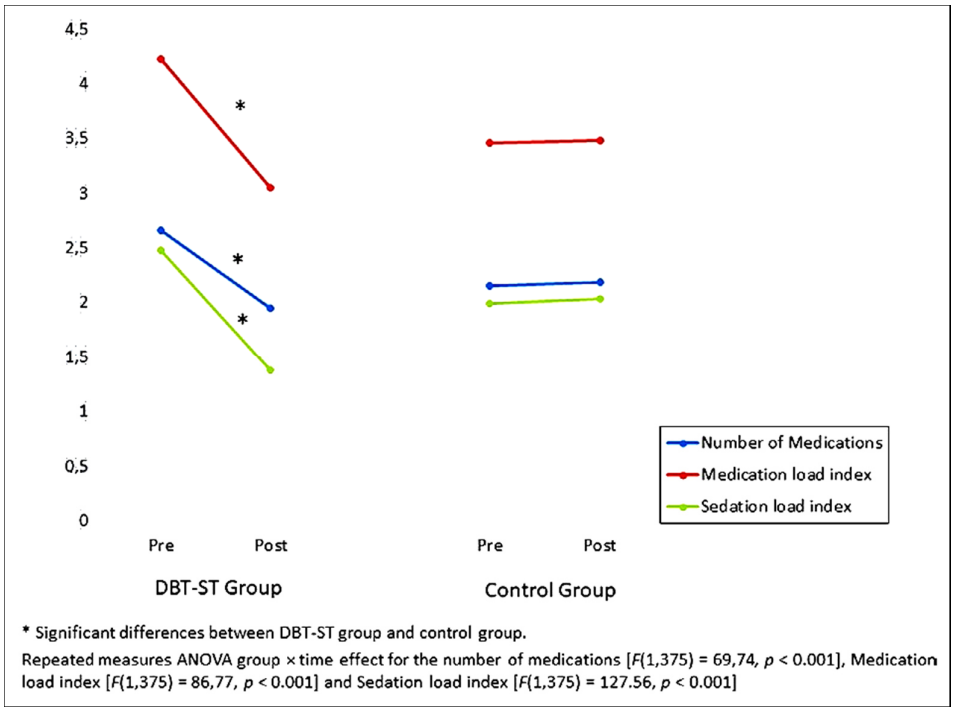
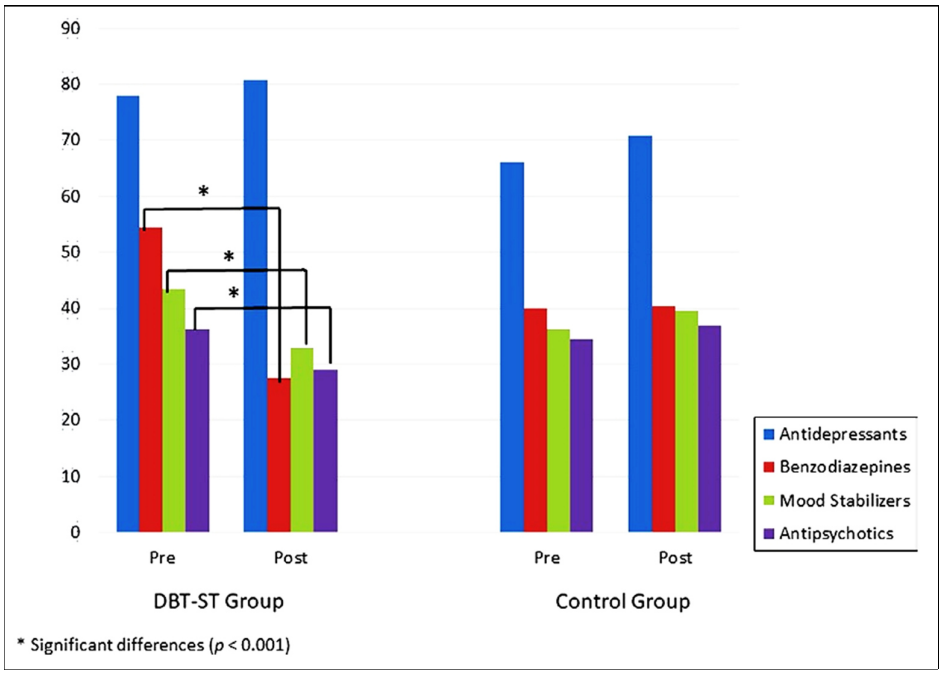


