ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

How to Join:
https://iecho.org/public/program/PRGM1708646970665RHK0C7J5TR

For attendance, purposes please text the following code: WENRAN to 608-260-7097

Session Date: Friday, February 21, 2025

Didactic Topic and Presenter:
Caring for Individuals with Co-occurring SUDs and Personality Disorders

Virginia Medinilla, MD, PhD (she/her/ella)
Assistant Professor (CHS), Department of Psychiatry
Core Faculty, Center for Healthy Minds
University of Wisconsin-Madison
Content Experts: Sheila Weix and Joe Galey

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation
    - Presenters:
        - Mario Giacobassi, MD - PGY-2 Family Medicine, Wingra Clinic, Department of Family Medicine and Community Health
        - Jillian Landeck, MD - Department of Family Medicine and Community Health
- 1 PM: Didactic Presentation
    - Presenter: Virginia Medinilla, MD, PhD
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN–MADISON
School of Medicine and Public Health
School of Nursing
School of Pharmacy

Project ECHO
University of Wisconsin

ECHO ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics 2025

Caring for Individuals with Co-occurring SUDs and Personality Disorders

2/21/2025

Didactic Presenter: Virginia Medinilla, MD, PhD

Case Presenter: Mario Giacobassi, MD and Jillian Landeck, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:

1. Identify key diagnostic features of antisocial and borderline personality disorder early in the course of treatment
2. Discuss evidence-based treatment options and provide recommendations that are patient-centered
3. Utilize specific strategies to create a strong therapeutic relationship and encourage behavior change

Policy on Disclosure

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Name	Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?	COI completion date
Randall Brown	RSS Chair	No relevant financial relationships to disclose	Yes	12/4/2024
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	1/15/2025
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	12/9/2024
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	12/9/2024
Paul Hutson	Planner	usona (Independent Contractor - Consultant), Midwest Pharmacokinetic Consulting, LLC (Independent Contractor - Consultant), Otsuka America Pharmaceutical, Inc. (Independent Contractor - Consultant), Tryptamine Therapeutics (Independent Contractor - Consultant)	Yes	12/4/2024
Susan Mindock	Planner	No relevant financial relationships to disclose	No	12/7/2024
Sheila Weix	Planner	No relevant financial relationships to disclose	No	12/12/2024
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	12/4/2024
Joseph Galey	Planner	No relevant financial relationships to disclose	No	12/12/2024
David Leinweber	Planner	No relevant financial relationships to disclose	Yes	12/4/2024
Virginia Medinilla	Presenter	No relevant financial relationships to disclose	No	2/6/2025

Mario Giacobassi	Presenter	No relevant financial relationships to disclose	No	2/7/2025
Jillian Landeck, MD	Presenter	No relevant financial relationships to disclose	No	2/3/2025

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Case Presentation

Mario Giacobassi, MD, PGY2
Jillian Landeck, MD
UWDFMCH

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Case Introduction

- One-liner (including age/sex):
  - 20 year old G3P1 with history of being unhoused, PTSD, anxiety, suicidal ideation, cannabis hyperemesis syndrome and cyclic vomiting presenting with vomiting and abdominal pain.

- Primary question for discussion:
  - Garnering patient buy-in on a diagnosis of cannabis hyperemesis syndrome
  - Secondary
    - Navigating negative impacts of carrying the diagnosis, ensuring confidence in the diagnosis
    - Have people found specific treatments more effective during pregnancy

Medical & Behavioral Health Diagnosis:	Current Medications:
• PTSD • Cyclic vomiting • PSTD • Anxiety • Suicidal ideation	• SSRI • Symptomatic management with: Antiemetics, PPIs, antipsychotics

Substance Use

- History: Cannabis – long history of cyclic vomiting with many ED visits predating pregnancy. First diagnosed at 17 and admitted to children's. Symptoms improved with cessation and then returned.
- Pregnancy: was advised to abstain although was using cannabis to control symptoms of N/V in first trimester. During first months of pregnancy, had several ED visits and thought symptoms due to hyperemesis gravidarum.
- Consequences of Substance Use:
  - Social/occupational/educational: Unemployed, without significant social support, loss of family support
  - Physical (including evidence of tolerance/withdrawal):
    - Persistent vomiting throughout her pregnancy, leading to 22 ED visits and multiple admissions
    - Mallory-Weiss tear with hematemesis during pregnancy
    - Hypokalemia
    - Iron deficiency anemia
- Past treatments: Antiemetics, PPIs, antipsychotics, counseling on cannabis cessation, SSRI

Social History:	Family History:
• Social Factors/History: G3 now P1, very limited family support, history of being unhoused. Kicked out of her mother's house during pregnancy, no transportation. • Education/Literacy: Completed high school • Income source: Currently unemployed, worked as caregiver in the past	• Reports that mother and partner with AUD.

