

2012  
Web Seminar Series

# ***PERSONALITY DISORDERS AND ADDICTION***

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# Outline:

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- Provide prevalence of substance use disorders among patients with personality disorders
- Present information on how substance use symptoms interact with personality features to place patients at high risk for Relapse
- Review clinical strategies based on evidence-based treatments for reducing risk of relapse

# Brief Review

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Personality is a relatively stable and enduring set of characteristic behavioral and emotional traits

The DSM classifies Personality Disorders (PD) into clusters:

- Cluster A = Schizoid, Schizotypal, Paranoid,
- Cluster B = Borderline, Histrionic, Antisocial, Narcissistic
- Cluster C = Dependent, Avoidant, Obsessive-Compulsive



# **SUBSTANCE USE DISORDERS-SUDs**

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# Substance Use Disorders - SUDs

- Primarily, we will be referring to SUDs as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)
- Alcohol Abuse (AA) and Alcohol Dependence (AD)
- Substance Abuse (SA) and Substance Dependence (SD)
- Most references will be to the combination of both disorders:

**AA + AD = AUD;**

**SA + SD = SUD**

# Alcohol Abuse & Substance Abuse

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Four Criteria in a 12 month period

A pattern of recurrent:

1. Substance-related role failure
2. Hazardous use
3. Substance-related legal problems, arrests
4. Substance-related social or interpersonal problems

# Alcohol and Substance Dependence

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Seven Criteria in a 12-Month period

A recurrent, maladaptive pattern of:

1. Marked increased amount to achieve intoxication (50% or more)
2. Withdrawal syndrome
3. Taken more/over larger periods than intended
4. Persistent desire to stop or cut down
5. Much time spent obtaining, using, recovering
6. Important activities given up
7. Continued use despite knowledge of problem(s)

# Prevalence

Epidemiologic studies find varying rates of AUD among patients with personality disorders (based on DSM-IV criteria) (Kessler et al., 1997)

<b>Alcohol (%)</b>	<b>Abuse</b>	<b>Dependence</b>
	Men	
Conduct Disorder	25.3	41.6
Any Antisocial Behavior	8.8	24.5
ASPD	6.1	16.9
	Women	
Conduct Disorder	13.5	22.8
Any Antisocial Behavior	8.0	13.9
ASPD	2.1	7.8

# Rates and Risk Among Ob. Comp. PD

- One study using the NESARC data set (43,000+) found a lifetime prevalence of 7.8% Ob-Comp PD. The DSM-IV lists prevalence of Ob-Comp PD at 1% in community samples
- Men with Ob-Comp have higher lifetime rates of alcohol and drug use disorders compared to women; 68.7 vs. 47.8%, 43.5 vs. 28.2%, respectively)
- However, ORs in the total sample are much less than for other disorders (1.3 and 1.3, respectively, adj. for demographic and clinical variables)

*Grant et al., 2012*

# Risk for Onset

## Drug Use Disorders

	OR	OR
Avoidant	3.4*	1.3
Dependent	7.3*	2.2*
Ob-Comp.	2.3*	0.9
Paranoid	3.5*	1.1
Schizoid	3.4*	1.5
Histrionic	4.5*	1.5
Antisocial	6.4*	2.9*

adj. for dem. variables; \*sig. at  $p < .05$   
*Compton et al., 2007*

adj. for dem & psych. variables \*sig. at  $< .05$

# Risk for Persistence

Axis II Personality D/O and Persistence of SUD at 3 Yrs.

