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Borderline Personality Disorder & Co-occurring Substance Use

MHPN Personality Disorders Interest Group Presentation
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Dual Diagnosis
Victorian Dual Diagnosis Initiative

Eastern DDx Service

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Broad Context

Dual diagnosis capability'

'*Dual diagnosis capability refers to the evolving capacity and orientation of workers, agencies and sectors to routinely identify, welcome and respond effectively to a range of co-occurring mental health and substance use concerns. It does this with an integrated treatment, recovery-oriented focus with the person and their family or carers driving their recovery*'
(VDDI Information Bulletin 2013)

Clinical realities/impact of DD in terms of diagnostic and treatment complexities

Compared with people who have a mental illness only, people with a dual diagnosis, on average, experience :-

- *an earlier onset of mental illness*
- *a worse course of mental illness*
- *more severe signs and symptoms*
- *more prominent positive symptoms*
- *greater use of emergency services*
- *more frequent hospital admissions*
- *poorer rehabilitation outcomes*
- *higher rates of unemployment*
- *higher rates of homelessness*
- *higher rates of incarceration*
- *higher rates of suicide*

Mental illness and substance use

you can`t treat one without the other

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Drugs as a mal-**adaptive coping strategy**

- People in acutely stressful situations often don’t have strategies to cope with negative memories and emotions, and seek to suppress them with substances that alleviate the symptoms but don’t necessarily address cause of symptoms.

Reasons for use

- Reasons for use:
  - Relieve: boredom, loneliness, insomnia, anxiety, depression, despair, unpleasant memories, peer pressure, inhibitions, restlessness, paranoia, medication side effects, voices, slow racing thoughts, to not feel
  - Improve: confidence, socialisation, talking with others, connectedness to a group, peer group activity, euphoria, enjoyment, relaxation, motivation, concentration, creativity

Drugs as a mal-adaptive coping Strategy

- Patients need to develop *adaptive coping strategies* and *alternative activities* to deal with unpleasant memories/emotions of events in order to overcome substance abuse.
- It can be a long road with many fluctuations.

Recovery Journey

Eventually!

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Dual Diagnosis Practice Pointers

- **Expect Dual Diagnosis**: Look for it even if it has not been identified before.

- **Start the conversation early**; let the person know you intend to focus on both as part of your work.

Dual Diagnosis Practice Pointers

Think Dual Diagnosis:

- Consider what the interaction is between A,B or C.

- Be aware of Masking, Mimicry, Exacerbation, Inducing, Impacting. SU may or may not complicate the MH issues and vice versa, Causal, Trigger, what maintains what.

- Do I understand why the client uses Substances?

Dual Diagnosis Pointers

- **Integrated Care**: Ask, “how can I provide a service for both MH and SU?” Develop a best practice approach for each person.

- **Need to treat SUD in those with BPD and treat BPD in those with SUD**

Dual Diagnosis Pointers

- **Collaborate:** Expect to work across teams, services, and sectors. Think about how to best facilitate collaboration with other parts of the broader care team. Consider potential barriers. Does an inter-service plan need to be developed?

