

MISBEHAVIOR VS. PSYCHIATRIC ILLNESS: PERSONALITY DISORDERS IN SUBSTANCE USE

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DISCLOSURES

Nothing to disclose.

OBJECTIVES

- Epidemiology: **Prevalence** of PDs in various populations and their **comorbidity** with SUDs.
- Review **DSM-5 criteria** of Personality Disorders in general and the two specific **PDs** that have the highest comorbidity with **SUDs**.
- Review **treatment strategies** for these two personality disorders including effective **medication management** of symptoms.
- **Clinical pearls** of working with “tough” patients and **behavior which should never be tolerated**.
- **Case Examples**
- **Discussion / Questions**

EPIDEMIOLOGY OF PERSONALITY DISORDERS: PREVALENCE

- **10-15%** of the **general population** (depending on study and population surveyed)
- **50%** of those in a **psychiatric setting**
- **66%** of those in the **criminal justice setting**
- **34.8% to 72.0%** in **patients treated for addictions**, with a median of 56.5%:

PREVALENCE OF PD IN SUD

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

COMORBIDITY & ASSOCIATED RISK

- Among patients with any PD: **5x risk of comorbid alcohol use disorder and 12x the risk of drug use disorder**
- **Comorbidity** of any Personality Disorder (PD) with any Substance Use Disorder (SUD) **positively correlates with the severity of the SUD:**
 - start using substances earlier
 - more relapses / shorter periods of abstinence
 - higher rates of suicide
 - more likely to drop out of treatment
- **Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (ASPD)** are the PDs with highest comorbidity in patients with SUDs.
- **Some studies demonstrate up to a 78% lifetime comorbidity of any SUD with Borderline Personality disorder.**

OVERVIEW: PERSONALITY DISORDERS

- A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This 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, lability, and appropriateness of emotional response).
 3. **Interpersonal functioning.**
 4. **IMPULSE CONTROL.**

OVERVIEW: PERSONALITY DISORDERS

- B. The enduring pattern is **inflexible and pervasive** across a broad range of personal and social situations.
- C. The enduring pattern **leads to clinically significant distress or impairment** in social, occupational, or other important areas of functioning.
- D. The pattern is **stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood**.
- E. The enduring pattern is **not better explained** as a manifestation or consequence of **another mental disorder**.
- F. The enduring pattern is **not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma)**.

DSM-5: 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**:
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-5: ANTISOCIAL PERSONALITY DISORDER

- B. The individual is **at least age 18 years old**.
- 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**.

PATHOGENESIS: HOW CAN WE EXPLAIN THIS HIGH COMORBIDITY?

- **Personality traits (IMPULSIVITY & AFFECTIVITY) → substance use?**
- **Trauma leading to both?**
- **Common biological factors leading to impulsivity?**



BEHAVIOR IN THE TREATMENT SETTING SUGGESTIVE OF BPD OR ASPD: SOME RED FLAGS

Manipulative, aggressive or disruptive behavior:

- malingering
- demandingness or intimidation
- dictating or refusing treatment
- refusing to talk to the treatment team and/or speak disrespectfully to staff
- angry outbursts that are grossly out-of-proportion to the situation
- yelling, screaming, or making verbal threats

NEGATIVE IMPACT OF THE PD ON SUD TREATMENT

- increasing non-adherence adherence to treatment
- increasing treatment dropout
- shorter time to relapse upon discharge
- have a more severe course (more relapse, less periods of abstinence)
- higher suicide rates

TREATMENT STRATEGIES: BPD

Psychotherapy (more helpful for BPD)

- Dialectical Behavioral Therapy (DBT & DBT-SUD)
- Dual-focused Schema Therapy (DFST)
- Dynamic Deconstructive Therapy (DDP)

Psychopharmacology

TREATMENT STRATEGIES: ASPD

- Psychoeducation (mainstay)
- Contingency management (positive reinforcement for desired behavior)
- Psychopharmacology

PSYCHOPHARMACOLOGY OF PD IN SUD : GENERAL PRINCIPLES

- Use appropriate **MAT for the SUD(s)**.
- **Medication** may be helpful for specific PD symptoms such as **affective instability, transient psychotic phenomena, rage, irritability, aggression, impulsivity, anxiety, and depression.**
- **Avoid PRN dosing**, if possible, as this may **reinforce aggression/agitation** that you are attempting to extinguish and **reduce patient's tolerance of transient anxiety and other uncomfortable feelings.**

