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SUBSTANCE DEPENDENCE AND PERSONALITY DISORDERS: RELEVANT VARIABLES FOR THEIR TREATMENT

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There is agreement on the notion that the treatment of substance dependent individuals with dual diagnosis has to be conducted from a comprehensive model that is able to address both addiction and concurrent psychopathology. In recent years several research studies have focused on the treatment of substance dependent individuals with personality disorders, thus providing increasing evidence on how to carry out effective interventions for these patients. This paper reviews a number of research studies about addiction treatment in the case of patients with personality disorders. This review underscores and discusses the relevance of key variables for treatment in dual diagnosed patients, including treatment retention, evolution of personality disorders, drug using patterns, the link between the Axis II diagnosis and drug use, assessment, the need of tailored interventions with respect to other cases without comorbid psychopathology, and the impact of Axis II diagnosis on the evolution of treatment and the evaluation of treatment outcomes. Cognitive behavioral therapy is an effective intervention for the treatment of substance dependent individuals with dual diagnosis, provided that the patients stay in treatment long enough.

Key words: *Personality disorders, Drug addiction, Effective treatment, Cognitive-behavioral therapy, Dual diagnosis.*

Se sabe que el tratamiento de pacientes con patología dual debe hacerse desde un modelo integral que aborde simultáneamente la adicción y la psicopatología concomitante. El tratamiento de drogodependientes con trastornos de la personalidad ha sido objeto de muchas investigaciones a lo largo de los últimos años, gracias a las cuales hoy podemos disponer de algunas evidencias para llevar a cabo tratamientos efectivos. El artículo hace una revisión de diversas investigaciones sobre el tratamiento de la drogadicción en pacientes con trastorno de la personalidad, destacando la importancia de variables como la adherencia al tratamiento, la evolución del trastorno de personalidad, los patrones de consumo, la vinculación entre el trastorno del Eje II y la droga, la evaluación, la especificidad del tratamiento con respecto a otros casos que no presentan esta psicopatología, el impacto del Eje II en la evolución del tratamiento y evaluación de resultados. El tratamiento cognitivo-conductual es un tratamiento efectivo para el tratamiento de estos casos, si bien es cierto que el paciente debe permanecer en tratamiento el tiempo suficiente.

Palabras clave: *Trastornos de la personalidad, Drogodependencia, Tratamientos efectivos, Cognitivo-conductual, Patología dual.*

Recent years have seen the emergence of various studies analyzing separately the different relevant aspects of the assessment and treatment of personality disorders in substance-dependent individuals, and such research has revealed the weight of certain variables considered less relevant in the past.

Advances in knowledge about the treatment of drug addiction can be attributed to two sources. On the one hand, research on specific behaviours in the drug-dependent population with this type of psychopathology (Martínez-González & Trujillo, 2003); on the other, the findings described in research on the treatment of non-drug-dependent individuals with personality disorders (PDs) (Skodol & Bender, 2007). From this latter group, and with the appropriate adaptation, we can extrapolate intervention strategies, conditions and variables of potential influence.

The design of an intervention seeking to establish abstinence from drug use and maintain it in the long term cannot be concerned solely with aspects of the addictive behaviour itself. A comprehensive approach to each drug addict with PD must take into account such important aspects as symptoms of the Axis II disorder, the peculiarities of the addiction and the combination of the two. This means discriminating between aspects relating to the course of the PD itself and those observed when such disorders coexist with drug dependence.

It is well known that the variables influencing treatment success depend to a large extent on the therapist's ability to identify the link between PDs and drug dependence. However, this concomitance has not always received sufficient attention from professionals in treatment centres,

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with the result that interventions are often clearly inadequate (Lorenzo, Arnaiz, & Varela, 1998).

The aim of the present work is to identify the variables relevant to the treatment of drug dependence when it coexists with PD, given that, on the basis of clinical experience, they represent crucial factors in the development of specific therapeutic strategies.

THE INCIDENCE OF PERSONALITY DISORDERS IN DRUG-DEPENDENT INDIVIDUALS

Whilst the incidence of PD in normal population is between 10 and 15%, in samples of drug addicts the figure rises to around 50%, even though the range of incidence found in studies is very broad. An illustration of this is provided in the work of San Molina and Casas (2002), who on analyzing different studies established a range of incidence of 30% to 80%. Such variability may be due to methodological aspects such as the formation of samples and their exclusion criteria, the assessment instruments employed and professionals' experience in the identification of this psychopathology. In any case, studies on the incidence of psychopathology in drug-dependent individuals show that the most common diagnosis in drug users is PD (Becoña & Cortés, 2008). Fassino et al. (2004) found that 58% of drug addicts presented some kind of PD, the most frequent being borderline, antisocial and dependent. On the other hand, in samples of homeless drug users the proportion is much higher, particularly those of Cluster A and obsessive-compulsive personality disorder (Ball, Cobb-Richardson, Connolly, Bujosa, & O'Neal, 2005).

