Personality disorders and alcohol and drug use: what clinicians need to know

Professor Brin Grenyer

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Key learning outcomes

By participating in this webinar, attendees will be able to:

- Identify personality disorders in the context of AOD challenges
- Select from various skills to effectively respond to people with concurrent AOD and personality disorder
- Apply key principles in managing their own personal and interpersonal reactions, when people with personality disorder and AOD are struggling or in acute crisis.

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Acknowledgements

- On the lands that we study, we walk, and we live, we acknowledge and respect the traditional custodians and cultural knowledge holders of these lands.
- To all consumers, carers, family, partners and peers with lived experience
- To the Project Air Strategy and partners, clinicians, researchers, administrators and visiting fellows – NSW Ministry of Health
- To the Illawarra Health and Medical Research Institute and University of Wollongong

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Some difficulties in substance use disorder

Personal factors:

- regularly using more of the substance than intended
- regularly trying to cut down or stop using, but never succeeding
- cravings: strong desire to use the substance
- tolerance: the substance does not have as much effect
- withdrawal symptoms: feelings of physical illness when not using

Interpersonal factors:

- **often failing to meet responsibilities at work, home or school because of substance use**
- **continuing to use a substance when it has caused relationship problems**
- **giving up social, work or leisure activities because of substance use**

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Personality Disorder and Substance Use

- Co-occurring disorders in personality disorder are very common: mood, anxiety, other … and SUD
- Challenges
  - Substance use may overlap with impulsivity criterion in BPD
  - Affective symptoms / interpersonal problems in intoxication or withdrawal phase may resemble BPD
  - Prevalence: Depends on index sample and setting – but high
  - Development: Bi-directional models

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Case study

- Suzie, 25, is recovering from entrenched methamphetamine and cannabis use, and has been working with a vocational rehabilitation counsellor, Tony, for 2 weeks to prepare for job retraining.
- One day, just after Tony gets everything set up for Suzie to begin her training, Suzie storms out of the office screaming at him, "You're just trying to get rid of me! You don't understand me at all! I hate you!" Later, when Tony calls to suggest that maybe Suzie would prefer to work with another counsellor, Suzie begins to cry and says, "Please don't drop me, Tony! I need you!

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Borderline Personality Disorder Criteria

INTERPERSONAL CRITERIA:

1. frantic efforts to avoid real or imagined abandonment
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

PERSONAL CRITERIA

3. identity disturbance: markedly and persistently unstable self-image or sense of self
7. chronic feelings of emptiness

COMORBID CRITERIA

4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
5. recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
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).
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

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BPD prevalence in SUD

Current rates of BPD = up to 53% (SUD index sample) across all studies (Trull et al., 2018)

- Current BPD prevalence in studies of specific substances:
  - Alcohol dependence: 0-30%
  - Cocaine dependence: 14-39%
  - Opioid dependence: 11-51%
- Current BPD prevalence across settings:
  - Residential: 26.7%
  - Outpatient: 15.8%
  - Forensic: 16.6%
  - Community: 24.7%

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SUD prevalence in BPD

Current rates of SUD = up to 72% (BPD index sample) across all studies (Trull et al., 2018)

- Lifetime prevalence = 45-86%
- SUD prevalence in specific studies:
  - Lifetime prevalence of alcohol dependence: 50-63%
  - Current drug use disorder prevalence: 28-72%
- SUD prevalence across settings:
  - Residential: 68% lifetime, 27.8% current
  - Outpatient: 81.2% lifetime, 48.8% current
  - Forensic: 34% current AUD, 47% current DUD

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Prevalence across PD diagnoses (Langås et al., 2012)

Langås et al. *BMC Psychiatry* 2012, **12**:180
http://www.biomedcentral.com/1471-2440/12/180

Table 2 Prevalence of different personality disorders in patients admitted for the first time with substance use disorders

	PD full criteria n (%)	PD including subthreshold diagnoses n (%)
Any Cluster A	*5 (8)*	*12 (20)*
Paranoid	5 (8)	11 (18)
Schizoid	0	1 (2)
Schizotypal	1 (2)	1 (2)
Any Cluster B	*13 (21)*	*17 (28)*
Antisocial	10 (16)	12 (20)
Borderline	8 (13)	10 (16)
Histrionic	0	1 (2)
Narcissistic	0	0
Any Cluster C	*11 (18)*	*19 (31)*
Avoidant	5 (8)	8 (13)
Dependent	1 (2)	4 (7)
Obsessive-compulsive	5 (8)	12 (20)
PD NOS	*5 (8)*	*na*
Any PD	*28 (46)*	*35 (57)*

Notes. Subthreshold diagnosis lacking one criterion for the diagnosis. Some patients have more than one PD within the same cluster. Some patients have PDs from more than one cluster; NOS not otherwise specified, *na* not applicable.