Dual Diagnosis Practice Pointers

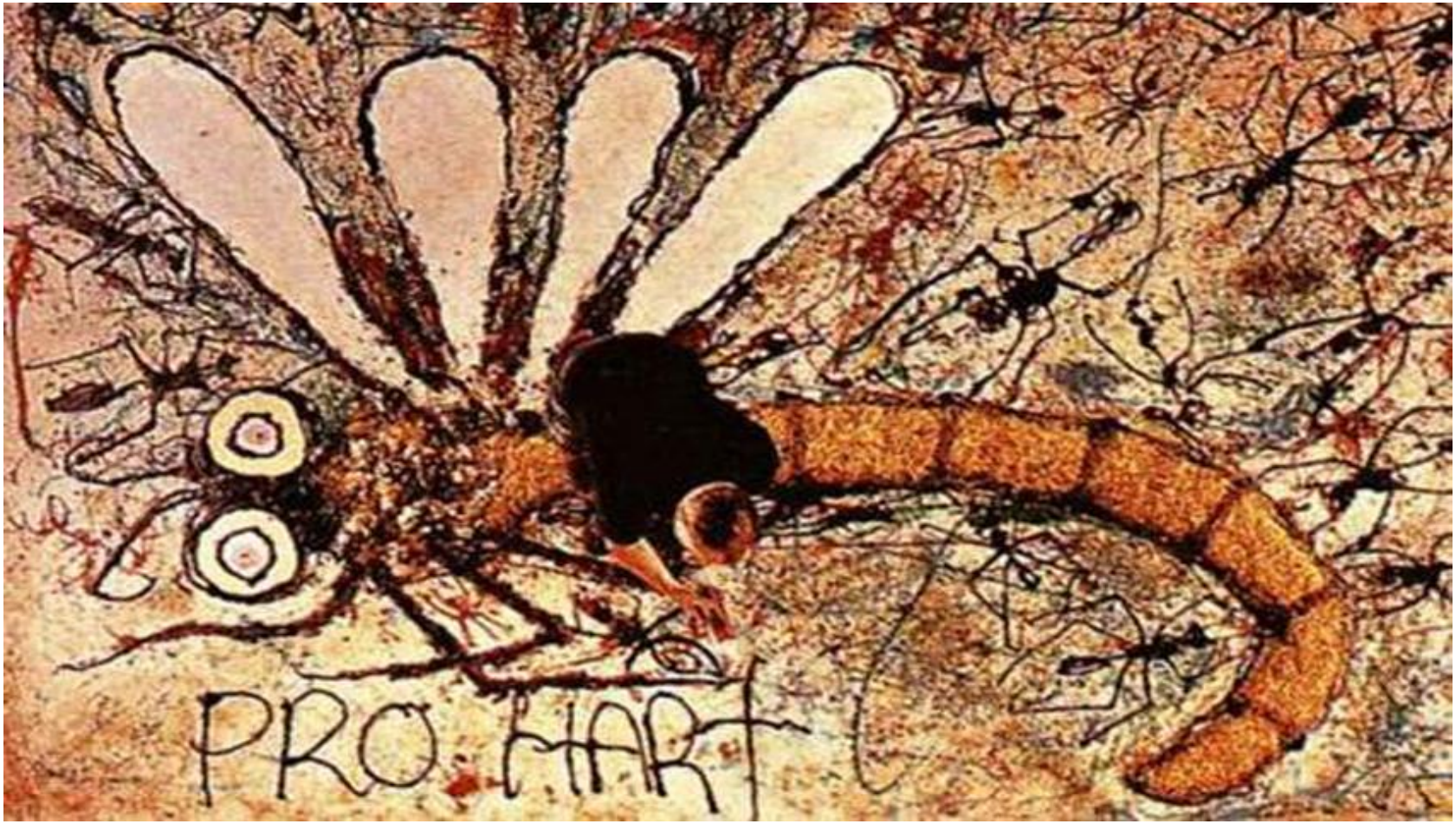
- **Be Welcoming**: of the client (and their family/Carer) in **their *current state***. Reflect on your own assumptions, preconceptions and negative ideas that may be barriers in the work of hopeful empathetic engagement.
- Is my work and my service responsive to the client's needs?

Dual Diagnosis Practice Pointers

- **Active Participation**: of the client, carer and family is essential. Recovery is a client centred process. Is the client an active participant as much as is possible? Am I “guiding” or “directing”? Do I trust the wisdom of the other to know what is best for them?
- How can I help them to work it out for themselves?

BPD and SU. From this……

To This…..