Figure 1
Differences between groups in prescription changes pre-post intervention:

Figure 2
Pre-post intervention differences in the prescription of antidepressants, benzodiazepines, mood stabilizers, and antipsychotics:



CAP Question 2 (20 marks)

EMDR for Depression: A Meta-Analysis and Systematic Review

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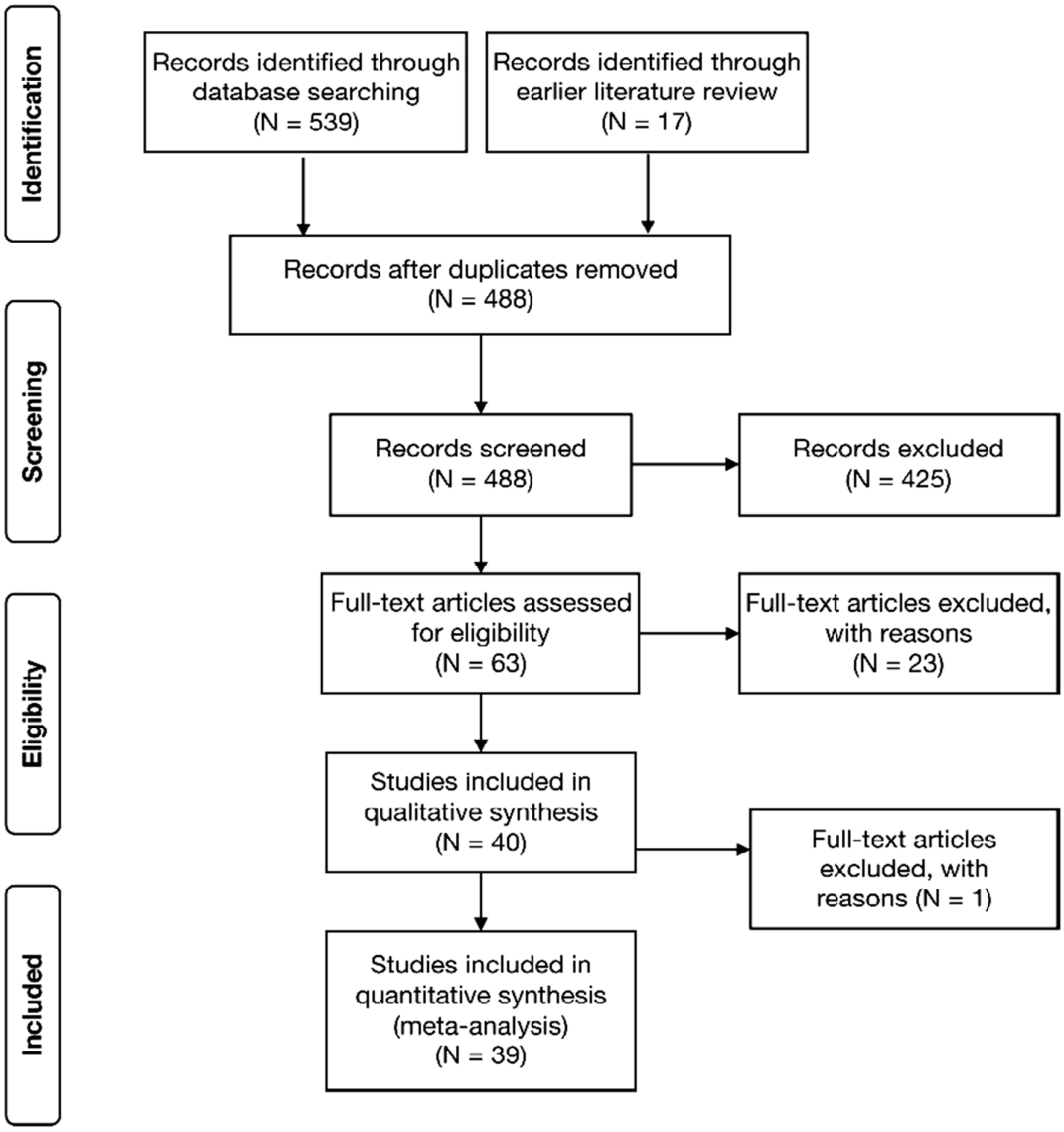
The literature on the efficacy of eye movement desensitization and reprocessing (EMDR) for treating depression is heterogeneous due to research design, quality issues, and trials methodology. The current meta-analysis seeks to examine EMDR for depression with the aim of answering the aforementioned limitations. Thirty-nine studies were included for analysis after a review of the relevant literature. Univariate meta-regressions were run to examine dose-response and the effect of moderating variables. Subanalysis for primary and secondary depression showed a large, significant, and heterogeneous effect-size estimates, where EMDR significantly improved symptoms of depression in contrast to all control types. At post hoc, data were reexamined and a significant and large, yet heterogeneous, effect-size estimate emerged between the EMDR and control arm after the removal of two outliers [Hedges' g = 0.70, 95% CI = 0.50–0.89, p-value < .01, I^2 = 70%, K = 37]. This is the first meta-analysis examining for the effect of EMDR comparing to various control modalities on depression with dose-response. We found (a) that studies were balanced at onset in terms of depression severity, and (b) a large and significant effect of EMDR on depression at the end of trials. Additionally, the significance of the aggregate effect-size estimate at the end of trials was unchanged by the intake of psychotropic medications, reported demographic variables, or EMDR methodology.

