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M D Pickersgill

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M D Pickersgill

ABSTRACT

The British National Institute for Health and Clinical Excellence (NICE) has recently (28 January 2009) released new guidelines for the diagnosis, treatment and prevention of the psychiatric category antisocial personality disorder (ASPD). Evident in these recommendations is a broader ambiguity regarding the ontology of ASPD. Although, perhaps, a mundane feature of much of medicine, in this case, ontological uncertainty has significant ethical implications as a product of the profound consequences for an individual categorised with this disorder. This paper argues that in refraining from emphasising uncertainty, NICE risks reifying a controversial category. This is particularly problematical given that the guidelines recommend the identification of individuals “at risk” of raising antisocial children. Although this paper does not argue that NICE is “wrong” in any of its recommendations, more emphasis should have been placed on discussions of the ethical implications of diagnosis and treatment, especially given the multiple uncertainties associated with ASPD. It is proposed that these important issues be examined in more detail in revisions of existing NICE recommendations, and be included in upcoming guidance. This paper thus raises key questions regarding the place and role of ethics within the current and future remit of NICE.

There are ethical dimensions to every diagnostic event within psychiatry.1 Nowhere is this more apparent than in the diagnosis of the controversial category antisocial personality disorder (ASPD). Individuals living under the label of personality disorder have long faced stigmatisation, although there are currently attempts to ensure that ASPD is “no longer a diagnosis of exclusion”.2–4 Furthermore, under current law in England and Wales, there continues to be important legal implications to the diagnosis of personality disorder in criminal offenders, including long-term incarceration in forensic settings.5 If psychiatry has an ethical valence, clearly it is exemplified in forensic mental health.3 6

Traditionally, many mental health professionals have not considered ASPD to be treatable.7 However, the tide of clinical opinion now appears to be turning.8 As a consequence of this and, perhaps, the significant attention that ASPD received following plans to alter the 1983 Mental Health Act of England and Wales, on 28 January 2009 the National Institute for Health and Clinical Excellence (NICE) released guidelines for the diagnosis, management and prevention of the disorder.9 In this paper, I draw on empirical data generated through a historical and sociological analysis of ASPD to identify and discuss some of the ethical implications of NICE’s guidance. The research took place between 2005 and 2008, and examined the ways in which ASPD has been operationalised within science, policy and practice from 1950 to 2007. In what follows, I examine some of longstanding uncertainties regarding ASPD within British psychiatry. This leads to a critical analysis of NICE’s failure to recognise these ambiguities. By reifying ASPD—by treating an abstract concept as a transparent, concrete phenomenon—NICE creates the very sort of ethical problems that its guidelines are purported to attempt at eradicating. I thus underscore the necessity of NICE engaging further with the ethical implications of its recommendations, and advocate the animation of fresh debate regarding the place and role of ethics within NICE guidance.

THE AMBIGUITY OF ANTISOCIALITY

Personality disorders associated with antisocial behaviour have long been an important, if contested, feature of psychiatric practice.10 In the UK, the culturally resonant construct of psychopathic personality disorder (psychopathy) has featured prominently within discourse in this area. Introduced to the UK from European psychiatry by the Edinburgh physician, David Henderson, psychopathy has often been regarded as a category in search of a referent.11 In spite of its longstanding role with mental health law, there has never been a clinical consensus regarding what causes psychopathy or what kinds of individuals should be classified with it.

Following the instatement of the 1959 Mental Health Act of England and Wales, which set out criteria for the management of criminal offenders with “psychopathic disorder”, social scientist and magistrate, Barbara Wootton, emerged as one of the most prominent UK critics of psychopathy. Articulating clearly what has become an enduring concern over psychopathy, Wootton argued that:

“[Psychopathy] is, in fact, par excellence, and without shame or qualification, the model of the circular process by which mental abnormality is inferred from anti-social behaviour while anti-social behaviour is explained by mental abnormality.” (p 250)12

Whereas not all psychiatrists would have agreed with her assertions, Wootton’s commentary nevertheless underscored a commonly held belief that psychopathy was an opaque category, problema-
tical to operationalise legitimately with clinical practice. Time did little to change matters; 15 years later, the eminent psychiatrist, Sir Aubrey Lewis, famously referred to psychopathy as a “most elusive category”.

