Personality Disorders and Addiction Disorders

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Ronald Fraser, Lori Isaif, Debora Teles, and Lise Laporte

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R. Fraser (✉)
McGill University, Montreal, QC, Canada
e-mail: ronald.fraser@mcgill.ca

L. Isaif · L. Laporte
McGill University Health Centre, Montreal, QC, Canada

D. Teles
Personality Disorder Program, McGill University Health Centre, Montreal, QC, Canada

Abstract

Addictive disorders and personality disorders (PD) have been connected since the early days of psychiatry to such an extent that initially substance use disorders (SUD) were conceptualized as personality pathology rather than distinct disorders in and of themselves. Admittedly, these two sets of disorders have

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many common features and indeed frequently co-occur in the same individual. Similarly, the presence of one disorder significantly impacts prognosis of the other disorder. Individuals with comorbid PD and SUD usually present with an earlier onset, an increased addiction severity, and greater impairment in functioning, and failure to accurately diagnose PDs could have an impact on their recovery and clinical prognosis. Severity of symptoms, resistance to treatment, and increased risk of relapse can potentially result in the presence of a comorbid personality disorder in individuals with addictive disorders. There is only a small amount of data available on treatment approaches for co-occurring addiction and PDs, but it seems that these patients are likely to respond to structured integrative psychosocial care and evidence-based relapse prevention pharmacotherapy for addiction. This chapter explores the interface between addictive disorders and personality disorders, attempting to highlight the complex interaction of the respective disorders and how this might inform treatment choices, specifically the need for comprehensive approaches for patients suffering from PDs and addiction, who tend to be stigmatized and marginalized.

Keywords

Personality disorders · Addiction
Comorbidity · Assessment · Treatment
Risk factors

96.1 Introduction: Conceptualization and Evolution of Personality Disorders

The initial Diagnostic and Statistical Manual of Mental Disorders (DSM) was conceptualized and actualized in 1952. Upon the DSM's inception, psychiatrists were generally consigned to hospitals and asylums for the severely mentally unwell and the focus was generally pragmatic rather than academic. There was minimal interest in nosology beyond practical uses. Classification of mental disorders was inclined to be broad and fluid. Consequently, there was much overlap of diagnostic groupings and radical differential diagnoses from one psychiatrist to the next. With the introduction of mental disorder classifications in the DSM, psychiatry began to have statistics. This brought into awareness prevalence rates, demographic patterns, disease courses and as a result, mental health public policy and increased funding came into play [9]. From this, professionals began to be able to better screen, assess, treat and monitor people who met criteria for psychiatric diagnoses. Initially, the DSM-I defined alcoholism as a form of sociopathic personality disturbance. The first actual mention of personality disorders (PDs) was in the DSM-II (1968) and at that time substance abuse was defined as a personality disorder [15]. In DSM-III (1980) and the successive DSM III-R (1987) and DSM-IV (1994), PDs were defined as distinct types, assembled into three clusters, positioned on different axis (Axis II). This categorical approach was in step with the medical model previously brought forth by Emil Kraepelin. Borderline and narcissistic PDs, which came into play in the DSM-III, were revised from psychoanalytical concepts [15]. With the introduction of the DSM-5, the multi-axial classification was dropped as it had become apparent that rather than allowing diagnoses on Axis II to receive the attention necessary by highlighting them as originally intended, the system had inadvertently resulted in even further marginalization of these diagnoses. By eliminating the Axis I and II dichotomy it was hoped to reverse this trend and promote a sense of equal legitimacy between various diagnoses.

96.2 DSM-5 Personality Disorders

The DSM-5 outlines the diagnostic criteria for a general personality disorder, and later provides the diagnostic criteria for the ten principal personality disorders. In general, an individual who has a personality disorder dem-

onstrates a long-standing pattern of thinking, behaving and emotional expression that is not consistent with what would be expected from within that individual's cultural background. Personality disorders develop in adolescence or early adulthood and must be pervasive in multiple domains leading to either significant clinical distress or functional impairment [2]. Typically, personality psychopathology involves four key components:

1. Cognition – the manner in which the individual conceptualizes themselves, others in their social sphere, and the world around them differs from the perceptions of their peers; for example, the individual with paranoid personality disorder would be perceived by others to be overly suspicious and distrustful without good reason.
2. Affective expression – the individual demonstrates emotional range, reactivity, intensity and appropriateness that is markedly different from what would be expected; for example, the individual with antisocial personality disorder would be observed to be overly aggressive and potentially explosive.
3. Interpersonal functioning – the individual has interpersonal relationships that are potentially chaotic and unstable, or simply not as satisfying in nature as might be expected by others in their community; for example, the individual with schizoid personality disorder who does not desire interpersonal contact with others including romantic or sexual relationships.
4. Impulse control – this can either be present as a lack of impulse control or as excessive behavioral inhibition; for example, the patient with BPD may exhibit tremendous self-destructive impulsivity in the form of substance misuse, shoplifting, self-injury or binge eating, whereas individuals with avoidant personality disorder may present as so inhibited that they are unable or unwilling to initiate simple social interactions.

DSM-5 divides the personality disorders into three Clusters and in two other categories [2]:

- *Cluster A – "Odd and Eccentric"* – consists of Paranoid Personality Disorder (PPD), Schizoid Personality Disorder (SPD), and Schizotypal Personality Disorder (STPD).
- *Cluster B – "Dramatic, Emotional, and Egocentric"* – consists of the most clinically prominent personality disorders, and includes Antisocial Personality Disorder (ASPD), Borderline Personality Disorder (BPD), Histrionic Personality Disorder (HPD), and Narcissistic Personality Disorder (NPD).
- *Cluster C – "Anxious and Fearful"* – includes Avoidant Personality Disorder (AVPD), Dependent Personality Disorder (DPD), and Obsessive Compulsive Personality Disorder (OCPD).

