ANTISOCIAL PERSONALITY DISORDER AND OUD

7TH SEPTEMBER 2022

ANTISOCIAL PERSONALITY DISORDER

"persons with this disorder are more commonly found in impoverished central city areas and many drop out of high school. There is a downward drift in the lives of these individuals who tend to make and lose money cyclically until they "burn out" in middle age, often accompanied by severe alcoholism and debilitation. Even though their impulsivity may improve with aging they continue to have struggles with work, parenting, and romantic partners. Some die prematurely." *Gabbard 2013*

ANTISOCIAL PERSONALITY DISORDER

- Common condition 1-2% to 6%. In the USA 3.6% lifetime prevalence.
- Men more than women – 4:1 - gender stereotypes?
- Common in mental health and judicial system, rising to up to 60% in the prison system.
- Associated with co morbidity
  - Other personality disorders
  - Other psychiatric disorders
  - Substances use disorders – comorbidity ranges from 42% to 95%
- Increased mortality – especially at young age due to reckless behaviour.

PUBLIC HEALTH IMPLICATIONS

- heavy demands on social services, mental health services, and the judicial system.
- a significant association with high levels of imprisonment.
- Social costs; broad impact on families, relationships, and social functioning.
- Treatment for those affected by violence costs an estimated 3% to 6% of the health budget in the U.K. *(Fonagy et al 2013)*
  - due to the association with substance use, suicide, early unnatural death, violent crime, unemployment, homelessness, and family violence
- In the U.K. prison population, the prevalence of people with ASPD has been identified as 63% male remand prisoners, 49% male sentenced prisoners, and 31% female prisoners. *(Fonagy et al 2013)*
- High health and non health service costs.
- High prevalence and psychiatric morbidity.

DSM 5

Symptoms & Criteria for Antisocial Personality Disorder

According to the DSM-5, there are four diagnostic criterion, of which Criterion A has seven sub-features.

A. Disregard for and violation of others rights since age 15, as indicated by one of the seven sub features:

1. Failure to obey laws and norms by engaging in behavior which results in criminal arrest, or would warrant criminal arrest
2. Lying, deception, and manipulation, for profit or self-amusement,
3. Impulsive behavior
4. Irritability and aggression, manifested as frequently assaults others, or engages in fighting
5. Blatantly disregards safety of self and others,
6. A pattern of irresponsibility and
7. Lack of remorse for actions (American Psychiatric Association, 2013)

The other diagnostic Criterion are:

B. The person is at least age 18,

C. Conduct disorder was present by history before age 15

D. and the antisocial behavior does not occur in the context of schizophrenia or bipolar disorder (American Psychiatric Association, 2013)

PATHOPHYSIOLOGY

- Genetics - Family studies of aspd suggest that children with one antisocial parent have approx. 16% likelihood of developing the disorder.
- Environmental abuse and neglect play a significant role.
- Genetic and environmental factors - interplay key.
- Genetic influence - greater for adolescent antisocial behaviour when parenting lacked warmth and showed greater negativity. (Feinberg et al., 2017)
- Psychopathy appears to have strong biological origins.
  - Role of 5-HIAA (hydoxyindolacetic acid)
  - Reduced amygdala reactivity to fearful faces.
  - Reduced thickness in the temporal cortex and reduced connectivity between the insula and the dorsal anterior cingulate cortex.
  - Lower autonomic nervous system responsiveness.

DEFICITS

- Internalisation
- Impairments and imbalances in the capacity to reflect about oneself and others
- Emotion recognition deficits
- Deficits in fear recognition in others
- Empathy – dysfunction of emotional resonance
- Emotional
- Psychopathy – lack of superego development

PSYCHOPATHY

- Psychopathy is an extreme form of antisocial behaviour.
- 1% prevalence in the general population, and 10–30% among incarcerated criminal offenders.
- the heritability of psychopathy is up to 50%, however the genetic background is unclear.
- There is no criteria for psychopathy in DSM 5.
- 20% -50% of individuals who meet criteria for ASPD also meet criteria for psychopathy.
- Hare's Psychopathy checklist aka PCL-R

PSYCHOPATHY PCL - R

Psychological Assessment:
A Journal of Consulting and Clinical Psychology
1990, Vol. 2, No. 3, 338-341

1040-3590/90/$00.75

The Revised Psychopathy Checklist: Reliability and Factor Structure

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The revised Psychopathy Checklist (PCL) is a 20-item scale scored from interview and file information. Analyses of data from 5 prison samples ($N = 925$) and 3 forensic psychiatric samples ($N = 356$) indicate that the revised PCL resembles its 22-item predecessor in all important respects. It has excellent psychometric properties, and it measures 2 correlated factors that were cross-validated both within and between samples. Correlations between the original PCL and the revised version approached unity for both the factors and the full scale. We conclude that the revised PCL measures the same construct as the original and that the PCL is a reliable and valid instrument for the assessment of psychopathy in male forensic populations.

