

8 Personality disorders and substance use

8.1 Personality disorders

A personality disorder is an enduring pattern of inner experience, of seeing the world and relating to others in a manner that markedly deviates from cultural expectations, and includes, and results in, problematic and habitual behaviours that are pervasive and inflexible.

The onset of personality disorders occurs in adolescence or early adulthood, is stable over time, leads to impairment or distress and is not due to mental disorder or substance use.

Personality disorders are long-standing and maladaptive patterns of perceiving and responding to other people and to stressful circumstances.

Personality traits are conspicuous features of personality and are not necessarily pathological, although certain styles of personality traits may cause interpersonal problems. Personality disorders are not regarded as illnesses. However, some dominant personality traits and personality disorders can be modified and some managed on a systemic level.

8.1.1 Personality disorder subtypes

Cluster A personality disorder

Includes paranoid, schizoid and schizotypal types. Individuals display odd and eccentric behaviour.

Paranoid

Person displays patterns of distrust and suspiciousness such that others' motives are interpreted as malevolent.

Schizoid

Person displays a pattern of detachment from social relationships and a restricted range of emotional expression.

Schizotypal

Person displays a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.

Cluster B personality disorder

Includes antisocial, borderline, histrionic and narcissistic types. Individuals display dramatic, erratic and emotional behaviour.

Antisocial

Person displays a pattern of disregard for, and violation of, the rights of others.

Borderline

Person displays patterns of instability in interpersonal relationships, self image and effects as well as marked impulsivity.

Histrionic

Person displays patterns of excessive emotionality and attention-seeking behaviour.

Narcissistic

Person displays patterns of grandiosity, need for admiration and lack of empathy.

Cluster C personality disorder

Includes avoidant, dependent and obsessive compulsive types. Individuals display anxious and fearful behaviours.

Avoidant

Person displays patterns of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation.

Dependent

Person displays patterns of submissive and clinging behaviour relating to the excessive need to be taken care of.

Obsessive compulsive

Person displays patterns of preoccupation with orderliness, perfectionism and control.

Personality disorders not otherwise specified

Personality disorders not otherwise specified are those where:

- The individual's personality pattern meets the general criteria for a personality disorder and traits of several different personality disorders are present, but the criteria for any specific personality disorder are not met.
- The individual's personality pattern meets the general criteria for a personality disorder, but the individual is considered to have a personality disorder that is not included in the classification.

Of all the different types of personality disorders, Cluster B personality disorders (including narcissistic, histrionic, borderline and antisocial) come to the attention of health providers and authorities the most. People with antisocial personality disorders frequently end up in the criminal justice system^(312,313).

8.1.2 Management approaches

- Limit setting and the use of therapeutic contracts are extremely important in this client group.
- It is important that clinicians remain vigilant when dealing with people who have personality disorders in order to avoid being manipulated.
- There is no specific pharmacological treatment for personality disorders. Personality disorders are not normally an indication for medication which adds to their management remaining controversial. A variety of medications have been reviewed for some types of behaviours associated with personality disorders such as impulsivity and aggression. However, good quality data relating to efficacy is limited.
- Antidepressants and mood-stabilising drugs such as carbamazepine, lithium, sodium valproate and other SSRIs are among those that have been studied. They do not provide a cure, but have assisted with some symptom control for some Cluster B personality traits^{****(314,315)}.
- Scheduling of brief, structured and frequent visits to primary care providers is recommended. Restriction of access to emergency services and last minute appointments may be helpful in the management of personality disorders⁽³¹⁶⁾.
- A balance must be ensured between the fostering of dependency and providing the support and crisis intervention that is required.
- Early case management with other primary care providers (emergency department staff, locum services, after hours staff, emergency services and mental health staff) is indicated.

8.2 Comorbidity with personality disorders

People with personality disorders have:

- High rates of additional mental disorders⁽³¹⁷⁾.
- Higher rates of psychotic symptoms and psychotic disorders than controls and those with other mental disorders⁽³¹⁶⁾.
- Significant psychosocial impairment^{†(312,316)}.
- Higher rates of impulsivity compared with those who do not have a personality disorder^(312,316).
- Higher rates of suicidal ideation and suicidal behaviour than the general population^(312,316).

