Screening for antisocial personality disorder in drug users – a qualitative exploratory study on feasibility

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ABSTRACT Knowledge about co-occurring personality disorders in drug users is important for planning therapy and prevention. The objective of this study was to assess whether the SCID-II (Structured Clinical Interview for DSM-III-R) Screen for antisocial personality disorder was feasible and acceptable in a population of opioid users. A qualitative study on veridicality and emotional quality in responses to SCID-II Screen was carried out by personal interview in a multifunctional addiction centre. The subjects were 10 outpatient participants (six female, four male) in methadone substitution treatment.

The SCID-II Screen triggered a high level of emotions. Some questions were mainly interpreted from a victim's perspective, even though the intention was the perpetrator's view. Questions were seen as sex-biased. Provision of support to deal with potential emotional problems should be supplied. Potential revision should be considered to include the female perspective in the screen.

Key words: antisocial personality disorder, SCID-II, opioid use

Background and objectives

Psychiatric co-morbidity among illicit drug users is disproportionately prevalent. For example, the large-scale Epidemiological Catchment Area Study (Regier et al., 1990) documented lifetime psychiatric co-morbidity prevalence of 65% in illicit opioid user populations – about 6.7 times the lifetime prevalence in the general population. Mood disorders have been found to be especially common in cocaine user populations: 61% lifetime prevalence in a population of cocaine users has been reported (Rounsaville et al., 1991); other studies have shown prevalence rates ranging up to 77% in cocaine user populations (Mueser, Yarnold and Bellack, 1992; Brown et al., 1998). Illicit opiate user populations also have been shown to exhibit high lifetime prevalence rates of affective disorders. A recent meta-analysis of 16 studies (Frei and Rehm, 2002) found an average

prevalence rate of 31%, with prevalence rates ranging up to 74% (Rounsaville, Weissman, Kleber and Wilber, 1982). In addition to the elevated rates of affective disorders, personality disorders are also highly prevalent. The meta-analysis mentioned above found an average prevalence rate for personality disorders among opiate addicts of 41% (Frei and Rehm, 2002). Specifically, antisocial personality disorder (APD) features as the most common Axis II disorder in drug-user populations; studies indicate lifetime prevalence rates ranging from 20% to 65% in cocaine users (Flynn et al., 1995; Barber et al., 1996) and 25% to 69% in opiate users (Kokkevi and Stephanis, 1995; Chutuape, Brooner, and Stitzer, 1997; Brooner, King, Kidorf, Schmidt, and Bigelow, 1997). Gender has been recognized as an important factor when considering personality disorder-related co-morbidity in drug user populations; male samples tend to indicate more

disproportionate levels of APD (Marlowe et al., 1995; Barber et al., 1996; Chutuape et al., 1997).

Effective recognition among drug users of psychiatric disorders is essential for a comprehensive and full diagnosis, as well as for prevention and treatment (Chutuape et al., 1997; Darke and Ross, 1997; Mueser, Drake and Wallach, 1998; Krausz, Degkwitz, Kuhne and Verthein, 1998). This nexus is further emphasized by schools of thought that suggest closely related, or even causal, dynamics between those two fields of morbidity – as, for example, proposed by the ‘self-medication’ model (Khantzian, 1985). While thorough examination for psychiatric disorders maybe more feasible for in-treatment (especially in-patient) populations, the majority of illicit drug users in North America are not in treatment, are predominantly marginalized, and are difficult to reach for both intervention as well as research purposes (Metzger, Navaline and Woody, 1998; Fischer, Medved, Gliksman and Rehm, 1999; Kuo, Fischer and Vlahov, 2000); and in many instances constitute the so-called ‘hidden populations’ (Spreeen and Zwaagstra, 1994; Kuebler and Hausser, 1997). This poses particular challenges for systematic research with illicit drug user populations focusing on key determinants of morbidity and treatment needs, including psychiatric indicators. Furthermore, research realities testify that illicit drug user populations can react adversely to intrusive, lengthy or exhaustive research procedures, making detailed psychiatric diagnoses procedures difficult or impossible, especially when conducting ‘field’ research. Thus, for the purposes of socio-clinical research with illicit drug user populations, the availability of sensitive, reliable and acceptable psychiatric disorder screening tools is of high importance for the objectives of evidence-based development of prevention and treatment.

