CO-SU/BPD:

[or: Co-Occurring Substance Use / Borderline Personality Disorder]

What Can Help

Graeme Lamont – MPsych (Clinical)

Senior Psychologist – Eastern Dual Diagnosis Service

Introduction and Fundamentals

[or: 'Who', 'What', 'Where', and 'How'; but never 'Why']

Eastern Dual Diagnosis Service (EDDS) – 'Who', 'What', and 'Where'

- One of eight dual diagnosis teams / services in Victoria; covering the EMR of Melbourne.
- Part of the Victoria Dual Diagnosis Initiative (VDDI).
- Vision: To improve service responses for consumers and their significant others.
- Aim: To build the capacity of stakeholder services from the CMH, AOD, and MHCS sectors.
- Work Focus: Clinical Leadership; Education & Training; Service Development.
- More about me: http://au.linkedin.com/pub/graeme-lamont/10/70b/a12
  ⇨ You'll also find a more detailed version of this presentation on my profile.

Dual Diagnosis (or CO-SU/MH) Cohorts – 'What' and 'Where'

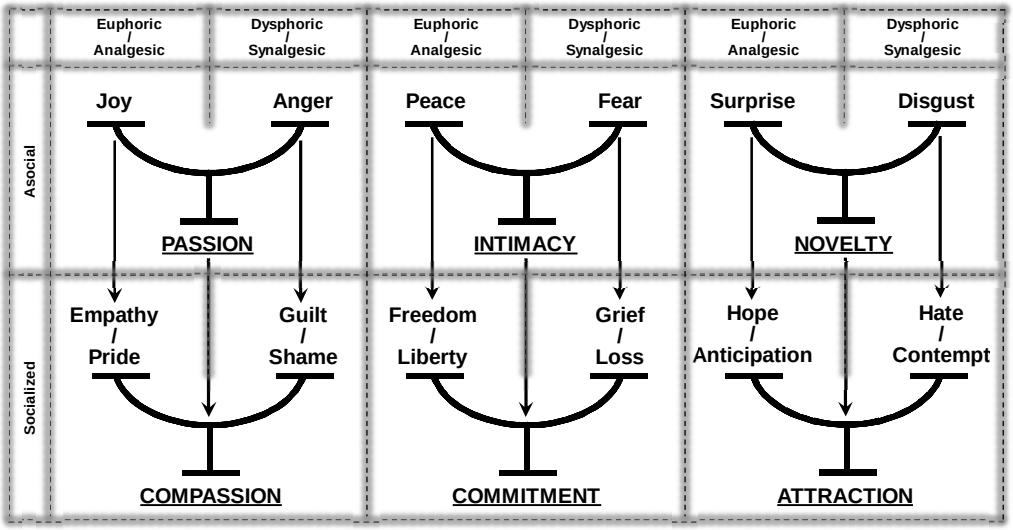
- **C**o-**O**ccurring **S**ubstance **U**se **/ M**ental **H**ealth disorders.
  ⇨ a.k.a. "Dual Diagnosis" (or DD_x), and sometimes "Comorbidity".

CO-SU/MH 'cohort' presentations typically seen at...

GP's / Primary Healthcare Services		AOD Treatment Services		MH Treatment Services	
SU	Alcohol Use Disorder	*SU*	CNS Depressant Use Disorder	*SU*	Episodic Poly-Substance Use Disorder
MH	Anxiety Disorder	*MH*	Post Traumatic Stress Disorder	*MH*	Cluster B-type Personality Disorder
SU	Alcohol Use Disorder	*SU*	Opioid Use Disorder	*SU*	CNS Stimulant or Depressant Use Disorder
MH	Mood Disorder	*MH*	Cluster B-type Personality Disorder	*MH*	Mood Disorder
SU	Cannabis Use Disorder	*SU*	Alcohol Use Disorder	*SU*	Alcohol, Cannabis, or Poly-Substance Use Disorder
MH	Early or first episode Psychotic Disorder	*MH*	Mood Disorder and/or Anxiety Disorder	*MH*	Schizophrenia or other Psychotic Disorder

Fundamentals of my "Hedonic Integration" Therapeutic Model – 'How'

- *"Emotions are the motors that motivate us."* – seek pleasure / avoid pain ("Hedonism").
  - ⇨ Set of Hedonic core emotions that sit on "Hedonic Scales" of interaction:



