

Antisocial personality disorder (aspd) treatment strategies



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1. TREATMENT OF ASPD BY PHARMACOLOGICAL MEANS

Treatment of antisocial personality disorder by pharmacological means is notoriously difficult, mainly because of the problems with non-compliance due to the side effects of the medication at doses high enough to produce a therapeutic response. A recent paper by Walker has claimed spectacular results from Quetiapine which reduced symptoms of irritability, impulsivity, and aggressiveness together with improvements in hostility and rage reactions with minimal side effects and therefore good levels of compliance. We should note however, that this study was in adults and there is little data on the effectiveness of this regime in children. (Walker C et al. 2003)

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A brief overview of the literature on the subject shows that there is huge controversy surrounding the areas of treatment (both psychotherapeutic and pharmacological) of the psychopathic and antisocial personality disorders in general. They range from some (usually the older texts) which suggest that the condition is largely untreatable (viz. Cleckley, H. 1964) to others which offer varying degrees of evidence of success. Critical analysis would have to conclude however, that the different methods of treatment that have been tried have largely suffered from a lack of controlled follow-up research and that comparison of trials is rendered difficult because of the lack of consistency in both the definition and the diagnosis of the disorder. (Martens W H J 2000)

There does appear to be a general acceptance in the literature that the core antisocial behaviours associated with the antisocial personality disorder are <https://assignbuster.com/antisocial-personality-disorder-aspd-treatment-strategies/>

difficult to manage (Myers W C et al. 2006) and that the bulk of pharmacological treatment is aimed at the control of the associated behaviours. The main clinical dilemma which faces healthcare professionals is whether it is better to target the untreatable aspects of the condition, on the grounds that they are what usually caused to patient to come into contact with the healthcare professionals in the first instance, or to treat the associated symptoms which may be more responsive to pharmacological intervention. (Hodgins S et al. 2007)

With these caveats in place, if one focuses on the treatment options most commonly employed in antisocial personality disorder, then one can observe that the options can be broadly categorised as the neuroleptics, anticonvulsants, lithium, antidepressants, psychostimulants and benzodiazepines.

It should be noted that many of these medication categories will typically take a substantial time to exert optimal effect and compliance is frequently a problem rendering treatment assessment difficult.

The treatment options will be considered by category

### Neuroleptics

This group typically have a tranquillising effect of disturbed and aberrant behaviour patterns. Anger, hostility and tension levels can be reduced by low dose regimes and this drug group and are also helpful in dealing with specific psychotic episodes, but in typically higher doses. (Black, D. A. 2002)

### Anticonvulsants

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This category of medication is thought to have a number of actions on many of the neuropsychiatric syndromes, as well as the behavioural disorders, in addition to their direct anticonvulsant activity. (Hudziak J J et al. 2006)

Carbamazepine has been found to be helpful in situations of angry outbursts, self-mutilation and violence. It is postulated that it may work in this respect through its activity in the limbic system. There is also EEG evidence of reduced abnormal activity in the EEG traces of the most explosively violent patients with antisocial personality disorder. (Cowdry, R et al. 1998)

### Lithium

Lithium has also been demonstrated to reduce the incidence of emotionally unstable behaviour patterns. It does have the drawback of producing clinical sedation at the higher ends of the therapeutic spectrum and may also be associated with both tremor and lack of coordination. Constant supervision is therefore essential and this may be difficult in an uncooperative patient.

(Paris J 2005)

### Antidepressants

The antisocial personality disorder patient will often demonstrate mood disturbances which may be helped by the antidepressants. Children are not good candidates for some antidepressants, for example the MAOIs used in adult patients are not appropriate in the younger age group. Imipramine has been found useful in children who have panic attacks, mood swings and dysthymia and also in some obsessive children. The antidepressants tend to be used in clinical cases where lithium has failed. (Gunderson J G et al. 2006)

## Benzodiazepines

These are perhaps the most effective in the anxiety states and in cases of insomnia. Because of their fast onset of action, the Benzodiazepine group are useful in the acute behavioural disturbance, particularly in aggression. Some studies have highlighted the downside of benzodiazepine treatment. This includes not only the problems of habituation, but also the possibility of dysinhibitory effects in certain patients. Alprazolam is arguably one of the most effective agents in this therapeutic area but its use is complicated by cases of serious dyscontrol. In some studies, episodes of drug overdoses and severe self-mutilation required the immediate withdrawal of the medication. (Frank E et al. 2002)

## Psychostimulants

These are particularly useful in the younger patient where they are known to reduce symptoms of dysphoria and anxiety. There have been a number of well conducted trials in this area. Medications such as amphetamine and methylphenidate have proved useful in reducing behavioural disturbances children, particularly when there is an overlap between antisocial personality disorder and attention deficit syndrome. (Turgay A et al. 2002)

