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Impulsive lifestyle counseling to prevent dropout from treatment for substance use disorders in people with antisocial personality disorder: A randomized study

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HIGHLIGHTS

- Retaining patients with antisocial personality disorder is a challenge in substance abuse treatment.
- A randomized trial tested the efficacy of a psycho-educational program.
- The program was based on the lifestyle model of antisocial behavior.
- 13 outpatient community substance abuse treatment centers participated.
- In the intent-to-treat sample, being randomized to the intervention reduced dropout by 37%.

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ABSTRACT

Patients with antisocial personality disorder in outpatient treatment for substance use disorders are at high risk of drop-out. Using a randomized design, this study tested the impact of adding a brief psycho-educational program, the Impulsive Lifestyle Counseling program, to outpatient substance abuse treatment in order to prevent treatment dropout. Patients (N = 175) were recruited from 13 municipal treatment centers in Denmark, and assigned to treatment as usual or to the experimental condition. In all, 172 patients could be included in the analyses. In the intent-to-treat analysis, the risk of treatment dropout was reduced among patients randomized to the experimental program (hazard ratio = 0.63, p = .031), after controlling for age, gender, and substitution treatment status. The study supported the efficacy of the Impulsive Lifestyle Counseling program as a method for preventing treatment dropout for patients with comorbid antisocial personality disorder in substance abuse treatment. Trial registration #ISRCTN67266318.

1. Introduction

Among people with substance use disorders (SUD), antisocial personality disorder (ASPD) is a common comorbidity (Goldstein et al., 2007). ASPD is a lifespan developmental disorder with its origins in childhood (Fergusson, Horwood, & Ridder, 2005; Walters & Knight, 2010), and the presence of conduct disorder before age 15 is a prerequisite to the adult diagnosis (APA, 2013). Individuals diagnosed with ASPD exhibit persistent antisocial behavior and pervasive antisocial character traits, such as impulsivity, irritability, social irresponsibility, manipulativeness, and lack of remorse (APA, 2013). Patients with ASPD are not likely to seek treatment for their behavioral problems, with the exception of drug and alcohol problems (Gardiner, Tsukagoshi, Nur, & Tyrer, 2010; Tyrer, Mitchard, Methuen, & Ranger, 2003). Furthermore, perhaps more than any other disorder, being diagnosed with ASPD has been linked to the exclusion of people from care. Accordingly, the National Institute for Health and Care Excellence specifically emphasizes that including patients with ASPD in care should be a priority, but little evidence exists on how to do so (Kendall et al., 2009).

Given that ASPD is so prevalent among people with SUD, one context for reaching patients with ASPD is at treatment services for SUD. When compared to patients with SUD and without an ASPD, patients with comorbid ASPD have a higher risk of dropping out of treatment (Hesse & Pedersen, 2006; Kokkevi, Stefanis, Anastasopoulou, & Kostogianni, 1998; Ohlin, Hesse, Fridell, & Tatting, 2011), at least when treatment is not a precondition for probation or parole (Daughters et al., 2008). When patients with ASPD drop out of treatment, they often cite conflicts with staff, boundary concerns or outside influences (Ball, Carroll, Canning-Ball, & Rounsaville, 2006).

Abbreviations: ILC, Impulsive Lifestyle Counseling; ASPD, Antisocial personality disorder; TAU, Treatment as usual; HR, Hazard ratio.

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In longitudinal studies of clinical samples of people with SUD, comorbid ASPD is associated with a poor prognosis, characterized by continuous offending behavior and poor social adjustment, often years or decades after the ASPD diagnosis is made (Fridell, Hesse, Jaeger, & Kuhlhorn, 2008; Jansson, Hesse, & Fridell, 2009). Improving services for people with SUD and ASPD could thus potentially benefit both individual patients and society. However, in order to improve the efficacy of treatment, one central goal is to prevent premature dropout, since patients who are not in treatment cannot be treated.

One way to address personality disorder, including ASPD, is through psychoeducation, that is, by teaching patients about their condition and how to best manage it. If done sensitively, providing psychoeducation may help raise the patient's awareness of his/her behavioral difficulties, and how they impact him/herself and others (Banerjee, Duggan, Huband, & Watson, 2006). This awareness may in turn help patients in making informed decisions about seeking and receiving help for their problems so that they are less inclined to drop out of treatment, including substance abuse treatment, due to frustrations or impulsive actions. Paradoxically, many clinicians report not providing psychoeducation to patients with PDs, although they consider it to be an important aspect of treatment (Rummel-Kluge, Kluge, & Kissling, 2013). At present, there is limited evidence on psychoeducation for personality disorders in general (for an example, see Zanarini & Frankenburg, 2008), and none that we are aware of for ASPD.