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Relationship between PD & SUD (Ekleberry, 2009)

Compared to people with SUD alone, people with SUD & PD:

- Experience greater effects of drugs
- More likely to engage in use from an earlier age
- More vulnerable to a compulsive & rigid pattern of use
- More likely to develop substance dependence
- More vulnerable to relapse
- Have more difficulty working cooperatively and collaboratively with service providers

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Personality disorder and comorbid substance dependence disorders

- Patients with comorbid substance dependence typically display greater impulsivity
- Manifesting in preference for short term rewards (Wilson et al., 2006; Coffey, Schmacher, Baschnagel, Hawk & Holloman, 2011)
- Patients with comorbid substance dependence typically show poor progress
  - Patients without comorbid addiction found to be four times more likely to experience remission within a period of six years (Zanarini, Frankenburg, Hennen, Reich & Silk, 2004)

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Emotion dysregulation and impulsivity

- "The dark side of addiction" (Koob, 2017): in SUD increasing focus on role of negative affective states – especially in later stages characterised by withdrawal ('negative reinforcement')
- Impulsivity and 'negative urgency' in SUD – compulsive use in times of stress and extreme distress (Zorrilla, 2019)
- Negative affect, affective instability, and impulsivity also hallmark symptoms of BPD

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DSM-5 Alternate and ICD-11

Personality psychopathology fundamentally emanates from disturbances in thinking about self and others

- Self: identity integration, integrity of self-concept, self-directedness of life goals
- Interpersonal: empathy, intimacy and cooperativeness, complexity and integration of representation of others

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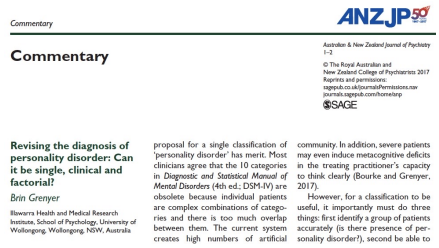
Diagnosis: Single, clinical, factorial



Commentary

Commentary

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SAGE

Revising the diagnosis of personality disorder: Can it be single, clinical and factorial?

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proposal for a single classification of 'personality disorder' has merit. Most clinicians agree that the 10 categories in *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV) are obsolete because individual patients are complex combinations of categories and there is too much overlap between them. The current system creates high numbers of artificial

community. In addition, severe patients may even induce metacognitive deficits in the treating practitioner's capacity to think clearly (Bourke and Grenyer, 2017).

However, for a classification to be useful, it importantly must do three things: first identify a group of patients accurately (is there presence of personality disorder?), second be able to

Grenyer et al ANZJP 2017

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ICD-11 and DSM-5

Table 7 ICD-11 "Cross Walk" for DSM-5 Alternative Model of Personality Disorders

ICD-11 Severity of Personality Dysfunction	DSM-5 Criterion A: Level of Personality Functioning
None	0) No impairment (Healthy Functioning)
Personality Difficulty	1) Some impairment
Mild Personality Disorder	2) Moderate impairment
Moderate Personality Disorder	3) Severe impairment
Severe Personality Disorder	4) Extreme impairment
ICD-11 Trait Domain Qualifiers	**DSM-5 Criterion B: Trait Domains**
Negative Affectivity	Negative Affectivity
Detachment	Detachment
Disinhibition	Disinhibition
Dissociality	Antagonism
Anankastia	[Rigid Perfectionism and Perseveration][a]

Note. The threshold for a Personality Disorder diagnosis is a 1 least Mild Personality Disorder (ICD-11) or Moderate impairment of personality functioning (DSM-5)
[a]These are facets from the domains of (low) Disinhibition and (high) Negative Affectivity, respectively