Some studies in this area have demonstrated good responses to both the tricyclic antidepressant group and the SSRI group, with fluoxetine appearing to be particularly favourable. The best studies however, do not claim a good response rate of higher than 27% in subjects with antisocial personality disorder. One should note also that some studies also record an apparent clinical worsening of their condition, with amitriptyline and haloperidol  
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producing increased levels of both aggression and hostility in some patients who did not exhibit these symptoms before treatment. The causal linkage was given further credence when it was found that these symptoms increased with longer duration of treatment and increased dosage of medication. (Tyrer P et al. 2004)

In conclusion, one can ponder the writing of Tyrer and Bateman who have written extensively on the subject of pharmacology of the personality disorders. When considering an appropriate drug choice for antisocial personality disorders and others, they note that any demonstrable neurobiochemical disorder may actually not be central to the condition, and may even be part of the peripheral syndrome (drug abuse etc.). to cite Tyrer:

The best that pharmacology and physiology can offer is the justification for trying drug treatment: it cannot predict its efficacy.

This argument can be followed in greater detail in the earlier writings of Cloninger:

Even when a dimension is agreed (e. g. affective instability as a core feature of borderline personality disorder) its definition may vary. Some see affective instability in terms of reward dependence, whereas others consider it as disinhibition. Which view is taken is of considerable importance when considering drug treatment. The author sees novelty-seeking as being determined through genetic predisposition via the dopamine system, whereas many others consider affective disinhibition to be related to the serotonergic system. When no biological marker is linked clearly to diagnosis answers can only be speculative. (Cloninger, C. R et al. 1993)

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## 2. TREATMENT BY CONVENTIONAL MEANS

Treatment by “conventional means” could be taken to include various psychotherapeutic approaches. A landmark study by Chiesa and Fonagy compared the results of a one-stage treatment model (in-patient treatment with no after care) with a two-stage model (shorter in-patient admission followed by outreach therapy) in a large cohort of patients with antisocial personality disorder (and other psychopathies). The paper is both long and complex, but, in essence, those patients treated in the two stage model did significantly better in both global assessments of mental health as well as assessments of social; adjustment.

Many papers refer to treatment regimes which, although varying in detail, tend to include elements of a socio-therapeutic programme which are generally managed primarily by the nursing staff, and a more formal psychoanalytic psychotherapy programme which tends to be delivered by medical and non-medical psychotherapists. The latter typically tends to target psychodynamic orientation and typically focuses on the interpretation of the internal conflicts of the patient, as well as on the confrontation and clarification of dysfunctional behaviour. It also will include analysis of institutional transferences as they become apparent during the treatment phase. (viz. Dolan, B et al. 2007)

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In very much the same way as we have observed in the context of pharmacological interventions, it would appear to be true that the literature relating to psychotherapeutic regimes suffers from difficulties inherent in <https://assignbuster.com/antisocial-personality-disorder-aspd-treatment-strategies/>

maintaining follow up and comparison of ostensibly similar trials because of the variations in both diagnosis and the nature of the various treatment regimes.

A number of sources place great emphasis on a holistic assessment of the patient's full history including their cognitive and affective levels of functioning. Particular attention should also be paid to the patient's criminal history if it is relevant (and it usually is) and to any available evidence of any previous behavioural disorder, including any associations such as attention deficit disorder. These factors will rely upon a combination of interviews, psychometric measures (including the MMPI scales, repertory grids and Hare's Psychopathy Checklist) and file information, in which records of social, psychiatric and criminal history can usually be found. (Soyka M 2000)

In addition to all of this, treatment decisions may also need to be based on factors and information which has been obtained from any number of independent sources such as family members, court records and victims.

Oldham states that an important element in treatment is as assessment of the degree to which the patient feels able to exert any control over the various aspects of their behavioural dysfunction as well as their own reaction to their perception of their antisocial activity and conduct. This latter element may necessitate enquiry into a number of lifestyle factors such as “deviant behaviour, including attitudes to self and others, interpersonal style and substance abuse”. (Oldham J M 2006)

All of these factors will have a bearing on the particular therapeutic approach to be adopted as well as an assessment of the patient's own intellectual abilities.

Lamberg points out that an important element in achieving any degree of success in treatment is to come to a realistic agreement with the patient as to the what both the healthcare professionals and the patient can expect as a result of the treatment programme adopted. Unrealistic attitudes or expectations on the part of either party are likely to lead to disillusionment and treatment breakdown. (Lamberg L 2006)

The fine details of the various treatment options are clearly beyond the scope of this essay and therefore they will be presented in overview.

