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Article 37

Program Considerations for Clients With Antisocial Personality Disorder

Edward Dunbar

Dunbar, Edward, is a doctoral student at East Carolina University. His research interests include antisocial personality disorder, addiction, and spirituality.

Abstract

Antisocial personality disorder is common in people receiving services in prison and substance abuse treatment centers. Symptoms of the disorder have contributed to clinical cynicism and a negative outlook for treating this population. Although there is no agreed upon specialized treatment modality for this population, programs serving this population can benefit from adapting their approach to meet the unique needs of clients with antisocial personality disorder. Special considerations for programs serving this population may help provide effective and efficient treatment and promote optimism for treatment providers.

Keywords: antisocial personality disorder, clinical programming

Antisocial personality disorder (ASPD) occurs in up to 70% of clients who are incarcerated or receiving treatment for substance use disorders (American Psychiatric Association [APA], 2013). The disorder is associated with criminality that results from long-standing patterns of maladaptive behavior and inability to conform to social norms and expectations. Symptoms of ASPD often lead to negative consequences such as institutionalization, incarceration, and premature death (National Institute for Health and Care Excellence [NICE], 2010). The symptoms of the disorder that necessitate treatment can be challenging for human service agencies.

"The essential feature of antisocial personality disorder [ASPD] is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy, sociopathy,* or *dissocial personality disorder*" (American Psychiatric Association [APA], 2013, p. 659). Characteristics of people with ASPD include irritability, impulsivity, grandiose self-appraisal, glib superficial charm, affective instability and unstable interpersonal relationships (APA, 2013). These symptoms have a strong impact on clinician outlook and optimism (Evans, 2011; Kurtz & Turner, 2007).

Long-standing clinical cynicism has perpetuated the belief that treatment for clients with ASPD is ineffective and that the disorder is untreatable (Salekin, 2002).

However, researchers indicate that clinical outcomes for clients with ASPD are similar to clients without the disorder (Wilson, 2014). The negative stigma associated with treating clients with ASPD may be due to treatment in underfunded facilities by professionals unequipped to manage symptoms that manifest during treatment (NICE, 2010). The symptoms of clients with ASPD can have a strong impact on the clinicians with whom they interact. This impact may affect professional judgment and job satisfaction (Evans, 2011).

Clients with ASPD are usually treated in public human service agencies since they have high rates of unemployment and frequently lack insurance (Black, 2013; NICE, 2010). Public human service agencies are often underfunded; therefore, they lack sufficient staff to care for clients with ASPD (NICE, 2010). Additionally public human service agencies have higher rates of employee burnout than private clinics (Lent & Schwartz, 2012), which may contribute to poor treatment outcomes for clients with ASPD. Furthermore, there is currently no agreed upon model of treating clients with ASPD, leaving service providers to manage symptoms of the ambiguous disorder. Agencies that develop objectives and outcome measures are encouraged to consider the special needs of this population (e.g., legal issues, propensity for violence, substance abuse, chronic nature of symptoms, etc.) and the impacts of organizational operations. Careful planning and evaluation will help agencies better serve their clients and communities (Lewis, Packard, & Lewis, 2012). The following program considerations for agencies that serve clients with ASPD may promote effective service provision, increase professional self-efficacy, and increase employee safety when serving this population. These considerations may serve as a framework for developing an effective treatment modality specific to the treatment of clients with ASPD. This article outlines common issues in treating clients with ASPD and provides suggestions for agencies to better meet the needs of this population.

Difficulty Conceptualizing ASPD

ASPD is often misdiagnosed due to clinicians focusing on isolated events rather than an enduring pattern of maladaptive behavior (Edens, Kelley, Lilienfeld, Skeem, & Douglas, 2014). For example, clients may begin engaging in criminal behavior due to a substance use disorder rather than a long-standing pattern of illegal behavior associated with ASPD. Clinicians need a thorough client history as part of a diagnostic assessment to diagnose ASPD (APA, 2013). Even with a thorough assessment, diagnosing ASPD can be difficult. Clients with the disorder use charm and deceit to mask their inner pathology in an attempt to appear normal (Black, 2013; Hare, 1993). They frequently evade diagnostic criteria by convincing caregivers that they are victims of circumstance and blaming others for their predicaments (Thompson, Ramos, & Willett, 2014).

