Antisocial personality disorder and Substance use

Kalina Clarke

Antisocial personality disorder

Antisocial Personality Disorder

Diagnostic Criteria **301.7 (F60.2)**

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Antisocial personality disorder

Since the publication of DSM-III (American Psychiatric Association 1980), psychopathy is no longer listed as a distinct psychiatric condition.

ASPD has featured in DSM and psychopathy has not, with the overlap being the behavioural "antisocial" facet of the PCL

Clusters 10 personality disorders allocates to three groups

Cluster A (Odd , Bizarre, Eccentric)
- Paranoid
- Schizoid
- Schizotypal

Cluster B (Dramatic, Erratic)
- Antisocial
- Borderline
- Histrionic
- Narcissistic

Cluster C (Anxious, Fearful)
- Avoidant
- Dependent
- Obsessive-compulsive

ICD 11

The ICD 11 has developed a model of personality disorder that focuses on one type of personality disorder with a severity rating (mild , moderate or severe), instead of the previously used definitions of 10 different types of personality disorder.

Clinicians have options for identifying additional qualifiers;

- Prominent traits of negative affectivity, detachment, disinhibition, dissociality and anankastia
- Borderline type/ pattern

Epidemiology

The prevalence of ASPD in the general population range from approximately 1-4%.

These estimates are broad, since a diagnosis of ASPD is predicated on a diagnosis of conduct disorder prior to the age of 15 which is not always fully assessed.

The requirement of this childhood criterion informs an understanding of ASPD as a persistent personality disorder with roots early in development.
Gender also seems to play a role in ASPD, as males are 3 to 5 times more likely to be diagnosed with ASPD than females, with 6% of men and 2% of women meeting DSM-IV criteria for ASPD in the general population

Kimberly B. Werner, Lauren R. Few, Kathleen K. Bucholz, 2016

Association between psychiatric symptoms and executive function in adults with attention deficit hyperactivity disorder.

EXPORT | Add To My List | Request Permissions | Database: APA PsycArticles | Journal Article

Arellano-Virto, Perla Teresa | Seubert-Ravelo, Ana Natalia | Prieto-Corona, Belén | Witt-González, Andrea | Yáñez-Télle

The Potential Pathway from Oppositional Defiant Disorder/Conduct Disorder to Antisocial Personality Disorder

Kayce Champion

Faculty Sponsor (for work done with a non-Winth
Darren Ritzer, Ph.D.; Merry Sleigh, Ph.D.; Sarah Reiland, Ph.D.

Attention deficit hyperactivity disorder and comorbidity: A review of literature

Sundar Gnanavel, Pawan Sharma, Pulkit Kaushal, and Sharafat Hussain

Author information | Article notes | Copyright and License information | Disclaimer

Review article

Attention-Deficit/Hyperactivity Disorder (ADHD), antisociality and delinquent behavior over the lifespan

Wolfgang Retz [a, b], Ylva Ginsberg [c], Daniel Turner [b], Steffen Barra [a], Petra Retz-Junginger [a], Henrik Larsson [d, e], Phil Asherson [f]

The etiology of antisocial personality disorder: The differential roles of adverse childhood experiences and childhood psychopathology

Matt DeLisi [a], Alan J. Drury [b], Michael J. Elbert [b]

Antisocial personality disorder and Mentalizing

- Lower reflective functioning
- General reduction in ability to read emotions accurately
- Failure to recognize fearful emotions from facial expressions

Lack of concern from others distress

- Limited response to externally expressed emotions
- Fewer references to internal states, related to low reporting of psychiatric symptoms and interpersonal problems

Antisocial personality disorder and Mentalizing

In individuals with Antisocial behavior, the failure to detect underlying intentions of others and the tendency to assume motives based merely on external appearance can cause real social problems .
This is pre mentalizing or Psychic equivalence often described as Concrete thinking

Antisocial personality disorder and attachment

People with ASPD have typically never had the opportunity to learn about mental states in the context of appropriate attachment relationships. Their attachment experiences may have been cruelly or consistently disrupted.

ASPD tend to have a insecure dismissing patterns of adult attachment
Tend to disavow the importance of attachment relationships
May deactivate attachment process when possible

Antisocial personality disorder and attachment

People with ASPD, need relationships, whether within a gang like group or in a more personalized context.