In alcoholics, the most common PDs are obsessive-compulsive (12%), followed by antisocial (8.9%), paranoid, dependent (both 7%), narcissistic (6.3%), borderline and histrionic (5.1%) (Bravo, Echeburúa, & Azpiri, 2008a). In cocaine addicts the most frequently-found PDs are borderline, antisocial, histrionic, narcissistic, passive-aggressive and paranoid (López & Becoña, 2006), though it is observed that the incidence in people addicted to cocaine differs depending on their pattern of use. Paranoid, borderline, avoidant and dependent PDs may be more strongly associated with cocaine abuse disorder, whilst in the case of cocaine dependence disorder, the most common PDs are antisocial, histrionic and narcissistic (Vázquez & Cittadini, 2007).

Gender differences have also been studied, and Bravo, Echeburúa and Azpiri (2008b) found differences by gender in a sample of alcoholics. Whilst 41.8% of women had some kind of PD, in the case of men the incidence was as high as 65%. The PDs most likely to be found in women were obsessive-compulsive, dependent and histrionic; in men, the most common were obsessive-compulsive, paranoid, narcissistic and antisocial. In women the most common cluster was C, followed by B and then A. In men the most common was B, followed by C and A.

THE ASSESSMENT OF PERSONALITY DISORDERS IN DRUG-DEPENDENT INDIVIDUALS

For the diagnosis of PDs both semi-structured interviews and self-reports are available (Philips & Gunderson,1996), though in drug-dependent populations the most widely used instruments have been the DSM semi-structured interview for the diagnosis of PDs, the SCID-II (APA, 2002), the International Personality Disorder Examination (IPDE, 1996) and the Clinical Multiaxial Inventory – Axis II, MCMI-III (Millon, Davis, & Millon, 1997).

The assessment of Axis II in drug addicts is particularly complex, since it involves dealing with difficulties related to establishing cut-off points between normality and abnormality, lack of consistency between PD categories, redundancy of symptoms between different PDs, the question of multiple diagnoses, the overlap of some symptoms with those of Axis I disorders, and the types of traits measured (Sánchez-Hervas, Morales, & Gradoli, 2004). Moreover, the well-known difficulties of assessment in dual pathology are exacerbated in these cases because drug addicts tend to be unaware of the fact that they have a PD, which prevents them explaining their psychopathology in symptomatic terms.

Given the difficulties inherent in the assessment of PDs in drug-dependent individuals, some authors question the validity of self-reports for addressing such problems, since there is a tendency to over-diagnose (Ball, 2005). Some works, such as those of Fernández-Montalvo, Landa, López-Goñi and Lorea (2006) or Fernández-Montalvo and Lorea (2007), which specifically address this question, assert that the percentages of PD in samples of drug addicts differ depending on the instrument employed. The structured interview yields a lower incidence of PD compared to that obtained through self-reports, indicating low consistency between instruments. With the interview, certain important aspects of the diagnosis can be put into context, thus increasing levels of concordance in results on the incidence of PD. It should also be borne in mind that on being ego-syntonic disorders, clinical history, interviews and observation are the best resources for diagnosing PDs in this population.

All the indications, therefore, are that the categorical assessment and diagnosis of these disorders in drug addicts should be made by means of interview (Lorea, Fernández-Montalvo, López-Goñi, & Landa, 2009). Nevertheless, Olthman, Friedman, Fiedler and Tarkheimer (2004) detected differences between assessors' observations, thus confirming that not all personality disorders are visible to the same extent. For example, it is easier to identify traits such as extraversion, whose assessment yields higher inter-rater reliability values.

In order to identify PD symptoms it is necessary to carry out a retrospective assessment, despite the difficulties involved (Burroughs, 1993). For this reason, the information provided by the patient's family takes on particular importance, and indeed is sometimes essential for verifying the continuing presence of certain personality disorders over the patient's life (Valbuena, 1993).

