

Special article

A behavioral treatment for opioid-dependent patients with antisocial personality

Karin J. Neufeld, (M.D.), Michael S. Kidorf, (Ph.D.), Kenneth Kolodner, (Sc.D.),
Van L. King, (M.D.), Michael Clark, (M.D.), Robert K. Brooner, (Ph.D.)*

*Department of Psychiatry and Behavioral Science, The Johns Hopkins School of Medicine, Baltimore, MD, USA
Addiction Treatment Services, Johns Hopkins Bayview Medical Center, Baltimore, MD, USA*

Received 7 August 2006; received in revised form 13 February 2007; accepted 13 February 2007

Abstract

Antisocial personality disorder (APD) is associated with increased problem severity in treatment-seeking opioid-dependent patients. Treatment studies have reported mixed results but generally show that patients with APD make progress that is often comparable to drug-dependent patients without the personality disorder. Much of this work is based on secondary analyses of studies evaluating responses to a variety of drug abuse treatment interventions. This study reports on a randomized prospective trial evaluating a behavioral approach for managing opioid-dependent patients with APD. Subjects ($N = 100$) met *Diagnostic and Statistical Manual of Mental Disorders* criteria for opioid dependence and APD using a structured clinical interview and were randomly assigned to either an experimental condition ($n = 51$), which used a highly structured contingency management intervention, or a control condition ($n = 49$), which reflected standard methadone treatment. Subjects in the experimental group had significantly better counseling attendance and some indication of lower psychosocial impairment compared to the control group. The experimental intervention increased attendance in subjects with low and high levels of psychopathy and with and without other psychiatric comorbidity. These findings support the development of interventions more tailored to drug-dependent patients with APD. © 2008 Elsevier Inc. All rights reserved.

Keywords: Antisocial personality disorder; Drug dependence; Treatment outcome; Contingency management

1. Introduction

Antisocial personality disorder (APD) is a debilitating long-term disorder that is strongly associated with substance use problems and other risks of harm to self and others (Black, Baumgard, & Bell, 1995; Cleckley, 1941; Eronen, Hakola, & Tiihonen, 1996; Lewis, Rice, & Helzer, 1983; Schuckit, Klein, Twitchell, & Smith, 1994; Vaillant, 1975). Prevalence rates of APD in the general population range between 2% and 4% (Kessler et al., 1994), which are considerably lower than the 25% to 50% rates reported in treatment-seeking drug-dependent patients (Brooner, King,

Kidorf, Schmidt, & Bigelow, 1997; Compton, Conway, Stinson, Colliver, & Grant, 2005; Compton et al., 2000; Khantzian & Treece, 1985; Kosten, Rounsaville, & Kleber, 1982). The overlap of antisocial personality to drug abuse has stimulated considerable research on the clinical characterization and management of patients with both disorders.

Studies have shown that drug-dependent patients with antisocial personality have more severe patterns and frequencies of drug use and HIV risk behavior and infection than those without antisocial personality (e.g., Brooner, Bigelow, Strain, & Schmidt, 1990; Brooner, Greenfield, Schmidt, & Bigelow, 1993; Brooner, Herbst, Schmidt, Bigelow, & Costa, 1993; Brooner et al., 1997; Compton, Cottler, Shillington, & Price, 1995; Dinwiddie, Reich, & Cloninger, 1992; Gill, Nolimal, & Crowley, 1992; Kelley & Petry, 2000; King, Kidorf, Stoller, Carter, & Brooner, 2001; Woody, McLellan, Luborsky, & O'Brien, 1985). APD in

* Corresponding author. Addiction Treatment Services, Johns Hopkins Bayview Medical Center, 5510 Nathan Shock Drive, Suite 1500, Baltimore, MD 21224, USA. Tel.: +1 410 550 0028; fax: +1 410 550 2957.

E-mail address: rkbrooner@aol.com (R.K. Brooner).

drug-dependent samples has also been associated with greater family and psychosocial problems, more psychiatric instability and suicide, and increased crime and violence (Bell, Mattick, Hay, Chan, & Hall, 1997; Bovasso, Alterman, Cacciola, & Rutherford, 2002; Brooner, Schmidt, Felch, & Bigelow, 1992; Cacciola, Rutherford, Alterman, & Snider, 1994; Cottler, Campbell, Krishna, Cunningham-Williams, & Abdallah, 2005; Cottler, Price, Compton, & Mager, 1995; Kosten, Kosten, & Rounsaville, 1989; Moeller, Dougherty, & Rustin, 1997; Rousar, Brooner, Regier, & Bigelow, 1994; Rutherford, Cacciola, & Alterman, 1994). In addition, prior studies have shown that about 40% of drug-dependent patients with APD also meet criterion for other psychiatric diagnoses (Alterman, Rutherford, Cacciola, McKay, & Woody, 1996; Brooner et al., 1997; Compton et al., 2005; Goodwin & Hamilton, 2003; King et al., 2001; Woody et al., 1985) and that the added comorbidity is associated with distinct clinical and drug use profiles and treatment response (Alterman, Cacciola, & Rutherford, 1993; Brooner et al., 1993, 1997; King et al., 2001; Rousar et al., 1994; Woody et al., 1985). For example, opioid-dependent patients with only APD appear to favor heroin and cocaine, whereas those with APD and other psychiatric diagnoses appear more likely to use sedatives (King et al., 2001).