Comorbidity/Prognosis

- Patients in detox with BPD more likely to have unplanned discharge

- BPD with alcohol dependence – ↑ unemployment, ↑ impulsivity and risky behaviours, ↓ school performance

- Co-occurring BPD and SUD predicted

- lifetime severity of alcohol dependence,
- earlier age at onset of drinking,
- worse adaptive coping and suicidal ideation

Function of Substances (as it relates to BPD)

- Soothes anxiety or arousal *(Tragesser 2007)*
- Enhances euphoria and short-term self-esteem *(Tragesser 2008)*
- Shuts down the prefrontal cortex, thereby fostering avoidance of emotions *(Goldstein 2004)*
- Satisfies attachment needs, thereby allowing patients to remain autonomous and detached *(Barr 2004)*

Robert J. Gregory *Borderline PD Co-Occurring With Substance Dependence: Understanding Mechanisms and Developing Treatments.* SUNY Upstate Medical University DDP 658_68_pres.NAMI.PPT

What could a BPD & SU response look like?

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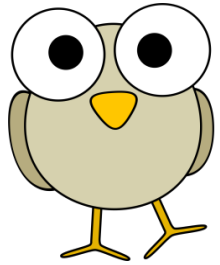
- Integrated treatment planning to include triggers for both DSH and SU
- Reasons For Use Scale (Process is important)
- Use Chain Analysis for both DSH & SU
- Risk Assessment to include intoxication, withdrawal and tolerance
- What have you found that works?



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Reasons for Use Scale (RFUS)

- Reasons for use Scale.

- Approach is supportive, curious, exploratory and collaborative. A "conversation NOT an interrogation" Pilot 1 Participant

RFUS (cont)

- Living the Assessment.
  - Each Substance may have a different function
  - What function does each substance provide?
  - Can be a conversation that draws out the different situations when each substance is used

RFUS (cont)

- Does SU replace DSH/ Suicidal Ideation?
- What is its/their function?
- Is there a tipping point where, when one does not work to achieve the desired effect, the other route is taken?

RFUS (cont)

- See-Saw effect?
- Alcohol and Deliberate Self Harm can be intertwined. One can routinely proceed the other and impact the other. (Prolonged alcohol use can lead to blood thinning)

OTHER TOOLS

- Decisional Balance
- Confidence /Readiness/Importance Scale
- Motivational interviewing (More info later)
- Value Cards

Therapeutic Principles (BPD and SU)

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Is there commonalities in ways of working with both co-occuring concerns? What are they?

Consideration given to Common Factors, GPM & MI?

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Common Factors

Common Factors in Empirically Supported Treatments of Borderline Personality Disorder

Weinberg, I., Ronningstam, E., Goldblatt, M.J. et al. Curr Psychiatry Rep (2011) 13: 60. doi:10.1007/s11920-010-0167-x

Common Factors (Cont)

Study examined the manuals of empirically supported psychotherapies for borderline personality disorder (BPD) by comparing their common and specific treatment strategies (Treatment Interventions Rating Scale)

- DBT (Dialectical Behavioural Therapy)
- MBT (Mentalisation Based Treatment)
- TFP (Transference-Focused Psychotherapy)
- SFT (Schema-Focused Psychotherapy)
- GPM (General Psychiatric Management)
- STEPPS (Systems Training for Emotional Predictability and Problem Solving)

Similarities

- Clear Treatment Framework
- Attention to Affect
- Focus on Treatment Relationship
- Active Therapist
- Exploratory Interventions
- Change-Orientated Interventions

Good Psychiatric Management

1. Clinician must be active and avoid being reactive in session
2. Support and Validation are key
3. Case management focusing on life outside therapy
4. Therapeutic relationship should be real, professional and attentive to maintaining the framework