For the clinician and the researcher there are several instruments available for the examination of personality disorders. Some are interviewer administered – for example, the Personality Disorder Examination (PDE) (Loranger, 1988), the Structured Interview for DSM-III-R Personality (SIDP-R) (Pfohl, Blum, Zimmerman, and Stangl, 1989), and the Structured Clinical Interview for DSM-III-R (SCID-II) (First, Spitzer, Gibbon and Williams, 1995). There are also self-administered instruments, including the Millon Clinical Multiaxial Inventory (MCMI-II)

(Millon, 1985), the Personality Diagnostic Questionnaire (PDQ) (Hyler et al., 1988), and the MMPI Scales for DSM-III Personality Disorders (Morey, Blashfield, Webb and Jewell, 1988). A review of methods for diagnosing personality disorders found that diagnostic and inter-rater reliability was good for standardized instruments (Zimmerman, 1994). However, it has been suggested that categorical instruments (rather than continuous measures) may have decreased reliability (Pilkonis et al., 1995); the SCID-II (First et al., 1995) is one such categorical instrument, as it relies on DSM diagnosis criteria. The SCID-II also includes a patient/participant-administered screening questionnaire (First et al., 1995). The SCID-II Screen is a relatively quick instrument (about 20 minutes for all personality disorder screening questions), and can be administered in sections (to cover individual personality disorders); in order to obtain a valid diagnosis, the clinician would follow-up the affirmative answers (First et al., 1995). The SCID-II Screen has been found to have high sensitivity, although it may be overinclusive and show lower specificity (Ekselius, Lindström von Knorring, Bodlund and Kullgren, 1994). A comparison between the PDE and the SCID-II Screen found a low false negative rate for all personality diagnoses, with the false negative rate for APD using the SCID-II Screen at 0.0 (35.4% of the 260 subjects, volunteers for HIV testing, were diagnosed with APD using the SCID-II Screen) (Jacobsberg, Perry and Fances, 1995). A low false-negative rate would suggest that those who warrant the diagnosis of APD are not being overlooked using the instrument but the instrument may identify others who will not be diagnosed later. It has, however, been suggested that the SCID-II Screen is appropriate for providing a rough estimate of the prevalence of personality disorders within a population (Ekselius et al., 1994), and is thus useful for epidemiological research purposes.

For a national, multi-site socio-behavioural cohort study in Canada with a total of approximately 500 illicit opiate users outside of treatment (‘OPICAN’, as part of an Interdisciplinary Health Research Team – ‘IHRT’ – on ‘Illicit Opiate Addiction’), the interdisciplinary investigator team proposed the inclusion of the SCID-II Screen for APD into the cohort research and assessment protocol. In research development meetings, doubts were raised by some investigators as

well as user community representatives about the acceptability of the SCID-II Screen instrument within the target population, and subjects' willingness to provide veridical responses. Before inclusion into the 'OPICAN' study protocol, this small exploratory study was thus conducted to test the feasibility and acceptability of the SCID-II Screen for APD in illicit opioid users.

Methods and sample

This small (two-part) exploratory study was conducted with a sample of 10 illicit opiate users currently in treatment (six female, four male) in a Toronto hospital-based outpatient methadone treatment program. The subjects (P1–P10) were invited to the study office to complete an unspecified research instrument on personality issues for a research fee (the study was conducted anonymously, and subjects were paid \$15 plus transit for participation). Upon arrival at the research office, the individual subjects completed the SCID-II Screen for APD as specified in the instructions of the manual, in a private location (Part 1). After completion of the instrument, the subjects were asked whether the two researchers could ask them a few questions about the instrument (Part 2). All subjects agreed to participate in Part 2. This part consisted of one researcher asking open-ended questions following an open-question protocol, with the other researcher noting explicit responses as well as ethnographic context data (subject's expressions, other comments, demeanour, silence and hesitation breaks). These manual response transcriptions and field notes were systematically documented, and then manually coded and organized into categories and themes by the field researchers (Strauss, 1987). In an iterative and interactive process, inter-agreement on key themes and categories was reached on the basis of the data, and specific data samples were extracted for theme illustrations.

