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Ewa Wojtynkiewicz

ABOUT DIFFICULT RELATIONSHIPS BETWEEN ALCOHOL USE DISORDER AND PERSONALITY DISORDERS — A CASE STUDY

Faculty of Clinical Psychology, Psychology Department, Kazimierz Wielki University in Bydgoszcz

alcohol use disorder
personality disorder
co-occurrence

Summary

The problem of co-occurrence of alcohol use disorders and personality disorders seems to be crucial from both the clinical and the therapeutic perspective. The co-occurrence rate is high and amounts to about 60% in clinical groups and about 29% in the non-clinical group. Despite the significant co-occurrence of alcohol use disorder and personality disorders, the nature of the relationship between these two is still vaguely known. All the more reason to acknowledge that the research on the above-mentioned relationship is significant and can lead to a better understanding of patients with dual diagnosis as well as to the optimisation of psychotherapeutic interventions directed at those patients. The article presents a case study of a patient with diagnosed alcohol use disorder and mixed personality disorders (borderline personality disorder, narcissistic personality disorder) and an attempt to understand the mutual dependence of these disorders in the context of the patient's life story, including the history of numerous treatment attempts. The case conceptualisation has been based on the psychodynamic paradigm referring to O. F. Kernberg's model of personality pathology as well as other psychodynamic concepts which directly address the issue of psychoactive substances abuse.

Introduction

The matter of co-occurrence of addiction to alcohol (alcohol use disorder[1], AUD) and personality disorders (PDs) is broadly described in the literature on the subject [1-3]. The problem of this co-occurrence appears to be significant from scientific, clinical, and therapeutic perspectives. According to empirical reports, the indicator of co-occurrence of AUD and PDs in the clinical groups fluctuates around 60% and PDs which are most frequently diagnosed among patients with AUD are antisocial personality disorder, borderline personality disorder, and avoidant personality disorder [4, 5]. Research conducted on a non-

[1] The author is using the terms: 'addiction to alcohol' (ICD-10) and 'alcohol use disorder' interchangeably because in the recent years' English-language literature, only the latter is used, although in Poland, taking into account the binding classification of mental disorders, the traditional term 'addiction to alcohol' is still used. It is worth mentioning that the dysfunctions referring to alcohol consumption in DSM-5 classification include both: harmful using (F10.1) and addiction to alcohol (F10.2) according to ICD-10.

clinical American population suggests that 29% of people with AUD symptoms suffer also from PDs [6, 7].

Despite such a significant co-occurrence of AUD and PDs, the nature of the relationship between both of them is still poorly known [3]. There are three main models explaining the aetiology of this relationship. The first two models suggest taking into consideration a direct causal link, namely that one disorder leads to the other to be developed [3]. To put it another way, according to the first model, AUD is a derivative of a primarily occurring PD, or — according to the second model — PD is a derivative of the primarily occurring AUD. The third model is not based on a causal relationship but it is emphasised that there are other common factors that lead to the development of AUD as well as PDs [8]. What is more, in the literature the concept of a mediator can be found, that is an indirect causal relationship, according to which one disorder influences on a third variable, by means of which it has an impact on developing the second disorder (for example a specific way of functioning of people diagnosed with dependent personality disorder or borderline personality disorder may increase the risk of experiencing psychological and/or physical abuse from their partner. This abuse can become an intervening variable for using excessive drinking as a way of emotion regulation) [3]. Researchers also emphasize the fact that empirical evidence seems to mostly support the model of primarily occurring PDs, in which the pathological personality traits contribute to the development of substance use disorder (SUD[2]) [8]. This process can take place on the basis of three mechanisms: (1) behavioural disinhibition pathway — which assumes that people with a high intensity of antisocial personality traits and impulsiveness as well as with a low intensity of inhibition or harm avoidance, can be characterised by a lower threshold for deviant behaviours; this mechanism is best documented because it is entwined with co-occurrence of antisocial personality disorder and SUD; (2) stress reduction pathway — occurring among people with a high intensity of stress reactivity, anxiety and neuroticism, who — being more prone to experience stressful life experiences — may, as a response to anxiety and mood instability, reach for psychoactive substances with the aim of autotherapy. This mechanism is also justified in longitudinal studies, confirming that high stress reactivity, negative emotionality, or anxiety disorders significantly increase the probability of substance abuse and/or addiction [9, 10]. This model also gives an explanation for late-onset alcohol addiction which seems to be more common among women; (3) reward sensitivity pathway — which suggests to assume that people with high intensity of traits such as seeking for novelty or reward, sociability, and extraversion can be motivated to use substances with the purpose of gaining a positive reinforcement. This model is confirmed by studies providing evidence that novelty seeking or extraversion can contribute to substance abuse [8].

