Approaches to Antisocial Personality Disorder, Substance Use and Violence

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Abstract

As antisocial personality disorder is getting more often diagnosed, more solid treatment basis should be constructed and in a more widely manner considering that this disorder is accompanied by worrying complications such as substance use and violence. At the present time treatment for this group of patients is extremely limited along with long-term monitorizing, and very few therapeutic approaches have been discovered to be effective. We are more likely to observe contradictions than specific guidelines in this matter. Diagnosing and treating antisocial personality disorder are profoundly affected by comorbid disorders such as substance use and violent behavior. Such issues both complicate the therapeutic process and make the clinicians embrace a negative perspective regarding the possibility of recovering these patients.

Keywords: *Antisocial personality disorder, violence, comorbidity, substance use*

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I. INTRODUCTION

Antisocial personality disorder (as referred to as ASPD) is characterized by a model of disrespecting and defying the rights of others through irresponsible, impulsive, aggressive and deceiving behavior (Daughters, et al., 2008). It is described as a pattern of antisocial and irresponsible behavior which develops from the age of 15 but can only be diagnosed as the person reaches 18 years old (Moss, Panzak, & Yao, 1990). The highest prevalence of this disorder (over 70% of the cases) was identified in samples of male subjects who also presented alcohol consumption disorders or were part of substance abuse treatment institutions, jails or correction institutions. Also, the prevalence is higher in samples of people coming from unfavorable socio-economical or socio-cultural environments (American Psychiatric Association, 2013).

Two particular aspects should be considered in approaching ASPD namely substance abuse and violence because the disorder is most commonly found to come with these two complications. People who suffer from ASPD cannot tolerate boredom and find themselves in a permanent state of tension, which makes them vulnerable to becoming alcohol and drug addicts (Daughters, Sargeant, Bornovalova, Gratz, & Lejuez 2008; McMurran, 2009). Considering violence, ASPD patients compared to non-ASPD are exposed to a higher probability of engaging in acts of violence towards others. The sooner aggression and violence are installed, the higher are the chances that it persists at mature age. This fact is seen as proof of a continuous in-born aggressive behavior, developed from childhood and that the disorder evolved from an early age, thus making prevention a priority even though the understanding upon this disorder is still quite limited (De Brito, Viding, Blackwood, & Hodgins, 2013).

II. ASPD AND SUBSTANCE USE

It should be noted that substance use issues are approached by psychiatry under the umbrella of emergency-related behaviors as they are often associated with pathological manifestations which sight this type of intervention including acute intoxication, harmful use, dependency syndrome, withdrawal states, psychotic symptoms and other cognitive disorders, to name some (Mihăilescu, Prelipceanu, & Udangiu, 2000).

Substance abuse is known as a harmful type of alcohol or other substances use which can lead to dependency or addiction which can manifest as physical, psychological or both (Feldman, Olds, & Papalia, 2010, p. 366). Dependency is characterized by the tendency of progressively increase drug doses and the impossibility of ceasing the use even for a few days, as withdrawal interferes. Also, it sights a behavioral disorder defined by the strong, compulsive wish of using a

psychoactive substance, the difficulty of ceasing the use and behaviors of actively and invasively seeking the drug (Dobranici, Tudose, & Tudose, 2011).

Substance use issues are also investigated under the aspect of psychological or physical dependency. Psychological dependency is defined by the consumer's beliefs that they need the substance in order to face their problems while the physical dependency is defined by the physical concrete modifications associated to drug use, with consequences related to withdrawal symptoms and tolerance levels. Although diagnosing is important in order to find the best treatment, the most essential aspect is to identify and treat the risk factors which contribute to the substance use (Blume, 2011).

ASPD tends to be excessively diagnosed among drug users, because substance use often implies illegal activities which allow access to the drugs (Blume, 2011). Individuals with ASPD tend to be irritated, physically aggressive, impulsive, behave recklessly and present high levels of substance use, as the disorder has been identified as an etiological factor for both alcohol and other substances use (Moss, Panzak, & Yao, 1990).

Daughters, Sargeant, Bornovalova, Gratz, and Lejuez (2008) hypotheses that ASPD drug users may show lower levels of stress tolerance compared to other drug users and concluded that stress tolerance can be regarded as a key-factor in understanding the disorder's development, establishing the basis for further and adequate interventions for this group of patients.

Myers, Stewart & Brown (1998) have investigated conduct disorder progression related to ASPD among patients treated for substance use in adolescence. Their findings show that ASPD at maturity and ASPD associated with drug use present common etiological grounds. The study have shown a higher rate of progression for ASPD among teenagers who abused drugs and suggest that a careful assessment of behavior disorders during treatment may be useful in planning and applying the suitable treatment, as the authors of the study suggest.

III. ASPD AND VIOLENCE

The other complication that comes with ASPD, as mentioned, is violence, which includes aggressive behaviors using physical, verbal, economic, political or moral force with the purpose of dominating the victim; the latter is basically reduced to the state of an object as they was spatially or vitally invaded by the aggressor. Violence represents a destructive act that cannot in no way be justified by the contemporary society and may lead to the victim's harm, social isolation or death (Muntean & Munteanu, 2011, pp. 13-24).

Violent behavior is one of the traits of ASPD. Among children with conduct disorders, the most exposed to developing ASPD were the ones who presented antisocial behavior consisting in physical aggression and violence (De Brito, Viding, Blackwood, & Hodgins,

2013). Violence was regarded as an occurring routine and believed to be necessary in order to reach social and personal objectives such as obtaining and maintaining social status in a violent environment and the perceived moral right of harming others if necessary. According to Glibert and Daffern (2011) we may encounter such believes among violent criminals which present criteria of ASPD.