	<b>Alcohol Dep.</b>	<b>Can. Use D/O</b>
Antisocial	3.5*	2.5*
Avoid/Dep	0.1	0.7
Borderline	2.5*	2.8*
Histrionic	1.0	1.1
Narcissistic	2.0*	1.3
Ob-Comp.	0.9	0.9
Paranoid	1.2	0.8
Schizoid	1.1	0.8
Schizotypal	3.4*	5.9*
*statistically significant		<i>Hasin et al., 2011</i>

# Risk for Onset at 1 Year

	Alcohol Dep.	Any Drug Dep.
	OR	OR
Avoidant	1.2	5.5*
Dependent	0.1	13.8*
Ob-Comp.	1.6	1.8
Paranoid	1.9*	2.5
Schizoid	1.4	2.3
Schizotypal	2.5*	10.2*
Borderline	3.9*	6.8*
Histrionic	2.3*	1.8
Antisocial	1.5	3.0*
Narcissistic	1.8*	5.4*
adj. for dem variables; *sig. at p<.05		<i>Grant et al., 2009</i>

# Prevalence in Borderline Disorder

12 Month		Lifetime	
Alcohol D/O	Drug D/O	Alcohol	Drug D/O
24.2%	50.7%	57.3%	72.9%
OR*	OR*	OR*	OR*
1.6 <sup>+</sup>	1.9 <sup>+</sup>	1.2	1.7 <sup>+</sup>
Prevalence with Other Cluster B D/O = 49.2%			
*Controlling for demographic and other psychiatric d/o			
<sup>+</sup> statistically sig. p<.01			
Grant et al., 2008			

# Risk for Onset of Any SUD in the WHO Study

<b>12 Month</b>	
	<b>OR</b>
Cluster A	2.8*
Cluster B	14.5*
Cluster C	3.2*

\*Statistically significant,  $p < .05$

Huang et al., 2009

# Prevalence & Risk of SUD

	<u>Cluster A</u>	<u>Cluster B</u>	<u>Cluster C</u>
Alcohol D/O	5.8%	26.7%	5.4%
Drug D/O	2.3%	12.9%	2.7%
	<u>OR</u>	<u>OR</u>	<u>OR</u>
Alcohol D/O	2.0	10.3*	1.9
Drug D/O	1.6	8.7*	2.2
*statistically significant at $p < .05$			
Lenzenweger et al., 2007			

# Onset Related to Disruptive Behavior

	Alcohol Dep.	Drug Dep.
T <sub>1</sub>	T <sub>2</sub>	T <sub>2</sub>
	OR	OR
Intermittent Exp. D/O	6.0*	6.3*
Oppos. Defiant D/O	3.9*	3.9*
Conduct D/O	2.0	3.5*
Attention Def. Hyp. D/O	1.8	5.2*
ASPD	2.4	3.8
*Significant at p<.05		Swendsen et al., 2010

# Epidemiologic Findings and Clinical Realities

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- Kessler (2004) notes the strong association of externalizing disorders with substance use disorders; even stronger in clinical samples
- Most non-substance related disorders onset prior to the onset of substance-related disorders
- The pervasiveness of a PD can have a profound impact on functioning, including feelings, symptoms etc., that lead to drug use

# Conclusions

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Conclusions based on this review:

- Risk for substance use disorder among people with PD varies based on diagnostic methods used
- Risk of substance use disorder is greatest among patients with Cluster B disorders
- Risk for substance use disorder among people with PDs decreases when the effects of other disorders are accounted for
- There is a need to integrate epidemiologic findings with clinical experience, especially as it relates to findings associated with the effect of “other disorders” on risk for developing an SUD

# QUESTIONS FROM PARTICIPANTS





# WHAT CAUSES INCREASED RISK?

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Two major issues are:

1. What increases risk for developing SUD?
2. Are there other additional risks for relapse during recovery?

# What Increases Risk for Developing SUD?

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The primary ways risk for onset increases are:

1. Psychiatric symptoms increase the need to use drugs for relief - “self-medication”
2. Genetic loading and developmental/environmental factors work together to increase risk
3. Interaction of the first two

