Bridging the Behavioral Health Divide: The Urgent Need for Integrated Post-Graduate Education in Co-Occurring Personality and Substance Use Disorders

Aubrey L. Sejuit [1,*], Crystal Hettinger [2]

[1]*Department of Social Work, Winthrop University, USA*

[2]*Independent Researcher, USA*

Abstract: The high rate of co-occurrence between personality disorders (PDs), particularly Cluster B presentations like borderline personality disorder and antisocial personality disorders, and substance use disorders (SUDs) presents a major clinical and economic challenge to behavioral health systems. Historically, these conditions have been treated in isolated single-diagnosis silos, forcing clients into fragmented care pathways that elevate relapse rates, suicide risk, and high-acuity healthcare utilization. This gap in care is driven by systemic educational and regulatory disparities: while addiction treatment is supported by dedicated state licensing pathways and multidisciplinary national credentials, training for personality pathology remains severely underrepresented across both master's- and doctoral-level curricula, with no corresponding state-level specialty endorsements. To bridge this divide, higher education and regulatory bodies must expand interprofessional training pipelines, embed early dual-diagnosis competencies in master's-level health programs, and establish formal state-level specialty credentials for personality pathology. Expanding specialized workforce training is an urgent clinical and economic priority to lower systemic costs and improve long-term recovery outcomes.

Keywords: Substance Use Disorders (SUD), Personality Disorders (PD), Dual Diagnosis, Co-Occurring Disorders, Integrated Care, Social Work, Counseling, Workforce Training, Credentialing, Licensure.

INTRODUCTION AND CLINICAL SCOPE OF DUAL DIAGNOSIS

The high rate of co-occurring personality disorders (PDs) and substance use disorders (SUDs) presents a persistent and complex challenge across behavioral health and addiction treatment systems. Although these conditions frequently intersect, care has historically been delivered in isolated environments, with mental health services targeting personality pathology and addiction programs addressing substance misuse independently. Importantly, this division rarely stems from a lack of multidisciplinary intent; consultation across specialties and cross-disciplinary referrals remain foundational principles of contemporary clinical practice. Clinicians routinely recognize the boundaries of their expertise and seek appropriate external input. Unfortunately, existing referral networks and multidisciplinary structures are frequently ill-equipped to manage the severe, interactive complexity of co-occurring PD and SUD. The primary breakdown occurs at the structural and administrative levels, where disjointed electronic health record systems, non-aligned billing mechanisms, and restrictive eligibility criteria (such as requiring demonstrated sobriety prior to mental health admission) convert well-intentioned cross-specialty referrals into fragmented, sequential care loops. This operational divide creates a critical treatment gap, leaving individuals without synchronized, dual-diagnosis care that addresses both conditions simultaneously (Stetsiv *et al.*, 2023). Consequently, clients routinely cycle between disparate outpatient providers, specialty addiction facilities, emergency departments, and acute psychiatric inpatient units without receiving integrated, long-term therapeutic support.

CLUSTER B PATHOLOGY AND CORE BEHAVIORAL MANIFESTATIONS

This clinical fragmentation is particularly pronounced among individuals with Cluster B personality disorders. Individuals diagnosed with borderline personality disorder (BPD) and antisocial personality disorder (ASPD) experience higher rates of substance misuse than the general population (Stetsiv *et al.*, 2023). Conversely, individuals seeking treatment for SUDs demonstrate a significantly elevated prevalence of co-occurring personality pathology compared to non-substance-using populations (Butelman *et al.*, 2026). This diagnostic overlap compounds clinical severity, contributing to marked emotional dysregulation, behavioral impulsivity, frequent psychiatric hospitalizations, heightened suicidality, premature treatment attrition, and elevated relapse rates.

*Address correspondence to this author at Department of Social Work, Winthrop University, USA, Email: alsejuit@gmail.com

THE STRUCTURAL GAP IN CO-OCCURRING CARE

Despite this clear diagnostic overlap, many treatment programs continue to operate within single-diagnosis frameworks. Addiction services frequently emphasize abstinence without addressing the underlying personality pathology that drives substance reliance, whereas mental health providers often target emotional regulation and interpersonal dysfunction while failing to address active substance misuse. Treating one disorder while overlooking the other consistently leads to diminished therapeutic engagement, elevated relapse rates, and recurring crises (Mancheño-Velasco *et al.*, 2024). A growing body of empirical literature supports integrated treatment models that address both disorders simultaneously. Coordinated care between mental health and addiction professionals yields superior treatment retention, reduced substance use, decreased psychiatric symptom severity, and improved global functioning compared to sequential or parallel care (Mancheño-Velasco *et al.*, 2024). Furthermore, Stetsiv *et al.* (2023) emphasizes the critical necessity of enhanced workforce preparation so that clinicians view co-occurring pathology through an integrated lens. Expanding comprehensive dual-diagnosis education within graduate counseling and social work programs, alongside robust post-graduate training pipelines, represents an essential mechanism to close this clinical gap.

