A Psychological Perspective on Learners with Addiction and Mental Health Needs

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Role of IPS Psychology Service

DUAL FOCUS

MENTAL HEALTH

OFFENCE-FOCUSSED

Contextual Factors

- Greater mental health comorbidity than general population (e.g. Mental illness + addiction+ PD)
- Very high rate of substance abuse difficulties (61-79% using multiple intoxicants; Kennedy et al., 2005)
- Social and Educational Disadvantage (10% illiterate)
- Overrepresentation of Traveller and Homeless population
- High rates of learning disability (28.8% < 70 KBIT; Carey et al., 2000)
- High rates of Personality Disorder (60-70%; Ministry of Justice, National Offender Management Service, 2011)

Spectrum of interventions

- Anxiety/Depression/Anger/ Coping: 4-16 sessions.
- Where there are co-morbid difficulties such as addiction, Personality Disorder and violent offending: longer term work including offence-focussed

Motivational interventions

- Offenders are difficult to engage and retain in treatment
- Cannot work with them if not engaged
- Increased risk if treatment drop out
- Readiness to engage

  = Motivation and responsivity- ready, willing and able

Wheel of change & readiness

- Pre-contemplation - denial, lack of awareness
- Contemplation - starting to reflect on lifestyle,
- Preparation- decision/commitment to change, some plan
- Action- some evidence of change for 3-6 months
- Maintenance- sustained lifestyle change > 2 years
- Cycling/relapse

Motivational interviewing

- 5 main principles of MI
  - Express empathy
  - Roll with resistance
  - Avoid argumentation
  - Develop discrepancy
  - Encourage self efficacy

CONFRONTATIONAL APPROACH IS COUNTERPRODUCTIVE

Personality Disorder

- Studies indicate that up to 78% of prisoners meet criteria for PD
- **Definition:** An enduring pattern of inner experience and behaviour that deviates markedly from cultural expectations, which is stable, long lasting, inflexible and pervasive across a wide range of situations
- The pattern must not be better accounted for as a manifestation of another mental disorder

Why work with PD?

- High rates of suicide, violence, imprisonment, self harm
- Disorders of personality reduce the effectiveness of treatments, again as person is difficult to engage and retain in treatment
- Little understanding of personality disorder or function of behaviours which can lead to a punitive approach, “they are just manipulative”, “devious” “splitting”.
- High rates of Borderline PD and Antisocial PD in prisons

Borderline Personality Disorder

1. Frantic efforts to avoid real/imagined abandonment, threat of loss can lead to changes in person's self image, emotion, thoughts and behaviour. Even loss of external structures like prison can cause huge changes. Interpersonally hypersensitive, intense fear and even anger with even appropriate criticism.
2. Intense and unstable relationships- see people as black/white, splitting, symptom of early insecure attachment characterised by fearful distrust or needy dependency.
3. Identity disturbance/ problems with sense of self- due to failure to learn to identify feeling states and motives for one's behaviour. Behaviour and values dominated by who they are with, change values, beliefs etc.
4. Impulsivity that is damaging- in its effects if not intentions (substance abuse, sex, driving)

Borderline Personality Disorder Contd.

5. Recurrent suicidal/parasuicidal behaviour- almost diagnostic
6. Affective instability- mood changes that last hours rather than days, with an underlying mood that rarely changes, "I have always been like that", extreme reactivity to stress that may be neurobiologically based.
7. Chronic feelings of emptiness- visceral, chest or abdomen
8. Inappropriate intense or uncontrollable anger- particularly where people are perceived as withholding.
9. Transient stress related paranoid ideation/severe dissociative syptoms- generally able to correct distortions with feedback.

4 main areas

- 1, 2, 7- interpersonal hypersensitivity
- 6,7,8,- emotional dysregulation
- 4 &5 – behavioural dyscontrol
- 3,9- disturbed sense of self

Development of Personality Disorder

- Bio –psycho –social model of personality development and difficulty or disorder
- Temperamental dispositions

In particular : Emotional sensitivity, reactivity

- Invalidating environments (poor attachment relationships, abuse, neglect) where the child fails to learn accurate ways to identify feelings or to accurately credit or attribute motives in self and others. Child learns that feelings, thoughts, perceptions are not real or do not matter.
- **Person's behaviour is their attempt to regulate their emotions and to communicate**

Self harm

- About 40% of self harm occurs during dissociation, during numbness or emptiness, a way of feeling real
- Physical pain to relieve mental pain
- Triggered very frequently by perceived rejection
- Sometimes to make a connection with people when very alone.
- Neurochemical basis- the act results in release of endorphins which inhibit inner turmoil
- Manipulation is the most cited reason although not one of the most common
- Substance abuse increases risk

Antisocial Personality Disorder

- Impairments in self-functioning:

a) Self-esteem derived from personal gain, power or pleasure

b) Self-directive: goal setting based on personal gratification, absence of prosocial internal standards

- Impairments in interpersonal functioning

a) Empathy

b) Intimacy

Antisocial Personality Disorder

- Following traits:

a) Antagonism (deceitfulness, hostility)
b) Disinhibition (impulsivity, irresponsibility)

Effective interventions for BPD and ASPD

1. Dialectical Behaviour Therapy

   Goal is to build a life worth living by teaching

   a) emotional regulation
   b) Interpersonal effectiveness
   c) distress tolerance skills

   which leads to stabilisation

2. Schema Therapy
3. Mentalisation Based Therapy

Schema Therapy (Young et al, 2003)