PSYCHOPHARMACOLOGY IN BPD: ADDRESSING THE MOST PROMINENT SYMPTOMS/BEHAVIORS

- **Mood Instability / Affective Dysregulation:** low-dose SGAs (e.g. aripiprazole – long half-life), traditional mood stabilizers (e.g. lithium, divalproex sodium), other AEDs (e.g. lamotrigine, topiramate)
- **Irritability / Aggression / Rage:** lithium, divalproex sodium, antidepressants (not amitriptyline), beta-blockers, buspirone, and antipsychotics
- **Transient Psychosis:** low-dose antipsychotics
- **Anxiety:** antidepressants (SSRIs), buspirone, gabapentin, hydroxyzine
- **Self-injurious behavior (e.g. cutting):** : naltrexone?
- **Suicidal ideation / attempts:** lithium

PSYCHOPHARMACOLOGY IN ASPD: ADDRESSING IMPULSIVITY & AGGRESSION

- AEDs (e.g. **divalproex sodium** and phenytoin)
- Antipsychotics (e.g. **olanzapine, quetiapine, risperidone**)
- Lithium
- SSRIs
- nortriptyline, bromocriptine, phenytoin

NOTE: Evidenced-based pharmacotherapy for ASPD is restricted to treatment of **impulsive aggression**. It is not likely to reduce **premeditated aggression**.

PSYCHOPHARMACOLOGY FOR ASPD AND BPD: COMMON ISSUES

Psychotropic medication may be useful, but management of them often comes with issues:

- Demands for frequent changes in the dose or type of medication.
- Overuse and overdosing.
- Overreport side effects.
- Non-compliance.
- Failure to accurately report therapeutic benefit.

CLINICAL PEARLS

- Pay attention to **countertransference**, it gives indication of personality structure:
 - **BPD** tends to evoke **helpless/inadequate, overwhelmed/disorganized, and special/overinvolved responses**.
 - **ASPD** tends to evoke **criticized/mistreated responses**.
- **Be firm, but kind**: There is compassion to be found in (almost) all patient's stories.
- Maintain firm **BOUNDARIES** and set clear **LIMITS**: be aware of overt and covert manipulative behavior and do not give in.

MORE CLINICAL PEARLS

- Set **clear and proper expectations**.
- Be **consistent**. Follow through with changes to treatment if failure to comply with expectations.
- **Team approach is ESSENTIAL**. Do not allow for splitting!
- **Outline for patient what behavior will be considered criminal and prosecuted as such**.
- **Written behavioral contracts** may be helpful.
- **Allow natural consequences**: Do not attempt to rescue them from the consequences of their own behavior unless there's an imminent threat of serious physical harm.

PROHIBITED CONDUCT: MISBEHAVIOR / CRIMINAL BEHAVIOR

- Acts of **physical aggression** (e.g. an assault or attempted assault on another person).
- Use or bring **weapons** into the treatment setting.
- Intentionally damaging property (i.e. **vandalism**).
- **Threats**: these can occur through face-to-face, written, telephone, e-mail, or other (e.g. social media) encounters.
- **Stalking** of staff.

OTHER BEHAVIOR WHICH SHOULD NOT BE TOLERATED

- **Comments (even joking) about violence or possession of weapons.**
- **Comments, acts, personal insults, slurs, or the like that a reasonable person would view as demeaning, disparaging, degrading, harassing, or intimidating.**
- **Repeated shouting or rudeness (e.g., hanging up on the phone, swearing).**

CASE PRESENTATION #1

CM is a 43yo M PPHx Depression, Anxiety, PTSD, Alcohol Use Disorder, Stimulant (cocaine) Use Disorder, recently discharged for disruptive behavior, BIB police after being found lying in the street verbalizing suicidal ideation, stating that he wanted detox and placement in rehab (future-orientation). Utox was negative. He was admitted.

He was clearly not suicidal; he reportedly told an NA during his first night of hospitalization that he "had to move two times [in an effort to avoid being hit]".

Given patient's determination to be hospitalized (despite clear benefit of hospitalization and potential of reinforcing unsafe behavior such that it increases the likelihood of further occurrence), he was offered a time-limited stay (two days).

CASE PRESENTATION #1

An attempt was made to mitigate symptoms of patient's character pathology by using medications (Depakote and low-dose Zyprexa) to target impulsivity, low frustration tolerance, and mood lability with aggressivity.

Discharge was being processed for this patient on the morning previously agreed upon, as no further benefit could be achieved by continued hospitalization (and likely only increasing risk to patient by reinforcing his behavior).