Patient strengths & protective factors:	Risk factors:
• Stated desire to improve physical symptoms • Desire to provide for health of her baby	• Lack of social support • Lack of financial support • Lack of transportation • Housing instability • Mental health comorbidities

Labs

- UDS in April positive for cannabinoids (aligned with what she reported)

Patient Goals & Motivations for Treatment

- Improved physical symptoms
- Health of baby

Proposed Diagnoses

- Cannabis use disorder
- Cannabis hyperemesis
- H.pylori
- Hyperemesis gravidarum

Proposed Treatment Plan

- Behavioral intervention and education
- Antiemetics

Discussion:

- Primary question: Garnering patient buy-in on a diagnosis of cannabis hyperemesis syndrome
- Secondary questions
  - Navigating negative impacts of carrying the diagnosis, ensuring confidence in the diagnosis
  - Have people found specific treatments more effective during pregnancy

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} **Physical Dependence ≠ Use Disorder**

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

By initialing here _____ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

Project ECHO University of Wisconsin

Caring for Individuals with Co-Occurring SUDs and Personality Disorders

Virginia Medinilla, MD, PhD
Assistant Professor, Department of Psychiatry
University of Wisconsin-Madison

February 21, 2025

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Learning Objectives

Upon completion of this educational activity, participants will be able to:

1. Identify key diagnostic features of antisocial and borderline personality disorder early in the course of treatment
2. Discuss evidence-based treatment options and provide recommendations that are patient-centered
3. Utilize specific strategies to create a strong therapeutic relationship and encourage behavior change

Overview

- Definitions
- Epidemiology of the Comorbidity
- Etiology
- Antisocial Personality Disorder
  - Diagnosis
  - Illness Course and Prognosis
  - Evidence-Based Treatment
  - Strategies for Skillful Engagement
- Borderline Personality Disorder
  - Diagnosis
  - Illness Course and Prognosis
  - Evidence-Based Treatment
  - Strategies for Skillful Engagement
- Conclusions

Definitions

- Personality Disorders (PDs) are collections of traits that

- are inflexible and pervasive in nature
- have their onset in adolescence and early adulthood
- are stable over time
- lead to significant impairment to the individual and others

Personality Disorder Clusters (DSM-5)

Cluster A	Cluster B	Cluster C
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive-Compulsive
	Narcissistic	

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

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- Much time obtaining/using/recovering
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- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

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Epidemiology

- PD Prevalence
- General population: 10-14.8%
- SUD population: 34.8-73.0%
  - ASPD and BPD most common
  - At least 25% of ppl seeking Tx for SUD have ASPD
  - ↑ severe SUD, ↑ likely to have PD

- SUD Prevalence
- General population: 16.7% (12 and older, NSDUH)
- PD population: 5x risk for AUD, 12x risk for drug use disorder
  - BPD: 22-78%
  - ASPD: 80% (lifetime)

Etiology of the Comorbidity

1. Personality psychopathology → secondary SUD
2. SUD and related trauma → PD
3. Common biological factors → impulsivity → PD + SUD

- 3 developmental pathways
  - Behavioral disinhibition
    - Stress-reduction
    - Reward sensitivity

Antisocial Personality Disorder

DSM-5—Antisocial Personality Disorder (301.7)

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are ground for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

You Might Be Dealing With ASPD if Your Patient …

- Demands immediate results
- Blames others for lack of progress
- Threatens when dissatisfied
- Evokes feelings of frustration and hopelessness

Illness Course and Prognosis

- Earlier onset and more severity of substance use problems
- Higher psychopathological burden
  - Often coexist with depressive (⅓ of patients), anxiety disorders (twice as likely as pts w/o ASPD), impulse control disorders, ADHD
- Poorer treatment response and outcome
- Challenging therapeutic relationship
- Nonadherence issues
- Low motivation for change
- Higher dropouts (patient and center-initiated)
- Poorer social functioning