Beyond individual clinical outcomes, untreated co-occurring personality and substance use disorders impose a profound financial burden on healthcare systems and broader public infrastructure. In the absence of early, specialized intervention, affected individuals require frequent high-acuity services, including emergency department utilization, acute psychiatric hospitalizations, medical detoxification, residential crisis stabilization, and criminal justice system involvement. Healthcare utilization is particularly elevated among individuals with BPD due to recurrent suicidal crises, non-suicidal self-injury, and involuntary psychiatric holds (Leichsenring *et al.*, 2023). Substance use disorders compound these expenditures through acute overdose management, treatment of associated infectious diseases, and prolonged rehabilitation efforts. When PDs and SUDs co-occur, the required level of care and associated costs far exceed those of either disorder alone (Butelman *et al.*, 2026).

This economic drain extends well beyond direct medical expenditures. Pervasive emotional dysregulation, chronic interpersonal conflict, and active substance misuse severely impair functional stability, leading to heightened rates of chronic unemployment, disability reliance, housing instability, child welfare involvement, and legal system processing. Recent findings further confirm that co-occurring personality and substance use disorders are linked to heightened suicidality and poorer overall treatment responsiveness than single-diagnosis presentations (Anona *et al.*, 2024). These compounding factors underscore the urgent clinical and economic necessity of early identification, integrated treatment delivery, and expanded workforce training. Although expanding specialized education and dual-diagnosis services requires an initial institutional investment, coordinated care provides a clear return on investment by mitigating repeated crisis utilization, supporting sustained recovery, and lowering cumulative healthcare expenditures across systems.

DIAGNOSTIC FRAMEWORKS FOR CO-OCCURRING PATHOLOGY

Substance Use Disorders (SUDs)

In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR), the umbrella diagnosis of substance use disorder (SUD) consolidates the previous DSM-IV categories of substance abuse and substance dependence into a single, dimensional continuum (American Psychiatric Association [APA], 2022). An SUD is defined as a problematic pattern of substance use leading to clinically significant impairment or distress, characterized by cognitive, behavioral, and physiological symptoms occurring within a 12-month period (APA, 2022).

The DSM-5-TR delineates ten distinct substance classes that can be diagnosed as specific use disorders, with severity categorized as mild (2 to 3 criteria), moderate (4 to 5 criteria), or severe (6 or more criteria). In standard clinical coding frameworks, mild presentations correspond to the .10 diagnostic extension, whereas moderate and severe presentations share the .20 extension. These standard categories include Alcohol Use Disorder (F10.10 mild, F10.20 moderate or severe), Cannabis Use Disorder (F12.10 mild, F12.20 moderate or severe), Opioid Use Disorder (F11.10 mild, F11.20 moderate or severe), Sedative, Hypnotic, or Anxiolytic Use Disorder (F13.10 mild, F13.20 moderate or severe), Cocaine Use

Disorder (F14.10 mild, F14.20 moderate or severe), Amphetamine or Stimulant Use Disorder (F15.10 mild, F15.20 moderate or severe), Hallucinogen Use Disorders (F16.10 mild, F16.20 moderate or severe), Inhalant Use Disorder (F18.10 mild, F18.20 moderate or severe), and Other or Unknown Substance Use Disorder (F19.10 mild, F19.20 moderate or severe). Tobacco Use Disorder follows a unique coding convention, designated as Z72.0 for mild cases and F17.200 for moderate or severe presentations (APA, 2022).

Clinical Example

A 34-year-old male presented for a clinical evaluation, reporting that his alcohol consumption had escalated significantly over the preceding three years following a transition to remote work. Although his drinking was previously limited to social settings, he reported consuming four to six alcoholic beverages nightly and eight to ten drinks daily on weekends. He described routinely intending to consume only one or two drinks during evening leisure time yet consistently losing control over his intake and finishing a six-pack of beer or opening a bottle of liquor. The client experienced chronic morning fatigue and fogginess, resulting in repeated tardiness and missed team meetings at work, culminating in a formal workplace reprimand two weeks prior. Additionally, his spouse reported that his evening intoxication led to increased marital conflict, irritability, and emotional disengagement from their young daughter.

Alcohol Use Disorder

A structured diagnostic assessment revealed that the client met five out of the eleven DSM-5-TR diagnostic criteria over the preceding 12-month period. Specifically, he demonstrated a failure to stick to self-imposed limits by consuming larger amounts over longer periods than intended, along with persistent, unsuccessful efforts to cut down or control his alcohol use. His drinking directly resulted in a failure to fulfill major obligations at work, evidenced by tardiness, missed meetings, and formal disciplinary action. Furthermore, he continued drinking despite persistent social and interpersonal problems, including ongoing marital distress and family strain. Finally, the client exhibited marked physiological tolerance, requiring increased quantities of alcohol to achieve the desired effect. Based on meeting five criteria, the formal diagnostic formulation yields a diagnosis of Moderate Alcohol Use Disorder, F10.20 (APA, 2022).