Diagnostic criteria for ASPD continues to be a topic of debate (Black, 2013; Hare, 1989; NICE, 2010; Samenow, 2014). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) criteria for ASPD include criminality, aggressiveness, deceitfulness, impulsivity, irritability, disregard for safety, irresponsibility, and lack of remorse (APA, 2013). Although these diagnostic criteria are clear, the disorder is often overlooked by clinicians (Black & Blum, 2010). Clients with ASPD are prone to co-occurring disorders such as substance abuse, depression, anxiety, bipolar disorder, and

borderline personality disorder, which confound the diagnostic process (Glenn, Johnson, & Raine, 2013). In fact, clients with ASPD rarely seek treatment for their personality disorder; instead, they seek treatment for co-occurring issues or as a result of coercion from family, the legal system, or employers (Black, 2013; NICE, 2010). Accurately diagnosing ASPD requires a holistic approach that may include interviewing family and friends, gathering historical documents (e.g., incarceration history, clinical documents from other agencies, etc.) and examining the role of co-occurring mental health and substance abuse issues (Black, 2013; Glenn et al., 2013; NICE, 2010).

Diagnosing ASPD can be difficult for clinicians; however, understanding how to respond to client symptomatology can also be challenging (Black, 2013; Bowers, 2003; NICE, 2010). Often professionals misunderstand the symptoms of ASPD and respond in a punitive manner, which contributes to poor treatment provision (Martens, 2004 NICE, 2010). For example, a client with ASPD may engage in bullying a staff member in order to get his or her needs met. An inexperienced clinician may respond to this acting out behavior in a punitive manner rather than examining how these behaviors have manifested over time and serve a purpose for the client. The punitive response reinforces the client's negative view of authority figures and perpetuates an environment of distrust.

Clinicians and agencies are encouraged to better understand how symptoms of the disorder manifest in treatment and to develop appropriate therapeutic responses. Effective treatment of ASPD requires a holistic strategy that addresses manipulation, violence, substance abuse, and environmental stressors (Black, 2013; NICE, 2010). Agencies can develop guidelines for better serving clients with ASPD by better understanding how symptoms of ASPD impact clinicians.

Conceptualizing ASPD

Understanding Manipulation

The defining characteristics of ASPD include lack of remorse and disregard for the rights and feelings of others (APA, 2013). People with this disorder may be described as callous or unemotional because they lack empathy; however, they compensate for their lack of empathy with superficial charm (NICE, 2010). They can be convincing storytellers who use their charismatic nature to portray themselves in a positive light (Thompson et al., 2014) or use others to satisfy their need for power and control (APA, 2013). They are skilled manipulators (Bowers, 2003) who are indifferent to how their actions affect those they manipulate (APA, 2013).

Professionals working with clients with ASPD are prone to being lied to, bullied, and manipulated (Bowers, 2003). Clients with ASPD have often experienced multiple incarceration and institutional settings and have refined their skills of manipulation (NICE, 2010). Clients with ASPD present plausible arguments in order to convince professionals there is nothing wrong with them and that they are victims of circumstance (Thompson et al., 2014). Their stories can be difficult to refute and professionals may experience a desire to rescue clients from their present circumstance (Evans, 2011). When professionals discover that they have been manipulated, they often experience embarrassment, shame, and frustration, which leads to negative feelings about the client (Bowers, 2003). These negative feelings contribute to a pessimistic attitude and a dislike

for the client, which contributes to negative interactions and poor treatment outcomes (Evans, 2011; NICE, 2010).

Violence

People with ASPD experience a shallow level of emotion, yet they mimic emotions in social interactions to convince others that they are caring and normal (Thompson et al., 2014). Although their general range of emotions is limited, people with ASPD experience heightened levels of anger that they have little ability to control (Lobbestael, Arntz, Cima, & Chakhssi, 2009). Their poor anger management increases their propensity toward violence (APA, 2013). They may engage in fights, bullying, and intimidation toward staff members or other clients while in treatment (NICE, 2010).

