Bad Behavior vs. Psychiatric Illness: Personality Disorders in Substance Use

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Disclosures

Nothing to disclose

Objectives

- Identify most prominent personality disorders comorbid with substance use disorders
- Review evidence based treatment strategies based on identified personality disorder
- Clinical pearls of working with “tough” patients
- Case example
- Discussion/Questions

Overview: Personality Disorders

- Defined as enduring patterns of inner experiences and behaviors that markedly deviate from the expectations of the individual culture.
- As per the American Psychiatric Association, these disorders and associated traits are **inflexible** and **pervasive** in nature
- onset in adolescence and early adulthood
- These traits are stable over time and lead to significant impairment to the individual and others.

Overview: Personality Disorders

Pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people and events)
2. Affectivity (i.e., the range, intensity, liability, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse control

DSM V: Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self image or sense of self.
4. Impulsivity in at least two areas that are potentially self damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self mutilating behavior covered in Criterion 5.
5. Recurrent suicidal behavior, gestures, or threats, or self mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

DSM V: Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following: having hurt, mistreated, or stolen from another.

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing.

DSM V: Antisocial Personality Disorder

B. The individual is at least age 18 years.
C. There is evidence of Conduct Disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Epidemiology of Personality Disorders

- Between 10-15% of the general population (depending on study and population surveyed)
- 50% of those in a psychiatric setting and over 66% of those in the criminal justice setting
- 34.8% to 73.0% in patients treated for addictions, with a median of 56.5%
- Comorbidity with Personality Disorder (PD) positively correlates with the severity of the Substance Use Disorder (SUD)

Epidemiology (cont'd)

- Highest comorbidity with Borderline Personality disorder (BPD) and Antisocial Personality disorder (ASPD)
- Among patients with a PD, 5x risk of comorbid alcohol used disorder and 12x the risk of drug use disorder
- Some studies show as high as 78% lifetime comorbidity with Borderline Personality disorder

Personality Disorders in SUD

Study	Country	Sample	Sample size (*n*)	Any PD (%)	ASPD (%)	BPD (%)
Brooner *et al.*[13]	USA	Opioid-dependent men and women admitted to the outpatient methadone clinic	716	34.8	25.1	5.2
Driessen *et al.*[14]	Germany	Alcohol-dependent patients seeking treatment	250	33.6	4.4	3.2
Kokkevi *et al.* [15]	Greece	Drug dependent patients admitted to drug-free treatment services	226	59.5	33.5	27.7
Morgenstern *et al.*[16]	USA	Alcohol-dependent patients	366	57.9	22.7	22.4
Rounsaville *et al.*[17]	USA	Substance-dependent patients entering treatment	370	57.0	27.0	18.4
Landheim *et al.* (2003)[18]	Norway	Polysubstance abusers and alcoholics	260	72	31	27
Singh *et al.* (2005)[19]	India	Alcohol-dependent subjects	100	NA	21	NA
Langas *et al.* (2012)[20]	Norway	Patients with substance use disorders admitted to inpatient or outpatient treatment	46	46	16	13

NA – Not available, PD – Personality disorder, ASPD – Antisocial personality disorder, BPD – Borderline personality disorder

Pathogenesis

- Primary PD → Substance use ?
- Trauma leading to both?
- Common biological factors leading to impulsivity

Impact of the PD on Treatment

- Poorer prognosis when PD present with SUD
  - Non-adherence
  - Problems in therapeutic relationship
  - More drop outs
  - Shorter time to relapse upon discharge
- Patients with PD and SUD start using substances earlier, have a more severe course (more relapse, less periods of abstinence), higher suicide rate, poorer social functioning
- Identifying type of personality disorder useful

Impact of the PD on Treatment (cont)

- NESARC showed antisocial, borderline, and schizotypal PDs were more consistently associated with persistent alcohol, cannabis, and nicotine use disorders at 3-year follow-up as compared to other PD
- Treatment of the SUD has little impact on the course of the PD
- focus is required also on the management of the comorbid PD, and it should be incorporated into the drug use treatment services