Personality Disorders

Personality disorders (PDs) are a group of mental health conditions characterized by engaging in patterns of thinking, feeling, and behaving that deviate from society's cultural expectations. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR), these patterns are not flexible, develop by adolescence or early adulthood, remain stable over time, and cause significant impairment in social, occupational, or other important areas of life (American Psychiatric Association [APA], 2022).

Unlike many mental health conditions that occur in episodes, personality disorders reflect long-standing patterns that influence how people view themselves, regulate emotions, relate to others, and respond to stress. These patterns often affect multiple areas of functioning, including family relationships, employment, education, and physical and mental health. Due to the fact individuals may see their behaviors and emotional responses as normal or consistent with their personality, they are less likely to seek treatment until symptoms become severe or another mental health condition, such as depression, anxiety, or substance use, prompts intervention.

The DSM-5-TR classifies ten personality disorders into three clusters based on shared behavioral characteristics. Cluster A includes Paranoid Personality Disorder, Schizoid Personality Disorder, and Schizotypal Personality Disorder, which are characterized by odd or eccentric thoughts and behaviors. Cluster B includes Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder, and narcissistic personality disorder and is characterized by dramatic, emotional, or erratic behavior. Cluster C includes Avoidant Personality Disorder, Dependent Personality Disorder, and Obsessive-Compulsive Personality Disorder, which are characterized by anxious or fearful behaviors (APA, 2022).

Cluster B disorders are particularly relevant when examining substance use because they share features such as impulsivity, emotional dysregulation, risk-taking, and unstable relationships. These characteristics increase vulnerability to substance misuse, and research consistently shows that people with Cluster B personality disorders experience significantly higher rates of SUDs than the general population (Stetsiv *et al.*, 2023).

Borderline Personality Disorder

One of the most frequently diagnosed and extensively researched personality disorders is BPD. It is characterized by pervasive instability in emotional regulation, interpersonal relationships, identity, and behavioral control. Individuals with BPD often experience intense emotional reactions, rapidly shifting moods, chronic feelings of emptiness, unstable self-image, and profound fears of abandonment that significantly interfere with daily functioning (APA, 2022).

BPD affects 1% to 3% of the general population but is far more common in psychiatric settings, where an estimated 15% to 25% of patients meet diagnostic criteria (Leichsenring *et al.*, 2023). It frequently co-occurs with depression, anxiety disorders, post-traumatic stress disorder (PTSD), eating disorders, and substance use disorders, making treatment more complex and increasing the risk of self-harm and suicide (White *et al.*, 2025).

The DSM-5-TR requires that an individual meets five or more of the following nine criteria for a diagnosis of Borderline Personality Disorder (APA, 2022): frantic efforts to avoid real or perceived abandonment; unstable and intense relationships marked by alternating idealization and devaluation; identity disturbance; impulsive behaviors in at least two self-damaging areas (e.g., spending, substance use, reckless driving, binge eating, or unsafe sex); recurrent suicidal behavior or self-injury; affective instability; chronic feelings of emptiness; intense or poorly controlled anger; and transient stress-related paranoia or dissociative symptoms.

Clinical Example

A 24-year-old woman becomes distressed when her partner does not respond to a text message for several hours. She interprets the silence as abandonment, repeatedly calls and texts for reassurance, then shifts to anger when she receives no response. Later that evening, she drinks heavily and engages in superficial self-injury to cope with overwhelming emotions. Although the situation appears minor to others, her reaction reflects emotional instability, fear of abandonment, impulsivity, and difficulty regulating emotions commonly seen in BPD.

Antisocial Personality Disorder

Antisocial Personality Disorder (ASPD) is marked by a long-standing pattern of violating the rights of others and disregarding social norms. Common features include deceitfulness, impulsivity, aggression, irresponsibility, reckless behavior, and a lack of remorse for harmful actions (APA, 2022). These behaviors typically begin during adolescence and often lead to significant legal, occupational, and interpersonal consequences.

The DSM-5-TR specifies that an individual must be at least 18 years old and have evidence of Conduct Disorder before age 15 for an ASPD diagnosis (APA, 2022). Additional diagnostic features include repeated unlawful behavior, dishonesty, impulsivity, irritability, reckless disregard for safety, consistent irresponsibility, and lack of remorse following harmful actions.

ASPD has one of the strongest associations with substance use disorders among all personality disorders. Shared traits such as impulsivity, sensation seeking, poor behavioral inhibition, and impaired decision-making increase the likelihood of early substance use and addiction (Arble, 2024). People with ASPD are also more likely to begin using substances at a younger age, develop more severe substance use disorders, relapse more frequently, and have poorer treatment outcomes than those without personality pathology (Low *et al.*, 2024).

Clinical Example

A 30-year-old man has a history of arrests for theft, assault, and driving under the influence. He frequently lies to family members for money, continues using illicit substances despite repeated legal and relationship problems, and shows little concern for the harm his actions cause others. When confronted, he minimizes his behavior and accepts little responsibility, demonstrating disregard for others and lack of remorse characteristic of ASPD.