Clients with ASPD have often been exposed to violence since childhood (NICE, 2010). They may begin displaying violent tendencies during childhood, which escalate when they reach adulthood (APA, 2013). While ASPD is often associated with violence, the broad nature of the diagnostic criteria of the disorder dilutes the validity of a diagnosis of ASPD as a predictor for violence (NICE, 2010). Furthermore, treatment facilities serving clients with ASPD often rely on an unstructured violence risk assessment, or clinical intuition, in predicting a client's tendency to act out violently while in treatment, which is unreliable and often inaccurate (NICE, 2010).

Substance Abuse

People with ASPD rarely enter treatment for their personality disorder; instead, they seek services for co-occurring disorders such as substance use disorders (NICE, 2010). Substance use disorders are common in clients with ASPD (Compton, Conway, Stinson, Colliver, & Grant, 2005). Estimated prevalence rates of substance use among people with ASPD is near 40% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). These clients present to treatment with varying levels of motivation to change their pattern of substance abuse (NICE, 2010). They may enter treatment to appease a family member or to satisfy legal obligations; however, they often believe that nothing is wrong with them and that other people or circumstances are responsible for their suffering (Perry, Presniak, & Olson, 2013). While external interventions are often used to motivate clients with ASPD to enter treatment, the effectiveness of treatment has been questionable (Krampen, 2009). Clients are often wrongly labeled as treatment resistant or unmotivated as a result of their long-standing belief that nothing is wrong with them (SAMHSA, 2013).

Lack of Trust

Clients with ASPD are often suspicious of others and have difficulty forming meaningful relationships (NICE, 2010). They believe that other people are out to get them, or that by trusting others they open themselves up to being embarrassed (Davidson et al., 2010). Martens (2004) identified that a lack of "click" (p. 55) in the therapeutic relationship is a contributing factor to poor treatment outcomes for this disorder and may be perpetuated by mutual distrust between clinician and client. The cyclical nature of distrust can contribute to clients resuming destructive behaviors.

These barriers to effective treatment of ASPD have contributed to the stigma of clients with ASPD and increased therapeutic pessimism (Salekin, 2002). This pessimism

is reinforced when clients with ASPD display symptoms (e.g., violence, distrust, manipulation) of the disorder while in treatment (Black, 2013; NICE, 2010). Clinical pessimism perpetuates a belief that clients with ASPD are destined for poor treatment outcomes (Salekin, 2002). Although poor treatment outcomes are often associated with ASPD, these outcomes represent a gap in therapeutic services that goes unaddressed in professional literature (Black & Blum, 2010). However, service agencies may better serve clients with ASPD by adapting their programming to better fit the needs of this population (NICE, 2010). The following program solutions highlight how agency adaptations in programming, training, and staffing may better meet the needs of clients with ASPD and the professionals with whom they interact.

Program Solutions for Treating ASPD

Hiring of Specialists

When developing and implementing a treatment program, agencies are tasked with matching service provider qualifications with consumer needs (Lewis et al., 2012). For agencies that treat clients with ASPD, this matching may include hiring professionals who are experienced in treating the disorder, or developing specialized treatment services for clients within the criminal justice system (NICE, 2010). Agencies may seek to include professionals who have worked in forensic settings or those interested in seeking specialized training for working with criminal offenders. These professionals can help conceptualize the disorder and educate other staff members in the agency. Specialists will understand the needs of this population and be familiar with the diagnostic process and effective treatment modalities.

Ongoing Training

Trainings specific to clients with ASPD are encouraged for professionals working within agencies that serve clients with ASPD (NICE, 2010) as professionals often believe they do not have the necessary skills to serve clients with this disorder (Priest, Dunn, Hackett, & Wills, 2011). Effective training will address daily applicable skills and should be presented in an interactive format that addresses learner's questions and concerns (Lewis et al., 2012), which may include treatment models and approaches that are effective in treating clients with ASPD.