[2]The most common theoretical co-occurrence models as well as empirical studies regarding the co-occurrence of alcohol use disorder and personality disorder include a whole group of all psychoactive substances (alcohol and different types of drugs; *substance use disorder*, SUD); there is a lack of separate, isolated models for AUD or DUD (drug use disorder). Therefore, in this article, the term SUD is used as a superior term which includes AUD.

It is also highlighted that the above-mentioned mechanisms can be connected with various personality disorders. The first one, as it has been mentioned, may be connected with antisocial personality disorder and — in some cases — with borderline personality disorder. Stress reduction mechanism can explain psychoactive substance abuse among people with avoidant, dependent, schizotypal, borderline, or obsessive-compulsive personality disorder, whereas the third mechanism can describe psychoactive substance abuse among people with narcissistic and histrionic personality disorder [8].

The aim of this article is to present a case study of a patient diagnosed with AUD as well as PD and to make an attempt to understand mutual relationships of both disorders based on the patient's life story, including the history of numerous treatment attempts. The conceptualization of the case was based on O. F. Kernberg's model of personality pathology as well as on other psychodynamic concepts which directly address the issue of using, overusing, and addiction to psychoactive substances.

Case study

Mrs B.: introductory information[3]

At the time when Mrs B. started therapy, she was a 55-year-old, slim, fit, and well-groomed woman. She had been addicted for about 35 years. She instigated an addiction treatment at the age of 36 in 1995. Two years later she began therapy in a leading therapeutic and educational alcohol addiction treatment centre; after completing the therapy and maintaining a few years of abstinence, she started to educate herself in this centre in order to obtain an addiction therapist certificate. She successfully completed this training. She remained sober for 10 years. After this period, there was a relapse of the addiction which lasted a few months; then, the woman decided to have disulfiram implanted after which she maintained 2-year abstinence. The following ten years were a time of alternate few months periods of abstinence, after implantation of disulfiram, and several months of alcohol drinking. Two years before starting the described therapy, she decided to undertake outpatient therapy, which she did not finish. After one year, the woman decided to begin a 3-month inpatient therapy in the centre where the author of this article worked. Mrs B. participated in group therapy three times a day and in individual therapy two times per week as well as in everyday psychoeducational interventions. The group therapy was conducted in a cognitive-behavioural approach, focusing on alcohol addiction treatment; individual therapy conducted in the psychodynamic approach was mostly concentrated around the diagnosis and treatment of the patient's personality psychopathology.

[3]Identification and biographical data have been changed. The patient has given her consent for the publication of this case study.

Mrs B.: life story

Before presenting Mrs B.'s life story, it should be pointed out that a consistent collection of all information which the patient revealed during the psychotherapy was difficult because of her presenting numerous facts and — what is characteristic for the patient — information, comments, and emotions 'engulfing', which in turn generated strong and chaotic countertransference reactions.

Mrs B. was born into a complete family. She did not remember her childhood in a good way. She lived with an alcohol-addicted father, her mother, older brother (who also became addicted to alcohol and committed suicide) as well as with her younger sister. About the father, she used to say: 'I was scared of him and I hated him, he was a tyrant and a despot, he beat his children and their mother.' Mrs B. recalled that when her father was beating her and her siblings, they had to be naked; he beat them with an iron cord or a belt. She remembers that she was always begging her father not to beat them, each time with no result. About her feelings towards the mother she kept saying: 'I blamed her, I felt anger and resentment towards her because she was not able to defend us.' The woman frequently emphasised that she harboured a grievance against her mother when the latter complained on her or her siblings to the father. She summarizes her relationships with the parents in the following way: 'I felt hatred towards them. I did not feel safe, I missed warm support, understanding, hugging, praising. My father was drunk all the time, my mother was always beaten and bruised... Fear, embarrassment, humiliation...' The patient's father died 3 years before her starting the psychotherapy. Mrs B. mentioned: 'I did not shed a tear. What I thought at that time was that he deserved it, he had worked hard for it.' The current attitude to the mother was reflected in her meeting with the mother while staying in the Ward. While participating in group therapy, the patient was crying that although her mother came to her to the Ward on her name day she did not bring her any name day gift.

