Addiction And: ASPD

By Chandler Scott McMillin

"Addiction And:" is a series of Recovery Systems Institute articles discussing counseling tips for complex cases that combine a substance abuse/dependence diagnosis with one or more Axis I or Axis II disorder.

We also discuss the topic of Antisocial Personality Disorder in our series on "Using Leverage with Court-referred Clients", but this article takes a more detailed look at the task of successfully treating the addict or alcoholic with pronounced antisocial traits.

Some common characteristics associated with the diagnosis of ASPD (based on DSMIV):

- Repeatedly performing acts that are grounds for arrest
- Deception (repeated lies, using aliases, conning others for profit or pleasure)
- Impulsiveness, failure to plan ahead
- Irritability and aggressiveness (fights or assaults); reliance on intimidation to get one's way
- Reckless disregard for safety (your own or others)
- A pattern of irresponsibility (can't sustain employment, doesn't honor financial obligations)
- Lack of remorse for harm done (indifference or rationalization).

The pattern begins in childhood, with conduct disorder, and continues on to later life. As a personality disorder, ASPD is remarkably resistant to change. It's far more common among males than females. Most importantly, estimates of substance problems among ASPD clients run in the neighborhood of 80%.

Easy to see this as a challenge to successful addictions treatment.

How Do I Evaluate My Client's Antisocial Behavior?

A formal diagnosis should be done by a mental health professional. But for a quick evaluation, you can use the "quick assessment tool" on page 4. You can print out a copy to use as needed.

First, do your ordinary psychosocial assessment. Then, using what you learned during the assessment, circle the items on the tool that seem to apply to your client.

If the total score is above the 20-25 range, you're probably best advised to formulate a treatment plan that addresses both addiction and antisocial behavior in an approximately co-equal manner.

This exercise also helps to elicit the specific traits and characteristics you will no doubt encounter during the course of treatment.

Developing a Treatment Plan

The goals of treatment might be stated as:

1. To promote recognition and awareness of the interrelationship of antisocial behavior and substance problems.
2. To address antisocial attitudes and behaviors as part of a recovery plan.
3. To counter the tendency towards substance relapse and criminal recidivism, and
4. To foster a sense of personal accountability for future actions.

We proceed on the assumption that we're treating two primary disorders that are linked to the point where we can't achieve the goal for one without addressing both.

Objectives are the steps involved in achieving a goal. Well-designed objectives are *specific*, *behavioral*, and *measurable*. It's important to be precise. If the objectives are vague, the treatment plan 'map' is difficult to follow—as if you'd instructed someone to meet you tomorrow morning somewhere in Texas.

When the goal involves a change in attitude or belief, then what you're doing is called *psychoeducation*, or therapeutic learning.

Suppose your client acknowledges the need to give up heroin and cocaine but expresses a continuing attraction to the glamour (*translation*: excitement and high living) of the dealer's lifestyle. It's the old dilemma of 'have my cake and eat it too'. The antisocial client may want to avoid the *consequences* associated with drug use, but be unwilling to sacrifice the rewards. His hidden goal is to become a more successful drug dealer.

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Just as alcoholics cling to idea of once again becoming social drinkers—despite mounting evidence that this is impossible—the antisocial individual may cling to the idea of making scads of cash or accumulating bling from excursions into crime.

Objective: Increase understanding of close relationship between drug dealing lifestyle and return to drug use, followed by consequences.

1. Have client identify 'slippery places and people' in past and current situation;
2. Critically examine get-rich-quick fantasies of criminal lifestyle;
3. Meet and interview other addicts who have had to renounce criminal lifestyle at AA/ NA meetings.

In practical terms, we can't adequately address anger management or improve conflict resolution skills without addressing traits such as low frustration tolerance, poor impulse control, and reliance on deception or intimidation to get one's way.

Three suggestions for treating antisocial addicts

First: *Strive to get past defenses to address attitudes and beliefs.*

Antisocial behavior is, at root, irrational, unrealistic, and self-defeating. But psychological defenses prevent the ASPD client from accurate perception of this reality. Much of the work of treatment involves getting past the denial, the rationalization, the externalizing, the intellectualizing, and the minimizing to make essential changes in attitude. In this respect, it's very similar to ordinary addiction treatment. Some of the defenses around antisocial behavior:

Denial: "I broke a lot of laws, but I never hurt anybody but myself."

Rationalization: "It wasn't all my fault. You weren't there, you can't understand."

Externalization: "I was provoked."

Minimizing: "I didn't do anything all that harmful."

Intellectualizing: "Technically, what I did is barely considered a felony."

Fantasy: "I though I'd get one last score, then get out."

Projecting: "I just did what others would do if they had the guts."

Second: *Antisocial behaviors are interrelated, so address them as a whole.*

Antisocial behavior is a vicious circle. For instance: low tolerance for frustration leads to angry outbursts which can get you fired. That results in a dramatic cash shortage that can motivate crime, which can result in an arrest that lands you back in jail. Upon release, you find yourself broke and without resources. You take some bad job that you resent and

eventually you wind up in a confrontation at work that results in your termination. Broke, you return to crime, get arrested again, are sent back to jail... a criminologist would deem that *self-perpetuating*.

