

Commentary for PMH

Redefining Dependency – a way forward

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In this case study of a 33 year old Romanian man with a range of comorbidities including Borderline Personality Disorder (BPD), substance abuse, and mood disorder the authors consider the challenging issue of 'dependence and its management'. Despite a range of short term psychological interventions and significant pharmacological treatments this man has entered a cycle of increasing in-patient admissions leading to hopelessness amongst clinicians – a familiar picture world wide.

The issue of 'dependency' on in-patient admissions is an important issue both for the health and social economy (Van Asselt, et al., 2007; Soeteman et al., 2008), but more importantly for the individual, as recurrent and often lengthy in-patient admissions deprive the individual of the opportunity to engage with value driven social roles such as employment or education, and develop healthy social relations in their communities. The individual is provided with a repeated message that the world is an unsafe place and they lack the competencies to manage their safety outside the protection of mental health services, thus increasing hopeless and helpless beliefs (Chapman, Specht, Cellucci, 2005). Furthermore an iatrogenic pattern often occurs in which the space which initially was a source of safety and comfort from intense distress, itself becomes a place of hostility as staff become increasingly frustrated and themselves despairing of recovery (Bodner, Cohen-Fridel, & Iancu, 2011). The first issue to be addressed is the use of the term 'dependency'. This vague term is unhelpful for the individual and staff as it does not provide a way forward. Behavioural theory would suggest that we redefine 'dependency' as the consequences of a set of observable and measurable behaviours (Hirschfield et al, 1977). This gentleman lacks the skills to elicit care from his social network and thus engages in risk behaviours. When he engages in suicidal or self harming behaviour, he then obtains care from the system. From the Dialectical Behavioural Therapy (DBT; Linehan, 1993) model we would suggest that the suicidal behaviour is an effective, but dysfunctional, solution to the problem of overwhelming and (perceived) unbearable emotional pain. By defining dependency as a consequence of a behaviour, we can then identify the reinforcers of the behaviour. This then leads to the use of contingency management as a means of reducing the risk behaviour (Swenson et al, 2001). Mental health staff are frequently caught in a difficult dilemma, as admission to hospital after a suicide attempt will, in this case, reinforce the behaviour. This increases its likelihood in future, yet the staff are often embedded in a system that demands they protect the individual from harm. However despite this, efforts can be made to reduce the reinforcing qualities of the admission, by providing

care and support in community settings, and through supporting staff to tolerate fears for the patient's safety and the repercussions from the system. A further complexity is the phenomena of the extinction burst (Carr, 1977). When a reinforcer is withheld, the individual is likely to escalate their behaviour in frequency and severity. This escalation in severity increases the risk, and evokes fear in staff who are attempting to continue with the decision to withhold the reinforcer (admission). A clear and agreed decision from the health care system is required to manage staff fears.

The second main point arising from this case study of behaviours leading to repeated admissions (dependency) is to highlight the value and importance of the psychological therapy tool, the case formulation (Kuyden, Padesky, Dudley, 2008). In this case the DBT biosocial model and DBT strategies and techniques suggest a way forward (Linehan, 1993). The DBT model suggests that individuals with BPD have a sensitivity to heightened and prolonged emotions. This transacts with an invalidating environment in childhood (and often in adulthood) leading to the development of the typical symptoms and behaviours. In the invalidating environment the individual is not provided with the opportunity to learn and strengthen the necessary skills in managing their emotions, tolerating distress, and managing relationships effectively. The extreme deprivation described in this case provides considerable evidence that this gentleman has not had the opportunity to develop these skills. In addition throughout the narrative there are multiple examples across his lifespan of social reinforcement of risk behaviours and ineffective communication. From a more cognitive perspective, the repeated failure to manage emotions, which leads to poor quality and limited relationships and failure to achieve value driven goals, has led to the development and strengthening of dysfunctional schema including most likely 'I am incapable' and 'I am unloveable' (Beck, Davis, Freeman, 2014). These beliefs maintain the emotion of despair which prompts the action urge of 'giving up', resulting in admission seeking behaviour and engaging in 'Bacovian states' behaviours.

The authors suggest that this individual has received 'skills coaching linked to DBT' for 'short periods of time'. The evidence base for the provision of DBT for complex and high risk clients, is for a year of fully programmatic DBT which includes all modalities facilitating all functions (Stoffers, et al., 2012). The DBT skills training mode equips the individual with the skills to manage emotions, tolerate distress, and improve relationships. The individual sessions assist the individual to clarify the behavioural sequence from trigger (antecedents) to behaviour to consequences (reinforcers) and to identify a range of solutions for breaking the sequence (Heard and Swales, 2015). The skills coaching provides the function of generalisation. There are two types of generalisation of skills required: response generalisation in which the individual is able to identify and utilise a range of different skills to solve a particular problem, and stimulus generalisation in which the individual is able to identify and rehearse any specific skill in a range of environments. Thus the individual is encouraged to learn skills in all

relevant environments. While in-patient services often provide the opportunity for intensive learning of the DBT skills, they lack the opportunity for the individual to generalise these skills to their home environment. The challenge for DBT in-patient settings is to identify sufficient opportunities for generalisation during admission and after discharge.

The antithesis to suicide is a 'life worth living', the ultimate goal of DBT. There is evidence in this case that this gentleman has improved in functioning and had limited contact with mental health services when he was engaged in education and was involved in a few supportive relationships (teacher and classmates). Repeated admission and long term stays reduce the opportunity for the individual to engage in value driven activities to move towards 'a life worth living', thus maintaining or increasing risk, leading to the vicious cycle of repeated admissions and further reduced opportunities. Several evidence based third wave CBT therapies promote the development of skills for living a value driven life including DBT and Acceptance Commitment Therapy (ACT) (Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009; Chakhssi, Janssen, Pol, van Dreumel, & Westerhof, 2015). Finally one needs to look at the evidence from the recovery model (Jacobson, & Greenley, 2001). Looking at the basic tenets of the recovery model, it is clear to see how repeated and lengthy in-patient admissions do not support the development of hope and empowerment, and reduce connection to the individual's social network. Furthermore, recovery from severe BPD with a range of co-morbidities will not be a simple upward trajectory to health. Recovery models suggest a staircase effect of improvement with movement followed by plateaus for consolidation, before there is further improvement. From a cognitive perspective, assisting both staff and the individual to measure change from this perspective is likely to reduce the hopeless and helpless cognitions, thus reducing frustration and despair (Butler et al., 2002). Returning to my original proposition, restating 'dependency' in terms of measurable and observable behaviours, allows for progress to be measured (and obstacles to be identified) which facilitate an awareness of progress up the recovery staircase. Drawing from the DBT for Substance Abuse adaptation, 'every set-back is an opportunity to learn'. Thus a lapse (re-engaging in dysfunctional behaviour such as suicide attempt or substance use) allow for the further identification of perhaps previously unidentified links in the chain of events, or points to failures in full generalisation (Dimeff and Koerner, 2007).

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