ASPECTS TO TAKE INTO ACCOUNT IN THE IMPLEMENTATIONOF TREATMENT

Course of personality disorders

Measuring the impact of PDs involves analyzing how they evolve when they do not coexist with drug dependence, thus showing the changes that can occur in abstinence. Personality disorders change slowly, improve or worsen depending on how they coexist with addiction, but follow a more or less well-known course in persons who do not use drugs (Cohen & Crawford, 2007). Therefore, a slow recovery does not necessarily imply ineffective treatment. On the contrary, it may be an indicator of efficacy, because remaining on treatment programmes is associated with higher remission rates than those found for spontaneous remission in PDs (Gunderson & Gabbard, 2002). Furthermore, there are substantial differences between disorders in this respect: while borderline, histrionic and narcissistic personality disorders improve with time, those in group A and obsessive-compulsive, schizoid and schizotypal PDs do not (Pérez, 2003).

Some studies aimed at exploring this aspect more closely by analyzing the ageing process in these patients have found that Cluster B disorders can show significant improvement (Grilo & McGlashan, 2007).On the other hand, Groot, Franken, van der Meer and Hendis (2002) observed that the stability levels of personality disorders were not as high as expected, describing changes in the dimensions of PD over time even in schizoid, avoidant, dependent, passive-aggressive, schizotypal and borderline disorders.

The changes people experience over time can be highly diverse, but research does not support the assumption that PDs are necessarily lasting and stable (Lenzenweger, Johnson, & Willett, 2004).

Patterns of use and personality disorders

The importance of studying the relation between PD and patterns of substance use resides in the identification of risk factors for use, given that the variables which facilitate the appearance of craving during treatment are linked to drug-use patterns.

Some studies analyze the differences that can be attributed to the presence of PD; for instance, Nace, Davis and Gaspari (1991) found some differences in alcohol use. In one of our studies we could observe how alcoholic patients with PD, in contrast to those without such psychopathology, present a pattern of use characterized by greater sensitivity to environmental circumstances, to stressful events and to physiological variables (Martínez-González, Graña, & Trujillo, 2009).

Differences have also been observed in drug-use history depending on the psychopathology in Axis II since, according to some research, patients with PD have had a longer drug-use history than patients without PD (Herrero, 2004). It has also been seen that patients with antisocial personality disorder present more serious addiction to cocaine (Grella, Joshi, & Hser, 2003) – indeed, it was specifically found that this disorder exacerbated cocaine use (Ford, Gelernter, DeVoe, et al., 2009). Analysis of the relation between Axis I and II and alcohol use patterns reveals that Axis II is the better predictor of type of alcohol use (Wagner et al., 2004).

In the light of these findings it can be said that the presence of PD does indeed appear to influence the way drugs are used, promoting particular patterns (Fernández & Gutiérrez, 2005).

The relation between drugs and personality disorders

Despite the fact that some studies have analyzed this relation, since PDs are frequently associated with the use of certain drugs, the results do not permit the specific and exclusive association of each PD with the use of a particular drug (Greene & Banken, 1995).

This association has been described in the so-called bio-behavioural model, which identifies three routes: disinhibition of behaviour, stress reduction and sensitivity to reward (Verheul & van den Brink, 2005). Accordingly, patients with paranoid PD, for example, tend to use alcohol, cocaine and amphetamines; those presenting schizotypal

disorder, cannabis and alcohol; people with antisocial personality disorder, all types of drugs; and those with obsessive-compulsive personality disorder, alcohol and others. Although some studies have shown an association between PD and particular substances – such as higher percentages of narcissistic and histrionic PD among cocaine users–, statistically significant differences by type of substance have not always been found (López, et al., 2007).

Pedrero (2002) found no significant differences between principal drug of use and the personality dimensions measured, so that the relation between substance and PD cannot be demonstrated with any clarity.

Impact of concomitance on treatment

The coexistence of the two disorders has been associated historically with a negative progression, it being considered that the very presence of PD in a drug addict has a negative effect on treatment outcome (Rounsaville, Dolinsky, Sabor, & Meyer, 1987). This comorbidity may increase the likelihood of relapse, though such a relationship has been shown to be stronger for certain basic personality scales (López, et al., 2007). For example, Bagge et al. (2004) found that difficulties for treating PDs increased when traits of impulsiveness and emotional instability were present, as occurs in the case of borderline personality disorder, in which these traits are clearly associated with poorer treatment outcome and poorer social interaction.

Another example of the impact of a PD on drug-dependence treatment is the case of self-efficacy expectations, which are known to play an important role in this context (Llorente & Iraurgi-Castillo, 2008). Perceived self-efficacy depends to some extent on personality traits, an inverse relationship being found between self-efficacy and severity of Axis II disorders, except in the case of obsessive-compulsive disorder, where the relation is in the opposite direction. On the other hand, self-efficacy level correlates with outcome in the early phases of treatment, whilst in more advanced phases personality patterns carry more weight (Chicharro, Pedrero, & Pérez, 2007).