Although treatment efficacy for ASPD is questionable (Krampen, 2009), many treatment approaches show promise (Black, 2013; NICE, 2010). Effective approaches to treating ASPD address day-to-day struggles and emphasize the importance of a supportive and collaborative therapeutic alliance (Black, 2013; Davidson et al., 2010; Samenow, 2014). Promising approaches include cognitive behavioral therapy for personality disorders (CBTpd), moral reconation therapy (MRT), relaxation training, problem-solving therapy, and cognitive therapy (NICE, 2010). These therapies may improve therapeutic outcomes, improve employee optimism, and reduce risk of client violence.

Structured Clinical Judgment

When working with clients with a high risk of violence, structured clinical judgment is encouraged (Skeem & Monahan, 2011). Structured clinical judgment utilizes

clinical intuition and standardized measures for predicting a client's potential for violence. In addition to clinical intuition, tools such as the Psychopathy Checklist (Hare, 1999), which screens for severity of ASPD, and the Historical Clinical Risk Management assessment (Douglas et al., 2014), which assesses for violence potential, may be beneficial in assessing clients with ASPD for potential violence (NICE, 2010). Understanding the potential for violence allows professionals to prescribe the appropriate treatment for clients with ASPD while promoting safety for clients and staff members. Clients may be more prone to acting out behaviors when they are treated in inpatient settings due to their perception of losing personal freedom (Martens, 2004).

Least Restrictive Interventions

ASPD is a long-standing pattern of beliefs and behaviors that requires long-term treatment (Evans, 2011); therefore, inpatient hospitalization is not recommended for treating this disorder (NICE, 2010). Clients with ASPD may require short-term crisis management services for co-occurring substance use and mental health issues (e.g., crisis stabilization, detoxification), but they achieve maximum benefit from less restrictive environments. They are less likely to act out when they are able to maintain a sense of personal freedom (Martens, 2004). When necessary, inpatient hospitalization for this disorder should include a clear purpose and endpoint, and agencies are encouraged to develop specific guidelines for managing violence. When clients present with a high level of violence, referral to a forensic agency may be required (NICE, 2010).

Motivational Enhancement

In order to best serve clients with ASPD and substance use disorders, organizations are encouraged to adopt a treatment model that addresses multiple levels of client motivation to change substance abuse behaviors, such as the Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1998). This treatment model includes interventions that can be tailored to the client's level of readiness to change and emphasizes a supportive and collaborative interaction. Research indicates that motivational enhancement strategies may be effective for decreasing substance abuse in clients with ASPD when used in conjunction with the Transtheoretical Model (Easton et al., 2012). These approaches are best applied in an outpatient setting; however, inpatient detoxification services may be necessary depending on severity of use (NICE, 2010). Effective transition throughout various levels of care is imperative to promote effective treatment (Black, 2013; NICE, 2010).

Continuity of Care

Clients with co-occurring ASPD and substance use disorders are at an increased risk of treatment dropout (Daughters et al., 2008). Agencies serving this population can improve treatment retention through engagement of legal resources throughout the treatment process for clients with pending legal issues (Daughters et al., 2008). In order to provide seamless transition between levels of care, agencies are encouraged to form collaborative relationships with community resources (SAMHSA, 2013). Agencies treating clients with ASPD and substance use issues are encouraged to develop service networks that promote collaboration and consultation and ease the transition process for clients (NICE, 2010). For example, a community detoxification center may include an

outpatient substance abuse therapy center, vocational rehabilitation, medical services, and a therapeutic community in its service networking. Agencies are encouraged to inform stakeholders of the priority of successful client transition and collaborate within the agency and community to overcome service gaps and provide comprehensive care (SAMHSA, 2013).

Stimulating Services

Clients with ASPD act out (e.g., stealing, vandalism, fighting) while in treatment as a continuation of their long-standing pattern of behavior, which often results from boredom (APA, 2013). Clients with ASPD require a stimulating environment with multiple interventions (Martens, 2004). Simulating interventions might include leisure activities as well as complementary and alternative approaches such as yoga, meditation, and acupuncture.

Developing Trust

White and Byrt (2013) suggested that an environment of trust and support for clients begins by developing a trusting relationship between front line staff and agency administrators. Professionals serving clients with ASPD need a supportive and transparent administrative presence, just as clients need a similar relationship with their caregivers. Consistent supportive interaction with agency administrators provides professionals with the freedom and confidence to establish a trusting relationship with clients with ASPD (Kurtz & Turner, 2007) and promotes an optimistic outlook for treating this disorder (NICE, 2010).