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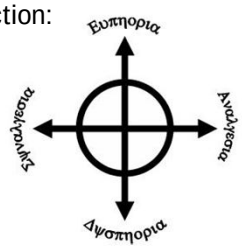
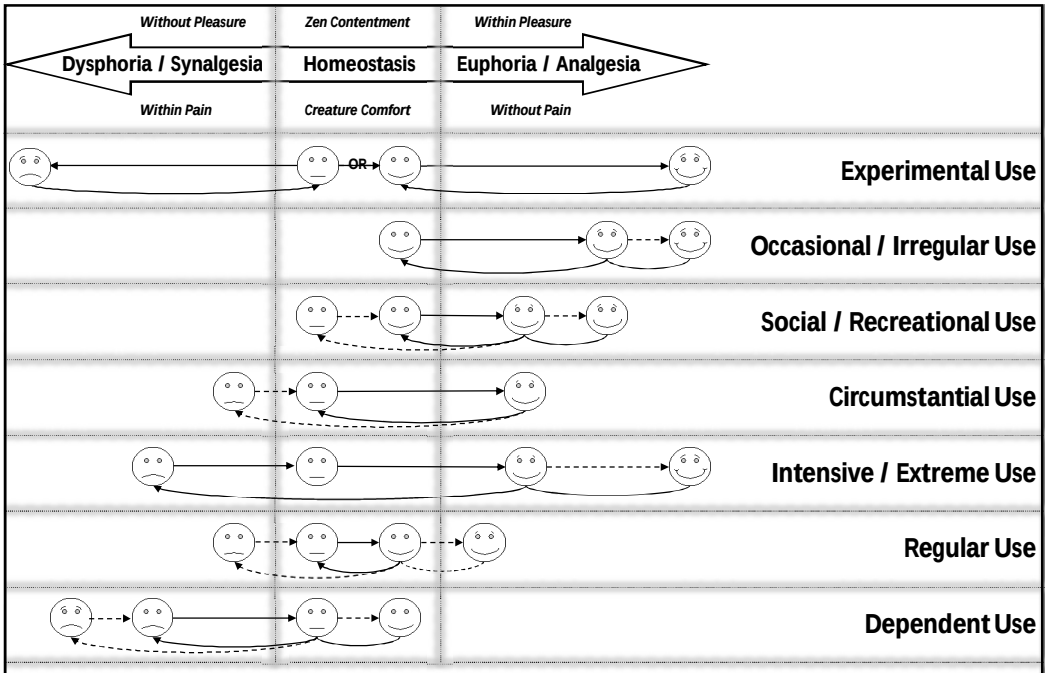


- Hedonic polar spectrums of being within / without pleasure or pain:
  - ⇨ "Euphoria - Dysphoria" (pleasure spectrum).
  - ⇨ "Analgesia - Synalgesia" (pain spectrum).
- Aim: To find "Hedonic Balance" on the pleasure and pain spectrums.
  - ⇨ Vision: *"Zen Contentment* [pleasure balance]*; Creature Comfort* [pain balance]".
- Cognitions / Behaviours ("Actions") and Relationships / Conduct ("Interactions") are considered / assessed via the "Hedonic Integration Triad":
  - ⇨ Functionality for the Self – *"How does this [Inter-/Action] work for you?".*
  - ⇨ Adaptability for the World – *"How does this [Inter-/Action] flex to work with others?".*
  - ⇨ Sustainability for the Future – *"How does this [Inter-/Action] keep working over time?".*

"Hedonic Integration" and CO-SU/PD's – 'What' and 'How'

- SU is learnt behaviour, experiential, functional, and variant in use patterns / related harms.
- Substances 'effect affect' and thus impact on one's Hedonic Balance and Inter-/Actions.
  ⇨ SU provides Hedonic "Payoffs" and "Paybacks" for a return to integrated homeostasis:



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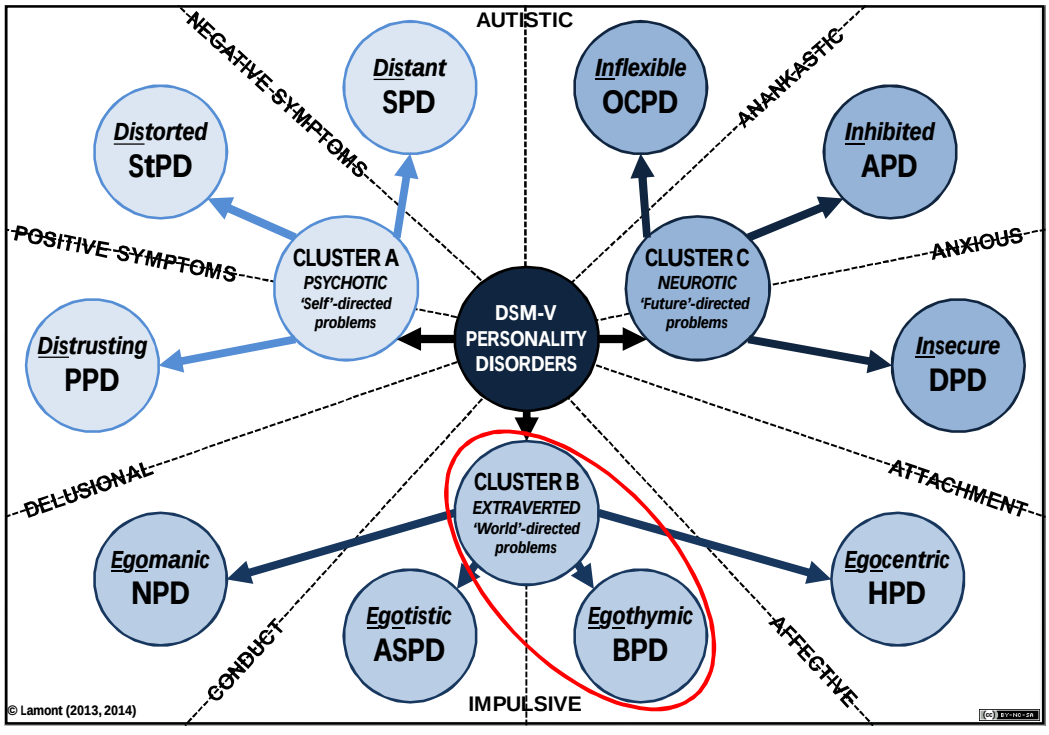
- Substances 'effect affect' and thus impact on one's Hedonic Balance and Inter-/Actions.
  ⇨ SU provides Hedonic "Payoffs" and "Paybacks" for a return to integrated homeostasis:
- SU Disorders = when the Paybacks outweigh the Payoffs on the Hedonic Integration Triad:
  ⇨ Dysfunctional for their Self; Maladaptive for their World; Unsustainable for their Future.
- PD = when their Inter-/Actions on the Hedonic Integration Triad are:
  ⇨ Arguably Functional; Predominantly Maladaptive; Questionably Unsustainable.
- PD Clusters and Hedonic Integration – the "Personality Disorder Wheel":



What Can Help: for Clinicians and Services to consider

[or: "Only the best for my clients and colleagues"]

General CO-SU/MH Treatment Principles

For both Clinicians and Services:

"Work with both; One stage at-a-time."	*"Others can help where we cannot."*
"Holistic Wellness IS Recovery."	*"Mind the Gap, or Bridge the Gap."*

For Clinicians:	For Services:
"Be a human first, and a clinician second."	*"They're the Expectation; Not the Exception."*
"Can't be all things to all clients."	*"No Wrong Door; Always Welcoming."*
"Can't do it for you; Can't do it without you."	*"One for All; All for One."*
"Be prepared for Re/Lapses."	*"There are NO Quick Fixes."*
"Some substances can be functional."	*"Help your Helpers in their Helping."*

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Recommended Psychotherapeutic Interventions for CO-SU/MH

- Manualized 'stepped-care' that integrates MET with CBT – for example:
  - ⇨ "C-BIT" for CO-SU/Severe MH Disorders.
  - ⇨ "Seeking Safety" for CO-SU/PTSD.
  - ⇨ "Dual-Focus Schema Therapy" for CO-SU/PD.

- DBT and ACT as relatively standalone / minimal adaptation – for example:
  - ⇨ "DBT Skills Training for Integrated DD_x Treatment Settings".
  - ⇨ "The ACT Matrix" and "Wise Choices".

- Peer-Support group programs for consumers and/or significant others – for example:
  - ⇨ "DD_x 'Persuasion' Group" program – EH AMHS and EDDS.
  - ⇨ "Well Ways Duo" program – MIF Victoria.

General Treatment Principles for CO-SU/BPD

- Become familiar with the following online resource books for working with CO-SU/BPD:
  - ⇨ "Engaging Conversations: Substance Use and Therapeutic Process" and "Making Waves".

- Define, plan, and draft-out the mutually agreed-to goals and direction of treatment.
  - ⇨ Include your boundaries and limitations.
  - ⇨ Align it to their stage-of-change.
  - ⇨ Type of integrated treatment – clinician, service, or system?

- Do your best to maintain treatment focus and utilize redirection within the contexts of…
  - ⇨ …the agreed-to goals, as well as your boundaries and limitations.
  - ⇨ …the other services involved, and how your service 'fits' within the integrated plan.
  - ⇨ …the time / opportunity available for supporting effective change.

- Consider prescribed medication; be it SU pharmacotherapy and/or atypical anti-psychotics.

