



Treatment of antisocial personality disorder: Development of a practice focused framework



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ABSTRACT

There is little to no evidence of effective treatment methods for patients with an antisocial personality disorder (ASPD). One of the reasons could be the fact that they are often excluded from mental healthcare and thus from studies. A treatment framework based on 'state of the art' methods and best practices, offering guidelines on the treatment of ASP and possibilities for more systematical research, is urgently needed. This research involved a literature search and an international Delphi-study ($N = 61$ experts in research, management and clinical practice focused on ASPD). The results suggested important preconditions with regard to organization of care, healthcare workers and therapy. Conclusions are that there are many ways to coordinate effective treatment and management and work toward the increased availability of evidence based care for persons with ASPD.

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1. Introduction

Despite increasing efforts to develop, evaluate, and implement evidence-based treatments for mental health problems within forensic settings, relatively less attention has focused on populations with antisocial personality disorder (ASPD). However, the prevalence of ASPD is estimated at 3% for men and 1% for women in the general population (Gibbon et al., 2010; NICE, 2013), indicating that ASPD has a higher prevalence than schizophrenia which is estimated at less than 1% of the population in the US (McGrath, Saha, Chant, & Welham, 2008).

ASPD has been defined as "a pervasive pattern of disregard for and violation of the rights of others, occurring since the age of 15 years, with evidence of conduct disorder beginning even earlier" (American Psychiatric Association, 2000, p. 706). ASPD is a robust predictor of violent recidivism (Coid, Hickey, Kahtan, Zhang, & Yang, 2007; Jamieson & Taylor, 2004). Further, those with ASPD commonly have co-occurring substance use disorders, which result in functional impairments, lost productivity, and are related to and compounded by involvement in criminal behavior and antisocial peer groups (Cottler, Price, Compton, & Mager, 1995; Kessler et al., 1997; Lewis, 2011). Finally, ASPD is associated with increased mortality, particularly at a young age, largely because of reckless behavior (Black, Baumgard, & Bell, 1996). ASPD also

is a common disorder in forensic settings, with findings suggesting that approximately half of the inmates in Europe and North America meet criteria for ASPD (NICE, 2013).

ASPD thus poses a significant burden for society (including health and mental healthcare and the criminal justice system) when untreated (Quinsey, Harris, Rice, & Cormier, 1998). Despite the substantial societal and personal impact of this disorder, research on psychosocial treatments for ASPD is scarce, and no empirically-supported treatment has been identified (Davidson et al., 2009; Glenn, Johnson, & Rayne, 2013; Wilson, 2014).

Compounding this problem is the stigma attached to ASPD based on misconceptions, misinformation, and mistaken assumptions about the disorder. Recent research (Djadoenath & Decoene, 2015) suggests that practitioners' countertransference – sometimes supported by an incorrect perceptions of ASPD – could be an important impediment to investment in the development of treatments for this target group. This hypothesis is supported by the results of a study in which standard DBT was implemented in an outpatient forensic program for borderline and antisocial females (van den Bosch, Hysaj, & Jacobs, 2012). Analysis of the clinical and sociodemographic of forensic and non-forensic females showed that hardly a difference between the groups could be found. The diagnosis of ASPD often is an exclusion criterion for mental healthcare, and some consider hospital admission to be contraindicated for people with ASPD (Reid & Gacono, 2000), despite evidence of elevated suicide risk associated with ASPD (Verona, Patrick, & Joiner,

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2001). Therefore, even if people with ASPD do seek treatment - and there is no evidence that they are less likely than other clinical groups to seek treatment (Djadoenath & Decoene, 2015)- or benefit from it (Ogloff, Talevski, Lemphers, Wood, & Simmons, 2015), they may not receive the care they need. When people with ASPD are considered suitable for treatment, intervention often focuses on the co-occurring disorders like substance use and depression or on the consequences of the Axis II personality disorder such as suicidality or detention. Although suicidality and substance use are reasonable treatment targets, interventions more uniquely targeting ASPD features are rare and difficult for clients to find.

The literature highlights some treatment possibilities. Although evidence is scarce, the NICE guidelines (2013) promote group cognitive and behavioral interventions that focus on impulsivity, interpersonal problems and antisocial behavior, among other targets. Furthermore, guidelines suggest that, when a client's past is characterized by criminal behavior, the intervention should focus on reducing delinquent and other anti-social behavior, including components such as reasoning and rehabilitation (R&R) and enhanced thinking skills (ETS) (NICE, 2013). For juveniles from 17 years onward, the advice is to offer group therapy especially adapted to young delinquents (Davidson et al., 2009; Glenn et al., 2013). Together with cognitive interventions, schema focused therapy (SFT) and dialectical behavior therapy (DBT) are mentioned as possible treatment programs. Research has yet to highlight a treatment that would be considered well established, efficacious and specific for ASPD (Bateman, Gunderson, & Mulder, 2015), and no published studies to date have compared treatments, systematically examined predictors of outcome, or determined which ASPD patients are likely to benefit from certain treatments (Emmelkamp & Vedel, 2010; Evans, 2010). These limitations in the extant literature make it difficult for clinicians to use research to guide their practice with ASPD clients.