CLINICAL EDUCATION AND INTERPROFESSIONAL TRAINING DISPARITIES

Disciplinary Disparities and Interprofessional Training Deficits

In an examination of workforce preparation, Fisher *et al.* (2014) observed that clinical training for co-occurring disorders "fell along disciplinary lines" (p. 634) when comparing social workers and addiction counselors. This finding aligns with prior literature indicating that social work curricula frequently underprepare graduates regarding the formal assessment and treatment of substance use disorders (Fisher *et al.*, 2014). Currently, structural differences

persist across accreditation bodies: while Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards often emphasize specialized intervention modalities that support targeted addiction tracks, many Council on Social Work Education (CSWE) accredited programs offer a broader generalist model wherein substance use content is couched within general psychopathology courses (Sejuit *et al.*, 2025). Furthermore, interprofessional educational deficits extend across the broader health professions. In a multi-disciplinary study evaluating faculty, staff, and trainees across medicine, pharmacy, dentistry, nursing, and graduate health sciences, Barenie *et al.* (2023) identified widespread challenges in clinical interactions with individuals diagnosed with substance use disorders, noting that stigmatizing attitudes among providers directly impaired the quality of therapeutic communication and care delivery.

Interprofessional Pipeline Models and Experiential Research Initiatives

To address these interprofessional educational deficits, targeted training frameworks have emerged to enhance workforce readiness. A prominent model is New York University's Substance Use Research Education and Training (SARET) program, established through a National Institute on Drug Abuse (NIDA) R25 education grant (Hanley *et al.*, 2018). The SARET curriculum was engineered to integrate core research topics into broader health professions curricula while providing a mentored summer research experience for in-depth clinical exposure across medicine, nursing, dentistry, and social work (Hanley *et al.*, 2018). Adapting this model to address regional health disparities in rural Appalachia, East Tennessee State University established the Mentored Substance Use Research (EMSUR) program (East Tennessee State University [ETSU], n.d.). The EMSUR program offers specialized population health and basic science tracks that recruit across public health, social work, psychology, nursing, health administration, and pre-medical studies (ETSU, n.d.; M. Ahuja, personal communication, June 10, 2026). Both SARET and EMSUR demonstrate how mentored interprofessional initiatives can effectively bridge generalist academic preparation and specialized addiction competencies.

The Educational Void in Personality Pathology and Antagonistic Traits

Despite these advancements in addiction education, a parallel, severe gap exists within training pipelines for personality pathology (Kimonis & Gooi, 2025; Levy & Ellison, 2022). Historical advocacy for specialized personality disorder training has focused on doctoral psychology programs, omitting master's-level disciplines such as social work, clinical mental health counseling, and marriage and family therapy (Kimonis & Gooi, 2025; Levy & Ellison, 2022). This disciplinary oversight is clinically concerning given that master's-level practitioners comprise much of the outpatient mental health workforce.

Even within doctoral psychology programs, specialized preparation remains remarkably scarce. In an analysis of 336 doctoral programs accredited by the American Psychological Association (APA) and the Psychological Clinical Science Accreditation System (PCSAS), Levy and Ellison (2022) found that only 16% maintained faculty dedicated to personality disorders as a primary research focus, and only 15% provided dedicated clinical practicum placements for treating personality pathology. Consequently, trainees routinely receive significantly less didactic coursework, clinical supervision, and direct experience in managing personality pathology and antagonistic traits compared to internalizing conditions such as major depressive disorder or generalized anxiety disorder (Kimonis & Gooi, 2025). This widespread lack of specialized exposure across both psychology and master's-level health disciplines reinforces systemic gaps in dual-diagnosis care.

LICENSURE AND CREDENTIALING FRAMEWORKS

State Level Credentialing-South Carolina

Although graduate students in clinical social work, mental health counseling, marriage and family therapy, and psychology receive foundational training in substance use disorders, generalist academic coursework is insufficient to satisfy state-level specialty licensure and credentialing standards. Jurisdictions such as South Carolina demonstrate this regulatory divide through explicitly mandated post-graduate clinical hours, specialized supervision, and board examinations required to treat substance use populations independently.

In South Carolina, specialty credentialing for addiction professionals is governed by two primary bodies: the South Carolina Department of Labor, Licensing and Regulation (SC LLR) and the Addiction Professionals of South Carolina (APSC). The SC LLR, which oversees state licensing boards for generalist

behavioral health professions, issues the standalone Licensed Addiction Counselor (LAC) and Licensed Addiction Counselor Supervisor (LACS) credentials (South Carolina Department of Labor, Licensing and Regulation [SC LLR], n.d.). Concurrently, the APSC offers the Advanced Alcohol and Drug Counselor (AADC) credential for eligible master's-level practitioners (Addiction Professionals of South Carolina [APSC], 2026). Obtaining the standalone LAC license requires holding a master's degree from an accredited program, completing 1,120 hours of post-master's clinical experience specifically within addiction treatment settings, accumulating 120 hours of direct clinical supervision under an LACS, passing a recognized national addiction examination, and fulfilling 40 hours of addiction-specific continuing education (Sejuit *et al.*, 2025). These rigorous post-graduate requirements underscore how state regulatory frameworks treat addiction treatment as an advanced, specialized domain distinct from generalist behavioral health practice.