When she was 8 years old, Mrs B. experienced an emotionally difficult situation. As she was going shopping, she took her one year younger neighbour with her. When they were coming home, she witnessed the boy being run by a car and dying instantly. The patient recalled a feeling of anxiety, terror, and enormous guilt. She came back home, hid under a duvet when her mother approached her sobbing and repeating 'What shall we do now, daughter?!' Mrs B. admitted that at that time, she had expected to be cared for and protected by her parents, 'which I did not receive from them.' She dreamt of moving out with her parents to another place but this did not happen. 'The neighbour, my friend's mother, blamed me a lot for what had happened.' The patient had felt helpless. What is important, the story about the accident was the first information provided by Mrs B. when she started her first individual meeting with the psychotherapist.

After the accident, Mrs B.'s mother signed her up for various extracurricular activities. The patient describes that time as the best time in her life. It was filled with 'school performances, obtaining diplomas, winning medals, cups for the first place in sports competitions, going abroad for sports contests.' The

patient remembers the primary and secondary school times as surrounded by an atmosphere of 'book awards, little theatre performances, where I was a star, school trips, stunts at sports events.' The patient remembers that never, even as a student (pedagogy), did she have any problems at school. To sum up her adolescence, Mrs B. emphasized that her best memories concern three things: winning the national championship in artistic gymnastics, playing in the theatre and being 'a star', as well as the fact that as the first person in the family she got into university.

Mrs B. had her first contact with alcohol when she was 11 years old – she stole a bottle of wine from her father. She recalled that since she was 17/18 years old, her drinking problem had worsened. At that time, she drank at parties, she remembers that she initiated and accelerated alcohol drinking among her friends, she used to get "sad" drunk. Since she was 18 years old, she has been treated by her parents with alcohol; besides this, Mrs B. was still stealing alcohol from her father. At the same time, she mentioned that during her adolescence she did not maintain any deep relationships with her peers, although quite often, especially when she was under the influence of alcohol, she engaged in sexual activities with random boys or slightly older than her men.

While she was a student, each successfully passed exam session became an excuse to drink alcohol. Mrs B. remembers that each time she was going to participate in a party she was always provided with her own, hidden from her friends, alcohol, which she sipped stealthily. At university, she engaged in a relationship with a boy with whom she split up after around a year because — as she claims — she noticed his alcohol problem (soon after splitting up the boy died as a result of alcohol overdose). While being in this relationship, both her and her partner engaged in sexual activities with other people.

Just after the studies, Mrs B. got married (being already pregnant) to a man who had elementary education and who was also addicted to alcohol. After giving birth she started working as a trainer in a sports club, returned to drinking, also with her husband and his friends. Three years later Mrs B. gave birth to the second child. In the same year her husband lost his job and started to drink intensively. Due to this situation, the patient resigned from her maternity leave and returned to work. During that time she was also drinking a lot. Additionally, she took up a job at school but was disciplinarily dismissed because she had come to work under the influence of alcohol. At that time, while being drunk, she initiated many situations which put her children's health and lives in danger. Mrs B. remembers that from time to time she beat up her mother, her mother-in-law, and that she got involved in fights with her husband repeatedly, she was also using physical violence towards her children. Mrs B. stressed also that while being drunk, she was getting engaged in random sexual contacts.

At the age of 36, she started her first outpatient therapy; she attended a few meetings with a therapist but failed to maintain abstinence. Mrs B. remembers also: 'My drinking problem was commented on very frequently everywhere; at work, in the neighbourhood. My drinking habits became a hot topic.' In 1997,

she began an inpatient therapy in a leading therapeutic centre, leaving her place of residence. She made her decision about the therapy on a day-by-day basis. Since that time, she remained sober for 10 years. After completing the therapy, she started a therapeutic work on her own development, including a therapy for Adult Children of Alcoholics, which she recalls as a 'nightmare because at that time I fell in love with my partner and the thought that he was there somewhere was the most important one.' Soon after, she participated in trainings regarding addiction treatment, which gave her the qualifications to conduct this kind of therapy on her own. She successfully finished these trainings. She got into a relationship with the man she met during the therapy for Adult Children of Alcoholics, got divorced from her husband, and resigned from applying for parental order over the children who stayed with her ex-husband.