Firm and Clear Boundaries

Clients with ASPD often engage in staff splitting (e.g., praising one staff member while belittling another) as a means of getting their needs met (Crawford et al., 2007). Agencies are encouraged to adopt a clear decision-making hierarchy in order to minimize the impact of staff splitting and promote interagency collaboration. Treating this population requires addressing acting-out behaviors immediately in a clear and supportive manner (SAMHSA, 2013). To promote appropriate staff responses, agencies are encouraged to develop clear guidelines for how to address behaviors prior to their occurrence (SAMHSA, 2013). Development of these guidelines should include input from the frontline staff as well as agency administrators (Lewis et al., 2012). In addition to clear protocol for decision making, agencies are encouraged to place a strong emphasis on the role of clinical supervision in the treatment of clients with ASPD (Kurtz & Turner, 2007)

Clinical Supervision

Clients with ASPD may engage in bullying, violence, manipulation, or threatening staff members or other clients (Evans, 2011). People with ASPD often demean and belittle others as a means of defending against their own negative self-image (Perry et al., 2013), which can have a profound, and often subconscious, effect on clinicians (Evans, 2011).

Kurtz and Turner (2007) found that staff members experienced increased feelings of emotional vulnerability while caring for clients with ASPD. Staff members reported

that while they felt physically safe, their increased levels of anxiety were associated with professional isolation and unclear protocol for managing clients with this disorder. While the emotional impact of working with clients with ASPD can be challenging for some clinicians, clinical supervision plays a key role in treating clients with ASPD (Evans, 2011).

Supervision from outside the agency. Clinical supervision from outside the agency is encouraged when serving clients with ASPD. Supervisors within the agency are more likely to be inducted into agency issues limiting their objectivity. Clinical supervision from an impartial provider offers unbiased treatment interventions, strategies, and support (Kurtz & Turner, 2007).

Interdisciplinary group supervision. Interdisciplinary group supervision provides professionals with multiple lenses from which to view clients with ASPD. For example, an interdisciplinary group supervision session may focus on the different styles of interaction clients use with different staff members. When possible, agency administrators are encouraged to attend as a means of establishing support and promoting clarity between front line staff and agency administrators (Kurtz & Turner, 2007)

Regular individual supervision. Individual supervision for clinicians serving clients with ASPD includes placing increased emphasis on the role of countertransference in treating clients with ASPD (Evans, 2011). Countertransference is the clinician's unconscious generation of thoughts and emotions about clients, shaped by the clinician's experience and worldview (Schwartz, Smith, & Chopko, 2007). Often, clinicians interacting with clients with ASPD experience a high level of countertransference (Evans, 2011). Effective supervision would focus on utilizing this reaction to gain a greater understanding of how others in the client's life may be impacted and developing creative interventions based on these reactions (Evans, 2011).

Discussion

Clients with ASPD have been associated with high rates of recidivism and poor treatment outcomes (Wilson, 2014). They are overrepresented in forensic populations, which has contributed to an attitude of "therapeutic pessimism" and a belief that they are not treatable (Salekin, 2002 p. 79). This long-standing clinical lore has resulted in a stance of managing rather than treating clients with ASPD (Gullhaugen & Nøttestad, 2011).

While funding greatly impacts treatment provision for human service agencies, careful planning and consideration specific to clients with ASPD may improve treatment outcomes and promote an attitude of optimism and support, which is necessary in treating clients with this disorder (NICE, 2010). Agency administrators are encouraged to take special considerations when designing a program that will serve clients with ASPD in order to better meet the clients' needs.

While the treatment efficacy of ASPD has been questionable, the importance of effective treatment of this population cannot be refuted. Continued research is needed regarding development of treatment modalities specific to the needs of clients with ASPD, as well as effective use of agency policies and procedures in relation to the symptoms of this disorder. Research on a holistic model of treating clients with ASPD

would include systemic as well as interpersonal interventions and be unique to clients with the disorder. Other areas of further research may include staff perceptions of clients with ASPD and provider self-efficacy when treating this population.

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