Good Psychiatric Management

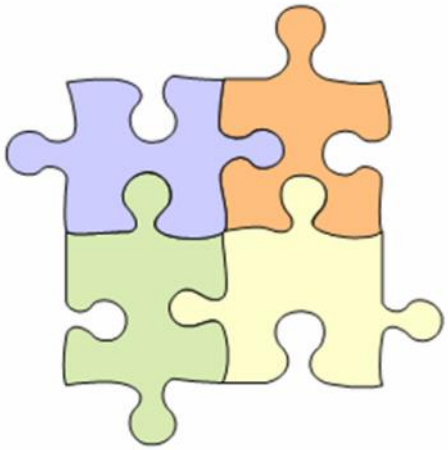
5. Change is expected as part of the treatment contract

6. The patient is viewed as competent adult who is expected to be an active participant

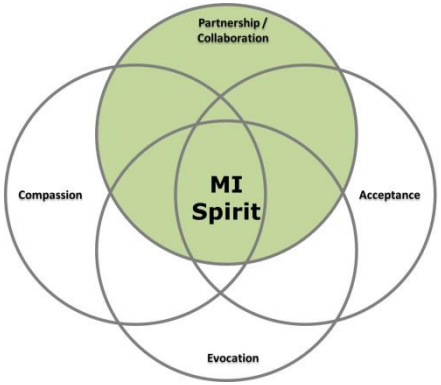
(Links, Ross and Gunderson 2015)

BPD and MI

- Is there a reasonably good fit with general principles and best practice for BPD and what Motivational Interviewing offers?