Together with her new partner, they left their jobs as addiction therapists. They both got involved in yoga. Mrs B. took a course on yoga instructor and shortly after she began working as an instructor at a yoga school and started treating her manager as a 'guru'. At that time, the patient resigned from participating in Alcoholics Anonymous meetings being certain that yoga will help her ('I was thinking then that I would show everyone that yoga is enough.') After a few years, Mrs B.'s manager turned out to be a financial fraudster.

The patient spent 'five rough years' with her partner. She remembers him as a person who wanted to keep Mrs B. distant from her own family, banned her from meeting with her children. The partner used physical violence towards her, and vice versa. A dozen times Mrs B. broke up with him, left and then came back again. After five years of this relationship the patient decided to run away from her partner and went to the United States of America. She started working there. After three months, she found out that her (ex-)partner had a new — 10 years younger — partner. 'I was filled with anger, fury, jealousy. I was very jealous, especially about the sex.' Then, after 10 years of being sober, she violated abstinence. She decided to bring her ex-partner over to America, she paid for his flight and apartment. 'In this chaos caused by coming back to drinking again and because of emotional burden I also sent money to my ex-partner's girlfriend.' Shortly after they both arrived, Mrs B. came back to Poland herself.

Afterwards, the patient decided about having disulfiram implanted. She did not drink for two years in total. At that time she worked as an occupational therapist in a youth sociotherapy centre, she also took a course for community carers for the elderly. After 2 years she broke abstinence, drinking secretively and hiding from the pupils and centre management. She resigned from this work, decided to have another disulfiram implanted. Then she went to Italy to work as a carer for elderly people. She was dismissed from this position as she stopped her abstinence. This situation of being dismissed from a workplace happened to her again a few months later, when she stopped her disulfiram treatment after 8 months.

In the next few years of struggling with maintaining and discontinuing abstinence Mrs B. met a man who was addicted to alcohol, who had not been drinking for a few years though. This relationship seemed

to her as a very difficult one because it was ‘hermetic’. Furthermore, the patient’s partner, in her opinion, encouraged her to drink, and when she did so, he broke up with her.

Two years before the described treatment of Mrs B. she undertook outpatient therapy. She participated in this therapy for 3 months, after which she stopped it and went to Germany in order to work. Shortly after her arrival she drank alcohol again. One year ago she decided to start inpatient therapy in the addiction treatment centre.

Mrs B.: interpretation

Mrs B. as a trained addiction therapist had a broad knowledge regarding alcohol addiction and its mechanisms. The essays which she wrote and read out loud during group sessions stood for evidence that at the intellectual level, the patient fully understood the issue of alcohol addiction. It seems to be significant that during group sessions, Mrs B. was frequently trying to be in the centre of everyone’s attention, revealing a tendency to be noticed and admired, which she accomplished in two ways: she always started the initial round in the therapy, during which she was exhaustively describing her mood, recalling various stories from her life, crying at the same time; and as the first or last person (even after the therapist) she gave feedbacks to other patients, which were quite frequently confrontational. The essays which she read often ended with a burst of negative emotions among the members of the group.

Taking into account the life story of the patient and the psychopathology disclosing in the course of her stay in the addiction treatment centre, it appeared that she demonstrated distinct personality deficits. According to the structural approach of personality disorders, which classifies the personality pathology based on the character of the most important processes or personality elements (identity, the character of the relationship with the object, prevalent level of defence mechanisms, reality testing and moral functioning) [11], Mrs B.’s personality structure seemed to be dysfunctional at the borderline personality organization level.