While the discharge was being processed, patient stated he could not wait for us to process the required paperwork (a process that takes 15-20 minutes) and demanded immediate discharge, stating that he needed to go meet with his employer immediately (another demonstration of future-orientation).

CASE # 1: RESOLUTION

- Although I proceeded to process the discharge as quickly as possible, within minutes the patient became threatening, again demanding immediate discharge and threatened to "wreak havoc" in an attempt to further expedite discharge.
- He then proceeded to lift his wheelchair above his head and threw it in the direction of another patient and attempted to break the nursing station door during an attempt to assault a male nurse.
- The police were called and when they arrived, patient became completely calm and complied with their orders perfectly (a demonstration of adequate impulse control).

CASE PRESENTATION #2

RR is a 37yo M PPHx Schizoaffective Disorder, Bipolar Type and Stimulant Use Disorder, severe, cocaine who presented to the ER requesting a refill for his Wellbutrin and was admitted on a Friday night after saying he wanted to “hurt people”. Urine tox was positive for cocaine.

His psychotic symptoms had remitted during a recent admission where he was placed on a LAI antipsychotic and was at psychiatric baseline during his most recent outpatient appointment.

During admission interview Monday morning, acute psychosis had resolved; he was demanding his Wellbutrin be restarted, refused to consider other treatment options and made threatening statements about assaulting me if his requests were not granted.

NOTE: On his last admission he assaulted a psychiatrist for falling to acquiesce to similar, specific demands.

Personality considerations? What else would you like to know?

CASE #2: RESOLUTION

- Patient was given final warning that if he made further threats of physical violence he would be discharged from the inpatient unit.
- Escalated again and broke a door.
- When confronted about his vandalism, patient denied having broken the door, screamed slurs at me, made verbal threats and attempted to instill fear by lunging toward me and growling.
- Hospital police were called to assist in safe discharge of patient from the unit with referral back to his outpatient psychiatrists in the clinic.

CASE PRESENTATION #3

JD is a 32yo male with a PPHx of PTSD, Anxiety, Depression, Alcohol Use Disorder and Opioid (heroin) Use Disorder who was BIB self and admitted for SI with intent and plan after his girlfriend of three months "dumped" him. Patient reports history of military-sexual trauma (MST) and only days of sobriety over the last 10 years.

He reports that he experiences "constant mood swings", usually triggered by people disappointing him by "not being there when [he] need[s] them". He hasn't been able to hold a job for more than a few months at a time because of frequent arguing with coworkers. Cutting and drug/alcohol use, he reports, are the only things that make him feel better.

CASE PRESENTATION #3

Patient states that he has been prescribed “just about every antidepressant out there”; he is currently taking Zoloft, from which he reportedly derives some benefit. He thinks maybe he’s “bipolar or something”. He’s confident that I’ll be able to help because I “really get him . . . not like those quacks [he’s] been treated by previously”.

Suicidal ideation completely remitted by day 2 of hospitalization.

Personality considerations? What else would you like to know?

What medications could we consider adding or replacing? What would be the best outpatient referral for this patient?

CASE #3: RESOLUTION

- Patient was started on Abilify which he tolerated without issue. Consideration was given to starting lithium in addition to or in place of SGA.
- Patient was also started on oral naltrexone. After 3 days (during which tolerability was established), Vivitrol was administered and patient was discharged with follow-up in SUD IOP with recommendation that he attend DBT groups.
- Patient called me approximately 2 months later to thank me. He reported reduced sensitivity to interpersonal dynamics, has been sober for the longest time in his SUD history and has not cut (also the longest time since this behavior began in his teens).

THE MORAL OF THE STORY...

- When personality appears to be driving maladaptive behavior, tailor treatment specifically to address specific coping styles.
- If driven mostly by **antisocial personality traits**, be very concrete about goals and expectations of treatment,
- Effective treatment depends on clinician and the patient believing that the patient has choice and **at least a degree of control over their behavior: they are to that degree responsible agents.**
- Not all behavior is attributable to a psychiatric illness or personality disorder.
- Do not allow criminal behavior in the treatment setting, even verbally threatening or menacing behavior should **NEVER** be tolerated!

QUESTIONS?

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RESOURCES

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DIFFERENTIATING BPD FROM BIPOLAR DISORDER

Three Major Differentiators:

1. Cycle of mood dysregulation
2. Duration of mood dysregulation
3. Precipitating factor of mood dysregulation