Other Personality Disorders (OSPD) and Unspecified Personality Disorder (UPD) are probably the two most common diagnosed personality disorders in the general population. They are diagnosed when individuals present with general features of the personality but do not meet the more specific diagnostic criteria for one of the ten major categories or there is insufficient clinical information to determine which specific personality disorder they have at the time of assessment.

96.3 Personality Disorders and Addiction: A Common Comorbidity

It is estimated that, in 2017, 14.8% of Americans aged 16–23 years and 6% of those over 26 years struggled with a substance use disorder [58] and approximately 10% of the general population have a personality disorder [61], with this rate being much higher (50%) in those receiving psychiatric treatment [7]. Among individuals who suffer from either of these mental illnesses, the lifetime joint comorbidity is very high. Adults diagnosed with these two disorders are a greatly impaired subpopulation and present significant challenges for addiction rehabilitation services [12].

96.3.1 Prevalence of Personality Disorders Among Individuals with SUDs

According to different systematic reviews, personality pathology is present in 5–91% of individuals with SUDs [45, 64]. Among individuals treated for their addiction, which represent only a small proportion of individuals with SUDs [20], the probability of co-occurring personality disorder is much higher. The overall prevalence of PDs among patients in treatment ranges from 35% to 73% (median of 56.5%) in Verheul [67] and from 33% to 91% in Casadio et al. [12].

Such significant variations across studies in reported rates of comorbidity between PDs and SUDs suggest the presence of large differences in the methodology used. Differences in the assessment procedures (standardized diagnostic tool vs. self-report vs. chart review, current vs. lifetime prevalence, drug abuse vs. dependence, etc.) as well as in the sampling (inpatient, outpatient, community, selective inclusion of gender, small sample size, etc.) have strong effects on observed prevalence [12, 48, 68]. Furthermore, large variations in reported prevalence rates reflect the fact that many studies have not investigated the full range of PDs. For these reasons, all prevalence rates should be interpreted with caution as should be ranking attributed to the most commonly detected PDs [51]. Nonetheless, all studies consistently report evidence of high comorbidity between these two disorders. They also highlighted that some types of PDs are more prevalent in SUD population, while some forms of SUD are more often associated with specific personality disorders.

96.3.1.1 Cluster B

Most research investigating the presence of PDs among individuals with SUDs, has focused on Cluster B PDs with the strongest and most consistent association found with BPD and ASPD [29], regardless of whether participants were from inpatient, outpatient, or community settings [64]. In a systematic review of 70 articles in 2018 [62] and a meta-analysis of 26 studies in 2000 [64] found a weighted prevalence of respectively 27.4% and 22% of patients in addiction treatment met BPD criteria. The literature further suggests that BPD is present in 24% of individuals with alcohol dependence, and in 46% of those with drug dependence [24]. ASPD is also highly comorbid with SUDs with reported rates ranging from 14% to 27% (review by [12, 68]). These figures are even more remarkable when one realizes that BPD and ASPD has a prevalence of only 1–2% in the general population.

These two PDs are prevalent among individuals who use a variety of addictive substances. Individuals with ASPD often report alcohol misuse [21] while patients with either of these PDs often have problems with illegal drugs, mainly cocaine [41, 29]. Finally, as patients with BPD often display chronic pain syndromes and might be prescribed opioid medications, they are more likely to misuse medication and at risk of developing opioid use disorder; in an outpatient buprenorphine maintenance clinic, 44% of those in treatment had BPD [53]. The incidence of cocaine, opioid, or alcohol use disorder is markedly high in patients with BPD [62].

A small number of research studies have looked at other Cluster B PDs with a suggested 12.4% lifetime prevalence of Narcissistic PD among individuals with alcohol dependence and 22% lifetime prevalence among those with any drug dependence (NESARC; [57]). Verheul [68] study reported a 12% rate for Histrionic PD. These PDs are often linked with alcohol misuse.

96.3.1.2 Cluster C

Studies of the association between Cluster C PDs and SUDs have extended the possible comorbidities beyond the focus on Cluster B [21, 51]. Results from the Wave 1 NESARC epidemiologic survey [24] reported a prevalence of 25.2% of OCPD among those with any drug dependence and of 15.9% among individuals with alcohol dependence. Casadio et al. [12], review of articles on substance-addicted patients, report prevalence rates varying from 0.7% to 26% for OCPD, from 2% to 35% for DPD and from 2% to 27.4% for AVPD. In a clinically large sample of individuals seeking treatment, Roncero

et al. [51] noted that Cluster C PDs was present in 18.5% of those in treatment for benzodiazepines (the most common substance for consultation), 9.4% of individuals in treatment for alcohol abuse, in 6.1% of those treated for opioids, in 9.7% for cocaine and 12.2% for those in treatment for cannabis. Patients who consumed benzodiazepines presented mainly with DPD while the presence of OCPD was more common among patients who consumed alcohol, opioids, cocaine, and cannabis.

96.3.1.3 Cluster A

Very few articles present rates of comorbidity between SUD and Cluster A PDs. Casadio et al. [12] reported prevalence rates varying from 0.9% to 7% for SPD and from 3% to 26.7% for PPD. In the NESARC survey [50], presence of STPD among participants with any drug dependence was 19.4%.