What is specific for Mrs B.’s relation with the object is instability, intensity and incoherence. All the more, the majority of her relationships with men were based on physical and/or psychological abuse. It seems that the archetype for these relationships could be the relationship with the father, described by the patient as a cruel person deserving to die, which was based on fear, hatred and rage. According to J. Steiner [12]: ‘The traumatic experience of abuse or extreme negligence, having its roots in external surroundings, may lead to internalisation of the brutal, dysfunctional object, which simultaneously can be treated by the person as a comfortable receiver of the projection of her own destructiveness’ [p.24]). Similarly one-dimensionally perceived was the mother of the patient — Mrs B. described her as an evil person, who could not help the patient in traumatic life events, did not defend her from the father’s abuse and who does not conform to the current needs of her daughter (does not bring her presents on her name day). At the same

time, together with Mrs B.'s ongoing therapy in the centre, a strong, devaluating attitude towards other patients and therapists as well as primitive idealisation of her own self came to light. The patient tended to say: 'I am better than other patients because I started writing my alco-biography earlier. I am better organised.' She finished one of her essays with the words: 'Amen. Confession has been made. The same has been happening for many years now. A hocus-pocus, so to speak.'

Likewise, the earlier supportive therapy and AA meetings abandonment in favour of yoga, choices regarding pharmacological treatment (disulfiram), abandoning the addiction therapist with the comment 'I was able to manipulate him and I did so' may be understood as a symbolic devaluation of the value within the therapy. In my countertransference, I felt that I am aggressively used by Mrs B. in order to accomplish her own aims. The feeling of emptiness, helplessness and powerlessness dominated. Sometimes I was thinking in a 'desperate' [author's term] manner what I could give/say to this patient in order to support the process of her sobering up. It seemed that while experiencing feelings of helplessness and powerlessness, I became similarly devaluated just like the mother figure who approached her daughter's bed asking 'What shall we do now, daughter?!'. My emptiness appeared to be an effect of the patient's aggressive using me. As a matter of fact, the patient — using a defence mechanism of projective identification — placed her own emptiness in me.

Another characteristic primitive defence mechanism revealed by Mrs B. was splitting. After having her life story analysed, one can notice that it is filled with the patient's mutually inconsistent attitudes and behaviours as well as contradictory representations of the self [13]. Mrs B. was a therapist working with addiction-endangered young people and yet at the same time she drank alcohol herself secretively; she hated her father for the abuse and yet she was abusing her children herself; she educated herself to be an addiction therapist in an approach which acknowledges therapy as the basic method of addiction treatment, simultaneously at recurrences of drinking episodes she decided to have disulfiram implanted and not to get engaged in psychotherapy. The splitting made the patient's identity non-integrated and fragmented. It appears that the patient revealed a severe identity pathology including the lack of coherent sense of the self or significant others. The patient's life story shows that Mrs B. frequently broke the rules set by the law or ethics regarding moral functioning.

Such a configuration of the relationship with the object, identity, defence mechanisms, or moral functioning implies that Mrs B. can be considered to be a person with a low-level borderline personality organization according to Kernberg's classification [11]. When it comes to the type of personality disorder, Mrs B. revealed symptoms of borderline personality as well as narcissistic personality disorders, also with antisocial elements.

In the context of massive and strong traumas, including the one connected with the abuse from the father and the lack of real reaction to that from the mother's side, Mrs B. as a child was deprived of the

possibility to establish a safe relationship with other people. In the early adolescence, she started developing two ways of coping with pain, suffering and terror, both based on the mechanisms of denial and omnipotent control. The first one was engaging in sport and theatre. On the one hand, those interests could be a constructive and healthy area of activity and development; on the other hand — they contributed to establish an image of the self as someone ideal, better than others, and admired to such an extent that the period of adolescence was remembered by the patient as the best in her life. At the same time, it reflects a need of being important, loved and exceptional, unfulfilled by early attachment figures. What is thought-provoking is to what extent the abused patient started at that time developing her identity around the falsely idealized object [14]. Collaterally to the sport and theatre activity, Mrs B. started developing the second way of coping with emotions — at the age of 11 she began drinking alcohol and abusing it at the age of 17/18. In the psychodynamic literature, it is pointed out that the addiction to psychoactive substances may be preceded by a pervasive feeling of helplessness and powerlessness, inevitably leading to narcissistic rage caused by the loss of ability to control one's life [15]. According to L. Dodes [15], the overwhelming emotional states originate as a result of early developmental deprivations, including failures in attachment development and experiencing feelings of humiliation and narcissistic trauma. Consequently, drinking alcohol becomes a compulsive response to the intense feeling of rage because of helplessness and may help to recreate the sense of being in control [15, 16]. Also, the fear of being overwhelmed by negative emotions predisposes to block those states through alcohol drinking [17]. It seems also that starting to drink alcohol at a young age could stand for an attempt to cope with intrapsychic influences of the father's representations and inactivating him as a terrifying and unpredictable internal image [18].