Substance use is common in people with personality disorders^(120,312,317-319).

The term 'borderline' was first used to capture the features of the personality disorder that is borderline between psychosis and neurosis and characterised by extremes of mood and thinking.

Substance use is most common in those with Cluster B type personality disorder, in particular, borderline and antisocial personality disorder^(120,313,318-320).

Conduct disorder in childhood (a necessary prerequisite to conclude that an adult has an antisocial personality disorder) is predictive of substance-use disorders between adolescence and early adulthood⁽³²⁰⁾.

People with comorbid personality disorder and substance use:

- Have more problematic symptoms of substance use than those without a personality disorder⁽³²⁰⁾.
- Are more likely to participate in risky substance-injecting practices that predispose them to blood borne viruses⁽³¹²⁾.
- Are more likely to engage in risky sexual practices⁽³¹²⁾ and other disinhibited behaviours.
- May have difficulty staying in treatment programs and complying with treatment plans^(312, 316).

Treatment for substance use in people with personality disorders is associated with a reduction in substance use⁽³¹³⁾.

Treatment for substance use is also associated with a reduction in the likelihood of being arrested⁽³¹³⁾, suggesting a reduction in criminal activity.

8.2.1 *General management approaches to comorbidity*

- People with personality disorders are difficult to manage. Often, the underlying disorders will only become apparent after previous attempts to treat comorbidities have failed.
- People with personality disorders should be counselled about substance use and the problems that arise from substance use, given their particular personalities.
- However, many clients have difficulty even recognising that their substance use is problematic.

8.3 Major clinical issues with personality disorders and cannabis/hallucinogen use

- People with personality disorders display more symptoms of cannabis use disorders than those who do not have a personality disorder.
- Advice regarding cannabis usage in these disorders depends on the degree of dysfunction associated with use.
- In the absence of other proven forms of treatment, CBT is, at present, the most widely-employed form of treatment for cannabis use.

8.3.1 *Effects of cannabis and other hallucinogens on personality disorders*

- Conduct disorder in adolescence increases the risk of initiating marijuana use⁽³²⁰⁾.
- Age of first use of cannabis is earlier in people with personality disorders compared to those without personality disorders⁽³²⁰⁾.

- People with personality disorders display more symptoms of cannabis dependence than those who do not have a personality disorder⁽³²⁰⁾.
- Symptoms associated with cannabis dependence increase over time in those with personality disorders⁽³²⁰⁾.

8.3.2 Interactions between cannabis and other hallucinogens and therapeutic agents for personality disorders

- Cannabis can exacerbate the sedative effects of carbamazepine, lithium and sodium valproate^x.
- Cannabis can exacerbate the sedative effects of antidepressants such as tricyclics^x.
- LSD may induce a serotonin syndrome (Appendix 1); therefore, caution should be exercised when prescribing SSRIs or MAO-I^{x(127)}.
- Cannabis and antidepressants are metabolised by CYP 450 enzymes which may result in the inhibition or induction of either drug group. Therefore, individuals should be monitored closely to ensure outcomes are appropriate^x.

8.3.3 Management approaches to comorbid personality disorders and cannabis use

- Advice regarding cannabis use for people with these disorders depends on the degree of dysfunction associated with use.
- Overall approach depends on the person's readiness for change.
- Abstinence from cannabis is a difficult goal to achieve in cannabis dependent people⁽¹²⁸⁾.
- In the absence of other proven forms of treatment, CBT is, at present, the most widely-employed form of treatment for cannabis use^{****(128)}.