(excerpt from Method)

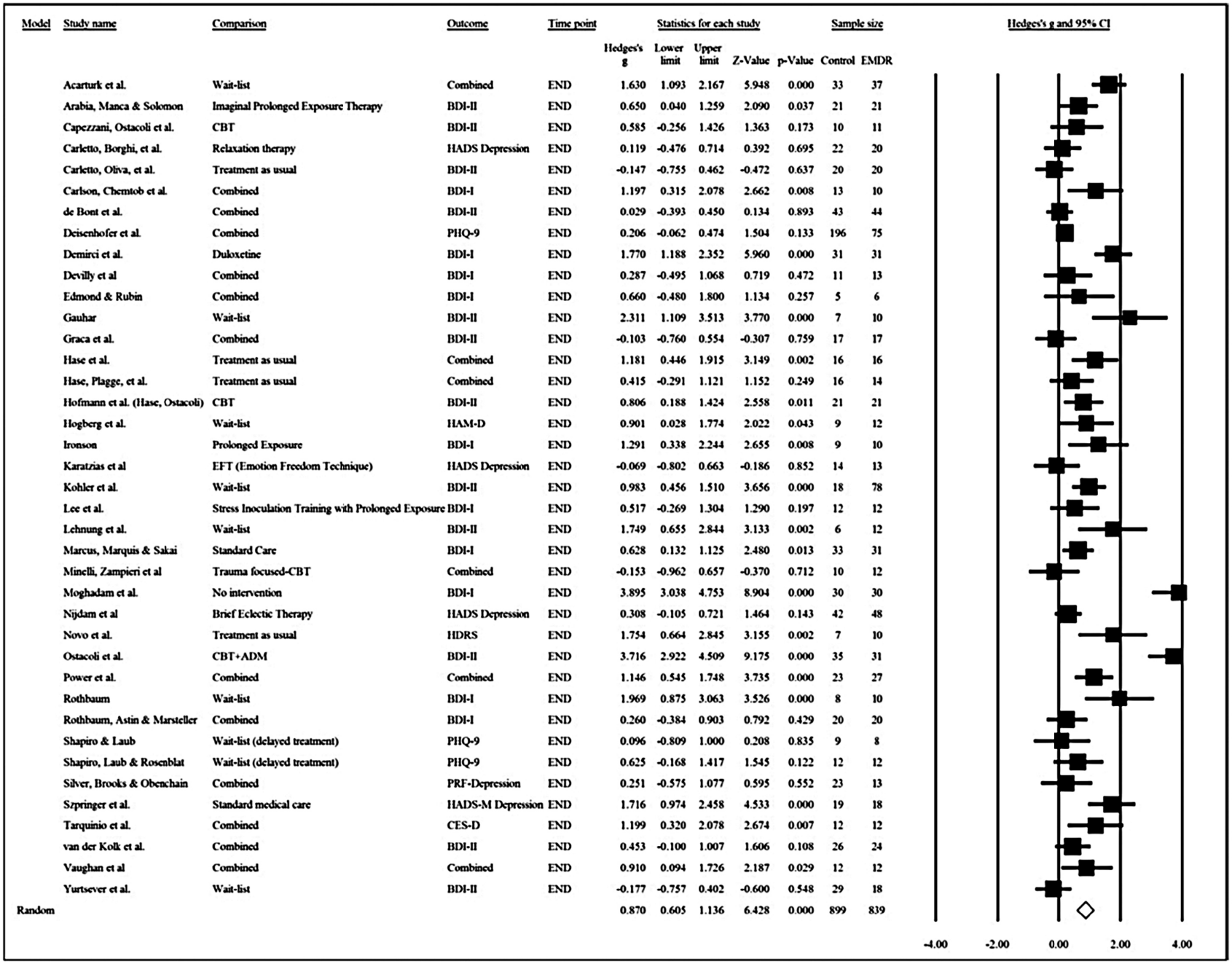
Studies were excluded if: (a) literature review, letter to editor, conference abstract, thesis/dissertation abstract, meta-analysis (pooled data studies, individual patient meta-analysis), single case experimental design, case report, case series (<5 person), book chapters, and reporting study protocol; (b) non-English language papers; (c) no data on depression assessment endpoint was reported; and (d) hybrid psychotherapy treatment as a treatment arm was also excluded. Also, we have excluded studies if their validity was questionable, as confirmed with the original publishing journal.