Management Strategies

- Psychotherapy
  - dialectical behavioral therapy (DBT)
  - dual focused schema therapy (DFST)
  - dynamic deconstructive therapy (DDP)
- Psychoeducation
- Psychopharmocology

Management: Psychotherapy

- DBT has most evidence but very little specifically in SUD treatment settings
- Limited resources makes this difficult in many settings
- Not effective in Antisocial PD
- Importance of patient-therapist relationship

Management Psychoeducation

- Mainstay for Anti social personality disorder
- Teach patient about the importance of learning coping skills

Psychopharmacology

- Use appropriate MAT
- Fixed dosing schedule preferable to PRN dosing
- Reserve medication for coexisting, anxiety, depression, agitation, psychosis (avoid reinforcing aggression/agitation)

Clinical Pearls

- Boundaries!
- Set proper expectations
- Follow through with changes to treatment if failure to comply with expectations
- Allow natural consequences

More Clinical Pearls

- Pay attention to countertransference, it gives indication of personality structure
- There is compassion to be found in (almost) all patient's stories
- Outline for patient what behavior will be considered criminal and prosecuted as such
- Team approach is ESSENTIAL, do not allow for splitting!

The moral of the story…

- Not all behavior is attributable to a psychiatric illness or personality disorder
- When personality appears to be driving maladaptive behavior, tailor treatment specifically to address coping styles
- If driven mostly by Antisocial personality traits be very concrete about goals and expectations of treatment
- Do not allow criminal behavior in the treatment setting, even verbally threatening or menacing behavior should NEVER be tolerated

Case Presentation #1

J.P is a 26 yo M PPHx Depression, Anxiety, Alcohol use disorder, Benzodiazepine use disorder presented to CPEP reporting suicidal ideation. Urine tox was negative but urine alcohol was 260. Patient appeared to be in alcohol withdrawal so was transferred to medicine and subsequently admitted to psychiatry. During admission interview was demanding of medication, refused to consider other treatment options and made threatening statements about destruction of property if his requests were not granted.

CURRENT PERSONALITY CONSIDERATIONS?

What else would you like to know?

Case Resolution

- Patient spent much of first day of admission trying to negotiate medications
- Patient was given final warning that if he engaged in physical violence he would be discharged from the inpatient unit
- Escalated again, destroyed computer
- Discharged from unit and clinic with referrals to outpatient clinic

Case Presentation #2

NS is a 36 year old female with a self reported past history of PTSD, “bipolar”, Anxiety, Depression, Methamphetamine use disorder, heroin use disorder, alcohol use disorder who was BIB EMS activated by self for suicidal ideation in context of feeling abandoned by fiancé of 1 week. Patient reports extensive trauma history, including multiple rapes, and extensive substance use with minimal periods of sobriety over the last 20 years. She has 5 children, none of which she has custody of. She states she is irritable, has daily suicidal thoughts, gets very emotional very quickly and gets disappointed easily. Currently she was prescribed Adderall, Lorazepam, Quetiapine, Lamotrigine and Hydroxyzine.

Personality considerations? What else would you like to know?

Case #2 cont'd

Treatment team explained to patient that her symptoms can all be explained by Borderline Personality Disorder (in the context of complex trauma). Patient was extremely relieved to hear this and when given a print out about it, revealed it sounded like a description of her. Patient's poor distress tolerance and impulsivity made her admission difficult.

What would be the best outpatient referral for this patient?

Case #2 Resolution

Patient did not follow through with getting her insurance changed so was not able to have immediate access to services in NYC. She was given referral to CITPD and intensive outpatient substance use treatment programs in addition to psychiatry.

Questions???

Resources

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Moran P, Jenkins R, Tylee A, Blizard R, Mann A. The prevalence of personality disorder among UK primary care attenders. Act Psychiatr Scand 2000;102:52-7.

Verheul, R. Co-morbidity of personality disorders in individuals with substance use disorders. Eur Psychiatry 2001: 16: 274-82.