A study conducted by Babcock & Ross (2009) focused on men who physically abused their partners and hypotheses that ASPD male partners may show the highest levels of proactive violence while those who only presented co-morbidity might be reactively violent. Result show that violence perpetuated by men with different personality structures function differently respectively men with ASPD use both reactive and proactive violence. This means that they use violence both when they perceive instigation and also as a modality of controlling their partners (Babcock & Ross, 2009).

Another study (Dolan & Fullam, 2004) focused on the applying the Theory of the Mind (ToM) on ASPD samples and was based on proof that ToM involves the same neuronal circuits which contribute to the pathogenesis of ASPD. The results suggest that for most criminals who present both ASPD and psychopathy ToM abilities may be relatively intact and serve them as an adaptive function in maintaining their criminal life-styles. Their key deficiencies mostly refer to their lack of worry regarding their impact upon potential victims and less of incapacity of perceiving the victim's perspective (Dolan & Fullam, 2004).

IV. CLINICAL APPROACH TO ASPD

Meloy, Psych, and Yakeley (2011) bring to discussion useful aspects to be considered while approaching patients with ASPD. As the authors note, most of psychiatrists are reserved in treating these patients because of a recurrent belief that they are untreatable, which has further led to lack of trustful guidelines for the treatment of ASPD.

The authors point out that the treatment should be set up in a manner that ensures the safety of both the patient and the involved mental health personnel and have noticed that under such conditions it is very likely that the patients would respond positively. They also show that before planning the treatment, the degree of psychopathy is essential to be assessed as correctly as possible as treatment response is most predictable among patients who show moderate psychopathy along with ASPD and who perceive the normative consequences of their actions or are aware of the emotional or concrete pain caused by their actions.

On the other hand it would be less likely to obtain results with high psychopathy ASPD patients based on the deficits of learning passive avoidance, their incapacity of foreseeing long-

term consequences of their actions and the lack of capacity to reflect upon the past (Meloy, Psych, & Yakeley, 2011).

Also they warn that the necessary trust between the therapist and client is more difficult to establish because of the incapacity of ASPD patients to invest trust and responsibly engage.

Cognitive-behavioral and social learning techniques are the most frequently used in treating ASPD and refer to prevention programs which combine cognitive and social abilities and problem solving, anger and violence management.

Group-based interventions may be the most effective as they emphasize the behavior effectiveness in reducing antisocial behavior and modifying patterns of thinking of the individuals with ASPD (Meloy, Psych, & Yakeley, 2011).

Cognitive-behavioral methods combined with developing social competencies and problem solving have offered the best results both among teenagers and adults. Despite the positive results, even such complex interventions did not succeed in major reduction in operating with mix groups and there is limited proof regarding the efficiency of cognitive-behavioral therapy under different situations for ASPD patients and issues of abusive use of substances (Bateman, Gunderson, & Mulder, 2015).

Among the main issues that Meloy, Psych, & Yakeley (2011) consider to be essential in approaching the ASPD patient we may find the clinician's emotional reaction to treating or helping manage risks of the patient? According to the authors, treating the ASPD patient should include six principles: determining the level of psychopathy during diagnosing, with special care to anxiety, connection and awareness; identifying all treatable aspects (mental health issues or drug use); discovering situational and environmental factors which can aggravate the patient's behavior; admitting the probability of possible legal involvement; starting the treatment only if has been proven to be effective and self for both the patient and the clinician as traditional approaches exclude the possibility of engaging in such a process; paying extreme care to any counter transference-type of reaction as it might bring new perspectives to the inner world of the ASPD patient and might somehow confirm the severity of their psychopathy.

Among such reactions we may encounter: therapeutic nihilism, illusory therapeutic alliance, fear of assault or harm, denial land misleading, lack of hope and guilt, devaluing and losing professional identity, hate and wish of destruction, assuming psychological maturity, being fascinated, being enchanted or sexually aroused. Such reactions seem to be possible indifferently of the type of applied treatment and will be more obvious the more the psychopath levels of the patient will manifest; also they should be sighted as reactive thoughts and emotions and should not be interpret as necessarily representing the clinician's inner conflict and can be used for objective re-assessment of the treatment (Meloy, Psych, & Yakeley, 2011).

V. DISCUSSION

Information regarding the treatment of ASPD patients is very limited along with available data on long-term treatment mostly because a majority of clinicians consider these patients to be untreatable. On the other hand, the interest to treating patients with ASPD has increased constantly in the past two decades along with optimism and the hope that the future will bring a better understanding of the biological and psychosocial development resulting in better and more specific treatment (Bateman, Gunderson, & Mulder, 2015).

Considering the clinician's perspective to viewing ASPD patients as untreatable, we should consider that they might generally be based on the clinician's attitude to the patient's lack of improvement during treatment. On the other hand such a negative reaction of the patients is their way of showing the effect of the clinician's attitude itself upon their process, a sort of a counter-reaction, and the way it may lead to a dysfunctional therapist-client relationship – considering that many times, the therapeutic alliance is not even reached.

It should be kept in mind that in the case of ASPD establishing therapeutic alliance is difficult to obtain and the therapeutic process is disadvantaged by the increased rate of affective comorbidity, abusive use of substance, violence and negative perceptions upon the treatment.

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