CAP Question 2 contd. **PRISMA Flow Diagram showing study selection for meta-analysis on EMDR for depression literature:**



The kappa rate of agreement beween study coders (AAS and KL) was 88%, and in the event of a discrepancy, the conflict was resolved by discussion between the coders.

For all data analysis, we set the alpha level to .05 and used the Comprehensive Meta-Analysis software (Ver 2.0) (Borenstein et al, 2005).



Model	Study name	Comparison	Outcome	Time point	Hedges's g	Lower limit	Upper limit	Z-Value	p-Value	Control	EMDR
	Acarturk et al.	Wait-list	Combined	END	1.630	1.093	2.167	5.948	0.000	33	37
	Arabia, Manca & Solomon	Imaginal Prolonged Exposure Therapy	BDI-II	END	0.650	0.040	1.259	2.090	0.037	21	21
	Capezzani, Ostacoli et al.	CBT	BDI-II	END	0.585	-0.256	1.426	1.363	0.173	10	11
	Carletto, Borghi, et al.	Relaxation therapy	HADS Depression	END	0.119	-0.476	0.714	0.392	0.695	22	20
	Carletto, Oliva, et al.	Treatment as usual	BDI-II	END	-0.147	-0.755	0.462	-0.472	0.637	20	20
	Carlson, Chemtob et al.	Combined	BDI-I	END	1.197	0.315	2.078	2.662	0.008	13	10
	de Bont et al.	Combined	BDI-II	END	0.029	-0.393	0.450	0.134	0.893	43	44
	Deisenhofer et al.	Combined	PHQ-9	END	0.206	-0.062	0.474	1.504	0.133	196	75
	Demirci et al.	Duloxetine	BDI-I	END	1.770	1.188	2.352	5.960	0.000	31	31
	Devilly et al	Combined	BDI-I	END	0.287	-0.495	1.068	0.719	0.472	11	13
	Edmond & Rubin	Combined	BDI-I	END	0.660	-0.480	1.800	1.134	0.257	5	6
	Gauhar	Wait-list	BDI-II	END	2.311	1.109	3.513	3.770	0.000	7	10
	Graca et al.	Combined	BDI-II	END	-0.103	-0.760	0.554	-0.307	0.759	17	17
	Hase et al.	Treatment as usual	Combined	END	1.181	0.446	1.915	3.149	0.002	16	16
	Hase, Plagge, et al.	Treatment as usual	Combined	END	0.415	-0.291	1.121	1.152	0.249	16	14
	Hofmann et al. (Hase, Ostacoli)	CBT	BDI-II	END	0.806	0.188	1.424	2.558	0.011	21	21
	Hogberg et al.	Wait-list	HAM-D	END	0.901	0.028	1.774	2.022	0.043	9	12
	Ironson	Prolonged Exposure	BDI-I	END	1.291	0.338	2.244	2.655	0.008	9	10
	Karatzias et al	EFT (Emotion Freedom Technique)	HADS Depression	END	-0.069	-0.802	0.663	-0.186	0.852	14	13
	Kohler et al.	Wait-list	BDI-II	END	0.983	0.456	1.510	3.656	0.000	18	78
	Lee et al.	Stress Inoculation Training with Prolonged Exposure	BDI-I	END	0.517	-0.269	1.304	1.290	0.197	12	12
	Lehnung et al.	Wait-list	BDI-II	END	1.749	0.655	2.844	3.133	0.002	6	12