In ASPD the self has to be externalized

This may occur in relation to a partner, who is made mindless or subservient, eg domestic violence relationships.
Or in relation to a system eg Police

Antisocial personality disorder and SUD

Table 1: Prevalence rates of PD among patients with substance use disorders

Study	Country	Sample	Sample size (*n*)	Any PD (%)	ASPD (%)	BPD (%)
Brooner *et al.*[13]	USA	Opioid-dependent men and women admitted to the outpatient methadone clinic	716	34.8	25.1	5.2
Driessen *et al.*[14]	Germany	Alcohol-dependent patients seeking treatment	250	33.6	4.4	3.2
Kokkevi *et al.* [15]	Greece	Drug dependent patients admitted to drug-free treatment services	226	59.5	33.5	27.7
Morgenstern *et al.*[16]	USA	Alcohol-dependent patients	366	57.9	22.7	22.4
Rounsaville *et al.*[17]	USA	Substance-dependent patients entering treatment	370	57.0	27.0	18.4
Landheim *et al.* (2003)[18]	Norway	Polysubstance abusers and alcoholics	260	72	31	27
Singh *et al.* (2005)[19]	India	Alcohol-dependent subjects	100	NA	21	NA
Langas *et al.* (2012)[20]	Norway	Patients with substance use disorders admitted to inpatient or outpatient treatment	46	46	16	13

10% to 14.8% in the normal population

Ranges from 35% -75% depending on sample and PD

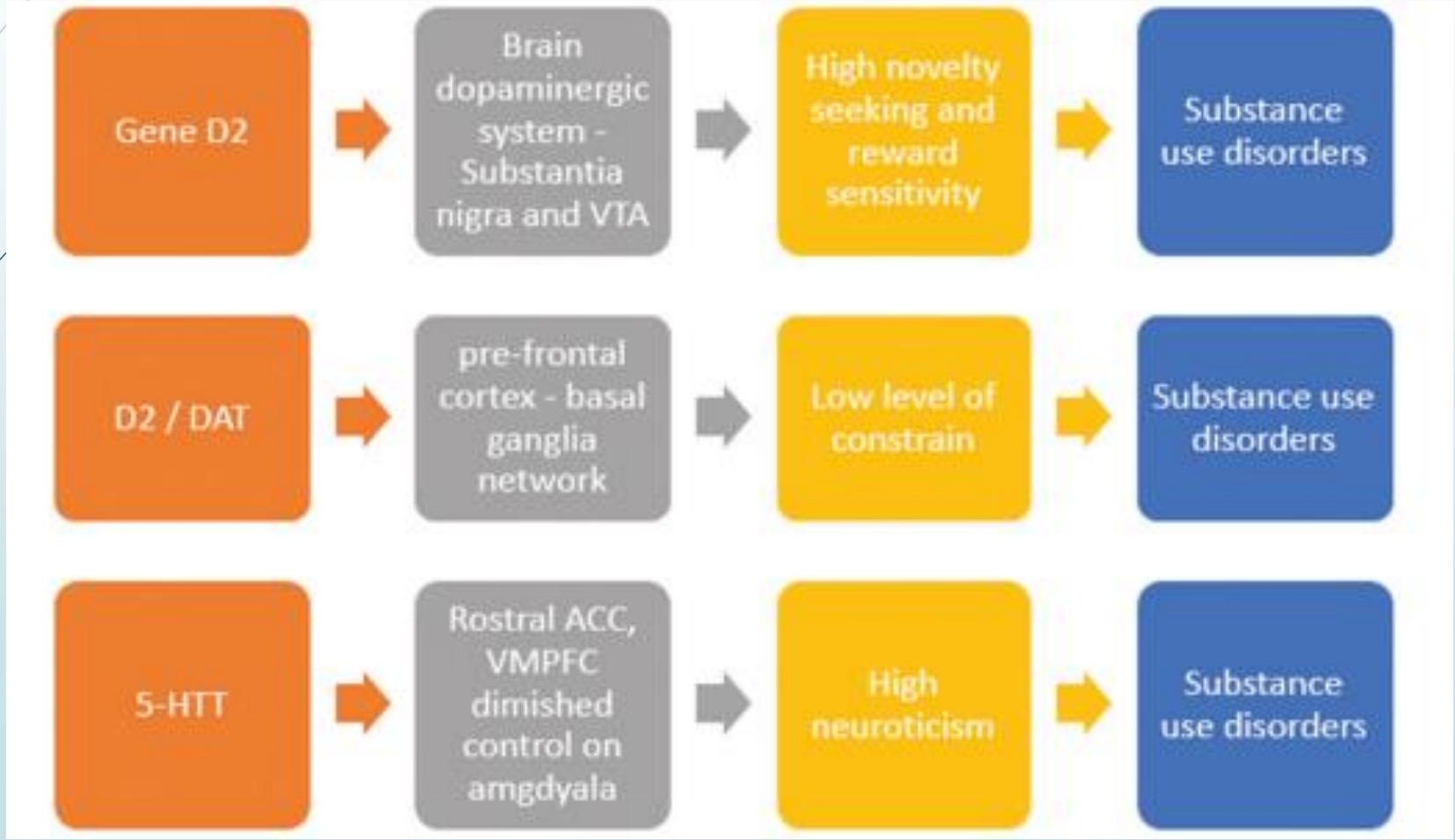
Around 50 – 60 % Prevalence or median of 56.5 %