PCL-R

- The Psychopathy Checklist-Revised (PCR) is a 20-item scale scored from interview and file information.
- The PCR includes 2 factors.
- Factor 1 is a measure of Emotional Detachment (e.g., superficial charm, manipulativeness, shallow affectivity, absence of guilt or empathy).
- Factor 2 is a measure of Antisocial Behaviour (deviance from an early age, aggression, impulsivity, irresponsibility, proneness to boredom). There is also a total score.
- 20 items are rated on a three-point scale (from 0 to 2) based on the degree to which the personality/behaviour of the subject matches the description of the item.

PCL -R

Items and factors in the Hare PCL-R.

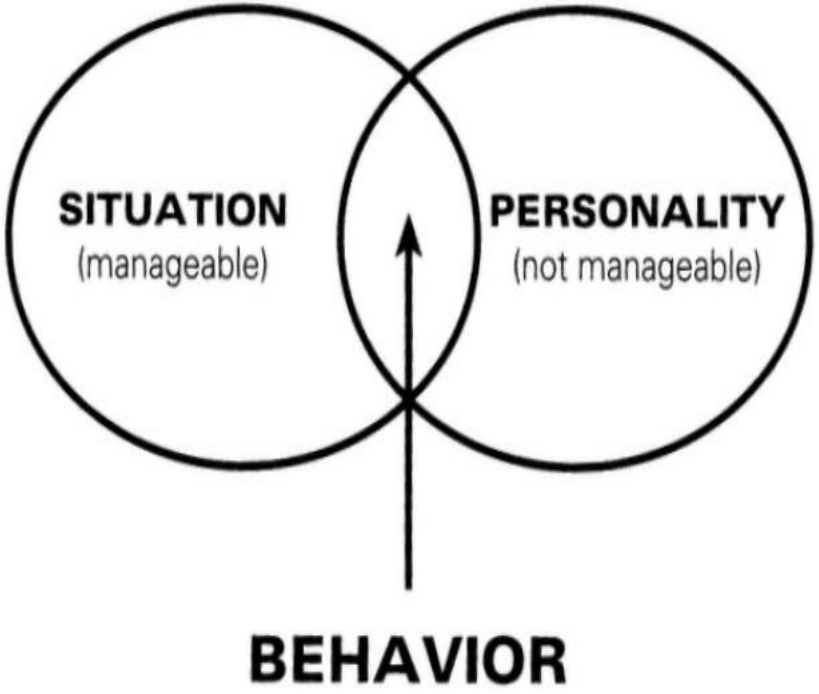
Interpersonal	Affective
1. Glibness/superficial charm	6. Lack of remorse
2. Grandiose self-worth	7. Shallow affect
4. Pathological lying	8. Lack of empathy
5. Conning/manipulative	16. Will not accept responsibility
Lifestyle	**Antisocial**
3. Need for stimulation	10. Poor behavioral controls
9. Parasitic lifestyle	12. Early behavioral problems
13. Lack of goals	18. Juvenile delinquency
14. Impulsivity	19. Revocation of conditional release
15. Irresponsibility	20. Criminal versatility

Note: The items are from Hare (1991, 2003). Note that the item titles cannot be scored without reference to the formal criteria contained in the PCL-R Manual.

TREATMENT

- Clinicians largely believe that psychological treatments are ineffective. (Bowers et al)
- Often rejected from mainstream services.
- Offered limited access to forensic psychiatric services
- Mentalisation – shown to be an effective treatment but limited availability.
- Emotion Recognition Training (ERT) - found to be effective for reducing problematic behaviours in children with high-callous unemotional traits.
- Easy access to effective treatment remains elusive.
- Consider risk issues – both static and dynamic.

FOCUS ON BEHAVIOUR CHANGE



PERSONALITY	BEHAVIOR
what we ARE	what we DO
CANNOT CHANGE	CAN CHANGE
a stable, consistent pattern of thoughts, behaviors and emotions.	is an expression of personality in context.