96.3.2 Prevalence of SUDs Among Individuals with Personality Disorders

As seen in the previous section, numerous studies have demonstrated that the prevalence of PDs among patients with SUDs is substantial. The opposite is also true. However, this has been established by a smaller number of studies [67], and has focused mainly on BPD and ASPD [48], the two PDs most likely to be diagnosed in clinical settings. In two systematic review articles examining the lifetime prevalence of SUDs in PD patients, Newton-Howes and Foulds [46] and Guy et al. [27] reported a similar pooled estimate of around 60%, while a register-based study of all people in Denmark treated for a PD in a 44-year period reported a 46.4% prevalence of any SUD [60].

The extent of comorbid addiction disorders among individuals with PDs varies according to types of PD [27]. A comprehensive overview provided by Trull et al. [62] on the co-occurrence of BPD and SUDs across different settings reported that 75% of participants with BPD received a lifetime unspecified SUD diagnosis and 59.5% a lifetime AUD diagnosis. Results from the NESARC study reported a very similar lifetime prevalence of 73% for substance use disorder for people with BPD [24], while review from Guy et al. [27] suggested a lower average prevalence rate of 52%. Using a strict diagnosis rule for diagnosing PDs, Trull et al. [63] reported high comorbidity rates of lifetime alcohol dependence for individuals with ASPD (52%) while comorbidity rates for lifetime drug dependence was 27%.

Minimal research exists on other personality disorders and addiction. In Guy et al. [27] review, lifetime prevalence of SUD in PDs other than BPD and ASPD, was 39% (29–49%). NESARC study reported a lifetime SUD prevalence of 64% for individuals with NPD [57] and of 68% of any SUDs for individuals with STPD [50]. Trull et al. (2010) reported high comorbidity rates of lifetime alcohol dependence for individuals with HPD (49.8%), while comorbidity rates for lifetime drug dependence, was 29.7%.

To summarize these data, there is extensive comorbidity between many PDs and a variety of SUDs regardless of whether the samples originate from a population of patients with PDs or conversely from a population of patients with SUDs.

96.3.3 Prevalence of Personality Disorders Among Individuals with Gambling Disorder

Literature has shown that there is high prevalence of personality disorders in individuals with gambling disorder. Some studies that have looked specifically at the prevalence of PDs in the general population of pathological or problem gamblers report a prevalence of around 42% for any PDs (Pietrzak et al. 2007 in [8, 65]) and a prevalence 28.8% specifically for comorbid ASPD (review article by [38]).

A review conducted by Brown et al. [11] reports that 43% of treatment-seeking problem gamblers met criteria for a PD. Another sys-

tematic review and meta-analysis among this population revealed a similar weighted average estimate of 47.9%, ranging from 12% to 93% for any PDs [18]. This review suggested that Cluster B PDs are the most prevalent with a mean of 17.6% with the highest prevalence for Narcissistic (16.6%), followed by Antisocial (14.0%) and Borderline (13.1%) PD. There was also a weighted mean effect of 12.6% for Cluster C PD (12.6%) with both AVPD and OCPDs at a prevalence of 13.4% and a mean effect of 6.1% for any Cluster A PDs with the highest.

96.4 Risk Factors for Persistent SUDs in Individuals with PDs

The presence of a PD seems to be a significant risk factor for persistent substance abuse issues, as illustrated in Table 96.1. Over a three-year period, ASPD, BPD and STPD consistently predicted persistence of alcohol, cannabis, nicotine, and drug disorder (cannabis, other illicit substances, and/or nonmedical use of prescription drugs) controlling for demographics and concurrent Axis I and II disorders. Among PD traits that influenced the persistence of SUD, deceitfulness

Table 96.1 Personality disorders as risk factors for persistent substance use disorders over a 3-year course

	Alcohol dependence[a] ($n = 1172$)		Cannabis abuse/dep.[a] ($n = 454$)		Nicotine dependence[a] ($n = 4017$)		Drug use disorder[b] ($n = 613$)	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Cluster B								
Antisocial	**3.51*****	**1.74–7.08**	**2.46***	**1.05–5.73**	**3.19*****	**1.64–6.18**	**2.75***	**1.27–5.99**
Borderline	**2.52*****	**1.64–3.85**	**2.78****	**1.40–5.50**	**2.04*****	**1.56–2.68**	**1.91***	**1.06–3.45**
Narcissistic	**1.96****	**1.32–2.91**	1.32	0.63–2.74	1.22	0.92–1.61	1.55	0.84–2.84
Histrionic	0.96	0.57–1.60	1.10	0.46–2.65	1.10	0.76–1.59	1.10	0.58–2.07
Cluster A								
Schizotypal	**3.36*****	**1.98–5.72**	**5.90*****	**2.68–13.00**	**1.65****	**1.19–2.28**	**2.77****	**1.42–5.39**
Schizoid	1.10	0.59–2.06	0.80	0.33–1.97	**1.47***	**1.08–2.01**	0.60	1.28–1.29
Paranoid	1.18	0.72–1.95	0.83	0.40–1.73	0.99	0.73–1.35	0.86	0.48–1.56
Cluster C								
OCD	0.89	0.57–1.38	0.91	0.44–1.87	**1.40***	**1.06–1.85**	1.05	0.54–2.03
Avoidant/dependent	0.92	0.49–1.74	0.73	0.29–1.83	1.02	0.69–1.51	0.75	0.37–1.52

