Exploring the Correlation Between Substance Use and Cluster B Personality Disorders

Joanne Schwartz, PhD, PMHNP-BC, CRNP, CNE, CARN-AP, FIAAN
Kimberly Garcia, DNP, PMHNP-BC, FNP-BC, GNP-BC, NP-C, CNE, CARN-AP

July 18, 2019
Disclosures

- There was no funding to the authors for the development or writing of this presentation.
- The authors have no conflicts of interest relevant to the content of this presentation.

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.
Educational Objectives

• At the conclusion of this activity participants should be able to:
  ▪ Describe the Cluster B personality disorders.
  ▪ Consider the risk factors associated with disease expression and progression.
  ▪ Identify the correlation between personality and substance use disorders.
  ▪ Formulate treatment recommendations that are guided by the state of the science.
  ▪ Recognize the unique challenges associated with treating individuals with substance use and Cluster B personality disorders.
A clinical tool used for diagnosing and categorizing psychiatric disorders developed by the American Psychiatric Association.

First version was published in 1952 as a variant of the International Classification of Diseases (ICD).

Each disorder has established criteria necessary for diagnosis.

Current version DSM-5 was published in 2013

- Developed over 10 years by mental health experts

“Cookbook” necessary for clinical work
What is a Personality Disorder?

- A personality disorder is an enduring and inflexible pattern of long duration leading to significant distress or impairment and is not due to use of substances or another medical condition.
  - Cause distress and disability in most of life’s domains on a daily basis
  - Thoughts and behaviors deviate significantly from cultural norms.
  - Pervasive—multiple life domains are affected
  - Symptoms emerge gradually and by adolescence

Personality Disorders

• There are ten personality disorders (PDs).
• Clusters A (“weird”), B (“wild”), and C (“worried”)  
• Tip for Remembering: 
  ▪ Weird, Wild, and Worried are alphabetical and correlate with Clusters A, B, and C.
Cluster A Personality Disorders

- Cluster A: “weird”; characterized by social ineptness and isolation
  - Paranoid PD
    - Characterized by mistrust and suspicion
    - Richard Nixon
  - Schizoid PD
    - Characterized by desire for self-isolation and aloofness
    - Albert Einstein, Kramer from *Seinfeld*
  - Schizotypal PD
    - Characterized by unusual, odd thoughts and beliefs; magical thinking
    - Willy Wonka in *Willy Wonka and the Chocolate Factory*

Cluster B Personality Disorders

- Cluster B: “wild”; characterized by drama, erratic behaviors, and flamboyance
  - Antisocial PD
    - Characterized by disregard for the rights and feelings of others and society’s expectations for right and wrong
    - Adolf Hitler; Saddam Hussein
  - Borderline PD
    - Characterized by emotional and behavioral instability; chaotic relationships; and anxiety
    - Diana, Princess of Wales; classic “teenage drama queen”

Cluster B Personality Disorders

- **Histrionic PD**
  - Characterized by attention-seeking, self-centeredness, and flirtatious behavior
  - Blanche Dubois in *Street Car Named Desire*; Scarlett O’Hara in *Gone with the Wind*

- **Narcissistic PD**
  - Characterized by self-importance and arrogance
  - Joan Crawford as portrayed in *Mommy Dearest*
Cluster C Personality Disorders

- Cluster C: “worried”; characterized by anxiety
  - Avoidant PD
    - Characterized by feelings of inadequacy and inferiority as well as extreme shyness that precludes a desired relationship
    - Self-acknowledged: Donny Osmond, Kim Bassinger
  - Dependent PD
    - Characterized by excessive reliance on others for emotional and physical needs; needy, clingy, and helpless
    - Can be take advantage of by others
    - Females sending fan mail to male prisoners convicted of murder
  - Obsessive-Compulsive PD
    - Characterized by perfectionism, orderliness, rigidity
    - Adrian Monk from *Monk*; the classic “anal” individual

WHAT DOES THE LITERATURE SAY ABOUT SUBSTANCE USE AND THE PERSONALITY DISORDERS?
Substance Use Disorders and Cluster B Personality Disorders

• In one study of the Cluster B PDs, antisocial and borderline PDs were significantly associated with persistent alcohol, cannabis, and nicotine use disorders.

• Of note, in this study, narcissistic PD was not associated with substance use disorders.

In a study examining early adolescence, borderline PD, as well as conduct disorder (the predecessor of antisocial personality disorder), were associated with SUD symptoms as well as elevated risk for future onset of SUD symptoms.

Analyses over 30 years suggest that Cluster B PD (specifically, borderline, histrionic, narcissistic) are independent risks for development of SUD and warrant clinical attention.