State-Level Credentialing-North Carolina

In the neighboring jurisdiction of North Carolina, specialty practice in addiction treatment is governed by the North Carolina Addictions Specialist Professional Practice Board (NCASPPB). The board establishes four distinct application pathways (Criteria A through D) for clinicians seeking to obtain the Licensed Clinical Addiction Specialist (LCAS) credential, reflecting a combination of advanced education, specialized coursework, supervised practice, and national examination standards (North Carolina Addictions Specialist Professional Practice Board [NCASPPB], 2026). Standard eligibility criteria mandate that applicants hold a master’s degree or higher in a human services or behavioral health discipline, such as clinical social work, mental health counseling, or psychology, inclusive of a documented clinical internship. Additionally, candidates must complete 180 clock hours of board-approved substance use disorder training, complete a 300-hour specialized practicum covering core addiction counseling domains, document 4,000 hours of clinical work experience focused on substance use pathology, and achieve a passing score on the International Certification & Reciprocity Consortium (IC&RC) Advanced Alcohol and Drug Counselor examination (NCASPPB, 2026). As in South Carolina, these extensive postgraduate mandates reinforce the structural expectation that addiction treatment requires competencies far beyond generalist master's preparation.

National Credentialing

In stark contrast to the formal state licensing frameworks established for substance use disorders, neither South Carolina nor North Carolina offers a state-level license, endorsement, or specialty credential for the assessment and treatment of personality disorders. Because state regulatory boards treat personality pathology as falling under generalist clinical scope of practice, practitioners seeking specialized expertise must pursue post-graduate credentials through independent national organizations. For instance, clinicians specializing in borderline personality disorder frequently seek certification through the DBT-Linehan Board of Certification (DBT-LBC, n.d.). Earning the DBT-LBC credential requires clinicians to demonstrate rigorous treatment fidelity through standardized national examinations, direct video review of clinical sessions, and adherence rating scale assessments (DBT-LBC, n.d.). Beyond formal DBT certification, clinicians frequently pursue post-graduate training in complementary evidence-based modalities established by the primary developers of these clinical frameworks. Specifically, practitioners utilize Motivational Interviewing, pioneered by Miller and Rollnick (2023), to address treatment ambivalence in substance use disorders. To target personality pathology directly, clinicians may train in Mentalization-Based Treatment, formulated by Bateman and Fonagy (2016) to enhance reflective capacity and emotional regulation, or Schema Therapy, designed by Young *et al.* (2003) to restructure early, deeply ingrained maladaptive schemas.

Conversely, national credentialing options for substance use disorders are extensive across both health professions and medical specialties. For non-physician behavioral health clinicians, the National Certification Commission for Addiction Professionals (NCCAP), a division of NAADAC, issues advanced credentials including the Master Addiction Counselor (MAC), National Certified Addiction Counselor, Level II (NCAC II), and National Certified Adolescent Addiction Counselor (NCAAC) (National Certification Commission for Addiction Professionals [NCCAP], n.d.). Similarly, the National Board for Certified Counselors (NBCC) awards the Master Addictions Counselor (MAC) credential to qualifying counselors who complete specialized coursework and pass the Examination for Master Addictions Counselors (National Board for Certified Counselors [NBCC], n.d.). Internationally, the International Certification & Reciprocity Consortium (IC&RC) establishes

standardized competencies for credentials such as the Advanced Alcohol and Drug Counselor (AADC), Certified Clinical Supervisor (CCS), and Certified Co-Occurring Disorders Professional (CCDP/CCDP-D) (International Certification & Reciprocity Consortium [IC&RC], n.d.).

For medical providers and advanced practice nurses, formal subspecialty certifications further institutionalize addiction treatment within healthcare systems. Physicians can attain board certification in addiction medicine through the American Board of Preventive Medicine (ABPM, n.d.) or the American Board of Addiction Medicine (ABAM, n.d.). Psychiatrists can complete specialized fellowship training to earn subspecialty board certification in addiction psychiatry through the American Board of Psychiatry and Neurology (ABPN, n.d.). In advanced practice nursing, the Addictions Nursing Certification Board (ANCB), in collaboration with the American Association of Nurse Practitioners (AANP), offers board certification for Certified Addictions Registered Nurses at both general and advanced practice levels (ANCB, n.d.; AANP, n.d.).

This stark divide, wherein substance use disorders maintain robust state licensing and multi-disciplinary national credentialing, while personality disorders lack any state-level endorsement, further illustrates the systemic educational and regulatory gaps facing clinicians treating co-occurring pathology.