- More family, social, and legal problems

Evidence-Based Treatment

- Psychotherapeutic Interventions
  - Psychotherapy
    - Dialectical behavioral therapy (DBT)
    - Dual focused schema therapy (DFST)
    - Cognitive behavioral therapy (CBT)
  - Psychoeducation
    - 1 RCT for ASPD + SUD

Evidence-Based Treatment

- Pharmacotherapy
  - For co-occurring anxiety disorders
    - Avoid benzodiazepines
    - Use SSRIs/SNRIs, buspirone, and/or trazodone, VPA, gabapentin, olanzapine, quetiapine
  - For co-occurring ADHD
    - Start with non-stimulants
    - Consider slow-release forms of stimulants

Strategies for Skillful Engagement

1. Don’t take it personally!
2. Develop empathy
3. Praise (rather than criticize)
4. Set limits
5. Use team approach in treatment
6. Take care of yourself

Borderline Personality Disorder

Borderline Personality Disorder

Diagnostic Criteria **301.83 (F60.3)**

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

You Might Be Dealing With BPD if Your Patient …

- Is frequently hostile, anger, or suicidal
- Evokes very different reactions from different staff members (splitting)
- Takes much more time than others during team meeting discussions
- Praises you or anyone on the team excessively ("you're the best doctor I've ever had," "you're the only one who really understands me")
- Evokes feelings of frustration, anger, and helplessness

Illness Course and Prognosis

- Earlier onset and more severity of substance use problems
- Higher psychopathological burden
  - Often coexist with depression, bipolar disorder, anxiety, and PTSD
- Poorer treatment response and outcome
- Challenging therapeutic relationship
- Nonadherence issues
- Low motivation for change
- Higher dropouts (patient and center-initiated)
- Poorer social functioning

- Increased risk of self-harm, suicide, and other self-damaging behaviors

Evidence-Based Treatment

- Psychotherapeutic Approaches
  - Cognitive behavioral therapy (CBT)
  - Schema-Focused Therapy
  - Dual focused schema therapy (DFST)
  - Dynamic Deconstructive Psychotherapy (DDP)
  - Transference-Focused Therapy
  - Interpersonal Therapy
  - Dialectical behavioral therapy (DBT-SUD)

Evidence-Based Treatment

- Pharmacotherapy
  - Identify and treat frequently co-occurring disorders (depression, bipolar disorder, anxiety disorders, PTSD)
  - Treat SUD with medications when available (MAUD, MOUD)
  - Antidepressants, anticonvulsant mood stabilizers, atypical antipsychotics have all been studied in BPD

Evidence-Based Treatment

- Pharmacotherapy
  - Guiding Principles:
    - Use medications with little or no lethal potential
    - Simplest possible regimen – avoid overprescribing
    - Prescribe at maximally effective doses to speed clinical improvement

- Complementary and Alternative Therapies
  - Ear acupuncture for BPD + tobacco use disorder

Strategies for Skillful Engagement

1. Don't take it personally!
2. Build trust
   - Be transparent and totally honest
   - Use clear and consistent communication
3. Validate
4. Set clear boundaries – assert yourself
5. Have a clear, structured treatment and crisis management plan
   - Hierarchy of treatment targets (life-threatening behaviors, success in treatment, QOL)
6. Use a team approach – seek supervision or discussion
7. Take care of yourself

Conclusions

- PDs are very common among individuals with SUDs
- PDs add a significant level of complexity to already complex SUD cases
- Individuals with co-occurring SUDs and PDs can and do recover with treatment
- Important to recognize the PD early in the course of treatment
- Specific strategies can help work with these patients more effectively
- Important to learn to manage own reactions and behaviors, and to seek consultation when needed

Questions?

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). American Psychiatric Pub; 2013.

2. Parmar A, Kaloiya G. Comorbidity of personality disorder among substance use disorder patients: A narrative review. Indian J Psychol Med 2018;40:517-27

3. Brooner K *et al*. (2010). Antisocial Personality Disorder in Patients With Substance Use Disorders. In Nunes EV *et al*. (Eds.), *Substance Dependence and Co-Occurring Psychiatric Disorders, Best Practices for Diagnosis and Clinical Treatment*, (pp 8-1 to 8-26). Kingston: Civic Research Institute.

4. Ekblad A *et al*. (2010). Borderline Personality Disorder in Patients With Substance Use Disorders. In Nunes EV *et al*. (Eds.), *Substance Dependence and Co-Occurring Psychiatric Disorders, Best Practices for Diagnosis and Clinical Treatment*, (pp 9-1 to 9-30). Kingston: Civic Research Institute.