Both DSM-5 and ICD-11 consider:

- Level of Functioning
- Personality Traits

Bach, B., & First, M. B. (2018). Application of the ICD-11 classification of personality disorders. *BMC Psychiatry, 18(1)*. doi:10.1186/s12888-018-1908-3

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SAPAS (Standardised Assessment of Personality Abbreviated Scale)

Answer Yes if "Most of the time and in most situations"

1. general, do you have difficulty making and keeping friends? Yes/No
2. Would you normally describe yourself as a loner? Y/N
3. In general, do you trust other people? Y/N
4. Do you normally lose your temper easily? Y/N
5. Are you normally an impulsive sort of person? Y/N
6. Are you normally a worrier? Y/N
7. In general, do you depend on others a lot? Y/N
8. In general, are you a perfectionist? Y/N

Cut-off = 4 or more

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BPD symptoms in Triple Care Farm youth D&A

- 56% in current Cohort B met screening criteria for borderline personality disorder
- Modelling found BPD symptoms were a significant predictor in 3/4 outcomes
  - Higher BPD symptoms associated with greater psychological symptoms and lower quality of life
  - Effect of BPD symptoms at baseline influenced severity of dependence differently over time – those with higher BPD symptoms benefited less over time

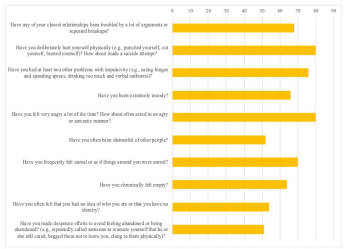

Figure 11. McLean Screening Instrument (MSI): Frequency of symptoms based on endorsement of each item in young people in residential substance use disorder treatment receiving dialectical behaviour therapy (DBT: 2018-2020).

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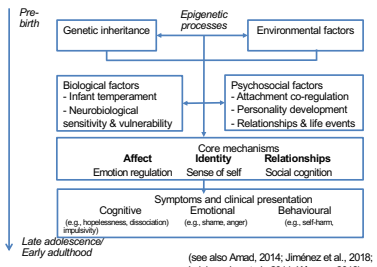
Project Air Biopsychosocial Model of Personality Disorder



(see also Arnad, 2014; Jiménez et al., 2018; Leichsenring et al., 2011; Winsper, 2018)

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Neurobiology of addiction

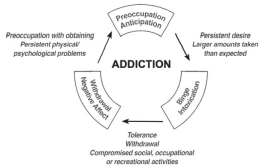

Figure 1. Diagram describing the addiction cycle—preoccupation/anticipation, binge/intoxication, and withdrawal/negative affect—from a psychiatric perspective with the different criteria for substance dependence incorporated from the DSM-IV.

Koob & Simon (2009)

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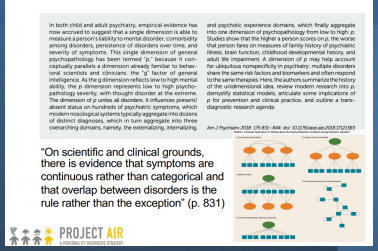
All for One and One for All: Mental Disorders in One Dimension

Avshalom Caspi, Ph.D., Terrie E. Moffitt, Ph.D.



"On scientific and clinical grounds, there is evidence that symptoms are continuous rather than categorical and that overlap between disorders is the rule rather than the exception" (p. 831)

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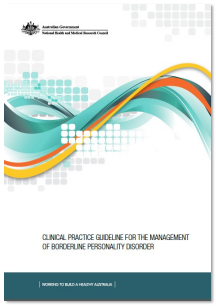
NHMRC Clinical Practice Guideline – Released 15 March 2013



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NHMRC Guidelines (2013)

26. For people with BPD who have a co occurring mental illness (e.g. a substance use disorder, mood disorder or eating disorder), both conditions should be **managed concurrently**.

27. Interventions for BPD and co-occurring mental illness should be integrated, where possible. If possible, the **same therapist** or treatment team should provide treatment for both conditions. Where this is not possible, the health service or therapist providing treatment for the co-occurring condition should **collaborate** with the person's main clinician who is responsible for managing their BPD.