# Need for Self-Medication

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- Commonly considered a natural response when people become dysphoric
- In the context of PD (e.g., borderline) this does not necessarily equate to the syndrome we call major depression
- It is likely more related to “affective instability;” rapid shifts in mood
- An indirect comment on the validity of the self-medication hypothesis is that found by Wilens et al., in 4 year follow-up for ADHD

# Self-Medication

- Wilens et al., found (uncontrolled study) in long term follow-up that treated ADHD patients had a lower rate of substance use disorder
- This finding is likely related to decreasing the potential for impulsivity
- Impulsivity is related to Cluster B PD in several ways;  
Examples:
  - ✓ Antisocial – Impulsivity and failure to plan ahead
  - ✓ Histrionic – Suggestibility and need for excitement
  - ✓ Borderline – Tendency to act impulsively due to affective instability

# Relationship of Age to Impulsivity

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- One important observation is that symptoms of non-substance related disorders onset prior to substance use
- Symptoms such as impulsivity and affective dysregulation, emotional instability have onset years prior to other behaviors or traits that come to be associated with PDs
- Recall Swendsen et al.

# More on Self Medication

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- Although risk for developing SUDs is greater in the Cluster B subtype; some epidemiologic studies (reviewed) have found increased risk with dependent (Compton et al.); schizotypal (Hasin et al., Grant et al.) and avoidant (Grant et al.)
- These findings are not as robust as those found related to development of SUD in Cluster B
- However, they can make sense as avoidant and dependent people can be highly anxious, possibly leading to use of drugs

# Self Medication for Psychosis

- Hasin et al. (2011) finding on cannabis use disorder among people with Schizotypal PD is of particular interest
- Recent studies suggest an association between use of cannabis to correct an imbalance in the endo-cannabinoid system among patients with schizophrenia
- It is possible that people with Schizotypal PD gravitate toward use of cannabis for similar reasons
- Unfortunately, probably related to dose used, more evidence is accumulating that cannabis puts people at risk for exacerbating psychosis

# Self Medication of Mood Disorders Among Men

	Alcohol Only	Drugs & Alc.
	<u>OR</u>	<u>OR</u>
Avoidant	1.8*	3.0*
Dependent	3.1*	8.7*
Ob-Comp.	1.4*	2.0*
Paranoid	1.8*	3.4*
Schizoid	1.3	1.7*
Histrionic	1.5	3.3*
Antisocial	1.6*	2.7*
adj. for demographic and other lifetime SUD variables		
*sig. at <.05		<i>Bolton et al., 2009</i>

# Self Medication of Mood Among Women

	Alcohol Only	Drugs & Alc.
	<u>OR</u>	<u>OR</u>
Avoidant	1.2	1.8*
Dependent	1.0	2.8*
Ob-Comp.	1.3	1.4*
Paranoid	1.5*	2.1*
Schizoid	1.3	2.3*
Histrionic	2.3*	2.4*
Antisocial	1.0	1.8*
adj. for demographic and other lifetime SUD		
variables; *sig. at <.05		Bolton et al., 2009

# Self Medication for Anxiety Disorder

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- Self medication for anxiety is highly prevalent with ORs between 10.8 for use of opioids to 20.0 for use of tranquilizers to relieve anxiety
- Increasing comorbidity is associated with increasing use of drugs to relieve anxiety
- This refers to use of multiple substances and with diagnosis of PDs
- These findings suggest increasing inability to cope and to tolerate negative affect

*Robinson et al., 2009*

# Environmental/Developmental Risks

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- The quality of parental bonds, including care, rejection, overprotection and neglect have been found to impact behavior and alcohol use
- Women with a caring mother were less likely to have antisocial tendencies and feeling neglected/rejected by parents was linked to pathological reasons for drinking and alcohol-related problems
- Feeling neglected by fathers was linked to alcohol-related problems in men
- Antisocial PD mediated the relationship between being rejected by mothers and overprotected by fathers and alcohol use

*Patock-Peckham & Morgan-Lopez, 2010*

# Environmental and Genetic Risks

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Recent research of environmental risk and genetic heritability finds that:

