
Specialized Approach Shows Promise for Treating Antisocial Drug Abuse Patients

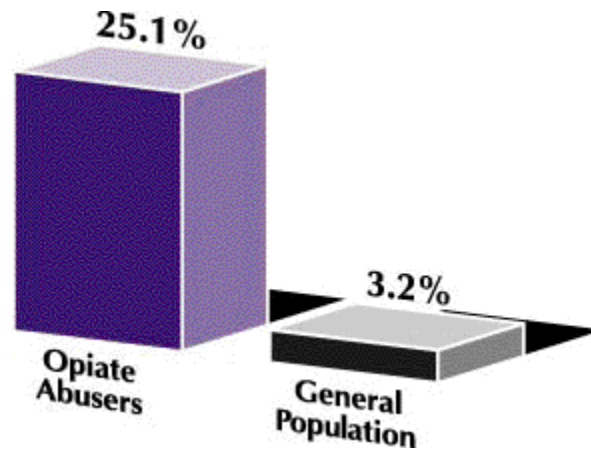
By **Robert Mathias**, NIDA NOTES Staff Writer

Drug-abusing patients with antisocial personality disorder (APD) often do poorly in drug abuse treatment and are at high risk of relapsing to drug use. Now, early results from a NIDA-funded clinical study indicate that a specially designed behavioral treatment may improve treatment outcomes of opiate-dependent APD patients in methadone treatment. The study found that APD patients who were rewarded quickly and frequently for not using drugs by being given progressively greater control over major aspects of their treatment had significantly lower rates of opiate and cocaine use than did similar APD patients receiving standard treatment who were rewarded only after they had achieved prolonged periods of abstinence.

"People in the experimental treatment are doing so well it's hard to believe our preliminary findings; they are so contrary to what is commonly thought about these patients," says Dr. Robert Brooner of Johns Hopkins University School of Medicine, who is the principal investigator for the 6-month clinical trial. "If the findings hold, the bottom line to the study is that it is possible with resources already available to community-based treatment programs to improve the treatment outcomes of antisocial drug abusers," he says. However, the specialized treatment will probably have to be continued indefinitely because these patients may not do well if returned to standard methadone treatment, Dr. Brooner cautions.

Drug abuse patients with APD display a variety of symptoms and problem behaviors, such as impulsivity and an inability to bond with others, that make them one of the most difficult populations for clinicians to treat, says Dr. Lisa Onken of NIDA's Division of Clinical and Services Research. Until this study, both drug abuse and mental health therapists have felt somewhat limited in their ability to treat drug abuse patients with APD effectively, she says. As a result, these patients often have not received the specialized treatment services that are needed to address the many problems they have, Dr. Onken says. That could mean that a substantial number of drug abuse patients are not being treated effectively since a diagnosis of APD is common among patients in drug abuse treatment, according to a number of studies.

Who Has APD?



A diagnosis of Antisocial Personality Disorder (APD) is common among patients in drug abuse treatment. In a recent study, Dr. Brooner found that opiate-dependent patients admitted to a methadone treatment program in Baltimore were eight times more likely to have suffered from APD during their lifetimes than were people in the general population in the Baltimore area.

In a separate study of the psychiatric characteristics of 716 opiate-dependent patients admitted to a methadone treatment program in Baltimore, Dr. Brooner found that APD was the single most prevalent coexisting psychiatric disorder. The overall prevalence of APD among these patients was 25 percent, says Dr. Brooner, with 34 percent of men and 15 percent of women having a diagnosis of APD. By comparison, the prevalence of APD in the general Baltimore population is about 3.2 percent, he says.

In his treatment outcome study, Dr. Brooner and his colleagues randomly assigned male and female opiate-dependent methadone treatment patients who had a diagnosis of APD to receive either an experimental behavioral treatment or the standard treatment administered by the methadone treatment program. Patients in the two groups were similar demographically, had comparable baseline drug use, and were stabilized on an identical dose of methadone.

Patients in the experimental group were put on a schedule that offered or took away desirable treatment options depending on the results of weekly urine testing and rates of attendance at counseling sessions. Patients who attended their counseling sessions and produced urine specimens free of illicit drugs earned the right to select a desirable treatment option as soon as 2 weeks after they began treatment. Then, every 2 weeks, patients who continued to do well would gain more control over aspects of their treatment, and patients who didn't do well would lose control of some treatment aspects.

As a result, experimental group patients who continued to do well could end up determining such treatment elements as the size of their daily methadone dose, the time of day they would get their medication, the right to take home up to three doses of medication per week, the day or days of their medication take-home doses, and the number of counseling sessions they had to attend each week. All medication dose changes and medication take-home doses were within limits established by the program's medical director, who had to approve all changes and take-home doses. By comparison,

patients in the control group could earn their first take-home medication only after achieving 12 consecutive weeks of drug-free urine specimens. The program determined all other aspects of their treatment.

Analysis of data covering the first 90 days of participation for 40 patients, 20 in each group, shows that experimental group patients had significantly lower rates of weekly urine specimens that were positive for opioids and cocaine than control patients did, Dr. Brooner reports. Specifically, 30 percent of all opioid drug tests for control patients during the 90-day period were positive. This was nearly three times as high as the 11 percent overall opioid-positive rate found among patients in the experimental group during the same period. In addition, 36 percent of the control group's urine tests for cocaine were positive, double the 18 percent rate found in the experimental group.

Because of their impulsivity, APD patients find it harder to delay any type of gratification than drug abuse patients in general do, Dr. Brooner says. However, most methadone treatment programs that offer treatment incentives only permit patients to earn a take-home dose of methadone after they have remained abstinent from illicit drugs for a period of 90 days, he notes. "To APD patients, these 90 days might seem like an eternity," and many of them are not able to stay drug free long enough to earn a take-home medication dose, he says.

"Basically, our model doesn't make APD patients wait for long periods of time before we reinforce positive behavior," says Dr. Brooner. Second, while previous studies have shown that selected treatment incentives, such as take-home medication doses, can help methadone patients do better in treatment, "we have made such individual incentives more powerful as reinforcers of positive behavior by bundling them together," to compete better with the reward the patient would experience from continued use of the substance, he says.

"If the study's preliminary results hold up, I think it would be significant in terms of providing a different type of treatment that is matched to a population in need," says Dr. Dorynne Czechowicz of NIDA's Division of Clinical and Services Research.

Previous studies have indicated that drug abuse patients with APD do not even respond well to enhanced behavioral treatments that have been successful with other difficult-to-treat populations. For example, in a recent study, Dr. Kenneth Silverman of Johns Hopkins University, Dr. Kenzie Preston of NIDA's Division of Intramural Research, and their colleagues found that about half of all injecting heroin abusers in methadone treatment who had a history of heavy cocaine abuse became abstinent and had sustained periods of abstinence from cocaine when they were rewarded for cocaine-free urines with vouchers that could be exchanged for items that promote healthy living. However, virtually none of the patients in this study who had a diagnosis of APD responded to this behavioral treatment.

"Our study shows that even though our treatment works for a lot of people, you really have to have something additional, something special for the patients with APD," Dr. Preston concludes. ([For more information on the voucher-based treatment, see NIDA NOTES, September/October 1995](#))

Sources

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From NIDA NOTES, September/October, 1996

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