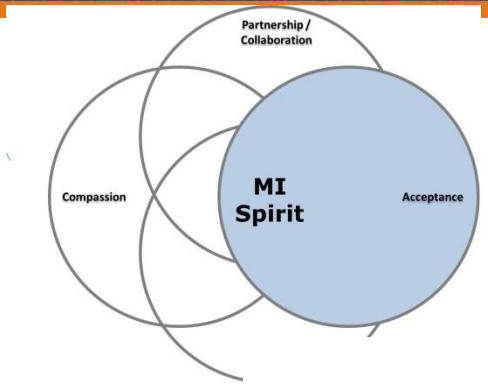
The Underlying SPIRIT of MI



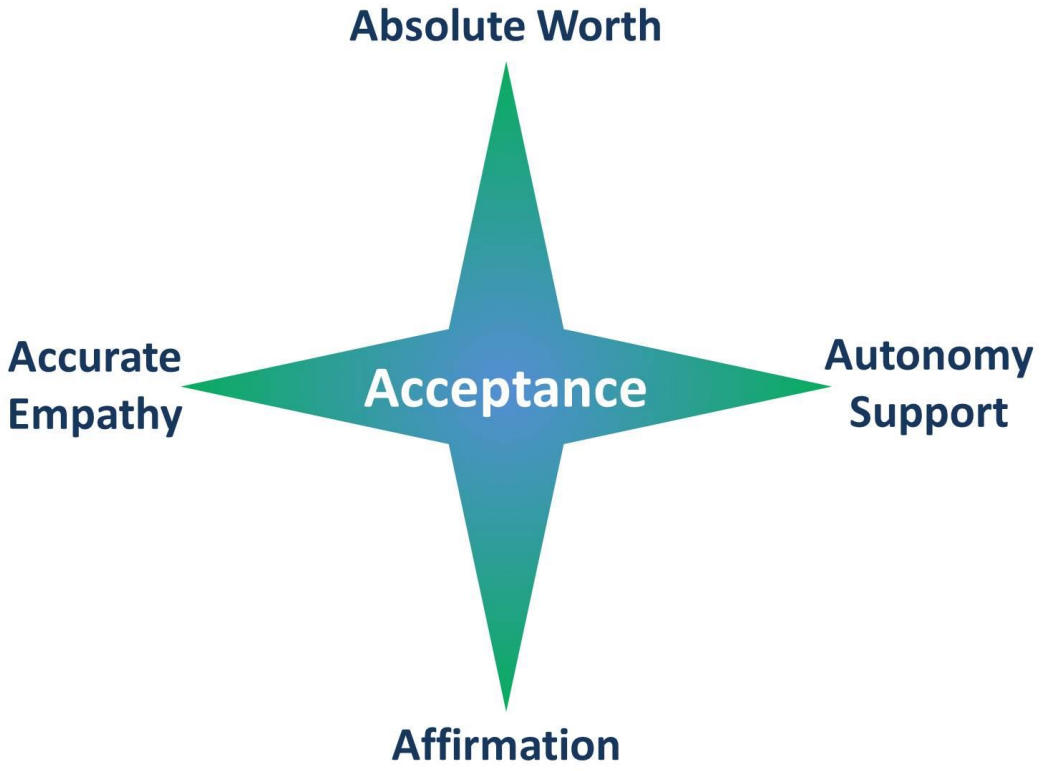
1. Partnership

- MI not '*done to*' or '*on*' a person but '*with*'
- collaboration between experts (*Avoid expert trap)*
- A dance rather than a wrestle
- Not *tricking into* change but *activating own motivation & resources*

The Underlying SPIRIT of MI



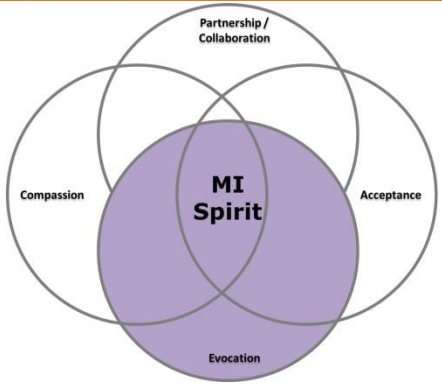
2. Acceptance



Self-efficacy

- A person's belief in the possibility of change is an important motivator
- The client, not the counsellor, is responsible for choosing and carrying out the change
- The counsellor's own belief in the person's ability to change becomes a self-fulfilling prophecy
- Existence of alternatives, reinforces hope
- Change is related to the person's important life goals

The Underlying SPIRIT of MI



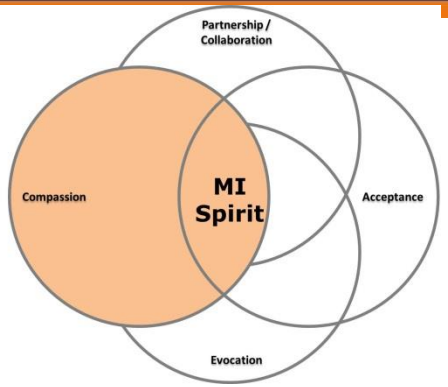
3. Evocation

- Opposite to a deficit model *"I have what you need and am going to give it to you"*

- **People already have what they need**

Your task is to call it forth…. *"to find it together"*

The Underlying SPIRIT of MI



4. Compassion (added in 3rd Edn 2013)

- Actively promote the person's welfare. *"A deliberate commitment to pursue the welfare of the other"*

- Give priority to their needs and interests rather than the counsellors

Motivational Interviewing

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Four processes

- Engaging
- Focussing
- Evoking
- Planning

O.A.R.S. (skills)

- Open questions
- Affirmation
- Reflective listening
- Summary

The spirit of motivational interviewing is the foundation of its value.

Collaboration, Acceptance, Evocation, Compassion

Resources

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- ADF website: https://adf.org.au/
- Co morbidity Guidelines. https://comorbidityguidelines.org.au/
- https://reasonsforusepackage.com/
- http://www.straightup.org.au/
- https://www.breakthroughforfamilies.com/ : Ice education for families.
- Righting Reflex: https://www.bing.com/videos/search?q=righting+reflex+mi&&view=detail&mid=335C9E7C6CE5F153EF89335C9E7C6CE5F153EF89&&FORM=VRDGAR
- Validation & Listening: https://www.bing.com/videos/search?q=not+the+nail&view=detail&mid=75E46C3FBD37D4166BD875E46C3FBD37D4166BD8&FORM=VIRE