Modified from [a][28] and [b][20]

Studies based on DSM-IV. Data from National Epidemiologic Survey on Alcohol and Related Conditions (NESARC/USA)

Odds ratios were controlled for demographics, axis I and II, as well as other factors depending on the study

OCD – Obsessive-compulsive disorder; Drug use disorder – abuse and dependence assessed in ten classes: cannabis, cocaine, inhalants, hallucinogens, heroin, opioids, stimulants, tranquilizers, sedatives, and other drugs

$^{*}p < 0.05$; $^{**}p < 0.01$; $^{***}p < 0.0001$

and lack of remorse (antisocial traits), identity disturbance and self-damaging impulsivity (borderline traits) and ideas of reference and social anxiety (ST traits) were the strongest predictors.

96.5 Screening and Assessment

Standardized clinical semi-structured interviews are regarded as the most reliable and valid assessments for PDs. Self-report questionnaires may have poor specificity and may be rather tiring for patients as they require significant concentration. Cooperatively, one could administer a short semi-structured interview in conjunction with a brief screening tool. A study completed by Gonzalez [23] described the use of two quick screening instruments for PDs: the self-report Standardized Assessment of Personality – Abbreviated Scale (SAPAS-SR) [44] and the Iowa Personality Disorder Screen (IPDS-SR) [33]. The study involved screening 53 inpatients dependent on drugs or alcohol, with a 42% prevalence of a personality disorder [23]. Both instruments were found to be quick and easy to administer, taking approximately 2 minutes to complete, and were deemed satisfactory to be used in clinical practice.

The Standardized Assessment of Personality – Abbreviated Scale [44] consists of an eight yes/no items screening questions focused on personality features interview, taken from a much more comprehensive the opening section of an informant-based semi structured interview (Standardized Assessment of Personality (SAP). It produces a dimensional score that signifies the probability that an individual has a PD in general and does not screen for any specific PD [43]. Please see Fig. 96.1.

The Iowa Personality Disorder Screen (IPDS) is a brief interview-based measure developed from the DSM III version of the Structured Interview for Personality Disorders (SIPD). This screen takes approximately 5 minutes to complete having 11 items to evaluate whether a PD is present. It was designed for use in out-patient settings. Most of the items have supplementary questions totaling 19 potential questions. The

Standardised Assessment of Personality – Abbreviated Scale (Moran)

Please ask your patients the following questions. Only tick a response if the patient thinks that the description applies *most of the time* and *in most situations*.

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

Responses in bold should be scored as 1, those not in bold as 0.

A total score of 3/8 or more indicates personality disorder is likely. (A score of 3 or more on this tool correctly identied 90% of psychiatric patients with DSM-IV personality disorder. Sensitivity 0.94 and specificity 0.85).

Fig. 96.1 The Standardized Assessment of Personality – Abbreviated Scale (SAPAS). (Reproduced from [44])

IPDS can be simply incorporated into standard diagnostic clinical interviews and primary validation research supports that it is satisfactory in detecting people necessitating additional testing to conclude if they meet criteria for a PD [33].

96.6 Treatment of Comorbid Addictions and Personality Disorders

96.6.1 The Role of Integrated Treatment

Historically, clinical wisdom held that patients needed to get their addiction successfully treated to subsequently be suitable to receive treatment for their mental health issues, or to receive therapy for their personality disorder before receiving addictions treatment. Patients were often bounced from one service to another because they did not meet specific inclusion criteria and therefore did not receive treatment. This approach is suboptimal and generated a great deal of frustration among clinicians, patients and their families. Resulting from this has been advocacy for the idea of integrated treatment where one clinical team provides treatment for both PD and SUD concerns [32].

For instance, the isolated treatment of SUD in patients with BPD might contribute to the rise of compulsive behaviors in other areas, such as for eating or for sex, while on the other hand, the sole treatment of BPD focusing on self-harm might increase substance misuse. Indeed, it is not possible to assume that substance use is an epiphenomenon that will resolve with remission of symptoms related to the PD. Apart from the limitations of the treatment diagnoses in isolation, another concern pertains to treatments that are held in parallel, as it may not provide a coherent whole and optimal cohesion among service providers and result in unintended mixed massaging.

On treatment modalities, psychotherapy is considered the most effective treatment for PDs, with pharmacotherapy having a possible adjunctive role for specific symptoms, while for SUD combined psychotherapy and pharmacotherapy is the most indicated approach. As for dual diagnosis, different treatment modalities should be offered when possible, considering individual, group and family therapy, medication, and involvement in peer support groups as they may all be useful at different points in the recovery [19]. Current analyses of available studies offer no clear guidelines of which therapy to prefer, and the core feature seems to be a systematic and integrative approach of treating the PD simultaneously with the SUD [31].

When one disorder is treated without addressing the other, the likelihood of suboptimal treatment outcomes dramatically increases. Decrease in symptomology of one, may positively impacts the other. Treatment success increases motivation for continuing treatment and moving towards recovery. Treatment frequently has common foci independently of the origin of symptoms (from addiction or PDs).