Substance Use Disorders and Cluster B Personality Disorders

- In respondents with an alcohol use disorder, the highest prevalence of PDs was: antisocial PD (12.3%); obsessive-compulsive PD (12.1%); and paranoid PD (10.2%).

Grant BF, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering RP. Co-occurrence of 12-Month Alcohol and Drug Use Disorders and Personality Disorders in the United States: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2004;61(4):361–368. doi:10.1001/archpsyc.61.4.361
Substance Use Disorders and Cluster B Personality Disorders

- Highest prevalence of antisocial PD—greater than 70%—existed among samples of males with alcohol use disorders and from substance abuse clinics, prisons, and other forensic settings.

What Does this Mean for the Clinician?

- PDs, in general, have greater risk of substance use disorders. This makes sense: social isolation (Cluster A); chaotic lives (Cluster B); and anxiety/fear (Cluster C).
What Do We See so many Borderline and Antisocial PDs in practice?

• Borderline PD and antisocial PD may be more commonly seen in treatment due to ongoing, pervasive, and severe: family and interpersonal conflict; legal issues; employment problems; self-harm and suicidal behaviors that are exacerbated by increased comorbidity of substance use disorders.

• Frequent interpersonal interactions lead to significant interpersonal conflict.
ANTISOCIAL AND BORDERLINE PERSONALITY DISORDERS A BIT MORE IN DEPTH...
Antisocial Personality Disorder

- Chronic irresponsibility and unreliability
- Persistent lying and stealing
- Deceitfulness, use of alias, conning others for personal profit or pleasure
- Lack of remorse for hurting others
- Reckless disregard for safety of self or others
- Do not typically show anxiety, depression, or irrational thinking

Risk Factors for Antisocial Personality Disorder

- Genetics
- Presence of family history of alcoholism, paternal criminality, conflict, divorce, and poverty
- Parenting characterized by physical punishment, rejection, poor communication, and lack of supervision
- Abandonment and physical and sexual abuse
Borderline Personality Disorder

- Difficulty controlling emotions ("faucet is all on or all off")
- Relationships involving intense anger and possibly physical fights
- Relationship instability is profound.
- Identity disturbance with a persistently unstable self image
- Frantic efforts to avoid real or perceived abandonment

Borderline Personality Disorder

- Frequent, dramatic changes in mood, opinions, and plans
- Chronic feelings of emptiness
- Impulsive (e.g. quit a job without another source of income; move in with someone they just met)
- Recurrent suicide attempts or self-mutilation
  - Self-mutilation may serve as self-punishment, catharsis, or distraction related to chaos

Risk Factors for Borderline Personality Disorder

- Genetics
- Unstable early environments characterized by abuse and neglect
- Parental psychopathology
  - Substance use disorders
  - Mood disorders

Premature Death in Antisocial and Borderline Personality Disorders

- Approximately 8-10% of individuals with borderline PD will commit suicide.
- Individuals with antisocial PD are at increased risk of early death due to accidents, suicide, or homicide.
- Substance use disorders, found at increased rates in individuals with antisocial and borderline PDs, raises the risk of suicide.
- Suicide often serves different purposes
  - Borderline PD: escape from the pain of chaos
  - Antisocial PD: escape from punishment

MANAGEMENT OF BORDERLINE AND ANTISOCIAL PERSONALITY DISORDERS
Therapeutic Management of Antisocial and Borderline Personality Disorders

• Focus is on helping patient learn new ways of coping.

• Strategies for effective management:
  ▪ Be aware of your reactions to the patient’s behavior.
  ▪ Use patience, consistency, and flexibility.
    – “Loving, but firm parent”
  ▪ Model appropriate problem-solving, interpersonal, and social skills.
  ▪ Set clear limits and follow through with consequences.
    – Newer clinician may need support with this
    – “We provide control, if you cannot.”
Treatment Considerations

• Due to limited insight, the patient with a Cluster B PD believes, “I’m not the problem, you are.”
  – Often do not see the value of staying in treatment
• Patients with antisocial PD may be in treatment only for external reasons (legal, employment, or spousal pressures).
Psychotherapeutic Treatment Modalities in Antisocial and Borderline Personalities

• Individual or group forums
  ▪ Group forum may present problems due to PD dynamics

• Therapies
  ▪ Supportive
    – Based on numerous therapeutic schools of thought
    – Can be done by any number of professionals
    – Provides support and encouragement as patient finds their way; focus on self-esteem and self-reliance
    – “Favorite aunt”
Psychotherapeutic Treatment Modalities in Antisocial and Borderline Personalities

- Psychodynamic
  - Unresolved childhood conflict results in anxiety; conflict is addressed

- Cognitive behavioral
  - Negative, automatic thoughts are challenged

- Dialectical behavioral therapy
  - Identifies triggers and more adaptive coping skills to use during stressful times
  - Particularly effective with borderline PD
Pharmacotherapy For Antisocial and Borderline Personality Disorders

- **Selective serotonin reuptake inhibitors (SSRIs)** are effective for depression and anxiety.