Treatment retention

The fact that a high percentage of these patients drop out of treatment during the first three months makes retention a key aspect, as well as an indicator of treatment effectiveness. If they remain in treatment, patients with PD can improve their general functioning (Skodol, 2007). Hence, the relation between therapist and patient is crucial, as it can influence the latter's will to continue or drop out of the treatment. Although retention is influenced by diverse variables, patients with PD who remain on programmes can receive effective treatment. The key is to remain, since good adherence to treatment reduces the probability of dropout, and it is well known that longer periods of treatment are associated with better outcomes (Jackson, 2002).

Although the diagnostic label of PD appears to have a negative influence on the therapist for setting up the therapeutic relationship – as occurs, for example, with Cluster B patients, with whom it is more difficult to establish an appropriate therapeutic climate –, it is well known that the therapeutic alliance is the most significant predictor of therapy outcome. The most influential aspect in this context is not the categorical diagnosis, but rather the quality of the therapeutic relationship (Bender, 2007).

The therapeutic relationship therefore has significant weight in treatment effectiveness, so that it is important to know about the patient's personality, with a view precisely to establishing a good therapeutic alliance (Verheul, 2001). This is illustrated, for example, by the finding that the patient's ability or need to form effective bonds is a predictor of treatment retention, whilst egocentrism and independence predict dropout (Gunderson & Gabbard, 2002).

EFFECTIVE TREATMENT FORPERSONALITY DISORDERS IN SUBSTANCE-DEPENDENT INDIVIDUALS

Evidence-based studies on treatment effectiveness for PD in non-dependent population

Current research is analyzing therapeutic interventions in PDs with a view to distinguishing effective therapies from ineffective ones. Although there is a still a long way to go, some studies have identified treatments with the capacity to have an influence in the right direction. Until recently, there was a belief among some mental health professionals that psychological and pharmacological treatments were totally incapable of having a positive influence on PDs, but today there is sufficient evidence for asserting that intervention can bring about changes in Axis II (Groot, Franken, van der Meer, & Hendriks, 2003), which demonstrates the effectiveness of psychological intervention in the treatment of PDs (Gunderson & Gabbard, 2002). Thus, the review by Quiroga and Errasti (2003) on effective treatments in PD shows the usefulness of cognitive-behavioural treatment, and particularly Dialectical Behaviour Therapy, for the treatment of borderline personality disorder, while Pretzer's (1998) review explores the effectiveness of cognitive-behavioural therapy in each PD. The results support the

treatment of PDs by means of this therapy, which has also been tested in the most severe cases of PD (Linehan, 1993).

In a similar supportive line is the work by Beck et al. (2001), which also shows the effectiveness of cognitive therapy in the treatment of PDs, since it confirms that when the patient is capable of identifying and modifying basic beliefs, various areas of functioning can be improved.

The common denominator in all studies on treatment effectiveness is the importance they attribute to the fact that the patient remains on the programme long enough. Effective treatments in PD, regardless of the intervention model used, are particularly concerned with the question of duration, since they should be prolonged, as well as covering a broad behavioural repertoire and having a theoretical basis; in any case they should always prioritize retention on the programme (Caballo, 2004).

Evidence-based studies on treatment effectiveness in substance-dependent population

Some reviews show that the treatment of PDs in substance-dependent individuals can also be effective, since the use of cognitive-behavioural therapy produces significant improvements in drug addicts with PD (Fisher & Bentley, 1996; Ball, 1998; van den Bosch, Verheul, Schippers, & van den Brink, 2002; Kienast & Foerster, 2008). For example, Kienast and Foerster (2008) highlight the efficacy of cognitive-behavioural intervention focused on relapse prevention that prioritizes the relationship between drug use and PDs. This is especially pertinent in the case of Dialectical Behaviour Therapy, which has shown its effectiveness in the treatment of substance-dependent individuals with borderline PD (van den Bosch, Verheul, Schippers, & van den Brink, 2002).

The evidence suggests, then, that drug-dependent patients with PD benefit from treatment as much as others (Cacciola, Alterman, Rutherford, McKay, & Suider, 1996; Fernández-Miranda, 2002), given the observation that treatment success depends to a large extent on the patient's motivation, which makes PD a predictor of relapse for less motivated patients, but not those with higher levels of motivation (Gerstley, Alterman, & McLellan, 1990). Thus, for example, in the review by San Molina and Casas (2002) on therapeutic recommendations for dual pathology cases, the authors reported an absence of studies in the specialist literature referring to the mistaken belief that drug addicts with PD derive no benefit from treatment.