Behaviour therapy

This type of approach effectively uses a mixture of learning theory and experimental psychology to the various maladaptions of the patient's behaviour. The (now largely outdated) reasoning behind this approach is that the patient is regarded as having learned abnormal behaviour patterns by inappropriate conditioning through interactions between their environmental past and their current environmental situations. (Gilligan J, et al. 2004).

Clearly this is not referable to the various associated organic syndromes which may present as comorbidities. Behavioural therapists therefore start from the assumption that all these behavioural aberrations can be both predicted and controlled. Their goal is therefore to use externally derived stimuli to either weaken or completely eliminate any of the unwanted

maladaptive behaviour patterns. In clinical situations, the therapeutic effect
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is sought through the mechanism of either positive or negative reinforcement techniques which can strengthen or enhance the desired behaviour pattern or occasionally through punishment mechanisms which make it less likely.

Robertson suggests that such techniques can be enhanced by the addition of other learning principles including “ avoidance, extinction, time-out, generalisation and discrimination” (Robertson M R 2000)

Aversion therapy appeared to be in vogue in the 1980s but is seldom used in current practice.

Other facets of behaviour therapy include the adoption of skills training where the patient learns appropriate responses to potentially aggressive encounters, the need to control anger, and the ability to deal with authority figures. (Kerr I B et al. 2007)

Cognitive approaches

This appears to be a more frequently used approach in the modern literature. It involves identifying, confronting and then questioning any maladaptive or irrational thoughts that the patient may have and establishing new cognitions to replace them. (Mack A H et al. 2003)

The basic concept behind this type of approach is that the clinical problems which are responsive to this type of intervention are disorders of either thought or feeling processes which modify or even dictate or behaviour patterns. It follows that modification of these maladaptive thought processes will change the maladaptive behaviour patterns. (Evenden J 1999)
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The commonest application of this technique is therapeutic modelling whereby treatment allows the patient to observe a competent, coping model of human

behaviour, and then embarking on a cognitive dissection in the hope that this will be reflected in the patient's future conduct. It has been successfully used in situations of response to provocation, physiological monitoring, assertiveness training, reappraisal, cognitive self-control, relaxation training and self-instruction. Cognitive approaches can be undertaken in either a group or individual basis. (Toone B 2004)

Individual and group psychotherapy

This approach differs from behavioural approaches (which focus primarily on externally observed behaviour patterns) insofar as it is primarily concerned with approaching the patient in an empathetic relationship which allows them to reach an understanding of what is happening in their own personal inner world

Freud believed that patients could both share and explore the underlying causes of their clinical difficulties and learn to change the psychological determinants through the process of experiencing of unrecognised forces in themselves. (Brown, D et al. 1979)

In broad terms, a psychodynamic approach to the treatment of antisocial personality disorder places emphasis on the " importance of personality structure and development, and is based upon the principle that antisocial behaviour is an expression of an underlying personality disturbance. Chronic

antisocial behaviour is held to reflect distortions in development and most particularly, the patient's primitive defences against trusting relationships". (Sugden S G et al. 2006)

Patients with antisocial personality disorder typically show damage to their ego strength and therefore their capacity to contain and manage various primitive anxieties and impulses. It follows therefore that a crucial part of psychotherapy is helping the patient to uncover the relevant mental states and meanings behind their behaviour patterns, and allowing them to explore and understand their feelings and maladaptive defence mechanisms.

(Grossman L S et al. 1999)

Therapeutic community approaches

Some authorities advocate the use of the therapeutic community. This involves a more democratic engagement between healthcare professionals and patients and encourages the more active participation of patients in their own treatment in addition to giving them a greater responsibility for the day to day running of their hospital community. It is hoped that this delegation of responsibility to patients in a 'living and learning' environment will help to encourage a more open expression of their feelings and a greater understanding and exploration of interpersonal relationships the lack of which is a major feature in antisocial personality disorder. The organisation and atmosphere in such a community is typically low key and fairly unstructured with regular meetings between the healthcare professionals and the patients. This type of approach is occasionally referred to in the literature as 'milieu therapy'. The therapeutic structure is that the

community allows for the provision of a combination of interventions such as pharmacotherapy, psychotherapy, cognitive therapy, group therapy and behavioural therapy. All of these elements are delivered by a wide range of staff from different professional backgrounds, so that the various patients in the community can receive different treatment packages, depending on their individual needs. (Connor D F et al. 2003)

3. ASSOCIATION OF ASPD WITH SUBSTANCE ABUSE

Another of the major themes apparent in the literature is the association of antisocial personality disorder with substance abuse. Part of the therapeutic regime should therefore include a direct approach to this element of the problem. It is known that the earlier the clinical manifestation of antisocial personality disorder (particularly at the age of 10 or younger) the greater is the risk of substance abuse in adolescent or adult life. (Joshi V et al. 2001)

It has also been shown that the involvement with substance abuse prior to the instigation of treatment is a predictor of poor therapeutic outcome. (Myers W C et al. 2006)

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Studies which have attempted to quantify the association of antisocial personality disorder with substance abuse have, almost without exception, identified the element of deceit on the part of the patients as being a major source of unreliability in their findings. Deceit is a commonly found behaviour pattern in antisocial personality disorder and the social stigma

associated with substance abuse makes the apparent need for deceit on the part of the patient more understandable.