96.6.2 The Role of Medication

There are no approved medications with the indication for the treatment of personality disorders. However, medications from all psychotropic classes are frequently used in an attempt to address certain specific symptomatology such as affective instability, anxiety, impulsivity, dissociation, and quasi-psychotic symptoms. This is often in spite of an absence of evidence of pharmacological effectiveness and unfortunately often results in polypharmacy with minimal benefits and potentially significant side effects (particularly metabolic syndromes), as additional medications are often added to earlier medications that were insufficiently effective. Whenever possible, one should strongly consider removing an ineffective earlier medication before initiating a trial of another medication. Also, one should strive to avoid prescribing medications with abuse or dependence potential, such as psychostimulants, opioids, and sedative hypnotics [5]. Instead, in individuals with co-occurring PD and SUD, one should give emphasis to the addiction pharmacotherapies that have quite robust evi-

dence of effectiveness and target the individual's substance use disorder, for example using opioid substitution therapy in opioid use disorder, various anti-craving medications for alcohol use disorder or potentially an opioid antagonist for gambling disorder.

96.6.3 The Role of Psychotherapy

The most effective treatment for individuals with PDs is psychotherapy, with most of the evidence relating to treatment of people with BPD [5]. Studies investigating psychotherapeutic models of intervention for patients with PDs and SUD are limited. Even in the field of PDs, evidence-based treatments are lacking for most disorders outside of BPD, and the level of evidence accumulated so far is not robust. Clinical trials often have limitations such as small sample sizes, and provide variable outcomes [32]. The knowledge on the field is largely empirical. It is not possible to have a definitive postulate of the preferred therapy so far and further research is urgently needed to show which treatment approach is effective for the treatment of PD and SUD [31].

96.6.3.1 Cluster B

Cluster B is the most prevalent and studied group of PDs in association with SUD. As such, most of the psychotherapeutic models for concurrent PD and SUD were tailored for individuals with Cluster B pathology. BPD and ASPD were the conditions most explored in scientific studies so far with some incipient evidence about treatment efficacy.

Borderline Personality Disorder

The few studies that evaluated the efficacy of models to treat both BPD and SUD don't allow for meta-analytic reviews, and the narrative reviews sometimes indicate slightly different conclusions from the same studies [31, 35, 48, 49]. Further research is definitely needed to determine which treatment approaches are effective for these co-occurring diagnoses. Models tested had a treatment length of approximately 1 year and some degree of integration with the current most widespread approaches specific to SUD.

Table 96.2 Hierarchy of targets in DBT-SUD [17]

1st: Reduce behaviors that are imminently life threatening (e.g., suicidal)
2nd: Reduce behaviors that interfere with treatment (e.g., not attending therapy)
3rd: Reduce behaviors that decrease quality of life (e.g., substance abuse)
4th: Increase behavioral skills

Dialectical Behavior Therapy (DBT) for Substance Abusers (DBT-SUD; [36]) is an adapted version of DBT, an evidence-based treatment for patients with BPD [37], developed specifically for patients with both BPD and SUD. In this model, BPD or drug abuse is viewed as attempts to regulate aversive emotions. The goal of DBT-SUD is to both encourage abstinence but also minimize the duration and severity of any potential relapses. Like other DBT approaches, therapeutic goals have a hierarchy of priorities to optimize treatment outcomes (see Table 96.2).

Overall, DBT-SUB studies were felt to be of good quality and demonstrated good clinical outcomes and effectiveness [35]. The first clinical trial of DBT-SUD showed positive results, but medication was a confounding variable. The second trial was better delineated to control for medication and to balance the number of activities and the resemblance between the conditions. The model tested consisted of weekly individual therapy focused in DBT; psycho-educational skills group that comprised mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness; phone coaching for patients; and consultation for therapists, aiming at keeping capability and motivation in the face of intense emotions. The control adopted in this second trial was very rigorous and the results came out mixed; there was a higher likelihood of decreased opiate use after 12 months in the DBT group, but not at 16 months, and no change was observed in the use of other drugs comparing both groups. Also, there was higher dropout in the DBT group [49]. Although results of outcomes studies are not always robust, DBT-SUD has been recommended

as a potentially beneficial treatment for patients with co-occurring BPD and SUD by many authors [32, 35, 48].

Finally, the similarities of DBT-SUD to specific therapies for SUDs such as motivational interviewing and relapse prevention might favor its acceptability among SUD clinicians. For instance, the model proposes a dialectical approach to abstinence, encouraging the patient to stop all harmful substance misuse and adopting abstinence, while also accepting that any relapse that should occur is not indicative of treatment failure and that abstinence is not possible. In this approach, the appropriate level of abstinence for each patient is determined by: (1) targeting the primary drug of abuse (the substance causing the most significant problems); (2) targeting other substances that lead to the use of the primary drug; (3) making sure that the treatment goals are attainable, which might mean gradual goals [17]. Patient will be helped to "fail well", which means learn from the incident through behavioral analysis. Thus, the philosophy of dialectics will play a role to counteract previously held rigid and extreme response patterns.

Another treatment model, Dual-Focus Schema Therapy (DFST), has been adapted from Schema-Focused Therapy [70]. This psychotherapy is not restricted to BPD but can be used for all PDs. The core principle of this approach is that PDs result from early adopted faulty schemas that are a response to failed attempts to satisfy important basic needs, resulting in harmful coping strategies. Maladaptive coping attempts to avoid or compensate for the activation of the schemas are seen as important triggering factors for patients with PD and SUD in this model. While Ball et al. [4] suggest that working on these triggers would be beneficial for the treatment of both PD and SUD, Lee et al. [35], states contrarily that DFST did not appear to be effective and demonstrated limited benefits.