TREATMENT OF COMORBID OUD

- Treat the OUD
  - OAT treatment
  - Focus on behaviour change and stability
  - Recognize and expect key characteristics of the personality disorder
  - Those on treatment (methadone) who abstained were less likely to engage in antisocial behaviours and had fewer family conflicts and emotional problems. (Cacciola et al 1995)
- Benefits of counselling and CBT?
- CBT may be helpful for those with milder forms of ASPD who have insight and have a reason to improve eg risk of loss of employment ,or partner/ family.

ANGER MANAGEMENT?

- Anger is not explicitly included in the diagnostic criteria for antisocial personality disorder.
- Interventions for the treatment or management of aggression have been developed.
- More readily accessed than other longer form therapies. However, the relevance of anger management programs may be limited.
- while anger may be related to impulsivity and aggression, reducing anger may not reduce impulsivity and aggression.
- anger management interventions may reduce levels of anger without having an impact on offending, aggressive, or violent behaviours if the causes of those behaviours in an individual are unrelated to anger.

Addiction

AUSTRALASIAN PSYCHIATRY

Long-acting injectable buprenorphine – 'best practice' opioid agonist therapy for Australian prisoners

Australasian Psychiatry
2022, Vol. 30(4) 498–502

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SAGE

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Abstract
Objective: To consider opioid agonist therapy in prisons.
Conclusions: Given the substantial risks of substance misuse by prisoners, long-acting injectable buprenorphine should be adopted as 'best practice' treatment in Australian prison populations.

- A prospective study of prison-based OAT in England found a 75% reduction in all-cause mortality and an 85% reduction in fatal drug-related poisoning in the first month during imprisonment. *(Marsden et al 2017)*
- Similarly, studies from NSW have demonstrated that OAT is highly protective against death both post-release. and in the first month post-release first 6 months of release. *(Larney S., et al 2014 Degenhardt, L., et al 2014)*
- A data linkage study has shown that OAT given on release to 13,468 NSW prisoners with a history of opioid dependence was cost-effective and halved mortality in the first 6 months post release.*(Gisev, N et al 2015)*

A CASE MANAGEMENT INTERVENTION

Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 84, No. 2
doi:10.1007/s11524-006-9144-4

The Effect of a Case Management Intervention on Drug Treatment Entry Among Treatment-Seeking Injection Drug Users With and Without Comorbid Antisocial Personality Disorder

Jennifer R. Havens, Llewellyn J. Cornelius, Erin P. Ricketts, Carl A. Latkin, David Bishai, Jacqueline J. Lloyd, Steven Huettner, and Steffanie A. Strathdee

Injection drug users attending the Baltimore Needle Exchange Program who sought and were granted referrals to opioid agonist treatment were randomized to receive a strengths-based case management intervention or passive referral.

IDUs with comorbid ASPD who spent 25 or more minutes with their case manager prior to their treatment entry date were 3.51 times more likely to enter treatment than those receiving less than 5 min, adjusting for intervention status, race, and treatment site.

FULL TEXT ARTICLE

Personality mediators of psychopathy and substance dependence in male offenders

Anthony A.B. Hopley and Caroline Brunelle

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Abstract

Psychopathy and substance dependence (SUD) is highly prevalent in incarcerated populations and tends to co-occur in the same individuals. The factors underlying this relationship are not clearly understood. The primary purpose of this study was to investigate whether two personality models mediate the relationship between psychopathy and substance misuse in male offenders. Ninety-two inmates in provincial correctional centers in New Brunswick completed questionnaires, including the Sensitivity to Reward Sensitivity to Punishment Questionnaire to measure behavioral activation and behavioral inhibition, the Substance Use Risk Profile Scale to measure anxiety sensitivity, introversion/hopelessness, sensation seeking and impulsivity, and the Psychopathic Personality Inventory—Revised to assess psychopathy levels. Results revealed that high impulsivity indirectly mediated the relationship between psychopathy and stimulant dependence. In addition, low anxiety sensitivity indirectly mediated the relationship between psychopathy and opioid dependence. Finally, impulsivity indirectly and inconsistently mediated the relationship between psychopathy and alcohol dependence. These results suggest that individuals with psychopathic traits are at increased risk of misusing certain drugs due to underlying personality-based differences.

Recent research has suggested that a *one size fits all* approach to the treatment of addiction and psychopathy is outdated, and that individualized treatments targeting the specific risk factors that contribute to addiction are more effective than generic prevention and treatment programs

An increased focus on matching treatment to individual personality profiles may increase the success rate in this difficult to treat population.