PSYCHOTHERAPEUTIC MODALITIES FOR PERSONALITY AND CO-OCCURRING SUBSTANCE USE

Diagnostic Evolution: From Categorical Constraints to Dimensional Models

Historically, personality disorders, particularly borderline personality disorder (BPD), were viewed as chronic, intractable conditions with limited treatment prognosis. Over the past two decades, however, empirical advances have fundamentally reshaped this perspective, demonstrating that structured, evidence-based psychotherapy can significantly reduce symptom severity, enhance interpersonal stability, and elevate functional outcomes (Kalin, 2025; Leichsenring *et al.*, 2023). Long-term longitudinal research further confirms that many individuals with BPD achieve sustained clinical remission or no longer meet diagnostic criteria over time when consistently engaged in specialized care (Jørgensen *et al.*, 2024). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR; American Psychiatric Association [APA], 2022) establishes psychotherapy as the primary first-line intervention for personality pathology. While psychotropic medications may assist in managing targeted symptoms or comorbid psychiatric conditions, they are not primary treatments for underlying personality structures. Because personality pathology reflects enduring, pervasive patterns of cognitive processing, emotional regulation, and interpersonal functioning, therapeutic interventions focus on cultivating adaptive coping mechanisms, restructuring core relational schemes, and stabilizing affective reactivity over time (APA, 2022).

Among the foundational psychotherapies applied to personality pathology, Cognitive Behavioral Therapy (CBT) serves as a principal framework for addressing maladaptive cognitive structures and co-occurring mental health conditions. Grounded in the premise that cognitive interpretations, emotional states, and behavioral responses operate interactively, CBT targets the identification and modification of persistent cognitive distortions (Kalin, 2025; Leichsenring *et al.*, 2023). Individuals with personality disorders often exhibit deep-seated cognitive biases; for example, an individual with BPD may interpret a delayed text message as imminent abandonment, whereas an individual with antisocial personality disorder (ASPD) may justify manipulative conduct under the belief that others are inherently hostile or untrustworthy. CBT assists clients in identifying these automatic thoughts, testing inaccurate core beliefs, and formulating balanced cognitive evaluations.

In addition to cognitive restructuring, CBT integrates behavioral interventions, such as systematic problem-solving, behavioral activation, coping skills acquisition, and direct exposure to anxiety-provoking stimuli, to improve daily functioning and mitigate affective distress. Much like personality pathology, substance use disorders are frequently treated using CBT, as well as Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), to resolve treatment ambivalence and alter reinforcement contingencies (Aalsma *et al.*, 2023; Guerrero & Khachikian, 2020). When applied to co-occurring personality disorders and substance misuse, CBT helps dismantle impulsive decision-making chains and cognitive rationalizations surrounding substance use (Guillot *et al.*, 2023). However, because traditional CBT alone may not fully manage the extreme emotional dysregulation and severe self-injurious behaviors characteristic of BPD, it is frequently augmented or replaced by dialectical behavioral approaches (APA, 2022).

Dialectical Behavior Therapy (DBT), developed by Marsha Linehan, stands as the gold-standard, primary psychotherapy for BPD. Designed to treat chronically suicidal individuals, extensive empirical evidence demonstrates that DBT significantly reduces suicide attempts, non-suicidal self-injury (NSSI), psychiatric hospitalizations, treatment attrition, and affective instability while enhancing interpersonal functioning and overall quality of life (Kalin, 2025; Leichsenring *et al.*, 2023; White *et al.*, 2025). The core theoretical framework of DBT synthesizes standard cognitive behavioral techniques with mindfulness and acceptance-based principles. The dialectical synthesis balances radical acceptance of current emotional experiences with the active acquisition of behavioral change skills across four core modules: mindfulness (cultivating non-judgmental present-moment awareness), distress tolerance (surviving crises without resorting to impulsive self-harm or substance use), emotion regulation (identifying and modulating affective states), and interpersonal effectiveness (asserting boundaries and maintaining relational stability). Long-term follow-up studies verify that skill gains achieved in DBT are maintained over extended periods, confirming its utility as a transformational treatment rather than a transient crisis management strategy (Jørgensen *et al.*, 2024).

The clinical utility of DBT extends directly into the treatment of co-occurring substance use disorders through Dialectical Behavior Therapy for Substance Use Disorders (DBT-SUD). Because individuals frequently utilize alcohol or drugs to temporarily escape overwhelming negative affect or interpersonal distress, DBT-SUD integrates explicit relapse prevention strategies with core emotion regulation skills. Integrated treatment protocols that address personality pathology and substance use simultaneously yield higher treatment retention, lower relapse rates, and superior emotional regulation compared to treating either condition in isolation (Mancheño-Velasco *et al.*, 2024; Stetsiv *et al.*, 2023). Recent research underscores the immediate temporal linkage between substance use and severe BPD behaviors; daily substance use significantly increases suicidal ideation during active therapy (McCool *et al.*, 2023), and acute alcohol consumption routinely precedes episodes of NSSI (Nance *et al.*, 2025).