28. If a person's substance use is severe, life-threatening or interfering with BPD therapy, health professionals should actively work to engage the person in effective BPD treatment, but give **priority in the first instance to the stabilisation of their substance use disorder** to allow effective BPD treatment. Treatment should focus on managing the substance use disorder before effective BPD treatment can continue.

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Dual treatments work

- The effectiveness of psychological therapies are robust
- 'Dual-focused' PD and SUD treatment improves both conditions – but SUD treatment alone did not improve BPD but only SUD (Gregory et al Psychotherapy, 2008; Ball et al., J Nerv Mental Dis 2011)
- Treatment for BPD using DBT also significantly reduce substance abuse disorder (e.g. Harned, Linehan et al., JCCP 2008)

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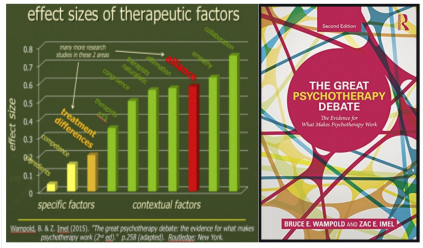
Common Factors



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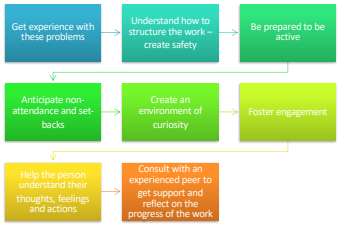
What does the therapist need to do?



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Assessment

A 'good' assessment

- identifies the primary personality disorder
- determines co-morbidity
- estimates the severity of impairment
- directs treatment options
- **engages the client in treatment**

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Manualised, structured approach to treatment

Manualised approach basis for the "Gold Card Clinic"

Four sessions for:

- Care planning
- Future focused
- Involving / connecting with carers
- Focus on safety, distress tolerance skills, goals and enhancing relationships

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www.uow.edu.au/project-air/resources/treatment-guidelines--intervention-manuals/

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Treatment Guidelines for Personality Disorders

Key Principles for Working with People with Personality Disorders

- Be **compassionate**
- Demonstrate **empathy**
- **Listen** to the person's current experience
- **Validate** the person's current emotional state
- **Take the person's experience seriously,** noting verbal and non-verbal communications
- Maintain a **non-judgemental** approach
- Stay **calm**
- Remain **respectful**
- Remain **caring**
- Engage in **open communication**
- **Be human** and be prepared to acknowledge both the serious and funny side of life where appropriate
- Foster **trust** to allow strong emotions to be freely expressed
- Be **clear, consistent,** and **reliable**
- Remember aspects of challenging behaviours have **survival value** given past experiences
- Convey **encouragement** and **hope** about their capacity for change while validating their current emotional experience

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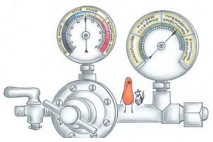
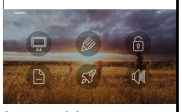
A modified DBT group therapy manual

For clinicians working with adolescents and young adults experiencing substance misuse

Regulator workbook

A Dialectical Behaviour Therapy skills manual





https://www.uow.edu.au/project-air/resources/treatment-guidelines--intervention-manuals/
https://www.dbtregulator.com.au/

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Acceptance vs. Change

- How do we strike the right balance between acceptance and change?
- Evidence based treatments (DBT and Psychodynamic) are both a mixture of:

Supportive | Expressive

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Supportive and Expressive Techniques

Supportive

Validation, empathy, reflection

Strengthen the person

Build understanding and rapport

Expressive

Help them to think and do things differently

Support healthier goals and relationships

Encourage positive but difficult change

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Approach to the work

Being curious about what is going on in the mind of the person to help them understand

Their own mind

The minds of others

A "not-knowing" stance

The person is the "expert" and the clinician is the "wondering student"

An expressive technique → asking the person to articulate their thoughts, feelings, and motives

Goal: strengthen self-understanding and theory of mind of others

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Therapist Stance

(Swenson & Choi-Kain, 2015)