Deconstructive Dynamic Psychotherapy (DDP; [26]) is a model based in psychodynamics developed for treatment-resistant patients with BPD, including those with a concurrent SUD. The goal of this treatment is to activate the ability "to form associations between different aspects of affective experience, to provide integrated attributions to those experiences, and to assess the accuracy of those attributions" [26]. This psychotherapy showed overall good outcomes, especially in reducing alcohol use and suicidal behavior. However, it is not possible to draw firm conclusions from these results due to the small number of studies, with small sample sizes, all from the same research group [32, 35]. These results would need replication. Furthermore, when DDP was studied in patients suffering only from BPD, it performed poorly [47].

Finally, Mentalization-Based Therapy (MBT) has shown efficacy for the two conditions separately, however, it was not tested for concurrent BPD and SUD [40]. Specific evidence on the efficacy of Transference Focused Therapy (TFT), Cognitive-Behavioral Therapy (CBT), 12-Steps programs (12S) or Motivational Interviewing (MI) was not found for this subpopulation of patients. It is also noteworthy that there is some evidence against long-term residential treatments, such as a therapeutic community for substance dependence, for BPD patients due to the high dropout rates [52] (Table 96.3).

Table 96.3 Clinical tips in treating individuals with ASPD and SUD [19]

Substances use may offer a way of coping with both physical and psychological distress
Self-injurious behavior can evoke strong feelings in clinicians, such as anxiety and anger
Dissociation is common
Under significant stress these individuals regress in functioning and become much less adaptable
A crisis management plan developed in collaboration is recommended
Clinicians should develop the professional support structure for both skill development and psychological wellbeing
Responses of clinicians may polarize between over-involvement believing they can "rescue" the patient versus resignation with a growing of a self-protective distancing, with excessive detachment counterproductive for therapy
In self-help recovery groups (12-steps, AA, NA) it may be beneficial to encourage selection of sponsors that are not likely to be potential romantic partners as it might pose a difficulty for the patient dealing with the proximity and the boundaries of these less formal helping relationships

Antisocial Personality Disorder

ASPD is associated with considerable personal, familial and societal adverse consequences. It is linked to poor occupational productivity and increased criminal justice costs, resulting in extensive economic impact. Consequently, the identification of interventions that could reduce these impacts should be a major research priority [22]. Prevention and intervention efforts of both antisocial syndromes and SUD can benefit from integrated approach, and programs that focus on adolescents are particularly indicated as a way to reduce later substance use disorders [14]. Unfortunately, there is scarce research and little good quality evidence as to what might (or might not) be effective for this condition. The Cochrane systematic review and meta-analysis conducted by Gibbon et al. [22] investigated psychological interventions for ASPD. The majority of the included studies were trials with a focus to reduce substance misuse, and ASPD was a subsample studied. Consequently, the interventions applied were not specifically focused on treating the ASPD, as was the case for BPD, where treatments originally tested for BPD were adapted into the scope of dual diagnose with SUD.

Gibbon's study observed some evidence that contingency management plus standard maintenance is effective in reducing substance misuse in ASPD and improving attendance in sessions (not interfering in dropout rates), while the aspects related to the symptoms associated to the personality were not measured. Noteworthy, the attractiveness of the positive reinforcements in contingency management seem to have a weight on the success of the intervention, such as providing high value vouchers [22].

A multi-component intervention utilising motivational interviewing principles plus incarceration [69] was superior to treatment as usual (incarceration alone) on number of drinking days and on consumption quantity in prisoners sentenced for driving whilst intoxicated for individuals with ASPD. Interestingly, the ASPD subgroup had heavier and more frequent drinking but showed significantly greater declines in drinking from intake to post-treatment assessments. Thus, it seems that non-confrontational treatment could be an option to enhance outcomes for individuals with ASPD.

The role of a psychoeducational approach for individuals with ASPD has been explored in one RCT showing some benefit regarding compliance and retention in SUD treatment [48]. The six sessions of the manualized impulsive lifestyle counseling focused on: (1) impulsivity, goals and life dreams, (2) behaviors, consequences, and triggers, (3) streetwise pride and crime, (4) values, and (5) social support. The style is non-confrontational, and the patient is invited to consider whether the themes are relevant to his or her life. Homework, handouts and worksheets are also used [59]. Results of the study suggest an increase inpatients' self-rated perceived help for their personality disorder, which was in turn associated with more days of abstinence, higher treatment satisfaction, and reduced risk of dropping out of treatment [59]. This single study suggests that psychoeducation could be beneficial for the treatment of individuals with SUD and ASPD.

Therapeutic community (TC) treatment is a psychosocial intervention for reducing substance use [16] which has been utilize with individuals with ASPD. It has been developed to the intertwined personality and behavioral issues that are found in severe ASPD and substance misuse. Results from the literature have provided mixed findings. Samuel et al. [52] suggest that the ASPD traits might lead to difficulty accepting the rules and regulations of a well-controlled long-term rehabilitation treatment center at first, and once the initial orientation period is over, those same traits might equip the individual for success within (or at least tolerance for) the confrontive atmosphere of this modality of treatment.

ASPD is also highly prevalent among problem gamblers, and is associated with elevated gambling disorder symptoms. An exploratory study suggested that this subgroup may benefit from specific behavioral therapies targeting the underlying neurocognitive dysfunctions of increased impulsivity, and impaired cognitive flexibility and executive planning [10] (Table 96.4).