- **Naltrexone** may be used to decrease self-harming behaviors as well as for opioid or alcohol addictions.

- **Lithium, divalproex sodium, and carbamazepine** may be used for irritability, impulsivity, and mood swings.

- **Atypical antipsychotics** may be used for transient psychotic symptoms and impulsive symptoms such as anger, hostility, and recklessness.
Use of Controlled Substances in Antisocial and Borderline Personality Disorders

• Cautious use of controlled substances in these PDs due to increased rates of substance use disorders
  ▪ Antisocial PD
    – Manipulation to obtain drugs (using or dealing)
  ▪ Borderline PD
    – Anxiety often significant
Use of Controlled Substances in Antisocial and Borderline Personality Disorders

- Treatment approaches
  - Treatment contracts with clear consequences
  - Increase therapeutic contact for support
  - Non-habit-forming medication for anxiety
    - Buspirone (Buspar)
    - Hydroxyzine (Atarax)
    - Gabapentin (Neurontin)
    - Propranolol (Inderal)
Case Study

- A 32-year-old male has a history of unstable interpersonal relationships, marked impulsivity and mood reactivity, and recurrent self-injurious behaviors/threats.
- His symptoms have become quite intense, with interpersonal conflict noted both at home and at work.
- He has been arguing with his girlfriend and, periodically, she asks him to leave the house. Typically, within a few days, he starts repeatedly calling her, begging her to reunite with him. He has threatened to harm himself if she doesn’t agree to his requests.
- When not in good standing with his girlfriend, he has been sleeping in his office at work. His hygiene is sub-par and he has smelled heavily of alcohol during work hours.
Case Study

• As part of his reunification agreement with his girlfriend, he begins outpatient psychiatric treatment with a psychiatrist. He expresses dramatic anxiety, which he believes fuels his anger and irritability. He also reports insomnia.

• He is started on Xanax and Ambien, which are initially quite effective. In the future, he requires escalating doses of both agents and is nearing the therapeutic ceiling for both medication dosages.

• When he is stressed or upset, he doesn’t get sufficient relief and is forced to ‘self-medicate’ with alcohol or by taking extra medication. As his relationship improves, this happens less frequently.
Case Study

• His quality of life is “much better” and his relationship is going well.

• He starts to develop new interests in hobbies and extra-curricular events, including going to animal rights advocacy demonstrations, dining out, and learning to safely handle a gun at the local shooting range.

• His father, recently deceased, left him his gun collection in his will and he has sought psychiatric clearance to carry a weapon.

• He makes improvements in his occupational functioning and, per his reports, his psychiatrist is very pleased with his progress.
Case Study Discussion

• When considering his bio-behavioral symptoms and history, what are your concerns?
• What risk factors have you identified?
• What interventions would you recommend?
• What risk-reduction or treatment strategies should be considered?
QUESTIONS
THE END!
THANK YOU!
PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS Mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medication-assisted treatment.
  
  - 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
  
  - No cost.

For more information visit: https://pcssNOW.org/mentoring/
PCSS Discussion Forum

Have a clinical question?

Ask a Colleague
A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now

http://pcss.invisionzone.com/register
**PCSS** is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

<table>
<thead>
<tr>
<th>American Academy of Family Physicians</th>
<th>American Psychiatric Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Neurology</td>
<td>American Society of Addiction Medicine</td>
</tr>
<tr>
<td>Addiction Technology Transfer Center</td>
<td>American Society of Pain Management Nursing</td>
</tr>
<tr>
<td>American Academy of Pain Medicine</td>
<td>Association for Medical Education and Research in Substance Abuse</td>
</tr>
<tr>
<td>American Academy of Pediatrics</td>
<td>International Nurses Society on Addictions</td>
</tr>
<tr>
<td>American College of Emergency Physicians</td>
<td>American Psychiatric Nurses Association</td>
</tr>
<tr>
<td>American College of Physicians</td>
<td>National Association of Community Health Centers</td>
</tr>
<tr>
<td>American Dental Association</td>
<td>National Association of Drug Court Professionals</td>
</tr>
<tr>
<td>American Medical Association</td>
<td>Southeastern Consortium for Substance Abuse Training</td>
</tr>
<tr>
<td>American Osteopathic Academy of Addiction Medicine</td>
<td></td>
</tr>
</tbody>
</table>
Educate. Train. Mentor

Funding for this initiative was made possible (in part) by grant no. 5U79TI026556-03 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.