- Overall, the genetic/environment split is about 40/60 with regard to risk for PD and 50/50 for SUD
- Shared environmental experience is influential in the development of personality disorders and substance use disorder early in adolescence but genetic heritability becomes dominant in contributing to these conditions later in adolescence

# Environmental and Genetic Risks

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- These findings may be related to a shift from passive gene-environment correlation effects to active gene-environment correlation later in adolescence
- Environment and experience are not independent in early adolescence because they are related to parental influence
- This changes in late adolescence as inherited factors such as temperament are given greater expression due to choice

*Bornovalova et al., 2012*

# Genetic Influence for Development of PD and SUD

- Kendler et al., research using data from twins has added some clarification about genetic and environmental risk for PDs and SUDs
- Factor analyses of genetic find that ASPD and Conduct Disorder load very strongly with AUD and SUD (the factor loadings are between 0.66 and 0.95) Borderline PD = 0.35
- Environmental factor loadings have ASPD, SUD and Conduct Disorder (0.58, 0.59, 0.40)

*Kendler et al., 2011*

# More on Genetic Risk

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- Kendler et al. (2012) finds that liability for ASPD is associated with two dimensions of genetic risk
- One that entails a “disinhibition factor” finds people who are novelty seeking and are vulnerable to depression at a younger age
- Another involves an “aggressive disregard factor” that is associated with conduct disorder, heavy alcohol use and low educational status
- This may relate to recent findings that some patients with ASPD are more responsive

# Risk for Relapse

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- We have been talking about risks developing SUDs among people with PDs
- Are there additional risks for relapse among people with SUDs?
- One is related to patterns that have been established with regard to lifestyle
- The 12-Step programs emphasize the need to control exposure to “people, places and things” that lead to relapse

# Relapse Risk

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- As discussed, patients with PDs display traits such as impulsivity, novelty seeking and affective dysregulation
- These are exacerbated by changes in neurotransmission related to substance use
- Drugs like opioids, alcohol, cannabis and stimulants cause depletion in serotonin and dopamine
- These changes contribute to impulsivity and mood changes, often through withdrawal and drug cravings

# Conclusions

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- Risk for development of PD and SUD are both genetic and environmental, with genetic influences being somewhat stronger and more influential later in life
- Risk is high for development of PD and SUD among those with childhood disruptive disorders
- Environmental and developmental experiences, trauma, neglect etc., heighten the risk
- Risk for relapse into SUD among those with PD is increased due to environment and lifestyle and neurological changes brought on by substance abuse

# QUESTIONS FROM PARTICIPANTS





# TREATMENT OF COMORBID PD & SUD

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# Treatment of Comorbid PD & SUD

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Treatment planning should be based on

1. Severity - higher levels of comorbidity require more and more types of treatments (Kelly, et al., 2012)
2. Most comorbid patients cannot be treated successfully with once weekly individual psychotherapy
3. Intensity of treatment should be based on the patient's place in recovery (Donovan et al., 2008); consider Stage of Change

# Treatment Intensity

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- Patients who have just completed detoxification do best when placed in high intensity treatments
- Residential treatment may be indicated based on motivation and degree of social support
- Partial Hospitalization (PH) should be recommended as the minimum for most comorbid patients with substance use dependence
- Patients with high levels of non-substance related psychopathology who are “abusing” substances may also be best treated in PH

# Evidence Based Treatments

Models of behavioral and psychotherapy that have shown the most effectiveness are:

1. Motivational Interviewing (MI)
2. Cognitive-Behavioral Therapy (CBT)
3. Dialectical Behavioral Therapy (DBT)
4. 12-Step Facilitation Therapy
5. Contingency Management (CM)

Note that combining Case Management services with treatment for addiction has been found effective; e.g., ASPD patients entering outpatient treatment