Table 96.4 Clinical tips in treating individuals with *ASPD* and SUD [19]

They may be distrustful and entitled, and not show appreciation for the services received. These characteristics may result in clinicians distancing themselves or conversely relaxing boundaries in an attempt to demonstrate the willingness to help
ASPD patients can be seductive and persuasive, and clinicians may find themselves positively responsive to their charm
ASPD patients are likely to push for special treatment or softening of rules, be aggressive and intimidating, and may seek to exploit vulnerabilities in the clinician or the system
Clinicians should demonstrate determination, strength, and incorruptibility. Individuals with ASPD respect power, tough-mindedness and a clear consistent stance, and do not relate well to clinicians that they perceive to be powerless
Major consideration should be given for the safety of the staff and other clients
Recovery should be presented as a road to freedom, reflecting on how antisocial behavior is disadvantageous in present and future, specially focusing on the lack of autonomy and mastery, such as not being able to sustain a job, a relationship, or being in difficulty with the law
Highlight the fact that the strengths inherent in their personality can make recovery possible or can worsen addiction and its consequences. Help them to see clearly potential outcomes

Table 96.5 Clinical tips in treating individuals with NPD and SUD [19]

Clinician's should strive to self-monitor impatience, indignation, counter-arrogance, as these responses are counterproductive. Team consultation or supervision can help support the therapeutic approach
Clinicians can model learning to tolerate one's own faults and frailties
Patients can utilize the motivation to look strong to lead to acceptance of recovery activities
Peer support groups might be beneficial for both SUD and NPD, as they may come to better understand and respond to the needs of others

Narcissistic Personality Disorder

Presently, there is no specific evidence-based treatment for NPD, such that there is also no treatment that has been developed for individuals with NPD who also present with SUD. The patterns of grandiosity, need for admiration, lack of empathy, and fantasies of being the smartest and feeling entitled to special privileges are known to cause negative reactions in therapists, thus challenging the therapeutic alliance and may negatively impact treatment efforts [19]. Stinson et al. [57] hypothesize that "SUD may reflect attempts on the part of men with NPD not only to re-establish or maintain grandiosity, but also to defend against the negative affect accompanying dysthymic disorder that often accompanies aging and life's inevitable limitations" ([57], p. 1042). The NPD cognitive pattern of self-indulgence is seen as characteristic that make them vulnerable to SUD [6]. Helping NPD patients to recognize these patterns and motivations may potentially assist them in their recovery from SUD (Table 96.5).

96.6.3.2 Cluster A

There is a lack of well organized randomized controlled trials of treatment for people with Cluster A personality disorders [5], while specific treatment for the dual disordered have not been developed and tested. Consequently, there are no evidence-based interventions to recommend for those with co-occurring Cluster A PDs and SUD. Some clinicians theorize that Cluster A personality disorders would be better conceptualized as subsyndromal disorders better conceptualized as part of the schizophrenia spectrum, and as such might have better outcome in programs developed for concurrent psychotic disorders and substance abuse, which often focus more on practical skills.

Schizotypal Personality Disorder

STPD differs from other Cluster A personality disorders in that social aversion is accompanied by more behavioral eccentricities and lapses in their sense of reality (dissociation and derealization). Empirical evidence suggests that cognitive therapy can promote change in both the cognitive and social disabilities of patients with STPD [5].

Cannabis has a high prevalence and persistence of use in people within the schizophrenia-spectrum. While the association between cannabis use and schizotypal symptoms is well

known, only one study addressed time order and found that the schizotypal symptoms preceded cannabis use [28], meanwhile the symptoms cannot be fully explained by STPD [1]. Cannabis users are significantly more prone to cognitive and perceptual distortions, and also to disorganization [54].

It is believed in the clinical field that STPD are inclined to use alcohol and other drugs to either manage their anxiety or connect socially, escaping from feeling odd and unaccepted, which needs to be considered to pace the treatment according to the need of the patient. Service providers who do not recognize the cost of abstinence may push too hard without considering their interpersonal losses [19]. Assisting with the development of social skills training and alternative anxiety management techniques may provide the STPD patient with an alternative to substance use (Table 96.6).

96.6.3.3 Cluster C

PDs in Cluster C are characterized by being anxious and fearful and may not be at elevated risk for developing SUD. Hasin et al. [28] demonstrated the odds of persistent SUD for PDs within this cluster as being statistically the same as for the general population. PDs in the cluster characterized by being anxious and fearful are not a major concern for developing SUD. The odds of persistent SUD for PDs within this cluster are statistically the same as for the general population, as can be observed in the data brought by Hasin et al. [28]. Exception should be made for OCPD, which was associated with persistent nicotine dependence [28] and weak evidence suggest associations with any substance and alcohol disorders [24]. Also, individuals with problematic gambling that had OCPD showed lower severity of gambling symptoms and treatments focusing on social support and skills to cope with stress and finances could be more effective to this comorbidity [42]. Specific treatments for Cluster C in association with SUD were not specified. As with Cluster A, unfortunately there are no robust studies demonstrating effective treatment modalities for Cluster C PDs alone, let alone with co^{m}-morbidities. Intuitively, clinicians have focused on traditional evidence-based treatments for addiction, emphasizing those that target anxious affect as a risk factor for use and relapse. Helping individuals develop skills such as distress tolerance, general stress management, relaxation exercises and self-soothing all may be potentially beneficial but any quality studies of efficacy remains lacking.