The Impulsive Lifestyle Counseling (ILC) program was adapted from the Lifestyle Issues program (Walters, 2005) and further developed by the authors of the present paper. The Lifestyle Issues program is a group-based approach that views crime as a lifestyle and involves framing the problem as a question of lifestyle, rather than through concepts that lead to negative self-labeling, such as offender or patient with personality disorder (Walters, 2005). The psychoeducational approach is ideal for people with ASPD, as it allows clinicians to discuss stigmatized behaviors and beliefs with patients in a non-judgmental atmosphere that nevertheless explicitly addresses the behaviors and their consequences. It shares with MI the non-judgmental attitude of the counselor, and the notion that the counselor maintains a focus on particular topics during treatment (Miller & Rollnick, 2012). However, the ILC also differs in numerous ways from MI, since it does not rely on the counselor being able to identify key issues and ask questions that help the patient explore the dynamics behind his or her choices. By contrast, in the ILC program, the counselor adheres to the questions found in the manual and functions as a facilitator.

The purpose of this study was to test the efficacy of the ILC program in preventing dropout among patients with comorbid substance abuse and ASPD who receive regular out-patient community substance abuse treatment in Denmark. We have previously reported the outcomes of the trial in terms of self-reported substance use and aggression (Thylstrup, Schroder, & Hesse, 2015).

2. Methods

2.1. Study design

This was a multicenter pragmatic randomized trial (Delgadillo et al., 2015; Zwarenstein et al., 2008), and patients were included between January of 2012 and June of 2014.

Randomized trials are pragmatic to the extent that they are designed to inform decision-making in treatment practice by using interventions and procedures that can have practical applications in general treatment services. Thus, a trial that utilizes a layman interview for diagnostic assessment rather than using an instrument that requires a high level of expertise is pragmatic, in the sense that it may be applied in settings where there is a high likelihood that clinicians with the expertise to conduct more sophisticated assessments are not available.

2.2. Sites

The 13 sites were community substance abuse treatment centers run by local authorities (municipalities) in urban and rural areas across Denmark. All of the sites offered substance abuse treatment for people with illicit drug use disorders according to the Danish Consolidation Act on Social Services under Part 18, § 101 of the, and treatment for people with alcohol use disorders under Part 40, §141 of the Danish Health Act.

According to both sections, treatment must be free of charge, and patients must be offered treatment for SUD within 14 days of contacting the services, and can choose a different treatment provider for psychosocial interventions such as counseling or group therapy.

2.3. Participants

Patients were included if they were currently seeking or in substance abuse treatment, and satisfied the criteria for both life time and current ASPD defined as all three of the following: (1) criteria for conduct disorder before age 13, (2) adult ASPD syndrome since age 18, and (3) at least one criterion for ASPD within the past 12 months.

Patients were excluded from the study if any of the following criteria were identified: having a psychotic disorder, the inability to complete informed consent procedures, any plans that would interfere with participating in the psycho-education intervention, such as plans to move away from the uptake area, or to enter drug-free inpatient treatment or a therapeutic community within the next three months. Finally, in order to reduce contamination through interaction with other patients in the trial participants were excluded if they were participating in group therapy or counseling with other patients participating in the study.

2.4. Procedures

Patients who were in treatment for SUD were recruited by clinical staff at each site. The 73 recruiting clinicians comprised of 54 with a BA in social work, three psychologists, one MD, four nurses, and 11 with brief training in related disciplines such as healthcare assistants, caseworkers and addiction counselors. Potential participants were referred to the study by their treating clinician or by one of the clinicians who were trained to conduct the study baseline screenings. Interested patients who met the eligibility criteria for participating in the study completed a baseline assessment after providing informed consent. If eligible, patients were then randomly assigned to one of two treatment conditions by one of the researchers.

Patients were randomized to the intervention, ILC, or to the treatment as usual (TAU) condition in blocks of varying sizes (4 or 6 patients per block). Each clinic had an individual list of random numbers to ensure randomization variation within each clinic. Clinicians who screened patients were not aware of the size of blocks and were only informed that patients were to be randomly allocated to ILC or TAU.

2.5. Treatment conditions

2.5.1. Treatment as usual

When patients were randomized to TAU, the clinics were instructed to provide the patient with the highest standard of care possible. The TAU condition consisted of the services available in the community outpatient clinics, including counseling and substitution treatment as indicated, although the level of service varied between sites. In Danish outpatient treatment, the patients have the opportunity to be referred to residential or inpatient treatment during the course of treatment if it is deemed necessary. Opioid substitution treatment is available at all treatment services after a consultation with a medical doctor, although at a few of the participating study sites, patients who were found to need substitution treatment were transferred to a specialized