8.4 Major clinical issues with personality disorders and alcohol use

- Personality disorders (in particular antisocial and borderline) and alcohol use disorders frequently co-exist.
- Alcohol can exacerbate the sedative effects of some antidepressants such as tricyclics and mirtazepine.
- Alcohol can exacerbate the sedative effects of carbamazepine, lithium, and sodium valproate.
- Acamprosate or naltrexone can be considered for long-term abstinence with naltrexone showing effectiveness in moderating drinking in those with antisocial personality traits.

8.4.1 Effects of alcohol on personality disorders

- Personality disorders (in particular antisocial and borderline) and alcohol use disorders frequently co-exist^(16, 120, 317, 319-322).
- Personality disorders are associated with an earlier age of onset of alcohol use disorders⁽³²³⁾.

- Symptom severity of alcohol dependence continues to increase over time in those with personality disorders⁽³²⁰⁾.
- Personality disorders (in particular anti-social characteristics) are associated with^(320, 324, 325):
 - More severe alcohol disorders.
 - Poorer long-term drinking outcome.
 - Poorer outcomes for treatment of alcoholism.
- Personality disorders and alcohol use disorders are associated with:
 - More criminal convictions⁽³²¹⁾.
 - High levels of novelty-seeking behaviour and impulsivity^(323, 326).
- Alcohol use also significantly complicates personality disorders⁽¹²¹⁾.

8.4.2 Interactions between alcohol and therapeutic agents for personality disorders

- Alcohol can exacerbate the sedative effects of carbamazepine, lithium, and sodium valproate^x.
- Alcohol can exacerbate the sedative effects of some antidepressants such as tricyclics and mirtazepine. Alcohol toxicity and risk of overdose may occur through the inhibition of CYPs involved in the metabolism of alcohol^{x(133)}.
- Interactions between antidepressants and acamprosate used to treat alcohol dependence are minimal, as are interactions between antidepressants and disulfiram and naltrexone also used to treat alcohol dependence^{xx(134)}.

8.4.3 Management approaches to comorbid personality disorders and alcohol use

- Carbamazepine^{***⁽³²⁷⁾} and sodium valproate^{***^(328, 329)} can be used in alcohol withdrawal to reduce the risk of seizures.
- While studies are yet to confirm this, carbamazepine has been discussed as being useful in the prevention of relapse to drinking^(330, 331).
- Acamprosate or naltrexone can be considered for long-term abstinence^{****^(141, 144, 235, 236)}, with naltrexone showing effectiveness in moderating drinking in those with antisocial personality traits^{**⁽³³²⁾}. However, medication adherence may be problematic.
- As people with comorbid personality disorders and substance use are more prone to risk taking and subsequent injury, individuals prescribed with naltrexone need to be aware of its implications for emergency pain management.
- Patients prescribed with naltrexone should be advised to carry a medical warning card or bracelet which states they will not respond to opioid analgesia (obtainable from Orphan Australia).
- Disulfiram may be problematic as these patients may drink alcohol impulsively despite being warned of the risks.

8.5 Major clinical issues with personality disorders and opioid use

- A significant number of people with opioid dependence also have personality disorders.
- Particularly in the opioid dependent population, it is important to try to determine whether the behaviours are due to the opioid dependence or due to antisocial personality disorder.
- The presence of a personality disorder does not appear to impact on the effectiveness of opioid treatment.
- Methadone maintenance appears to be effective in people with personality disorders.
- Carbamazepine is a potent CYP inducer and will induce the metabolism of methadone and buprenorphine.
- Opioids can increase the sedative effects of carbamazepine, lithium and sodium valproate.