The primary aim of this study was to develop a practice-based framework to identify the necessary criteria and resources required to offer adequate treatment to patients with ASPD. Because an evidence-based practice framework requires a combination of clinical expertise with the best available evidence (APA, 2000), we addressed the best available research through a structured literature review and practice/clinical expertise through a Delphi study (further described below). The focus was on the treatment of ASPD as opposed to psychopathy. Despite evidence (Frick, Ray, Thornton, & Kahn, 2014; Guy, Edens, Anthony, & Douglas, 2005) and nosological systems (Kosson, Lorenz, & Newman, 2006; Gregory et al., 2012) clearly distinguishing ASPD from psychopathy - only 25% of the ASPD population can be diagnosed with psychopathy (Hare, 2003a) - these syndromes often are undifferentiated in study populations (Decoene et al., submitted for publication). In this article, we focus on ASPD as distinct from psychopathy. We make an exception when studies differentiate between factor 1 and factor 2 of psychopathy (Psychopathy Checklist- Revised, Hare, 2003b), given evidence (Lammers, 2007) that factor 2 correlates highly with ASPD symptomatology. For an overview of studies on psychopathy, using the PCL-R, see Chakhssi, de Ruiter, & Bernstein, 2010.

We focused on the following research questions:

- What evidence is available with regard to effective treatment for ASPD?
- What competencies does a mental health care professional require to be able to work with this target group?
- What are the possibilities for psychotherapeutic treatment for patients with ASPD?
- Which preconditions does an organization have to meet in order to be able to offer patients with ASPD the care they require?

2. Method

Data collection for this research involved (a) a literature search, and (b) a Delphi-study.

At the beginning of the literature search, four recent published reviews were appraised (Daghestani, Dinwiddie, & Hardy, 2001; Gibbon et al., 2010; NICE, 2013; Wilson, 2014), followed by a search for new published studies or missing research articles using MEDLINE/PubMed and PsycINFO. Search keywords were relevant to the target group (Antisocial Personality Disorder ASPD, ASPD and treatment; interventions; ASPD and substance abuse, detention), and we limited the review to RCT's. The reference lists of the systematic reviews (Bateman et al., 2015; Davidson et al., 2009; Duggan, Adams, & McCarthy, 2007; Duggan, Huband, & Smailagic, 2007; Duggan, Huband, & Smailagic, 2008; Edmunson & Conger, 1996; Emmelkamp & Vedel, 2010; Evans, 2010; Farrington & Welsh, 2006; Fonagy, Target, & Cottrell, 2002; Hollin, 1999; Landenberger & Lipsey, 2005; Lipsey, Landenberger, & Wilson, 2007; NICE guidelines, 2013; Warren et al., 2003; Wilson, Bouffard, & Mackenzie, 2005), and the Cochrane reviews (Gibbon et al., 2010; Khalifa et al., 2010) were searched for relevant additional trials. The search period was limited to January 2017. The search results were divided on the basis of the title and the abstract in order for the studies' summaries to be reviewed independently by two researchers. In the following phase, the references were reviewed as full texts. During the systematic review four inclusion criteria were used: (1) Randomized study controlled trial design, (2) focused on psychosocial interventions for patients with ASPD, (3) a minimum of 70% of the participants were adults or young adults, (4) diagnosis of ASPD was made using a validated semi-structured clinical interview, or in the case of psychopathy, the Psychopathy Checklist-Revised (Hare, 2003a), distinguished between factor 1 and factor 2, (5) diagnoses were made by trained clinicians on the basis of DSM-III (27) or DSM-IV (1), (6) experimental interventions based on well-defined, theory driven psychotherapeutic treatments, (7) control conditions or interventions consisting of 'no treatment', 'treatment as usual', 'clinical management', or 'a well defined other treatment', (8) the inclusion of published, validated instruments to measure outcomes, and (9) published in peer-reviewed journals.

In view of the objective to ascertain the competencies and conditions required for the treatment of ASPD, a Delphi-study constituted the second phase of our research. The Delphi-method focuses on the experience, insight, and "informed judgment" of clinicians. This method is particularly appropriate when the definition of the problem implies a degree of uncertainty. This uncertainty may be evident in the lack of information about causes and consequences, or more fundamentally, in the absence of a conceptual framework (Ziglio, 1996). In a structured way, knowledge is gathered from a group of experts, chosen because of their specific knowledge or experience with the research topic, using questionnaires or discussion rounds. The literature suggests a range of expert perspectives on ASPD; thus, the experts were chosen to represent this range. The data collection consists of multiple rounds. The goal of the first round is to gather as much information as possible using a series of semi-structured expert interviews. The goal of the subsequent rounds is to have experts comment on the anonymous results of the previous round(s) in order to test the researchers' analysis of the previous rounds and finally gain consensus among all experts in the study (Ziglio, 1996).

In our Delphi-study, the researchers, all members of an international expert platform on antisocial behavior formulated a number of semi-structured questions as a starting point to gather as much information as possible (see attachment). Based on information delivered by the Dutch Expert Centre on personality disorders, a selection was made from experts originating from forensic or general mental healthcare and represented a mix of mental healthcare professionals (e.g. clinical psychologists, psychiatrists, registered nurses), managers and researchers ($N = 61$). Nine of these experts (from the Netherlands and the USA) participated in a semi-structured interview (round 1). We asked them about necessary preconditions, preference for setting, professionals' attitudes, required competences of the care system, organizational preconditions, process of needs assessment and therapy

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