	Marcus, Marquis & Sakai	Standard Care	BDI-I	END	0.628	0.132	1.125	2.480	0.013	33	31
	Minelli, Zampieri et al	Trauma focused-CBT	Combined	END	-0.153	-0.962	0.657	-0.370	0.712	10	12
	Moghadam et al.	No intervention	BDI-I	END	3.895	3.038	4.753	8.904	0.000	30	30
	Nijdam et al	Brief Eclectic Therapy	HADS Depression	END	0.308	-0.105	0.721	1.464	0.143	42	48
	Novo et al.	Treatment as usual	HDRS	END	1.754	0.664	2.845	3.155	0.002	7	10
	Ostacoli et al.	CBT+ADM	BDI-II	END	3.716	2.922	4.509	9.175	0.000	35	31
	Power et al.	Combined	Combined	END	1.146	0.545	1.748	3.735	0.000	23	27
	Rothbaum	Wait-list	BDI-I	END	1.969	0.875	3.063	3.526	0.000	8	10
	Rothbaum, Astin & Marsteller	Combined	BDI-I	END	0.260	-0.384	0.903	0.792	0.429	20	20
	Shapiro & Laub	Wait-list (delayed treatment)	PHQ-9	END	0.096	-0.809	1.000	0.208	0.835	9	8
	Shapiro, Laub & Rosenblat	Wait-list (delayed treatment)	PHQ-9	END	0.625	-0.168	1.417	1.545	0.122	12	12
	Silver, Brooks & Obenchain	Combined	PRF-Depression	END	0.251	-0.575	1.077	0.595	0.552	23	13
	Szpringer et al.	Standard medical care	HADS-M Depression	END	1.716	0.974	2.458	4.533	0.000	19	18
	Tarquinio et al.	Combined	CES-D	END	1.199	0.320	2.078	2.674	0.007	12	12
	van der Kolk et al.	Combined	BDI-II	END	0.453	-0.100	1.007	1.606	0.108	26	24
	Vaughan et al	Combined	Combined	END	0.910	0.094	1.726	2.187	0.029	12	12
	Yurtsever et al.	Wait-list	BDI-II	END	-0.177	-0.757	0.402	-0.600	0.548	29	18
Random					0.870	0.605	1.136	6.428	0.000	899	839

Figure 2. Forest plot showing studies (K = 39) with omnibus effect-size estimate at the endpoint (follow-up not included).

(excerpt from Results of Data Analysis)

When reviewing for heterogeneity, we removed the studies by Ostacoli et al. (2018) and Moghadam et al. (2015)

(excerpt from Limitations)

Another possible limitation is that we did not examine, either categorically or otherwise, for the effect of depression severity (e.g., treatment resistant), or personality factors related to depression (e.g., self-critical or socially focused depression). By the same token, we did not examine, per se, for clinical depression, as by scales' cut-off scores, or determine how many individuals out of those treated with EMDR actually improved versus those that did not. Furthermore, future studies are needed to link the EMDR treatment response to neurobiological underpinning.

End of Stimulus handout