REVIEW ARTICLE

Possible role of a dysregulation of the endogenous opioid system in antisocial personality disorder

Borwin Bandelow* and Dirk Wedekind

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Around half the inmates in prison institutions have antisocial personality disorder (ASPD). A recent theory has proposed that a dysfunction of the endogenous opioid system (EOS) underlies the neurobiology of borderline personality disorder (BPD). In the present theoretical paper, based on a comprehensive database and hand search of the relevant literature, this hypothesis is extended to ASPD, which may be the predominant expression of EOS dysfunction in men, while the same pathology underlies BPD in women. According to evidence from human and animal studies, the problematic behaviours of persons with antisocial, callous, or psychopathic traits may be seen as desperate, unconscious attempts to stimulate their deficient EOS, which plays a key role in brain reward circuits. If the needs of this system are not being met, the affected persons experience dysphoric mood, discomfort, or irritability, and strive to increase binding of endogenous opioids to receptors by using the rewarding effects of aggression by exertion of physical or manipulative power on others, by abusing alcohol or substances that have the reward system as target, by creating an "endorphin rush" by self-harm, by increasing the frequency of their sexual contacts, or by impulsive actions and sensation seeking. Symptoms associated with ASPD can be treated with opioid antagonists like naltrexone, naloxone, or nalmefene.

TREATMENT TIPS

- Set realistic goals that focus on behaviour change not personality change.
- Rules will be broken. Don't set too many treatment rules – only the key ones.
- If you encounter anger, deception and manipulation, don't be offended or surprised.
- Don't expect gratitude or apologies. The emotional expressions of others go unrecognized.
- Brief interventions to protect against threats to self esteem eg loss of employment or relationship can be effective.
- Consistency – maintain structure.
- Collaborate with other service providers
- Seek support and supervision
- **Key question**: Is a particular patient treatable under the circumstances?

MENTALISATION

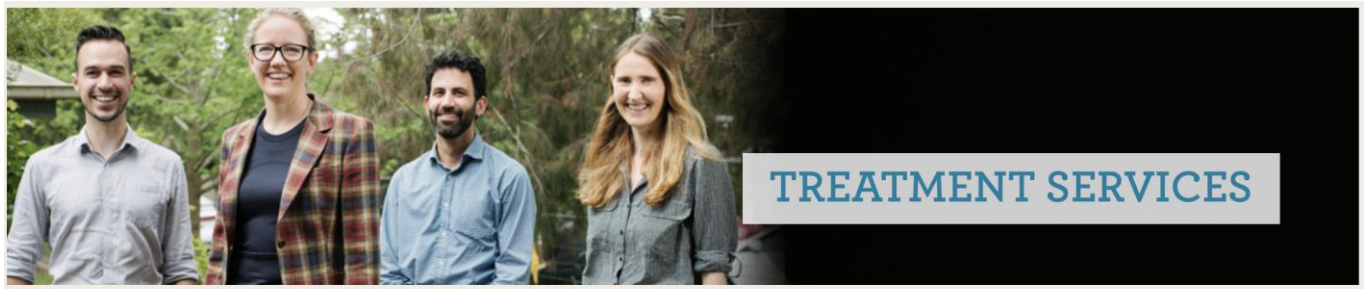
- Mentalising is the implicit or explicit perception or interpretation of the actions of others or oneself as intentional, that is, mediated by mental states or mental processes
- *"Mentalisation is the ability to understand the mental state of oneself or others that underlies overt behaviour."*
- Mentalisation can be considered as four intersecting dimensions: automatic/controlled or implicit/explicit; internally/externally based; self/other oriented; and cognitive/affective process.

MBT FOR ASPD

- Understanding emotional cues: external mentalizing and its link to internal states.
- Recognition of emotions in others: other/ affective mentalizing.
- Exploration of sensitivity to hierarchy and authority: self/cognitive.
- Generation of an interpersonal process to understand subtleties of others' experience in relation to ones' own: self/other mentalizing.
- Explication of threats to loss of mentalizing which leads to understanding of motivation: self/other mentalizing and self/affective mentalizing. *(Fonagy et al 2013)*

TREATMENT – MBT

spectrum
Specialising in Personality Disorder and Complex Trauma



You are here: Home / Treatment services / What kinds of treatments are available through Spectrum?