Mrs B.'s adult years looked similarly; they were filled with recurrent attempts to work on herself and destroying the effects of it; attempts to create relationships with men, which eventually turned out to be a recapture of the relationship with the negligent, unreliable, and aggressive parent; an attempt to build up a family, which as a consequence became a scene, on which, similarly to the family of origin, a certain scenario was played. Mrs B.'s contact with her children has never been re-established. These relationships, as well as the lack of other relationships based on mutuality and trust, picture Mrs B. as a person deprived of the ability to build a safe relationship with other human beings. These deficits are additionally validated by the presence of attachment relationships marked by a disorganised structure. Also in terms of interdependence needs Mrs B. shows certain deficits. On the one hand, in her life story one can observe her attempts to find a certain place in a specific social structure — at school as a teacher, in the system of addiction treatment training, in supportive institutions as a patient or as a therapist, at a yoga school as an instructor, in other people's houses as a carer. Nevertheless, all these attempts were ended unsuccessfully because of breaking basic rules in those structures. Concerning the individuation needs — it seems that

they became a manifestation of her narcissistic needs to be: a ‘star’, to be an exceptional patient (also due to her education), to be an extraordinary alcoholic, whose drinking habits were ‘widely commented.’

The analysis of the above-mentioned facts and the life story of Mrs B. shows that her disorders, including dysfunctions regarding personality structures, personality disorders, as well as alcohol addiction, were developed collaterally. At the same time, it is difficult to predicate without doubts which form of these psychopathologies has originated first, though they all reinforced one another. It appears that the common factor leading to developing AUD and PD in the patient was experiencing multiple traumas during her childhood. According to L. Wurmser’s [19] cycle of personality-forming in addicted people, one can assume that the real traumatisation, including serious exposure to violence, which took place in Mrs B.’s life, prevented establishing strong psychic structures and boundaries, which on the other hand could lead to a basic defect in the defence mechanisms being shaped and to develop denial and splitting as the main ways of escaping from painful affects and superego conflict (which causes for instance a feeling of worthlessness). Wurmser [19] claims that these mechanisms may appear to be insufficient and, therefore, they can be strengthened by externalisation, that is pharmacologically by alcohol consumption which escalates the illusion of narcissistic strength. These mechanisms become consolidated and reinforce the identity fragmentation; the initial psychopathology deepens.

In this context of Mrs B.’s psychopathology, her reaction to comments from the therapists who confronted her psychopathological mechanisms seems to be symptomatic. Along with these remarks, the patient started declaring to have symptoms of poor physical well-being, headaches, chest and stomach pain, which after medical examination did not find grounds from the medical point of view. Suddenly, the patient’s body, previously fit, looking young, muscular, healthy, admired by other people, became weak and the patient herself seemed to be terrified of it. The patient made the following comments on her state: ‘I have been moving forward, now I have taken several steps back. I feel terrible about it. I would like to be great, the best of all people, but I cannot. I am broken, I am completely broken’. It appears that this state of being ‘broken’ means a state of being threatened by the awareness of her own weakness, projections of previously splitted bad fragments of the self and many strong, overwhelming emotions and anxieties originating from various, even early-life phases of Mrs B. (What is interesting, the patient was describing in an equally emotional manner the events from before 40 years as well as the events which had taken place a few days before; what is more, as it was mentioned, the first information the patient provided in the unrestrained interview at the first meeting with the individual psychotherapist was the information regarding the accident which happened when she was 8 years old.) Mrs B. said: ‘Usually when I felt so broken, I drank alcohol.’ It seems then that the pathological personality organisation with highly structuralized defence mechanisms system stood for the patient’s psychological asylum — according to Steiner [12] — a safe area to which the patient pulled out, the leaving of which causes the loss of balance

and fear. Mrs B.'s confrontation with this way of functioning, which was possible due to referencing to the more confrontational part of the patient's ego, caused leaving the psychological asylum, which as a result led to experiencing strong psychological pain, expressed also through somatic body 'falling apart' [author's term].