MBT	DBT
MBT therapists try to sustain a mentalising stance themselves: 1. Remaining curious and inquisitive 2. Proceeding with a not-knowing attitude 3. Remain experience near in thinking and inquiry 4. Repeatedly invites the client into collaboration 5. Remaining transparent, using self-disclosure of their own thought process and feelings to model the mentalising process.	DBT therapist adopts both a responsive and irreverent stance: 1. Remaining curious and inquisitive (adopting the beginners mind) 2. Insists on assessing rather than assuming (consistent with the MBT therapists "not-knowing" attitude) 3. Breaks the narrative down into chunks and analyses these chunks 4. Repeatedly invites the client into collaboration 5. Practices "radical genuineness", remaining transparent through self-disclosure

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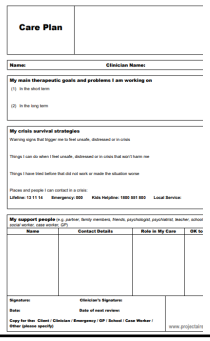
The Care Plan

(page 11 Treatment Guidelines)

- **Goals** – "main goals and problems I'm working on – short and long term"
- **Crisis survival strategies** Warning signs/triggers Things to do that won't harm What to do in crisis
- **Support people** Who are main supports who can connect with therapy


Care Plan

Name: Clinician Name:

My main therapeutic goals and problems I am working on

(1) In the short term

(2) In the long term

My crisis survival strategies

Warning signs that trigger me to feel unsafe, distressed or in crisis

Things I can do when I feel unsafe, distressed or in crisis that won't harm me

Things I have tried before that did not work or made the situation worse

Phone and people I can contact in a crisis:

Lifeline: 13 11 14 Emergency: 000 Kids Helpline: 1800 551 800 Local Service:

My support people (e.g. partner, family members, friends, psychologist, psychiatrist, teacher, school social worker, case worker, GP)

Name	Contact Details	Role in My Care	OK to

Signature: Clinician's Signature:

Date: Date of next review:

Copy for me: Client / Clinician / Emergency / GP / School / Case Worker / Other (please specify):

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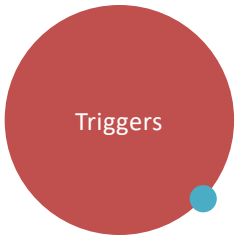
- Most people struggling with problematic personality disorder and substance use difficulties can identify the triggers or cues that initiate:
  - Increased self-harm, emotional dysregulation
  - Greater drug involvement
  - Crisis-prone behaviours
- Ask the question "Do you have warning signs that trigger you to feel unsafe, distressed or in crisis?"



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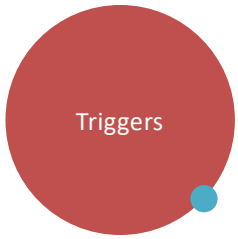
- Ask "What are things you can do when you feel unsafe, distressed or in crisis that won't harm you?"
- Ask "What are things you have tried before that did not work or made the situation worse?"
- Recognise that underneath triggers may be severe self-critical core beliefs such as "I don't deserve good things" "I'm to blame for all my problems" "I hate myself"
- Self-compassion can take time. The therapist may need to "hold onto the positive" even if the client cannot yet.



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Crisis Survival Strategies

What has worked in the past? What has not worked?

When you can't solve the problem right now:

- **Focus** on the here and now (not the past or the present): brief mindfulness exercises e.g. focus on breathing and say 'one' each out breath; name 5 things you can hear
- **Distract** (do something different, hold ice, loud music, clean house, go to the beach)
- **Self-soothe** (hear, see, smell, taste, touch) e.g. stroke cat
- **Connect** with others who can help or listen e.g. lifeline
- **Accept** 'shit happens', find some humour at life

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Clinical Considerations

Role of an Invalidating Environment:

- Expression of private experiences is punished or trivialised
- Highly contextual (individual factors) – absence of mirroring or being cherished; or family overwhelmed by a sibling's health issues/family life stressors
- Invalidating family (chaotic, perfect, typical)
- Self-invalidation (self-blame for being black sheep)
- High guilt, shame, anger

Role of interpersonal hypersensitivity:

- Sensitivity may be so high that any family will be experienced as invalidating

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Radical Acceptance

- This does not indicate surrendering to negative situations, but rather accepting all reality as it is so that the most **effective and competent way to deal** with a situation can be chosen (skill of problem solving)
- People who are "stuck" can have an external locus of control and think that others need to do the work of change, that a medicine can cure, or a doctor/therapist can make it better or "make the problem go away"
- Radical acceptance can include the idea that "I might not have caused my problems, but I have to solve them anyway" i.e. irrespective of trauma history, living better today and tomorrow will require active hard choices
- Using humour can sometimes help to radically accept

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Understanding relationship conflicts

- Ending entrenched substance use often brings up guilt, shame and grief about what has been lost and unresolved issues around identity and relationships come up
- Understanding these patterns can provide a window into ongoing problematic ways of relating, understanding and responding to conflicts
- Relationship conflicts may powerfully trigger and perpetuate ongoing difficulties if not better mentalised

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Case study

- Suzie, 25, is recovering from entrenched methamphetamine and cannabis use, and has been working with a vocational rehabilitation counsellor, Tony, for 2 weeks to prepare for job retraining.
- One day, just after Tony gets everything set up for Suzie to begin her training, Suzie storms out of the office screaming at him, "You're just trying to get rid of me! You don't understand me at all! I hate you!" Later, when Tony calls to suggest that maybe Suzie would prefer to work with another counsellor, Suzie begins to cry and says, "Please don't drop me, Tony! I need you!

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Suzie

- What are her relationship conflicts?
  - Wish: to be understood and valued by others
  - Response of others: expects to be rejected, abandoned
  - Response of self: gets angry, pleads not to be left alone
- Talking about these patterns with her can:
  - Help understand these repetitive triggers
  - Put in place ways to see differences between relationships
  - Help her do things to reduce the intensity of h fears

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Clinical considerations

→ Narratives of those who come to us for help **Personality disorder** and **substance misuse** can occur in response to experiences of **repeated empathic failures and invalidation** in development leading to problems in:

- Developing trust in others
- Developing a sense of autonomy and agency
- Developing a sense of identity and goals in life
- Developing the capacity for intimacy and interpersonal relationships

→ Personality dysfunction as failure to develop self/other

→ Use of substances to overcome intolerable feelings and try to obtain a feeling of belonging

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- **Apply key principles in managing their own personal and interpersonal reactions, when people with personality disorder and AOD are struggling or in acute crisis.**

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Managing countertransference

- Emotional reactions (countertransference) are common:
  - Confusion and uncertainty
  - Feelings of inadequacy
  - Time urgency
  - Difficulty maintaining the therapeutic frame
  - Reactions to the client as victim or perpetrator
    - Therapist rescue fantasies vs. punishing punitive responses
  - Responses to suicidality

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- *Make tea – **be reflective rather than reactive** – take time to let your understanding of self and other develop before being shared*

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Stigma words

Stigmatising	Language for respect and hope
Manipulative	Trying hard to get their needs met
Attention seeking	Attention needing
Drama queen/melodramatic	Trying hard to get their needs met
Overreacting	Having a rough time
Non-compliant/ uncooperative	Choosing not to
Needy/dependent/attention seeking	Feeling vulnerable and insecure

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- Consultation is **essential** to working effectively, no matter what the occupational background, level of experience or theoretical orientation of the worker or service
- Team consultation means **the risks are shared** so that decisions made are not just based upon one's person's decision making process
- Consultation provides the necessary space to reflect upon one's **tolerance and sensitivity** towards people with complex and chronic problems

Team consultation

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Rupture and repair: The therapists tasks

'Hold' the feelings that are being stirred up in you without acting upon them

Reflect on these experiences (mentalise)

Determine what these experiences are telling you about the client's internal world

Use this information to inform your therapeutic responses

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Key learning outcomes

By participating in this webinar, attendees will be able to:

- Identify personality disorders in the context of AOD challenges
- Select from various skills to effectively respond to people with concurrent AOD and personality disorder
- Apply key principles in managing their own personal and interpersonal reactions, when people with personality disorder and AOD are struggling or in acute crisis.

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Resources
• https://www.projectairstrategy.org
• Guidelines for working with people with PD
– Fact Sheets for clients, parenting, family members and carers
– Therapy Cards
– Parenting resources
– Workshops for partners, families and carers
– Personal stories
– Annual Conference and Events
– Research
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