Antisocial personality disorder Alcohol use disorder

Life time prevalence of AUD up to 50 % in BPD Populations and 77% in ASPD

Prevalence of PD amongst AUD approx. 25-50%

Newton Howes et al, 2018
Trull et al, 2018
Helle et al, 2018


Gene D2
Brain dopaminergic system - Substantia nigra and VTA
High novelty seeking and reward sensitivity
Substance use disorders
D2 / DAT
pre-frontal cortex - basal ganglia network
Low level of constrain
Substance use disorders
5-HTT
Rostral ACC, VMPFC dimished control on amgdyala
High neuroticism
Substance use disorders

Antisocial personality disorder & Treatment

Patients with ASPD have mental health needs and present to general mental health services and the criminal justice system but receive only brief intervention or, more likely, punishment.

A study of looking at contact to mental health services in the UK noted in their sample size that 96% met criteria for anxiety disorder and 64% had evidence of alcohol misuse;
50% presented to emergency medical services and 21% were admitted to a mental health inpatient unit during the following year. Despite this, few were provided with follow-up care from mental health services when they presented. Of those that were offered some treatment, levels of alcohol and drug misuse were significantly lower over follow-up, suggesting that general psychiatric support can be useful.

Bateman A, Fonagy, P 2013

4 What is *mental illness*?

(1) Subject to subsection (2), ***mental illness*** is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

(2) A person is not to be considered to have ment illness by reason only of any one or more of t following—

(a) that the person expresses or refuses or fa to express a particular political opinion belief;

(b) that the person expresses or refuses or fa to express a particular religious opinion belief;

(c) that the person expresses or refuses or fa to express a particular philosophy;

(d) that the person expresses or refuses or fa to express a particular sexual preference, gender identity or sexual orientation;

(e) that the person engages in or refuses or fails to engage in a particular political activity;

(d) that the person expresses or refuses or fails to express a particular sexual preference, ntity or sexual orientation;

rson engages in or refuses or fails in a particular political activity;

rson engages in or refuses or fails in a particular religious activity;

rson engages in sexual ty;

rson engages in immoral conduct;

rson engages in illegal conduct;

rson engages in antisocial behaviour;

(k) that the person is intellectually disabled;

> For people with BPD who have a co-occurring mental illness (e.g. a substance use disorder, mood disorder or eating disorder), both conditions should be managed concurrently.

General (good) Psychiatric Management

Penzenstadler et al. Substance Abuse Treatment, Prevention, and Policy (2018) 13:10
https://doi.org/10.1186/s13011-018-0145-6

Substance Abuse Treatment, Prevention, and Policy

RESEARCH Open Access

Effects of substance use disorder on treatment process and outcome in a ten-session psychiatric treatment for borderline personality disorder

Louise Penzenstadler[1*], Stéphane Kolly[2], Stéphane Rothen[1,6], Yasser Khazaal[1,3,4] and Ueli Kramer[2,5]

Integration of Practice

Literature supports use of evidence based strategies across therapies in a transdiagnostic manner
(eg combining contingency management with pharmacotherapy)

Consider risks related to prescribed medication

Targeting specific traits eg impulsivity may effectively reduce Substance use

Thank you