- Accessing treatment and services in Victoria
- What kinds of treatments are available through Spectrum?
  - The dialectical behaviour therapy (DBT) clinic
  - The mentalization based therapy (MBT) clinic
  - Wise Choices - the acceptance and commitment therapy clinic

The Mentalization Based Treatment (MBT) Clinic

Print

The Spectrum **Mentalization Based Treatment (MBT) Clini**c requires clients to attend individual and group therapy on a weekly basis. They meet in a context where relationships are actively engaged, and current life experiences examined and understood in terms of each individual's desire for change.

MBT is an evidence-based treatment approach initially developed and evaluated for treating adults with BPD. MBT focuses mainly on mental processes such as thinking, feeling, reflecting, remembering, desiring, or having beliefs. Through this approach, the MBT clinic offers clients an opportunity to reflect and learn more about themselves from the perspective of what is happening inside their own mind, as well as in the minds of others. Over time, this allows clients to gain new perspectives on what's happening in their lives and relationships. Clients also grow in understanding themselves, as well as understanding others.

Project ECHO®

St. Vincent's Hospital, Melbourne
Australia

HiROADS HIGH RISK OFFENDERS ALCOHOL & DRUG SERVICE

HiROADS is a specialist forensic alcohol and other drug (AOD) service designed to address the treatment needs of offenders with complexities that may increase their risk of recidivism.

This may include problematic substance use and difficulties reintegrating into the community upon release from a custodial setting, and those who may have difficulty engaging with other community based providers.

HiROADS is a dual diagnosis service, that aims to address the substance use and associated mental health issues.

Referrals **03 8417 0500 or email hiroads@caraniche.com.au**

TREATMENT AND SUPPORT IN AUSTRALIA - FORENSICARE

Victorian Institute of Forensic Mental Health

Forensicare

rvices / Community Forensic Mental Health Service / Problem Behaviour Program

Problem Behaviour Program

The Problem Behaviour Program provides psychiatric and psychological consultation and treatment for adults aged 18 years and over with a range of behaviours associated with offending and for whom services are not available elsewhere. The program is specifically directed at people known to have recently engaged in, or are at risk of engaging in, one or more problem behaviours, for example:

- serious physical violence
- threats to kill or harm others
- stalking (repeated unwanted contact)
- sexual offending, including adult sexual assault and rape
- paedophilia
- collection and possession of child pornography, including internet child pornography
- fire-setting
- querulous (vexatious) complainants.

The program provides primary and secondary and consultations, together with ongoing treatment for clients assessed as needing specialist forensic intervention.

Individuals may be referred as a condition of an order or parole. Alternatively, anyone may make a referral on behalf of another person, with their consent, or a person may self-refer.

More information

For more information download our Problem Behaviour Program brochure or telephone 9947 2500.

FORENSICARE – PROBLEM BEHAVIOUR PROGRAM

What are problem behaviours?

Problem behaviours are defined as problems associated with offending. They include:

- serious physical violence
- threats to kill or harm others
- stalking (repeated unwanted contact)
- adult sexual assault and rape
- paedophilia
- other problematic sexual behaviour related to offending (e.g. indecent exposure)collection and possession of child exploitation material including internet child pornography
- fire-setting

How to make a referral

Referrals to the PBP are made when a client:

- has significant behavioural issues associated with offending and requires a specialist risk assessment or management plan
- is unable to be managed due to high risk issues, and may benefit from treatment.

Referrals can be made for:

- people aged 18 or over.
- Individuals who have referral to the program as a condition of an order or parole (please note – these referrals will not necessarily be automatically accepted).

Anyone can make a referral on behalf of another person with their consent. Self referrals are also accepted.

Our services

Primary Consultation

A primary consultation involves the assessment of referred clients by a psychologist and/or psychiatrist. Depending on the complexity of the case, other mental health clinicians may also be involved in the assessment process.

Following the consultation, a risk assessment is completed and recommendations are made for the ongoing management of the client. This is documented in a report which is sent to the referrer.

Except for specialist work undertaken in partnership with the Department of Justice & Regulation, clients are seen at the Community Forensic Mental Health Service clinic, or by video conference link.

Secondary Consultation

A secondary consultation involves a discussion about a specific client, usually via telephone, between a Problem Behaviour clinician and the referrer. The client is not present during the consultation. The discussion aims to clarify issues and provide advice about ongoing management. A secondary consultation may lead to a primary consultation, if appropriate.

Tertiary Consultation

Tertiary consultations may involve developing the skills of staff in other services in areas such as agency approaches or procedures regarding risk management not related to a specific client.

Ongoing Treatment

Ongoing treatment and therapeutic work is provided to clients assessed with having treatment needs that will benefit from specialist intervention. This service is only available after a primary consultation.

Forensicare

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