Myers published a tour-de-force on the issues linking substance abuse and the adolescent with antisocial personality disorder. (Myers M G et al. 1998). A number of well constructed studies (viz. Windle M 2000) have stated that antisocial behaviour patterns diagnosed in children and adolescents are predictive of both adolescent and adult involvement in substance abuse with Robins going further and stating that conduct disorder (considered to be part of the same spectrum of conditions as antisocial personality disorder) is a strong prognostic indicator for both antisocial personality disorder and abuse of psychoactive substance in adulthood. (Robins L N et al. 2001). These observations have led a number of commentators to conclude that adult antisocial personality disorder and substance use disorders may share common aetiological pathways. This however, is rather speculative. There is some evidence that there may be a genetic link between the two but the situation should be regarded as “ not proven”. The two elements are certainly linked but the nature of the linkage is unclear.

The thrust of this theme can be considered further with the examination of an interesting viewpoint which is expressed by Fu (Fu. O et al. 2002) who was exploring the genetic background between antisocial personality disorder and alcohol dependence. The comments made in the Myers paper (cited above) relating to the possibility that antisocial personality disorder and substance abuse may have a common or related aetiology is given further credence by Fu’s work in which he cites evidence in studies by

Kessler and others for separate increased genetic susceptibility to antisocial  
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personality disorder, marijuana dependence and alcohol dependence. Both marijuana dependence and alcohol dependence have been found to be familial in some studies with monozygotic separated twins showing higher incidences than the normal population. (Kessler R C et al. 2006)

Slutske suggests that common genetic risk factors have been suggested to account for between 76% and 71% of the genetic association between antisocial personality disorder and alcohol dependence in twin studies. (Slutske W S et al. 1998) a finding that was replicated in the True study showing the possibility of a genetic link between antisocial personality disorder, alcohol dependence and marijuana dependence. It should also be noted that the same study reported the presence of a statistically significant genetic link between antisocial personality disorder and major depression which is believed to also be linked to increased risk of alcohol dependence. (True W R et al. 1999)

There is a disproportionately high prevalence of antisocial personality disorder amongst substance abusers. Those substance abusers who have antisocial personality disorder are likely to have started abusing earlier than their non-affected counterparts. (Carroll K M et al. 2003) . Other authorities demonstrate a preponderance of polysubstance abusers in substance abusers who have antisocial personality disorder with the same studies showing worse prognostic outcomes in this sub-set. (Cacciola J S et al. 2005)

If one considers the problem from a developmental viewpoint, some years ago Moffitt identified two distinct sub-types of deviance in adolescence. By far the largest group were those where the problem and challenging

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behaviour patterns begin and end before the end of adolescence. The second, much smaller group were those where the behaviour patterns persisted into adulthood. (Moffitt T E 1993). Studies which have attempted to further define these issues have suggested that early emergence of antisocial personality disorder (or conduct disorder in the child) together with a demonstration of these deviant behaviour patterns across a wide spectrum of settings are both good prognostic indicators of likely persistence of antisocial personality disorder and substance abuse into adult life. (Loeber R et al. 2003)

Moffitt (who has written extensively on this issue) proposes the concept of “snares” in which a number of features of the behaviour patterns of the antisocial personality disorder are critical in serving to limit options for the individual to escape their antisocial lifestyle. The concept that deeper commitment to drugs or alcohol may, in themselves, limit the “escape options” for pro-social behaviour or they may habituate the patient to environments which are more “risky” in terms of relapse. Both of these mechanisms unfortunately serve to perpetuate a deviant or antisocial lifestyle.

This concept can be considered further with the realisation that antisocial personality disorder and substance abuse expands into most of the major life domains. The problems that all sufferers with antisocial personality disorder have in areas such as school or work, interpersonal relations, and legal difficulties, are greatly increased by the coexistence of a problem with substance abuse. All these areas are clearly important to the developing adolescent persona. This also is reflected in the fact that such “high risk”  
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individuals increase their difficulty further by indulging in substance abuse and this, in turn, is associated with an increased persistence of antisocial personality disorder into adult life. The persistence of symptoms into adult life in this sub-group can be viewed as being associated with the presence of additional psychopathology. In the words of Moffitt

The substance abuse and emotional difficulties apparent in the group with antisocial personality disorder may well be reciprocally related in such a way that each serves to exacerbate the other. (Moffitt T E 1993)

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