*(Havens et al., 2007)*

# Note on Harm Reduction

- Therapists often find themselves using harm reduction because comorbid patients do not define abstinence as a goal
- Patients with severe addiction will be unlikely to maintain “controlled use”
- This is borne out in research; one recent 10 year follow-up study finds 75% of “non-problem users” who stayed in treatment relapsed into more severe drug use vs. 48% of abstainers
- Discuss objective approach in treatment related to patient self-determination

*Mertens et al., 2012*

# Motivational Interviewing (MI)

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- Motivational Interviewing (Miller & Rollnick, 2002)
- A patient-centered therapy with the focus on helping patients resolve ambivalence
- Based on taking an empathic stance and:
  1. Asking Open-ended questions
  2. Providing Affirmations
  3. Using Reflective Listening
  4. Allowing for Self-Determination

# Motivational Interviewing

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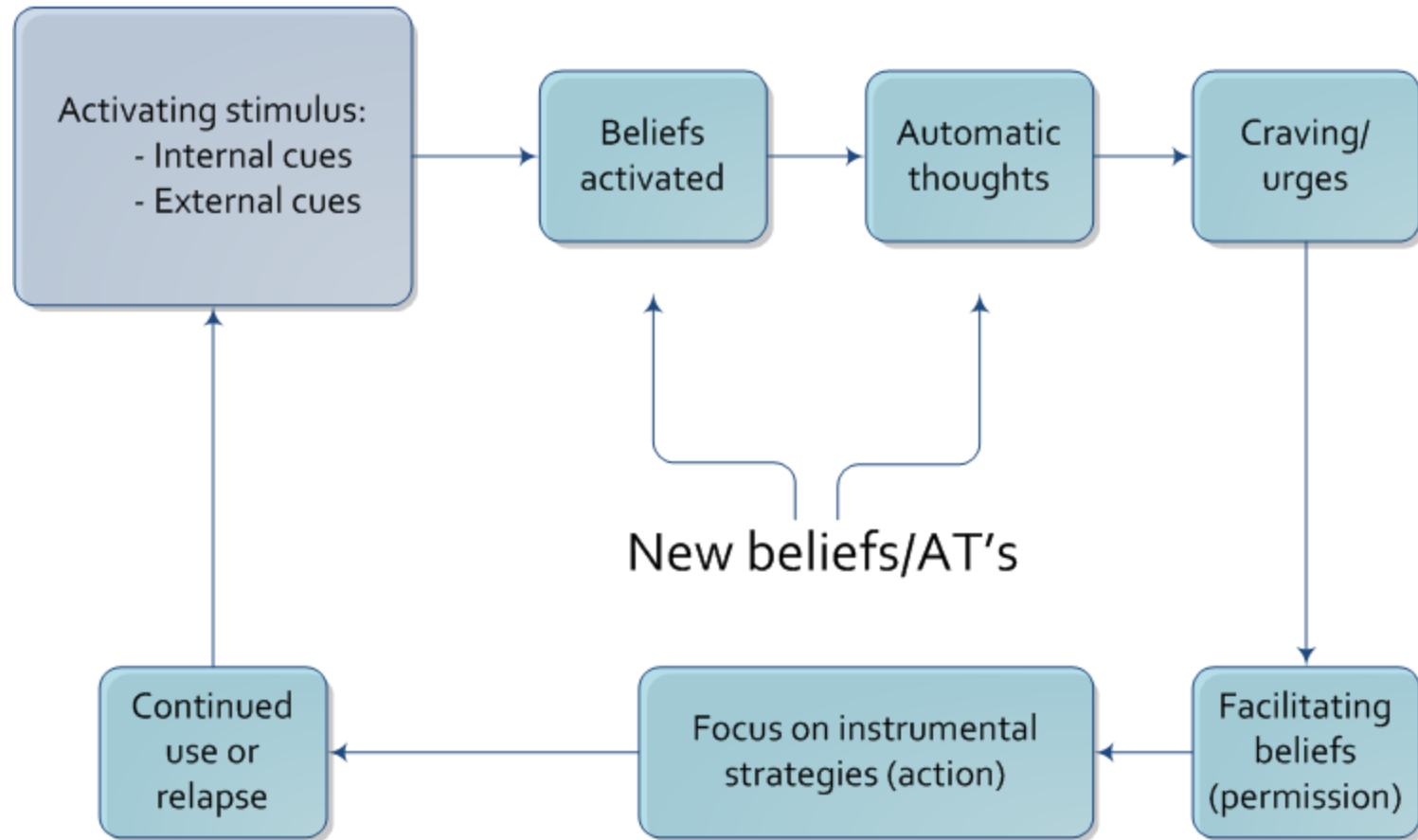
- MI is the best model of treatment early in therapy; does not assume patients want to discuss drug use
- MI is a “style of relating,” emphasizes decreasing resistance; it works best for establishing a therapeutic alliance
- One difference between MI, CBT and 12-Step in Project Match is that MI worked better with angrier patients
- Kendler et al., (2008) report on BPD having a negative factor loading for “agreeableness”