8.5.1 Effects of opioids on personality disorders

- A significant number of people with opioid dependence also have personality disorders^(312, 333). Particularly in the opioid dependent population, it is important to try to determine whether the behaviours are due to the opioid dependence or the antisocial personality disorder.
- Opioid dependent people with personality disorders have more severe substance dependence as well as polydrug dependencies⁽³¹²⁾.
- Individuals with comorbid personality disorders and opioid dependence^(312, 333):
 - Participate in more criminal activities (likely related to procurement of drugs).
 - Participate in more risky injecting behaviour.
 - Have higher rates of suicidality and overdose.
 - Have more psychological distress compared to opioid dependent individuals without personality disorders.
- The presence of a personality disorder does not appear to impact on the effectiveness of opioid treatment; however, it may affect retention and result in continual switching between treatment regimes^(312, 334):
 - Treatment reduces participation in crime and improves injecting behaviour as well as risk of overdose and psychological distress. However, rates still remain above those without personality disorders⁽³³⁴⁾.
 - Treatment improves risk of suicide to a level that is comparable to those without personality disorders⁽³³⁴⁾.
- As with others who have initial legitimate needs for opioids to control pain, people with personality disorders may go on to develop dependence to opioids and feel a need to increase their dosage. This may be a contributor to the above-mentioned switching of treatment regimes or treatment providers in order to obtain subsequent increases in opioid dose.

8.5.2 Interactions between **opioids** and therapeutic agents for personality disorders

- Opioids can increase the sedative effects of carbamazepine, lithium and sodium valproate[✗].
- Carbamazepine is a potent CYP inducer and will induce the metabolism of methadone and buprenorphine as well as reduce plasma concentrations^{✗✗^(149, 157)}. This has the potential to result in withdrawal and failure of retention in treatment^{****⁽¹⁵⁸⁻¹⁶⁰⁾}.
- Opioids can exacerbate the sedative effects as well as increase the risk of overdose with tricyclic antidepressants^{✗✗⁽¹⁶¹⁾}.

8.5.3 Management approaches to comorbid personality disorders and **opioid** use

- Methadone maintenance appears to be effective in people with personality disorders^{**^(335, 336)}.
- Close liaison between the prescribing clinician and the pharmacist dispensing the opioid maintenance will assist with gaining insight into adherence to treatment, levels of self care and general stability.
- Considering the potential of personality disorders to impact on treatment retention, oral naltrexone is less likely to be effective in individuals with personality disorder.

8.6 Major clinical issues with personality disorders and **stimulant** (including methamphetamine) use

- Personality disorders are frequently observed in stimulant users.
- Use of stimulants may exacerbate impulsivity, mood disturbance and anger in people with Cluster B type personality disorders.
- MAO-Is (either irreversible or reversible) are contraindicated in people using amphetamines or MDMA. Deaths have been associated with concurrent use of moclobemide and MDMA.
- CBT can be used to address stimulant use and is effective.
- Assistance with coping skills may assist with impulsive use of stimulants.

8.6.1 Effects of **stimulants** on personality disorder

- Personality disorders are frequently observed in stimulant users, in particular cocaine and ecstasy users^(41, 337).
- Use of stimulants may exacerbate impulsivity, mood disturbance and anger in people with Cluster B type personality disorders^(338, 339).

8.6.2 Interactions between **stimulants** and therapeutic agents for personality disorders

- Stimulant drugs are likely to exacerbate the effects of SSRI and SNRI antidepressants (and vice versa) and may result in serotonin syndrome (Appendix 1)^{✗^(127, 179, 180)}. Patients should be warned of signs of serotonin syndrome and be monitored.

Opioids

Stimulants
(including
metham-
phetamine)

- MAO-Is (either irreversible or reversible) are contraindicated in people using amphetamines or MDMA. Deaths have been associated with concurrent use of moclobemide and MDMA **✖✖✖**^(181, 182).
- Fluoxetine, paroxetine and norfluoxetine can inhibit the metabolism of MDMA through inhibition of the CYPs involved in its metabolism and may therefore cause toxicity **✖**.

8.6.3 Management approaches to comorbid personality disorders and stimulant use

- The adverse behavioural, psychological and physical effects of stimulants should be discussed with the patient.
- CBT is effective at reducing stimulant use *******^(49, 183). In particular, assistance with coping skills may assist with impulsive use of stimulants.

8.7 Major clinical issues with personality disorders and benzodiazepine use

- Benzodiazepines have been associated with reduced impulse control, disinhibition and increased levels of violence, particularly in people with Cluster B type personality disorders.
- There is an increased risk of sedation and overdose with the combination of benzodiazepines and sedative antidepressants.
- Benzodiazepines can increase the sedative effects of carbamazepine, lithium and sodium valproate.