- Integrative theory and treatment for long standing difficulties including personality disorder
- Emphasises therapeutic relationship (corrective experience and empathic confrontation)
- Focuses on childhood origins and developmental processes
- Emphasises core themes (schema) and coping styles

Core emotional needs

1.	Safety, stability, nurturance	➢	Disconnection and rejection
2.	Autonomy, competence and sense of identity	➢	Impaired autonomy and performance
3.	Freedom to express needs and emotions	➢	Other directedness
4.	Spontaneity and play	➢	Overvigilance and inhibition
5.	Realistic limits to help development of self control	➢	Impaired limits

<u>No hierarchy of needs, all equal importance</u>

Early Maladaptive Schema

- Develop when core needs are not met
- Stable, pervasive themes/patterns(trait like)
- Made up of memories, emotions, sensations, cognitions- reflect a tone
- Developed in childhood and adolescence
- Related to self and other relationships
- Are dysfunctional to a large degree
- Are not behaviours but drive them

Overview of Early Maladaptive Schemas

Disconnection and rejection

1. abandonment,
2. mistrust / abuse,
3. defectiveness,
4. social isolation,
5. emotional deprivation

Impaired autonomy and performance

6. dependence,
7. vulnerability,
8. enmeshment,
9. failure

Overview of Early Maladaptive Schemas Contd.

Impaired limits

10. entitlement,
11. insufficient self control

Other directedness

12. self sacrifice,
13. subjugation,
14. approval seeking

Overvigilance and inhibition

15. punitiveness,
16. negativity,
17. emotional inhibition,
18. unrelenting standards.

Schema Modes

- Used in more complex presentations
- Explain shifting mood states of BPD- mode flipping
- Use modes with BPD as so many EMS
- Are specific emotions, cognitions, and behaviours that are currently active for an individual.
- The predominant state we are in at a particular time.

Child modes: Vulnerable child

- Feels helpless about getting needs met or finding protection, appears vulnerable, depressed, needy, frightened
- Nature of the wound depends on the unmet needs
- Goal of ST is to get needs met
- Need to access vulnerable child to heal schema
- Because it feels so bad, can mode flip

Child Modes: Angry/impulsive child

- Its function is to get basic needs met, person acts impulsively to get needs met, vents feelings in inappropriate ways.
- Angry, impulsive, demanding, controlling, suicidal threats, DSH (to punish others).
- Does not appear in control
- Let them “vent vent vent”, then empathise, THEN reality test

Parent modes: Punitive or demanding parent

- Internalised dysfunctional voice of experience with others/carers usually
- Functions to punish the child for expressing needs and feelings or for making mistakes
- Presents as very critical of self and others, self denial, DSH (to punish self), anger at self for neediness

Maladaptive Coping Modes

- Detached protector- Avoidance: substance abuse as self-soother
- Compliant surrenderer- Surrender
- Overcompensator – Bully and Attack

Healthy Adult Mode

- Part that nurtures and protects the vulnerable child, sets limits for angry child, battles/moderates the maladaptive coping modes or punitive parent to meet the child's emotional needs

Aim of treatment

- Put simply, aim is to facilitate the client to reduce their dysfuntional coping mode (e.g. detached protector) and Punitive/Parent mode and allow the Vulnerable Child to be supported, nurtured and facilitated in expressing emotions.
- This reduces need for Angry Child and overcompensatory modes to feature as anger and underlying feelings of vulnerability can be expressed and managed in a healthier way

Addiction and Personality Disorder

- There is a 50-75% chance that individual with an addiction issue meets criteria for at least 1 PD
- Borderline and Antisocial PD most frequently co-occur with Substance Abuse
- Very powerful coping style (Self-soother) and development of emotional regulation skills necessary to replace role of substances
- Psychological attachment to substance is significant, not just physical dependence
- Good lives model – APPROACH goals as well as AVOIDANCE goals

Techniques that help

- Goals – go slowly
- Change is difficult to achieve and full of fears. When a person hears they are making great progress, this can trigger fears of abandonment
- Lower expectations- set small goals to ensure success; lapses are inevitable
- Don’t get defensive in the face of accusations, allow yourself to be hurt (emotionally!), admit to what is true in the criticism

Techniques that help Contd.

- Don’t ignore self harm or threats of self harm, or keep them a secret, tell a professional
- Listen; Avoid phrases such as “don’t be silly”, “that isn’t the case”, “there’s nothing to worry about”. Person needs to feel validated. It is positive that they are expressing themselves in words rather than through (destructive) action

Techniques that help Contd.

- Unity : inconsistency fuels conflicts. To prevent splitting, have people with good relationships deliver bad news and those with less positive relationships deliver good news.
- Make the limits of your tolerance clear and be consistent
- Do not protect from the natural consequences of actions.
- Do not tolerate abusive treatment- walk away, talk later

Techniques that help Contd.

- Only use threats/conditions when you have considered the outcomes beforehand and are prepared to follow through
- Involve the person in the solution- ask what the person can do, ask whether they want to do it
- Be firm but be careful of lapsing into punitiveness
- People with PD can elicit strong reactions in others - be mindful of your own self-care and seek support

THANK YOU!

Questions and Discussion

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