# CBT for Cravings

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- Works best with patients who have made progress in resolving ambivalence about drug use
- Once a patient indicates that they want to stop using substances, therapies like CBT work to replace thoughts or cravings
- CBT emphasizes distraction techniques that focus on shifting away from internal stimuli, e.g., simply focusing on the things around – describe surroundings, count cars, take a walk

# Thought Changing



From: Beck, A.T. Wright, F.D., Newman, C.F. & Liese, B.S. (1993). *Cognitive therapy of substance abuse*. New York: The Guilford Press

# DBT for PD and SUD

- DBT focuses on how reducing or stopping substance use leads to healthier lifestyle
- The overarching message is that substance use is another harmful behavior and that it detracts from the quality of life
- Like MI and relapse prevention, unlike 12-Step facilitation, DBT recognizes self-determination of goals, e.g., abstinence vs. controlled use
- Allowing for self-determination, DBT suggests there is a low percentage of PD patients who can successfully control substance use

*McMain, Sayrs, Dimeff and Linehan (2007)*

# DBT and Relapse Prevention

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- DBT recognizes the importance of expecting abstinence only as long as the patient believes they can maintain it
- The time may vary but like the 12-Step tenet “one day at a time” helps the patient identify what they can deal with
- While abstinence is the goal even lapses can be helpful for providing insights into how to improve chances for staying abstinent longer; similar to relapse review

# DBT and Ways to Avoid Relapse

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- DBT uses the dialectic for synthesizing the “Clean Mind” with the “Addict Mind” – which is the “Clear Mind.”
- DBT has value for avoiding relapse in several ways, including its emphasis on mindfulness and self management
- Emphasis in treatment is on managing cravings, this can include urge surfing as in relapse prevention

# More on DBT

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- An area of mindfulness in DBT that is helpful is the creative way cognitions are used to help patients control their impulses
- Cravings to use drugs are changed through emphasis on cognitive restructuring; patients learn to substitute the target of their addiction with a healthier choice; i.e., craving something else they find enjoyable, a warm bath, a nap
- This fits with “self-soothing” techniques that help regulate emotion

# CBT and DBT

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- It is important to note that CBT and DBT are therapies that were developed for other conditions, CBT for depression, DBT for BPD
- They can be effective but it is less the models (as a whole) that work and more the techniques that are used that work as addiction therapies
- McMMain, Sayrs, Dimeff and Linehan (2007) note that DBT therapists must adjust to treating patients with significant substance abuse as they are not as responsive in forming a therapeutic alliance

# 12-Step Facilitation

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- 12 Step-Facilitation treatment can be a stand alone treatment but works best as an adjunctive therapy for addiction; can be implemented as part of a comprehensive dual-disorders treatment
- It emphasizes content related to the 12-Step philosophy of treatment, including going to meetings, getting a sponsor, working the steps, etc.
- The treatment also includes actively supporting patients meeting people in AA/NA and getting to meetings