The high comorbidity between personality disorders and substance use disorders is well documented throughout the literature. Individuals with dual diagnoses experience significantly heightened symptom severity, pronounced psychosocial impairment, higher rates of emergency medical utilization, and elevated suicide risk compared to those with single-diagnosis presentations (Butelman *et al.*, 2026; Stetsiv *et al.*, 2023). Rather than operating as isolated pathologies, the co-occurrence of personality disorders and substance use disorders is best understood through a comprehensive biopsychosocial framework, in which genetic predispositions, neurobiological vulnerabilities, and adverse environmental experiences interact dynamically across the lifespan.

Genetic Predisposition

Genetic factors contribute to the development of both personality disorders and substance use disorders. Rather than inheriting a specific diagnosis, people may inherit personality traits and biological characteristics that increase their vulnerability to psychopathology. Traits such as impulsivity, emotional reactivity, sensation seeking, and poor behavioral inhibition are linked to both Cluster B personality disorders and substance misuse (Guillot *et al.*, 2023).

For example, people with BPD often demonstrate heightened emotional sensitivity and impulsivity, whereas those with ASPD are more likely to exhibit novelty seeking and reduced behavioral inhibition. These inherited traits can increase the likelihood of experimenting with alcohol or drugs while making it more difficult to control substance use over time. A family history of substance use disorders may also reflect inherited differences in brain reward pathways and stress-response systems that increase vulnerability to addiction (Butelman *et al.*, 2026).

Evidence also points to shared biological mechanisms between ASPD and substance use disorders. Low *et al.* (2024) found strong associations between ASPD and multiple forms of substance misuse, suggesting that common genetic and neurobiological factors contribute to the development of both conditions. Rather than existing as separate disorders, PDs and SUDs share many of the same biological risk factors.

Although genetics contribute to vulnerability, environmental experiences often determine whether these vulnerabilities develop into clinically significant disorders. Childhood experiences, family relationships, peer influences, educational environments, and workplace stress all influence emotional development

and coping abilities throughout the lifespan. Individuals exposed to chronic adversity are more likely to develop maladaptive coping strategies, including substance use, particularly when underlying personality vulnerabilities are already present.

Environmental Factors

Home Environment

The home environment is one of the strongest influences on emotional and psychological development. Childhood adversity including emotional neglect, physical or sexual abuse, domestic violence, parental substance use, inconsistent caregiving, and chronic family conflict is associated with an increased risk of both personality disorders and substance use disorders (Leichsenring *et al.*, 2023). These experiences can disrupt secure attachment, emotional regulation, and healthy coping, leaving individuals more vulnerable to psychological distress later in life.

Children raised in unpredictable or invalidating environments often struggle to identify and regulate their emotions. As they grow older, some begin using alcohol or drugs to escape emotional pain or cope with overwhelming feelings. Over time, substance use may become a maladaptive coping strategy that reinforces the emotional instability already associated with personality pathology (Stetsiv *et al.*, 2023).

School and Work Environment

Environmental influences extend beyond the home. Bullying, peer rejection, discrimination, academic failure, unemployment, financial instability, and chronic workplace stress have all been linked to increased psychological distress and substance use.

People with personality disorders often experience difficulties maintaining healthy relationships, managing conflict, and regulating emotions. These challenges can contribute to repeated problems at school or work, limiting social support while increasing emotional stress. Marceau *et al.* (2023) found that people with co-occurring PDs and SUDs experience poorer psychosocial functioning than those diagnosed with either disorder alone.

As academic, occupational, and interpersonal functioning declines, some individuals turn to alcohol or drugs to cope with stress, creating a cycle in which substance use further impairs emotional regulation, decision-making, and overall functioning. Breaking this cycle often requires integrated treatment that addresses both personality pathology and substance use simultaneously rather than treating each disorder in isolation (Mancheño-Velasco *et al.*, 2024).

RECOMMENDATIONS FOR EDUCATION, CLINICAL TRAINING, AND POLICY REFORM

To address the profound clinical complexities of co-occurring personality disorders and substance use disorders, higher education programs and state licensing boards must expand specialized training across all Master's-level behavioral health disciplines. While clinical psychology doctoral programs frequently emphasize severe personality pathology, non-physician professions, including clinical social work, mental health counseling, and marriage and family therapy, require significantly greater curricular integration of both addiction science and personality frameworks. As Kimonis and Gooi (2025) argued, specialized evidence-based frameworks should be introduced early in clinical preparation alongside innovative pedagogical methods, such as deliberate practice and simulation-based training. Experiential learning allows trainees to build essential clinical distress tolerance, preserve the therapeutic alliance, and navigate challenging relational dynamics, such as hostility, boundary testing, or intense emotional dysregulation, prior to entering post-graduate practice (Kimonis & Gooi, 2025). Clinicians seeking advanced competency can further pursue rigorous post-graduate certifications, such as becoming certified through the DBT-Linehan Board of Certification (DBT-LBC, n.d.).