This work has led to a growing interest in the treatment of drug users with APD. Early studies showed that APD was an indicator of poor treatment response, particularly in opioid-dependent samples (Alterman & Cacciola, 1991; Cacciola, Alterman, Rutherford, & Snider, 1995; Rounsaville, Dolinsky, Babor, & Meyer, 1987; Rounsaville, Kosten, Weissman, & Kleber, 1986; Woody et al., 1985). Later studies report mixed findings. Several of these studies have reported higher rates of cocaine and heroin use in opioid-dependent patients with versus without APD (Alterman et al., 1996; King et al., 2001), whereas others have reported few or no differences in outcome (e.g., Cacciola et al., 1995; Darke, Finlay-Jones, Kaye, & Blatt, 1996; Gill et al., 1992), and at least one study (Carroll & Rounsaville, 1993) reported better outcome in those with APD.

Some of the variability across studies may be related to differences in outcome measures, samples, and treatment settings. For example, APD is often unrelated to outcome when defined by retention rate (Havens & Strathdee, 2005). Similarly, drug use outcomes can vary depending on how it is measured. Studies that rely on self-reports of drug use might produce findings that vary from those relying on urinalysis drug testing (e.g., Alterman, Rutherford, Cacciola, McKay, & Boardman, 1998). It has also been shown that a substantial proportion of drug users with and without APD meet diagnostic criterion for other psychiatric diagnoses, including ones that likewise convey a poor treatment prognosis (Alterman et al., 1996; Brooner et al., 1997; Cacciola, Rutherford, Alterman, McKay, & Snider, 1996; King et al., 2001; Nace, Davis, & Gaspari 1991). For example, studies have reported that opioid-dependent

subjects with APD as the sole comorbid diagnosis respond poorer to drug abuse treatment than subjects with APD and other psychiatric problems (e.g., King et al., 2001; Woody et al., 1985). Collapsing these subgroups of drug users with APD into one group and comparing it to samples without APD that often include cases of other psychiatric comorbidity might obscure meaningful subgroup differences. Some studies have also shown that drug users with APD often improve as much as subjects without APD but appear to have poorer outcomes because of greater baseline problems. Compton, Cottler, Spitznagel, Ben-Abdallah, and Gallagher (1998) found that injection drug users with APD had higher rates of HIV risk behavior at baseline and follow-up compared to subjects without APD but noted that both groups reported comparable decreases in risk behavior over time.

Much of the prior work on the treatment response of drug-dependent patients with APD is either retrospective or post hoc evaluations of response to routine drug abuse treatments (Brooner, Kidorf, King, & Stoller, 1998). Less is known about the response of these patients to interventions that target both unique and shared symptoms of both disorders (Alterman & Cacciola, 1991; Brooner et al., 1992; Gerstley, Alterman, McLellan, & Woody, 1990; Longabaugh et al., 1994). Specialized interventions that emphasize behavioral reinforcement may be a promising approach (e.g., Alterman & Cacciola, 1991; Arndt, McLellan, Dorozynsky, Woody, & O'Brien, 1994; Gerstley et al., 1990; Rounsaville et al., 1986; Vaillant, 1975; Woody et al., 1985). Vaillant (1975), for example, suggested that interventions for APD should be highly structured, provide consistent limits and frequent monitoring, and offer clear incentives for improvement.

Opioid agonist programs are ideal settings for this type of work. They offer a highly structured environment with frequent monitoring and considerable opportunity for contingency management (Kidorf, Stitzer, Brooner, & Goldberg, 1994; Stitzer & Higgins, 1995). For example, making the delivery of some aspects of routine methadone treatment (e.g., take-home doses, dose changes) contingent on reduced drug use has often produced higher rates of drug-free urine specimens in opioid-dependent samples (Iguchi, Stitzer, Bigelow, & Liebson, 1988; Magura, Casriel, & Goldsmith, 1988; Stitzer, Bickel, Bigelow, & Liebson, 1986; Stitzer et al., 1977; Stitzer, Iguchi, & Felch, 1992). An earlier report by Brooner et al. (1998) reported preliminary findings from a two-group randomized trial evaluating the efficacy of a highly structured contingency contracting intervention for opioid-dependent patients with APD. Data from the first 40 subjects showed good outcomes across treatment conditions but only modest evidence of greater improvement in those assigned to the experimental condition.

The present study tests whether an intensive contingency management intervention will improve treatment outcomes among subjects with opioid dependence and APD and extends the earlier study by Brooner et al. (1998) by reporting

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات