ANTISOCIAL PERSONALITY DISORDER: IS IT TREATABLE?

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Why care about ASPD?

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- Common condition – general prevalence 2-3%; up to 70% prison population
- Associated with considerable morbidity and mortality
- Costly both to the individual and to society
- Preventable and treatable (NICE Guidelines, 2009) but current lack of effective treatments and services
- Political interest in high-risk offenders: PD Offender Strategy

Demand on health services

- People with ASPD access many services
- Most in contact with primary care – but needs often not recognised
- Secondary mental health services treat some –but often only for other mental disorders
- Forensic mental health services often only take if co-morbid psychotic illness

Current treatment approaches

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- Not specifically for ASPD, but anger management, violence, general and sexual offending
- Most based in Criminal Justice System
- Mostly CBT
- Focus on high risk offenders e.g. DSPD, Offender PD Pathway
- Lack of treatment provision in the community

Not in our neighbourhood

Untreatable or untreated?

The treatment debate

- Political context – public protection versus individual rights
- Treatment aims - risk reduction versus health improvement
- Difficulties in engagement – ASPD patients tend to be treatment rejecting and in turn are rejected by service providers

- Diagnostic confusion – different subgroups of ASPD: psychopathic versus anxious

Punish or treat?

NHS
National Institute for
Health and Clinical Excellence

ANTISOCIAL PERSONALITY DISORDER

Implementing NICE guidance

NICE recommendations for treatment of adult ASPD (2009)

- General principles: Be aware of poor concordance, high drop-out, misuse of prescribed medication and drug and alcohol abuse.
- Psychological interventions: group based cognitive and behavioural treatments.
- Pharmacological interventions: only for co-morbid disorders, not for primary traits of ASPD (anger, aggression and impulsivity)
- Staff training, supervision and support

Lack of evidence base for ASPD

- Only small number of studies have been conducted among people with ASPD
- Challenges of working with ASPD – engagement, risk, substance misuse, co-morbidity
- Confusion over diagnostic criteria and conceptualisations of psychopathy versus ASPD
- Differences in defining and measuring outcome
- Focus on behavioural and symptomatic change rather than personality traits.

Cochrane review (2010)

- No study reported change in any antisocial behaviour
- Insufficient trial evidence to justify any psychological intervention for adults with ASPD
- ‘Further research is urgently needed for this prevalent and costly condition’

DSM-V criteria for ASPD

A. Pervasive pattern of disregard for and violation of rights of others since age 15:

- Failure to conform to social norms
- Deceitfulness
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness
- Reckless disregard for safety of self and others
- Consistent irresponsibility
- Lack of remorse

B. At least 18 years

C. Conduct disorder < 15 years

D. Antisocial behaviour not due to SZ or mania

Diagnostic confusion

- ICD-10 and DSM-V describe constellations of behaviours that may be the outcome of different aetiological pathways
- Psychopathy and ASPD not synonymous
- Assess psychopathy independently as a separate dimension
- Higher psychopathy scores predict poorer response to treatment
- Presence of anxiety and depression predict better response to treatment

Why MBT?

Why MBT?

- **Psychodynamic treatment developed by Bateman and Fonagy for Borderline Personality Disorder, shown to be effective in trials**
- **Mentalization model based on attachment theory**
- **Increasing evidence that a sub-group of ASPD is a disorder of attachment, particularly those who are less psychopathic**
- **Ability to mentalize protects against violence**

Why MBT?

- Trials of MBT for BPD have included patients with ASPD.
- In a trial comparing MBT with structured clinical management (SCM) which included problem solving and social skills, MBT was found to be more effective than SCM in patients with ASPD for reduction in hospital admissions, self-harm and suicide incidents and use of psychotropic medication.
- However, effectiveness of both was reduced when compared with BPD patients without ASPD.

What is mentalization?

- A focus on mental states in oneself and others, especially in explanations of behaviour (Fonagy, 2002)
- “The process by which we interpret the actions of ourselves and others in terms of underlying intentional states such as personal desires, needs, feelings, beliefs and reasons” (Fonagy and Bateman, 2008).
- An essential human capacity underpinning interpersonal relations

Normal development

- **Developmental process –normal mentalization develops in the first few years of life in the context of safe and secure child-caregiver relationships**
- **The infant finds its mind represented in the mind of the other, and develops a sense of self as a social agent, learns to differentiate and represent affect states, and regulate his impulse control.**

Abnormal development

- **Childhood neglect, emotional, physical or sexual abuse disrupt this developmental process.**
- **Inadequate maternal responses and disorganized attachment undermine the capacity to mentalize, so that internal states remain confusing, unsymbolized and difficult to regulate.**

The antisocial mind

- **Primitive affects, defences, and modes of thinking**
- **Inadequate affect regulation**
- **Emotions of toddler – envy, shame, boredom, rage and excitement**
- **Lack of more mature emotions: guilt, fear, depression, remorse and sympathy**

Treating toddlers?