Results

A number of respondents pointed out that a key effect of some items of the SCID-II Screen (for example, the items trying to identify past actions of 'bullying' and 'sexual assault') may be that it will bring back rather unpleasant or hurtful memories, or trigger hurtful or upsetting emotions. For example, some respondents were reminded of physical or emotional transgressions

against persons that they committed, or of which they were victims, which had produced difficult or silenced memories that were re-awakened through the screener questions. This was particularly true for the 'sexual assault' item, which triggered bad memories and undesired emotions of victimization for a couple of study subjects. It should be noted that this item intended to identify perpetrators – subjects who committed transgressions – but the main effect seemed to be on victims of such actions. Subjects stated that 'It kind of triggered me . . . it brought up some anger' (P5); 'It brought back memories, bad memories' or even 'excitement' (P1); 're-opened [issues]' (P4); one subject was 'reminded of childhood, bad things, wished things were different' (P7), another one of a 'roller coaster' (P2). Respondents questioned whether, in a research setting, such disturbing trigger or flashback effects from the instrument would then be properly supported or responded to: 'It would bring up my abuse and . . . if I were to function as a normal woman would I like to pursue it and would you help me with it?' (P4). Numerous respondents emphasized that these dynamics would be likely to have a strong effect on the truthfulness with which people would respond to these sensitive and laden items – one respondent suggested that therefore the likely reaction may be to 'hurry up fast and put "no" [as a response to sensitive question items]' (P5).

Partly related to the issue of memories, a number of respondents commented that the SCID-II Screen for APD clearly represented and practised a 'gendered' view of deviant (antisocial) behaviour, both privileging male and neglecting relevant female behaviour. It was suggested that the majority of interpersonal transgressions probed for in the SCID instrument were 'more boy things' (P4) to do, and that, for example, 'not a lot of women set fires and a lot of boys do it' (P6), making these target issues more likely for males and more difficult for women to relate to as potential perpetrators. Correspondingly, subjects even commented that some males might accentuate their identity by 'bragging' (P4) or acting like a 'tough guy' (P8) about some of these deviant behaviours. On the other hand, the point was raised that women will be more likely to have been the victims or on the receiving end of these kinds of transgressions ('a lot of women will have a trauma issue . . . and were hurt' (P6)), but also that female antisocial behaviour may

occur in ways that are different from the explicit items of probes included in the instrument.

Furthermore, respondents referred to a number of factors or circumstances that might influence truthfulness in responding to the various question items. Some suggested that fear about legal implications (P3, P4) might hinder some from giving truthful answers; others thought that 'telling the truth' was recognized by many as a therapeutic deed, and thus appreciated as an opportunity (P7). Others suggested that possible shame, stigma or embarrassment, and thus negative impact on their current identity, might be factors that may prevent people from answering certain items truthfully, for example fearing that truthful answers may make them 'look bad or that they did something wrong' or '[were] a bad person' (P9), or 'they don't want to be known as . . . that bad' (P8), or that 'the person might think that you might see them differently' (P10). Specifically, these may also be problematic dynamics for subjects who saw themselves as having made improvement in their lives since possible transgressions occurred and are now 'knowing that they are doing good and you brought up this shit' (P4).