That's why in practical terms, we can't adequately address anger management or improve conflict resolution skills without addressing traits such as low frustration tolerance, poor impulse control, and reliance on deception or intimidation to get one's way.

Third: *Seek to link addiction and antisocial behavior.*

The ASPD client doesn't experience addiction and antisocial behavior as separate phenomena. To him, it's all part of 'my problems'. Treatment works best when it's based on the precept that an addict can't stay clean and sober without addressing these other behaviors, and can't address the other behaviors without giving up alcohol and drugs.

'Each One Teach One' Method

'EOTO' activities involve two clients assisting one another in becoming more aware of certain behaviors that are interfering with recovery. Say Mel and Ben are offenders with acknowledged problems with anger management. Both tend towards impulsive displays of temper that they later regret.

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Instead of working with each individually, the counselor might pair them up with an assignment of pointing out to one another when one of them appears to be escalating towards more anger. By watching one another more closely, they can increase awareness of their own anger and the various triggers and traps that activate it. They can then report back to the group on what they may have learned.

It's also teaches an invaluable lesson: that what we can't do alone, we can often accomplish with the support of others.

Common Problems to avoid in addressing the ASPD substance abuser:

Focusing too much on childhood antecedents

Try not to get caught up in the assumption that antisocial behavior is really the result of your client's attempt to 'self-medicate" some emotional or psychological distress rooted in childhood. We don't really know what causes antisocial behavior --- or why some people become antisocial while others don't, despite similar early environments. Stick to the here and now – that's where change occurs.

Allowing too much ventilation of feelings

Ventilating negative emotions may make the client feel better temporarily, but we're not going to manage ASPD through expression of feeling. Ultimately, what counts is positive action. Just as the addict learns to stick to sobriety in the face of craving, the antisocial individual learns that certain behaviors must be avoided, no matter how he feels at the moment. Cognitive approaches derived from Reality Therapy, Rational Emotive Therapy, and Moral Reconation Therapy can help ASPD clients develop skills to deal with difficult or uncomfortable feelings.

Summary

Antisocial offenders are quite capable of stable, successful recovery. That depends, however, on their ability to recognize and address their own antisocial traits and behaviors. Those traits will likely never disappear entirely. Nonetheless, they can be managed in the context of a personal recovery program, and often respond well to recovery fellowships in the community.

Chandler Scott McMillin, Principal of Recovery Systems Institute, has created and operated successful addiction treatment programs for more than thirty years. He has written countless articles and co-authored seven books on addiction treatment and helped hundreds of families with successful interventions.

TOOL

Evaluating Antisocial Behavior

RSI Recovery Systems Institute

TREATMENT PROFESSIONALS

Quick Assessment Tool

A formal diagnosis should be done by a mental health professional, of course. But for a quick and dirty evaluation of a substance abusing offender, use your own psychosocial assessment to answer the following questions:

Does your client:	Score
1. Have an established pattern of arrestable activity?	1
2. Engage in crime not directly related to drug/alcohol use?	1
3. Exhibit a pattern of violent behavior?	3
4. Appear undeterred by prospect of arrest or punishment?	1
5. Have a history of arrest, violence, or conduct problems since childhood?	3
6. Repeatedly lie to cover activities other than drug or alcohol use	1
7. Assume aliases or con others for profit or pleasure?	1
8. Complain about others' inability to meet his/her needs?	1
9, Relate to you or others mostly through demands for gratification?	1
10. Have great difficulty tolerating frustration?	1
11. Seem unable to formulate realistic plans for the future?	1
12. Acknowledge a tendency towards physical fights or aggression?	1
13. Experience difficulty resolving conflicts verbally?	1
14. Antagonize others with a confrontational approach?	1
15. Intimidate others with temper?	1
16. Have "enablers" related to her/his potential for anger?	1
17. Show a pattern of aggression/intimidation to others since childhood?	3
18. Repeatedly engage in reckless behavior, endangering self or others?	1
19. Appear to be unusually egocentric?	1
20. Repeatedly engage in high-risk acts?	1
21. Exhibit lack of awareness of, or concern for, others?	1
22. Exhibit behaviors in 18-21 since childhood?	3
23. Appear chronically irresponsible in everyday life?	1
24. Show a pattern of lost jobs or aborted employment?	1
25. Repeatedly fail to honor financial obligations?	1
26. Fail to show remorse for previous actions?	1
27. Deny adverse effects of behavior on others?	1
28. Appear indifferent to others' feelings	1
29. Rationalize effects of their behavior on others?	1
30. Blame others for criminal activities?	1
31. Minimize consequences of negative behavior?	1
32. Show a pattern of absence of remorse since childhood?	3
TOTAL	

If the total score is above the 20-25 range, you're probably best advised to formulate a treatment plan that addresses both addiction and antisocial behavior in an approximately co-equal manner.