It has been found that at 3 and 6 months of treatment there are no significant differences in abstinence depending on the presence or absence of PD; hence, we can conclude that the presence of PD does not have a decisive influence on treatment outcome as long as both disorders are approached from a comprehensive dual pathology model (López, et al., 2007; López, 2007; Martínez-González, Graña, & Trujillo, 2009). This independence between PD and treatment outcome is also analyzed by Verheul, van den Bosch and Ball (2007), who list various studies that have explored this question. According to these works, PDs do not constitute a robust predictive factor of improvement magnitude, and nor can they be associated with premature dropout or less time spent on treatment programmes. McMahon, Kelley and Kouzekanani (1993), on analyzing personality characteristics and their relation with coping styles linked to treatment dropout in cocaine addicts, concluded that personality profile cannot be related to dropout.

In the review by Becoña and Cortés (2008) the authors carry out an extensive analysis of diverse studies on psychological interventions in addictions. The following points emerge from this work in relation to the concomitance of addiction and PD: there is research that shows reduced effectiveness of cognitive-behavioural therapy when drug-addiction and PD coexist; Dialectical Behaviour Therapy is effective for the treatment of borderline personality disorder in addicts; in interventions with addicts presenting severe PD using psychodynamic group psychotherapy and cognitive-behavioural therapy combined, it is observed that the majority of these patients complete the treatment without substantial complications and give good indications of improvement; interventions addressing both disorders obtain promising results, even in patients with antisocial PD, which are particularly difficult cases to treat in the absence of certain specific conditions.

Assessment of intervention outcomes

An important issue is that of how the intervention is assessed and the criteria employed. For example, if treatment is assessed only by means of self-reports, the benefits observed may correspond solely to the transitory relief of certain symptoms (Quiroga & Errasti, 2001), so that evaluation should be ongoing and based on different sources of information.

It should also be borne in mind that the speed with which therapeutic objectives are achieved varies from case to case. Whilst some programmes need at least four years to obtain significant positive outcomes with regard to personality disorders and addiction, others yield such results after just one year of treatment. Tyrer and Davidson (2003) propose

the following criteria for rating the effectiveness of the intervention: changes in symptoms, bearing in mind that some symptoms change more quickly than others (impulsiveness, for example, diminishes with age); and social functioning and quality of life, aspects that are increasingly employed in analyses of drug-addiction intervention outcomes (Iraurgi, 2002).

Some studies with substance-dependent individuals show that those with PD report lower quality of life levels than those without PD (Pedrero, Olivar, & Chicharro, 2008;Martínez-González, Graña, & Trujillo, 2010), though cessation of use is associated with an increase in quality of life (Karow, Verthen, Krausz, & Shäfer (2008). Research has also revealed that Axis I (Narud, Mykletun, & Dahl, 2005; Martínez-González, Graña, &Trujillo, 2010) and character play very important roles in the way quality of life is perceived (Fassino, Abbate, Delsedime, Rogna, & Boggio, 2004), and although specific traits are the most significant predictors, each PD gives rise to different perceived level of quality of life (Cramer, Torgersen, & Kringlen, 2006). Quality of life is perceived as poorer, in descending order, by people with the following PDs: avoidant (poorest), borderline, schizotypal, dependent, paranoid, schizoid and antisocial (least poor).

CONCLUSIONS

Some evidence emerges from research on the treatment of drug addiction when it coexists with a PD. Drug-dependent individuals with PD can be treated effectively, though certain differences as regards intervention should be taken into account with respect to other cases. The evidence on effective treatment is related to the following points: the course of PD sets a certain pace that obliges therapeutic strategies to be adapted to the changes occurring in the person; it has been shown that patients with PD may present a pattern of use different from those of others, and this can affect relapse prevention programmes; although it has not been confirmed, there are some indications of a link between psychopathology and certain drugs; the diagnosis of PD in drug addicts should be made through clinical interview, with a view to overcoming some of the difficulties inherent to diagnosis in this population; the treatment of drug addiction in patients with PD differs from programmes in which the addiction is not accompanied by this psychopathology, since these interventions must be guided by patients' personality; it is well understood that the treatment must be prolonged, making it crucial for the patient to show good treatment adherence; there is sufficient evidence to assert that the cognitive-behavioural approach is effective in the treatment of drug-addiction when the patient presents a PD; and assessments of intervention should take into account variables related to addiction, to personality traits and to quality of life.

The treatment of substance-dependent individuals with PD is changing, and this is probably due at least in part to the development of integrated treatments clearly adapted to the peculiarities of each case, which is, after all, the key to effective treatment for drug dependence. Indeed, we have come from considering addicts with PD as untreatable to a much healthier situation in which increasingly precise and effective interventions are being designed.

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