Table 96.6 Clinical tips in treating individuals with STPD and SUD [19]

Clinicians should be emphatic and show acceptance in face of surprising statements and peculiar ideas, as a trusting therapeutic relationship will allow for reality testing
Clinicians must sustain appropriate involvement in treatment, as STPD clients might elicit boredom or anxiety
Treatment is most effective when structured, supportive, and focused on the teaching of social skills
Group settings are valuable for potential growth, while 12-step groups that meet in mental health centers can often deal with more acceptances with the unusual behaviors, attitudes, or beliefs that may be expressed

96.7 Barriers and Challenges to Treatment

96.7.1 Stigma

It is well documented that individuals with SUD, as well as those with PDs, notably BPD and ASPD, experience stigma, both from family members and society, and from health professionals) [3, 66]. Despite recent advances in the neurobiology of these disorders, SUD continues to be viewed as a result of moral weakness [12], whereas PDs are simply people behaving badly due to character flaws [55]. Thus, according to these societal views, these disorders have not been viewed as requiring "treatment" in the medical sense.

Treating patients with comorbid disorders can be extremely challenging as the behaviors common to both conditions can elicit strong emo-

tional reactions from therapist and the change of rigid patterns can be a slow process.

Patients with concurrent PD and SUD can experience a double stigmatization, with associated multiple negative consequences, including exacerbation of symptoms and reduction in healthcare utilization and treatment adherence [56]. These individuals can also experience difficulties in accessing treatments that are made available to other individuals because of systemic prejudices denying them these appropriate therapies. Stigmatization can also stem from the use of a certain language by health professionals. Research has showed that an individual referred to as 'a substance abuser', as 'an addict' or as 'a PD' instead of individual having a "substance use disorder" or having a "personality disorder" has been judged by service providers as less deserving of treatment [30]. Individuals with SUD and PDs, notably BPD, are also very vulnerable to self-stigma, a 'maladaptive process in which individuals accepts societal prejudices and integrate this evaluation into their self-concept" [25], which result in further discrimination.

As stigma is often based on preconceived ideas and collective myths, and rarely on facts, it is possible to alter negatives attitudes and beliefs from the general population with effective education and with more familiarity with mental illnesses [56]. Stigma can also results in rejection and discrimination on the part of health professionals. This can be changed with knowledge and skills, and could begin with the identification of negative countertransference reactions.

96.7.2 Countertransferential Challenges

A positive therapeutic relationship is central to the management of individuals with PDs and SUDs and mental health professionals, who have negative attitudes toward this clientele and are judgemental and rejecting, make engaging and maintaining an effective therapeutic alliance extremely difficult [39]. It is important for all therapists to recognize their negative countertransference and how it might impact their treatment or their responses to crisis [39]. In her book on PDs and addiction, Ekleberry [19] describes well what it takes to work with dual disordered clientele:

> The work requires uncompromising integrity, a strong commitment to ethical practice, continuous learning, interpersonal skills, personal resilience, and a unyielding honesty about feeling, reactions, and behaviors elicited from interacting with these individuals. (page 207)

On the other hand, many authors also describe the many rewards of working with this clientele [19], which is not often the focus of articles on clients with SUDs or PDs. Choi-Kain and Gunderson [13] describes that the work with a difficult clientele can foster personal growth and can be seen as a "highly personal, deeply appreciated, life-changing role".

Working effectively with this dual disordered population often requires openness on the part of the clinician to receive regular supervision, even if only in the form of peer support. Consulting with colleagues can help tremendously in the challenges that arise from working with these complex clinical cases, and such professional support is often essential in preventing burnout and fostering personal and profession resilience [34, 19]. As the most studied PD, data derived from evidence-based treatments for BPD have in common the characteristic of maintaining regular supervision of therapists. Clinicians discuss cases, including personal reactions, with others professionals [5]. The DBT model have treatment interfering behaviors as the second most important target of treatment, just behind life threatening behaviors. It includes behaviors from both clients and therapists, as they might be highly deleterious of treatment efficacy and contribute to early termination of therapy. In this model, clinicians work as a collaborative team and have weekly consultation meetings to focus on therapist's emotional reactions and motivation to treat patients, sustained in principles like non-judgement and acceptance, in an effort to diminish defensiveness and increase effectiveness [37]. Therefore, self-monitoring and peer-supervision or consultation should be part of

Table 96.7 Strategies to work with negative countertransference [39]

To receive clinical or collegial supervision
To share the responsibility of client management with a team of service providers
To seek external consultation when necessary
To put in place policies to manage difficult behaviors
To seek support from colleagues to "review treatment plan, help identify blind spots, offer alternatives, validate efforts, and hold hope for changes" (p. 378)

treatment when looking for best practices for dual disordered populations.

In this light, some strategies to work with negative countertransference were suggested by experts (see Table 96.7) and are important to consider in working with this clientele.

96.8 Conclusion

Addictive disorders and personality disorders frequently co-occur and the presence of one significantly impacts the expression and prognosis of the other. There is a greater likelihood that people with a PD will use multiple substances at a younger age, as well as having an increased compulsive and severe substance use pattern. They are also more likely to become physiologically dependent, more susceptible to relapse, and more resistant to collaborating with treatment. Individuals with PDs who misuse substances results in an increase their personality disturbance and have reduced treatment outcomes. PDs raise the susceptibility to SUDs while SUDs reduce willingness to adapt for PDs, while both disorders are heavily stigmatized and the combination of the two only worsens this. Recognizing the coexistence of SUDs and PDs early on in treatment allows the opportunity to optimize treatment outcomes by offering structured comprehensive integrated treatment for both disorders concurrently. It is essential that clinical staff have training and supervisory support in dealing with this challenging patient population.

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