Mentalizing in ASPD

- Antisocial characteristics stabilize mentalizing by rigidifying relationships e.g. gang hierarchies
- But when relationships are challenged, mentalization collapses and violence can result
- Feelings of shame, vulnerability and humiliation cannot be controlled by representational and emotional processing, but only by violence and control of the other person

Mentalization and violence

- Violence in ASPD is a defensive response to feelings of shame and humiliation, which have their roots in disorders of attachment.
- Violence occurs when there is an inhibition in the capacity for mentalization
- Mentalization protects against violence.

Pilot trial over 2 community sites

Research hypothesis and questions

- **MBT improves interpersonal functioning and capacity to think rather than act, resulting in improvements in frequency of violence, psychiatric symptoms and psychosocial function**
- **Does participation in an MBT-ASPD programme for 18 months result in**
  - **A) reduction in aggressive acts**
  - **B) improvement in indices of psychological functioning**
  - **C) lower use of services**

Participants

Inclusion criteria

- **Men over 25**
- **SCID-2 diagnosis of ASPD**
- **Evidence of aggressive acts in 6 months prior to assessment**
- **Willing to accept treatment**
- **Able and willing to provide written informed consent**

Exclusion criteria

- **Current diagnosis for schizophrenia or bipolar disorder**
- **Substance or alcohol dependence**
- **Psychopathy score above 25**
- **Learning disability or significant cognitive impairment**
- **Inadequate English to participate in informed consent and group therapy**

The patients

- Age – thirty to fifty
- Depression and anxiety prominent
- Moderate psychopathy scores
- History of drug and alcohol abuse, some still abusing
- All report difficulties in interpersonal relationships
- Many are socially isolated, afraid to go out for fear they will act on violent impulses

MBT-ASPD treatment programme

- **Initial assessment including psycho-education**
- **Weekly group therapy (slow open group) plus monthly individual therapy for 12 months**
- **Crisis and risk management and psychiatric review**
- **Psychotropic medication only for co-morbid conditions, not ASPD per se**
- **Manualised treatment, video recording of sessions and supervision to ensure adherence to model**

Principles of treatment

- **Focus on techniques that facilitate mentalizing**
- **Focus on violent and aggressive behaviours outside and within the group and link to internal states**
- **Focus on improving self-regard and social and interpersonal awareness**
- **Avoid interventions aimed at considering effects of actions on others e.g. victim empathy**

Who’s is in charge?

Hierarchy and power

- ASPD patients experience relationships in terms of power and control
- Avoid assuming position of power in relation to patient, by readily apologising for perceived errors and accepting criticism
- Developing shared code of conduct is key task of group
- Highlight and explore their own code of conduct by discussing interactions with others and what leads to violence

Establishing a group process

- Lack of engagement and dropout
- Attendance a major issue, difficult to maintain themes which arise from one session to the next
- Slow but general development of solidarity between group member, supportive feel to the group
- Tendency to mentalize their own experiences, much more difficult to think about others' thoughts and feelings