As a specific factor, being 'in' versus 'out' of treatment was judged ambivalently by the subjects with regards to its potential effects on 'truthfulness' of responses. Some respondents suggested that truthful responses would be more likely to come from people in treatment because treatment makes people more 'evolved . . . more mature and [they] learn to talk about [their] emotions' and that 'opening up to people has become part of [their] survival' (P2). Respondents in treatment were also expected to know that it is 'better to answer truthfully' (P4) as well as that 'they have nothing to hide' (P7) and they 'want to do things the right way' (P10). Conversely, a respondent suggested that subjects in treatment may not be truthful 'because they are in denial of who they are . . . and they would want people in the treatment program to "think the best of them"' (P9), indicating social desirability as an important motivator for answering the questions. On the other hand, people not in treatment were seen by some as being the ones likely to answer more truthfully, since they 'have nothing to hide' (P6) or because they are 'under no obligation to anyone, [there is] no risk of anything' (P5). Conversely, a couple of respondents expected that subjects not in treatment would be likely to 'lie because they're in denial and they are still

using [drugs]' (P5), because they 'don't have a hold on what's going on' (P9).

Discussion

The objective of this small exploratory study was to test the feasibility of using the SCID-II Screen for APD in epidemiological research with the target population of illicit drug users, specifically illicit opiate users. In general, the use of the screen instrument seems feasible; however, some key issues emerged that require consideration for the future use of this screen instrument. The 'trigger' effect of some of the screen items, as described above, may be problematic in the research setting, especially when adequate support for the exposed sensitive memories and emotions is absent or the veridical quality of answers to screen items is compromised. These undesired and potentially unpleasant memory or emotional consequences of the screen also suggest that the screen in its current form may be burdened with ethical limitations. Certainly, it seems advisable that the screen should be applied only in an interactive interview (rather than a written questionnaire) format, and that support is provided in order to adequately detect and respond to emotional reactions if they occur.

The gendered nature of the instrument suggests possible deficiencies in both capturing both the nature of female antisocial behaviour, as well as triggering distinct emotional memories of victimization for female participants. In fact, other research indicates that antisocial behaviour among female adolescents can differ substantially or occur in distinct forms from that in young males (for example, school suspensions, being drunk in public, promiscuity) (Marcus, 1999; Talbott and Thiede, 1999); existing DSM criteria are also insensitive to antisocial behaviour displayed by young females in that they are biased towards male forms of antisocial behaviour (such as violence and aggression) (Zoccolillo, Tremblay, and Vitaro, 1996). The phenomenon of undesired emotions or memory reactions mentioned above might have particular implications for female subjects. As described in our exploratory interviews, the screening questions may trigger negative emotional memories of victimization, especially for female participants, rather than memories of aggression. These emotions may in turn influence the veridical quality of the responses given to other questions, as events associated with these emotions can become more salient (Strack, Schwarz

and Gscheider, 1985; Eisenhower, Mathiowetz and Morganstein, 1991). This may even lead to non-response (Groves and Cooper, 1998) or to the provision of answers to the screen overshadowed by the experience of victimization, for example by minimizing one's own aggressive acts. All of these tendencies may distort the answers to the screen as well as to subsequent parts of the survey.

A final point has to do with the fact that dynamics of social identity and desirability connected to the respondents and their environment (addiction treatment) may possibly influence the truthfulness of answers given to the screen instrument considerably. Although there was no consensus or clear-cut pattern in the perceptions offered by the study sample about the determinants of truthfulness of answers – whether being in treatment would, in their view, increase or decrease the likelihood of veridical answers – the issue of truthfulness in answering items requires consideration in the real social and identity setting of respondents. In therapies of drug and alcohol dependence there are often strong normative views about the disorder of addiction and its ideology; these have been shown to influence and shape patients' perceptions and interpretations about their own problems (Arminen and Perala, 2001). Appearance, in the context of social interaction (in this case, a research interview) or a social setting (addiction treatment and a research environment), is meaningful for establishing and developing the self (Goffman, 1959; Stone, 1962). For example, the dynamics of social desirability – as evidenced for other fields – for participants assessed by the SCID-II Screen in a treatment setting may give way to the overall desire to demonstrate that the 'participant' is a 'good person', and has left 'bad behaviours' problematized in association with drug use behind, thus potentially influencing the truthfulness of answers to screen items.

In sum, the SCID-II Screen seems overall to be a feasible and valid research instrument. However, reflections, precautions and efforts seem required in correcting its undesired effects, balancing its gender sensitivity as well as correcting for potential compromising factors in the truthfulness of responses emerging from participants' social contexts.

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