# 12-Step Facilitation in the CTN

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- One variant was used in a Clinical Trial Network Study (CTN) over 6 months
- The model included 5 group therapy sessions and 3 individual sessions that focused on various aspects of involvement in 12-Step activities
- It was compared to Treatment as Usual (TAU) in Partial Hospitalization programs
- It was found to be effective for increasing attendance at 12-Step meetings; not as clear that patients in the 12-Step arm had less drug use

# The Value of 12-Step Treatment

- As noted in our discussion of DBT, abstinence is more likely to help people achieve a healthy lifestyle than “controlled use”
- 12-Step Treatment should be emphasized even outside its use in a formalized model as it has things to offer that cannot be offered by professionals
- Therapists should explore/recommend 12-Step activities to patients who are trying to achieve abstinence
- Recovery = Abstinence + Lifestyle Change

# Contingency Management (CM)

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- CM is another adjunctive treatment that is quite effective for treating addiction
- Works through use of behaviorism by pairing completion of a target behavior with an incentive
- CM is quite effective in methadone maintenance programs targeting patients to come to counseling sessions and remain abstinent from illicit drugs
- The literature to date suggests that it is as effective in reducing addictive behaviors among patients with PD as among those who do not have PD

# More on CM

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- One recent study of CM found it to be more effective for increasing attendance at treatment and lowering psychosocial impairment among patients with ASPD being treated in a methadone program
- Weinstock et al., (2007) found reduced treatment dropout among very severe patients with SUD and psychiatric disorder who were in CM compared to TAU
- Messina et al., (2003) compared patients with ASPD on cocaine use who were treated with either CBT or CM and found reduced use among those in the CM condition

# CM in Partial Hospitalization

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- We used CM in our Partial Hospitalization program quite successfully to increase attendance
- Provided incentives in a graduating fashion so that more consistent attendance was reinforced by increasing opportunities to receive incentives
- Used the “fishbowl” method
- Increased attendance was associated with decreased psychiatric symptoms and stress

*Kelly et al., 2009*

# Medications for Personality Disorder

- Research suggests second generation antipsychotics (especially aripiprazole and olanzapine), mood stabilizers (other than divalproic acid) are best for BPD depression and anger (Mercer et al., 2009; Vita et al., 2011)
- Gianoli et al., (2012) suggest that these medications may reduce cravings and use of alcohol among patients with BPD
- Gerra et al., 2006 found olanzapine more effective against anger and aggression than SSRIs and benzodiazepines for heroin dependent patients

# Medications for Substance Use Among PD Patients

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- There is little research in this area but what there is suggests that medications developed to treat SUD are as effective among patients with PD as among patients with other disorders
- Ravelski et al., 2007 found disulfiram and naltrexone as effective for patients with PD and AUD as among patients with Axis I disorders and AUD

# Conclusions

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- Patients with PD and SUD require highly structured treatments consisting of psychotherapy, behavioral interventions and pharmacotherapies
- Treatment intensity can be reduced consistent with stability in recovery
- Self-determination with regard to goals of treatment must be honored but clinical experience and research indicates that patients who pursue abstinence are less likely to relapse

# Conclusions (cont.)

- MI is the best psychotherapeutic approach for addiction, especially early in treatment when establishing a therapeutic alliance; the MI manner of relating should be maintained throughout treatment
- CBT and DBT techniques can be helpful as patients become more consistently motivated toward controlling substance use
- 12-Step Facilitation therapy is very effective with patients who want to pursue abstinence
- CM works particularly well as an adjunctive treatment because of its behavioral foundation; cooperation with it does not require agreeing with particular principles or philosophies and it does not require patients to develop “insight”

# QUESTIONS FROM PARTICIPANTS



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