Group cohesion

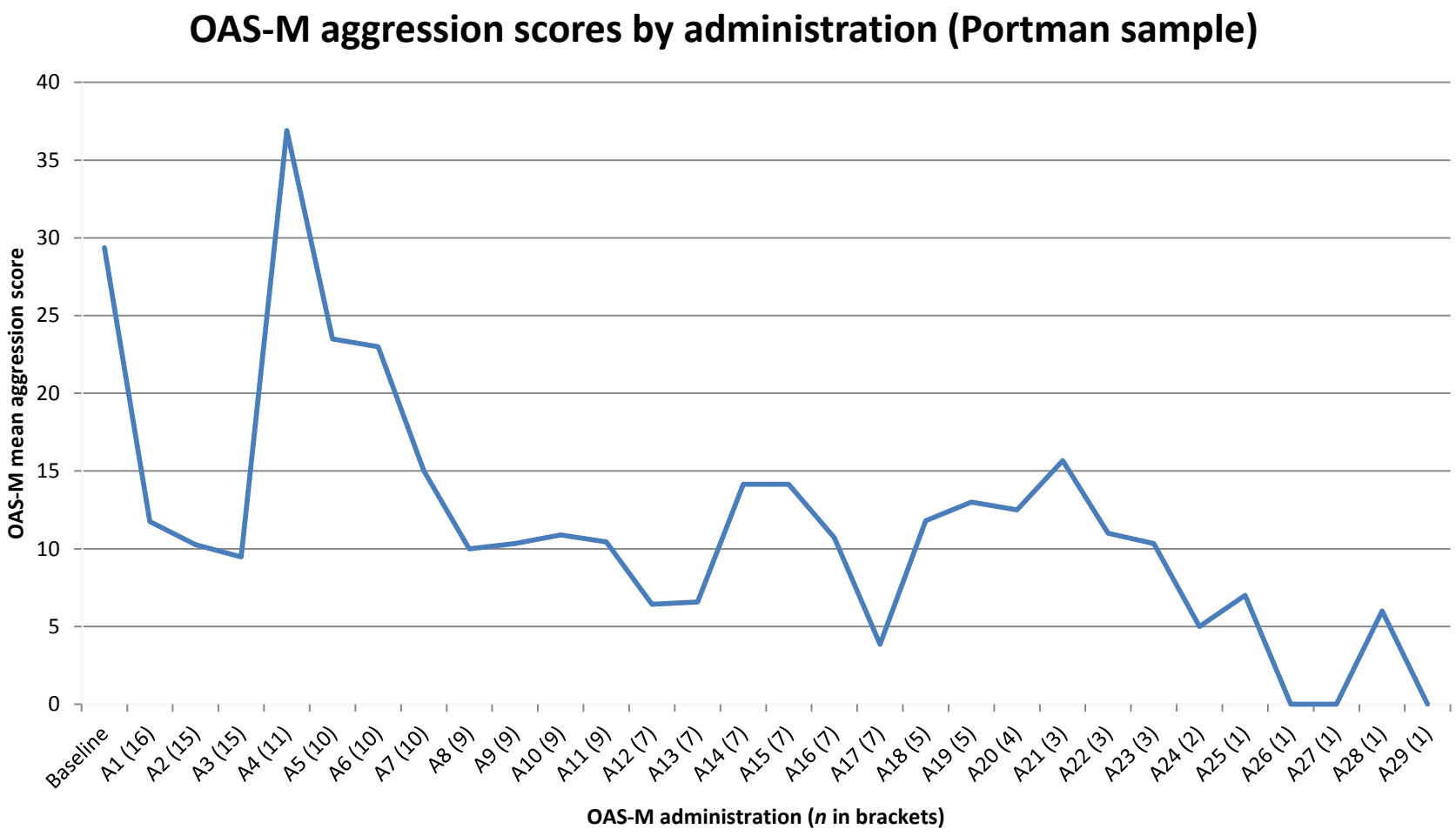
Shame and disrespect

- **Anger easily activated when describing emotive topics – mentalization stops at this stage**
- **Threat to self-esteem and shame common trigger for violence 'walking on egg shells'**
- **Need to be careful about expecting patients to examine their feelings – often feel stupid or unable to put feelings into words**
- **Hypersensitivity to being criticised or corrected - 'narcissistic fragility'**

Pilot results

- Problems with engagement, drop-out, attendance, minor boundary violations
- 1/3 drop out rate
- Those that do complete treatment show significant decrease in self-reported aggression on OAS-M, and scores on Brief Symptom Inventory

Overt Aggression Scale – Modified mean aggression scores from Baseline assessment to Administration 29



Furthering the PD Offender Pathways Strategy

- Development of new MBT/ASPD community services across 12 sites in England and Wales
- Sites are current Probation Trust/Health Service Providers delivering the Personality Disorder (PD) community service specification
- Services delivered jointly in probation premises by probation staff and health service provider clinicians
- Initial pilot feasibility RCT in 4 sites with view to expanding RCT to all sites

Participating sites

LONDON

- East London
- North London
- Southeast London

SOUTH

- Bristol
- Devon and Cornwall
- Wales

MIDLANDS

- Nottinghamshire
- Lincolnshire
- Staffordshire

NORTH

- Yorkshire
- Lancashire
- Merseyside

Collaborators

- Prof Anthony Bateman
- Dr Colin Campbell
- Dr Jackie Craissati
- Prof Peter Fonagy
- Dr Nikki Jeffcote
- Dr Paul MacAllister
- Dr Anna Motz
- Dr Phil Minoudis
- Dr Celia Taylor
- Dr Nick Wakefield
- Dr Andrew Williams
- Dr Heather Wood
- Dr Jessica Yakeley