General Treatment Principles for CO-SU/BPD (cont...)

- Mindfulness and Emotional Validation / Regulation are fundamental in-practice:
  ⇨ *"Emotions are the motors that motivate us; and the Mind is needed in the driver's seat"*.

- They are also an existential 'two-way street' in-practice:
  ⇨ *"Even though you're a clinician; you're only human, first and foremost."*
  ⇨ *"Practice what you Preach."*

- Expect 'World-Maladaptivity' in the sessional 'here-and-now' (including SU intoxication):
  ⇨ Explore how their 'here-and-now' has played-out / may play-out in the 'there-and-then'.
  ⇨ Reflect upon how their 'Self-Functionality' impacts upon others 'World-Maladaptivity'.
  – Explore the Payoffs and Paybacks for both of the above.

Specific Treatment Practices / Techniques for CO-SU/BPD

- Your case formulation / conceptualization must define the interrelating dynamism.
  ⇨ Assess the functionality of their SU, and provide matching treatment responses.

- Assess the dynamics of their SU and any deliberate self-harming behaviours.
  ⇨ Provide practical harm reduction techniques for these.

- Continually tally the Payoffs and Paybacks of continued SU versus SU change.
  ⇨ Plan any agreed-to SU change that is SMARTER goal-oriented.

- Utilize the following tasks / techniques / practices in-situ:
  ⇨ 'Behavioural Chain Analysis'.
  ⇨ 'Cycle of Relapse'.
  ⇨ 'Delaying / Distraction'
  ⇨ 'Defusion / Urge-Surfing'.

What Can Help: for Consumers and Significant Others to consider

[or: A selection of my "Quotable Quotes"]

A selection of my "Quotable Quotes" – for Consumers

- *Emotions are the motors that motivate us; and the Mind is needed in the driver's seat.*
- *At one-hour per-week; who do you think does most of the work? Me?*
  ⇨ *I can't do it for you, and I can't do it without you; but we can always do it together.*
- *I don't know it all, and I can't do it all – but I'll try and find others who could fill-in-the-gaps.*
- *Lets focus more on wellness than illness; it'll make for a more content and comfortable life.*
- *Your substance use has to serve a purpose, otherwise someone has ripped you off...*
  ⇨ *...and when it comes to substance use: Payoff is great, but Payback's a bitch.*
- *I can't stop you from harming yourself, but I'll do my best to help with reducing the harm.*

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A selection of my "Quotable Quotes" – for Consumers (cont...)

- *If you ask me if something is good/bad or right/wrong, I'll ask you to consider three things:*
  - ⇨ *How does it work for you?*
  - ⇨ *How can it flex to work with others?*
  - ⇨ *How will it keep working over time?*

  ...so if you can provide answers for these which satisfy the both of us – who am I to judge?

- *My ultimate aim for the PD side-of-things is to 'readapt the maladaptive'.*
  - ⇨ *Improvise, Adapt, Overcome.*

- *These techniques can help if we give them a try – only the best for my clients.*

- *Instead of saying "should"; say "could", and add to the end of it "...or I could not".*
  - ⇨ *It'll help you with weighing up 'Change / Same', versus feeling 'Guilt / Shame'*

A selection of my "Quotable Quotes" – for Significant Others

- *When it comes to treatment: You can help me where I can't, so I'll help you however I can.*

- *There are no quick fixes. Believe me; if there were, I'd be using them.*

- *The difference between "Pre-Contemplation" and "Contemplation" is 'Thought'...*
  - ⇨ *...and if you want to get someone thinking; ask them a question.*
  - ⇨ *So be open and curious – don't let one dead cat hold you back.*

- *Zero Use equals Zero Harm, and zero clients quit on that premise alone. However...*
  - ⇨ *...we can always aim to lower the harm, which could be done by lowering their use.*

- *As much as I want to see how you interact: If any arguments arise during our joint-session; I'm going to shut them down, and at-least for one good reason I'm sure you'd agree with:*
  - ⇨ *I charge by the hour, and I ain't cheap; you could argue outside of my office for free!*

and one final quote

[but not from me – credit where credit is due]

Ball, S.A. (1998). Manualised treatment for substance abusers with personality disorders: dual focus schema therapy. Addictive Behaviours, 23, pg 887

"Any attempt to cognitively dispute a personality disordered person or push for rapid behaviour change will be ineffective if it fails to appreciate the historical origins of these problems, the reasons why certain coping styles developed, and the 'rationality' of the self-defeating behavioural cycle that forms the core of personality pathology and [subsequent] resistance to change. A therapist can push for significant behaviour change and recovery after the patient feels that their resistance to change is empathically understood."

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