8.7.1 Effects of benzodiazepines on personality disorders

- Benzodiazepines are thought to have a negative effect on many of the problematic behaviours associated with these disorders.
- Benzodiazepines have been associated with reduced impulse control, disinhibition and increased levels of violence, particularly in people with Cluster B type personality disorders.

8.7.2 Interactions between benzodiazepines and therapeutic agents for personality disorders

- Benzodiazepines can increase the sedative effects of carbamazepine, lithium and sodium valproate **✖**.
- There is an increased risk of sedation and overdose with the combination of benzodiazepines and sedative antidepressants such as tricyclics and mirtazepine **✖**.
- Benzodiazepines and antidepressants are both metabolised by CYP 450 enzymes which may result in the inhibition or induction of either drug group. Therefore, individuals should be monitored closely to ensure they are experiencing the appropriate therapeutic effect **✖**.
- Fluvoxamine will inhibit the metabolism of alprazolam, midazolam, triazolam and diazepam causing increased sedation and potential toxicity **✖**.
- Citalopram and sertraline are the least likely SSRIs to have cytochrome mediated drug interactions **✖**.

8.7.3 Management approaches to comorbid personality disorders and benzodiazepine use

- If benzodiazepine dependence has developed, then graduated withdrawal through slow reduction of dosage should be commenced ^{****(194-196)}, possibly after transferring the patient onto a long acting benzodiazepine.
- If benzodiazepine use is indicated or to occur, then:
 - This should be subject to a contract with the patient.
 - Authorities should be advised, including registration with the relevant local government health authority.
 - The seeking of additional benzodiazepines from other prescribers should be monitored (e.g. using the *Authority to release personal PBS claims information to a third party form*).
 - A more direct liaison approach between clinicians who are dealing with individuals with suspected comorbid personality disorders and benzodiazepine use may help to minimise unnecessary prescribing.
 - Daily or weekly dispensing of benzodiazepines should be considered and may also assist with controlling use.
- If large quantities of benzodiazepines (e.g. 40mg diazepam daily equivalent) are being consumed, then inpatient withdrawal to lower levels should be considered to avoid seizures⁽¹⁹⁴⁾.

8.8 Major clinical issues with personality disorders and inhalant/solvent use

- Inhalant users have high rates of personality disorders with early-onset inhalant use in particular being strongly associated with personality disorders.
- Inhalants will exacerbate the sedative effects of carbamazepine, lithium, sodium valproate and antidepressants such as tricyclics.
- Inhalant users should be encouraged to try and reduce or cease use.

8.8.1 Effects of inhalants/solvents on personality disorders

- Inhalant users have high rates of personality disorders with early onset inhalant use, in particular, being strongly associated with personality disorders⁽²⁵⁰⁾.

8.8.2 Interactions between inhalants/solvents and therapeutic agents for personality disorders

- Inhalants will exacerbate the sedative effects of carbamazepine, lithium, sodium valproate and antidepressants such as tricyclics^{*}.

Benzo-
diazepines

Inhalants/
solvents

8.8.3 Management approaches to comorbid personality disorders and inhalant/solvent use

- As with most other substances, inhalant users should be encouraged to try and reduce or cease use.
- In general, with respect to inhalant/solvent use⁽⁶⁵⁾:
 - Outline the harms associated with inhalant/solvent use.
 - Investigate polysubstance use as this is common.
- Standard CBT approaches to both sets of issues should be used, with particular attention to the development of:
 - Assertiveness skills (refusal skills).
 - Coping skills for controlling and managing emotions such as anger and sadness.
- Offer alternatives to inhalant use, for example, recreational activities.
- Community reinforcement approaches should be developed by mobilising the local health and welfare service system in individual care plans.
- Family interventions need to be considered, for example, increasing communication between the person and the family.
- Assertive outreach and follow-up may be required.