Institutional frameworks, such as New York University's Substance Use Research Education and Training (SARET) program and East Tennessee State University's Interprofessional Education program, illustrate effective models for structural reform. Recommendations synthesized from these pipeline models emphasize four core pillars for healthcare education: embedding interprofessional collaboration across multidisciplinary care teams, implementing early destigmatizing education to shift clinical attitudes toward complex populations, integrating modular digital curricula into core academic coursework, and providing hands-on research mentorship to cultivate future clinician-scientists. Implementing these interprofessional strategies ensures that future clinicians are equipped to treat dual-diagnosis presentations collaboratively rather than in isolation.

Crucially, the primary operational challenge facing behavioral health infrastructure is not whether

multidisciplinary framework mechanisms exist, but whether current behavioral health systems are structurally coordinated and clinically prepared to handle dual-diagnosis complexity. Standard generalist training programs correctly teach clinicians to recognize the boundaries of their scope of practice and refer out when necessary. When both the mental health system and the addiction treatment system consider a co-occurring presentation beyond their primary scope, however, the client is caught in a "referral vacuum." True integration requires expanding interprofessional education so that clinicians do not simply pass care across discipline boundaries, but actively co-manage complex presentations within unified, coordinated treatment plans.

Finally, state regulatory bodies and academic institutions must streamline the pathways for clinicians to obtain specialized credentials and maintain licensure. Educators and professional organizations should expand access to board-approved continuing education units (CEUs) focused specifically on substance use disorders, not only for ongoing license renewal, but as embedded coursework required for initial state licensing across national certification boards and state platforms, such as those in South Carolina and North Carolina. Furthermore, given that formal state-level specialty licenses exist for addiction but remain absent for personality pathology, state licensing boards should establish a dedicated specialty credential or formal practice endorsement for clinicians specializing in personality disorders.

Establishing formal state-level specialty credentials or practice endorsements for personality pathology serves three vital systemic functions. First, it ensures consumer protection and quality assurance by verifying that clinicians treating high-acuity personality pathology have demonstrated treatment fidelity in evidence-based modalities (such as Dialectical Behavior Therapy [DBT] or Mentalization-Based Therapy [MBT]) rather than relying on introductory continuing education workshops. Second, it establishes reimbursement parity with state addiction credentials, creating recognized billing mechanisms that incentivize healthcare systems and private practices to offer specialized, high-acuity care. Third, it provides scope-of-practice clarity and risk management, establishing explicit competencies for managing acute self-harm and severe emotional dysregulation within outpatient and community settings. Creating a recognized state credential would ultimately elevate standards of care, validate specialized clinical competency, and ensure that practitioners are systematically prepared to treat co-occurring conditions effectively.

LIST OF ABBREVIATIONS

Abbreviation	Definition
AADC	Advanced Alcohol and Drug Counselor
AANP	American Association of Nurse Practitioners
ABAM	American Board of Addiction Medicine
ABPM	American Board of Preventive Medicine
ABPN	American Board of Psychiatry and Neurology
ANCB	Addictions Nursing Certification Board
APA	American Psychiatric Association
APSC	Addiction Professionals of South Carolina
ASPD	Antisocial Personality Disorder
BPD	Borderline Personality Disorder
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CARN	Certified Addictions Registered Nurse
CBT	Cognitive Behavioral Therapy
CCDP	Certified Co-Occurring Disorders Professional
CCS	Certified Clinical Supervisor
CEU	Continuing Education Unit
CSWE	Council on Social Work Education
CU	Callous-Unemotional (traits)
DBT	Dialectical Behavior Therapy
DBT-LBC	DBT-Linehan Board of Certification
DBT-SUD	Dialectical Behavior Therapy for Substance Use Disorders
DSM / DSM-IV, DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders (4th Edition / 5th Edition, Text Revision)
EMSUR	East Tennessee State University Mentored Substance Use Research (program)
ETSU	East Tennessee State University
IC&RC	International Certification & Reciprocity Consortium
ICD-10	International Classification of Diseases, 10th Revision
LAC	Licensed Addiction Counselor
LACS	Licensed Addiction Counselor Supervisor
LCAS	Licensed Clinical Addiction Specialist
MAC	Master Addiction Counselor / Master Addictions Counselor
MBT	Mentalization-Based Treatment
MET	Motivational Enhancement Therapy
MI	Motivational Interviewing
NAADAC	National Association for Alcoholism and Drug Abuse Counselors (now the Association for Addiction Professionals)
NBCC	National Board for Certified Counselors
NCAAC	National Certified Adolescent Addiction Counselor
NCAC II	National Certified Addiction Counselor, Level II

NCASPPB	North Carolina Addictions Specialist Professional Practice Board
NCCAP	National Certification Commission for Addiction Professionals
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NSSI	Non-Suicidal Self-Injury
NYU	New York University
PCIT	Parent-Child Interaction Therapy
PCSAS	Psychological Clinical Science Accreditation System
PD	Personality Disorder
SARET	Substance Use Research Education and Training (program)
SC LLR	South Carolina Department of Labor, Licensing and Regulation
SUD	Substance Use Disorder

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