Conclusion

The above-presented case study shows the very significant issue – highlighted in the literature [20] – of the relationship between AUD and PDs for understanding the patient as well as the difficulty regarding their analysis and interpretation. As it was already mentioned, it seems that the model which most accurately describes the pathology of the patient is the model of a common factor — in this case, in all likelihood, the patient's traumatic relationship experiences.

The examination of interdependencies between AUD and PDs may allow to optimize the psychotherapeutic interventions for people with such a dual diagnosis. It makes it possible to direct the interventions not only at the current behaviours connected with alcohol drinking but also at the factors escalating the intensification of PDs symptoms, which can be a basis for AUD [21]. The need for better understanding of the underlying factors of the co-occurrence of PDs and AUD as well as optimisation of therapeutic interventions is being emphasised in the source literature [4, 22, 23]. In the traditional treatment model, SUD is treated as a separate disorder which is treated with isolated methods [4]. Nowadays, in the situation of the co-occurrence of SUD and PDs it is usually advised to use integrated therapeutic approaches which are aimed directly at both disorders [4, 23].

There are a few therapeutic models, the majority of which are in the phase of efficacy study, which have been created in such a way that it is possible to use them to treat both PDs (especially borderline personality disorder), as well as AUD. One of the models is called *Dynamic Deconstructive Psychotherapy* (DDP) [24], which implies that alcohol overusing is a compensatory, non-adaptable way of seeking relief while having no verbal/symbolic capabilities for coping as well as relational abilities, the deficits of which are caused by the personality disorder. Similarly, the *Modified Dynamic Therapy* (MDGT), which perceives SUD as a mechanism of deficits treatment concerning affect, attachment relationships, self-care, self-esteem, focuses on developmental and structural personality deficits, assuming that the treatment of character disorders is a way to treat addictions [25, 26]. Also, Linehan and co-workers formulated *Dialectical Behaviour Therapy-S* (DBT-S), which involves additionally in comparison with classical DBT, dialectical strategies helpful for maintaining abstinence and attachment strategies which are aimed at keeping a patient with a difficult personality in the therapy [3]. The next psychotherapeutic model, which was created for the simultaneous treatment of PDs and AUD is *Dual Focus Schema Therapy* (DFST) understood as a modified version of schema therapy, integrating the techniques of preventing relapsing and

treating non-adaptational functioning of the patient with personality disorder and their style of coping with problems [3]. In the conditions of Polish alcohol addiction treatment centres and clinics, except for the attempts to apply the above-presented therapies, perhaps a solution could be the introduction of a sequential or parallel integrated treatment, during which, apart from direct therapeutic interventions aimed at treating AUD, patients with a dual diagnosis (parallel integration) or soon after basic treatment (sequential integration) would cooperate with psychotherapists working in such therapeutic approaches that are known as the most effective in PDs treatment (that is: psychodynamic therapies, especially those focused on transference, based on mentalization, as well as cognitive-behavioural therapies, especially dialectical-behavioural therapy and schema therapy).

The development of therapeutic models for patients with PDs and AUD is all the more important since studies indicate that the people diagnosed with — for example — borderline personality disorder and AUD seem to be characterised with a higher indicator of therapy ceasing and drinking relapsing in comparison with people with a single diagnose [27]. At the same time, studies conducted among teenagers and young adults who are looking for help show that borderline personality disorder — regardless of other variables — may lead to AUD [21] and AUD diagnosis among young adults also with borderline personality disorder is made 5–10 times more often than among healthy adults and 2-3 times more often than among patients with other personality disorders, and is also connected with serious difficulties, a higher number of risky behaviours, suicidal behaviours, and legal problems in comparison with people diagnosed with isolated borderline personality disorder or AUD [22]. Therefore, it appears that the cognition of mechanisms leading to the intensification of PD symptomatology in the group of people with diagnosed AUD, as well as an attempt to understand mutual correlations between PDs and AUD are crucial for the effectiveness of undertaken therapeutic interventions.

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e-mail address: ewa.wojtynkiewicz@gmail.com