Although, later, in the 1980s and 1990s, the prominence of the revised version of the Hare psychopathy checklist (PCL-R), a psychometric tool used to measure the severity of so-called psychopathic characteristics, came, to a large degree, to mute debate about the legitimacy of the “disorder” as a clinical entity and object of technoscientific concern, the degree to which the PCL-R captured the psychopathy construct continued to be contested.

In 1980, the American Psychiatric Association (APA) further complicated the ontology of psychopathy with the introduction of the category ASPD in the highly influential third edition of the Diagnostic and Statistical Manual (DSM). This text soon gained clinical purchase in UK psychiatry. With it, the APA idiom of antisociality began to resound through British research, discourse and practice. From the early 1980s, psychopathy was, therefore, no longer the primary categorisation psychiatrists employed when speaking of and working with especially antisocial individuals.

The degree to which psychopathy and ASPD were isomorphic constructs was not, however, obvious. In spite of statements by the APA that these labels might be used as synonyms, debate continues to revolve around this point. Some of this discourse originates from clinicians and researchers such as Robert Hare, who have a considerable stake in one of these categories or the other. This might thus indicate the importance ascribed to professional claims-making rather than the existence of more profound questions of ontological uncertainty. However, the soundness of the latter interpretation is supported by the great extent to which opinion varies at the coalface of practice.

Over 2005–8 I formally interviewed and informally spoke with a number of psychiatrists and clinical psychologists, and conducted ethnographic work at clinical conferences and seminars relating to forensic mental health. It is abundantly clear that the longstanding ambiguity regarding the ontology of personality disorders associated with antisocial behaviour endures. In particular, there are considerable uncertainties regarding the aetiologies of ASPD and psychopathy, as well as the relationship between them. For instance, whereas, for the most part, these constructs are thought to “overlap” (Dr 6), some clinicians consider there is, nevertheless, “a difference between the two” (Dr 6). Others, however, view them as being on the same psychopathological spectrum, with psychopathy simply more “severe” than ASPD. Yet some mental professionals think differently still, noting how they “don’t see much difference” (Dr 9) or not “a huge difference” (Dr 7) between the conditions. In line with the APA, these professionals instead consider ASPD and psychopathy as synonymous. However, others doubt the legitimacy of these constructs at all. Echoing Wootton, one senior clinical psychologist reflected:

What’s psychopathy? It’s something that’s high scoring on the Hare Checklist. And what’s the Hare Checklist? Well it measures psychopathy. I, I don’t know that we know what it is. I don’t think the Hare Checklist can make up its mind as to whether it’s a risk assessment or a personality assessment. That’s my problem with it. And a lot of the research that seems to be done with psychopathy defines it using the Hare Checklist. So I don’t know what they’re looking at.” (Dr 4)

The extract above exemplifies the uncertainties apparent within contemporary psychiatry and psychology concerning personality disorders associated with antisocial behaviour, and the scepticism regarding tools such as the PCL-R to resolve them. More generally, this brief review highlights the clear lack of consensus regarding how ASPD and psychopathy correspond to one another, and thus, what these categories are. These ambiguities sit alongside claims from highly credentialled investigators that assert psychopathy to be a well-validated psychological construct.

However, the mere existence of scientific facts about psychopathy is not enough to resolve uncertainty at the clinical coalface, particularly in instances in which the laboratory-generated data clash with the realities and perspectives experienced and considered by those working in the clinic. Even within scientific settings there are multiple ambiguities about ASPD and psychopathy. It is clear, therefore, that the ontological uncertainty so characteristic of personality disorder in the mid-20th century has endured.

**THE DANGERS OF REIFICATION**

The lack of consensus regarding personality disorders associated with antisocial behaviour is also apparent in the recent NICE guidelines for the treatment, management and prevention of ASPD. For instance, the guidelines suggest healthcare professionals consider a standardised assessment for the severity of ASPD (NHS, p8) when working with individuals in forensic or specialist personality disorder services. In order to do this, the use of the PCL-R is recommended. As described above, the PCL-R is a widely used tool for categorising psychopathy, not ASPD. At this point, the NICE guidelines thus follow the conceptual compression advocated by the DSM—the official terminological standard for ASPD—implicitly presenting ASPD and psychopathy as synonymous constructs.

The relationship between ASPD and psychopathy that is construed by the guidelines is not static, however. As the narrative shifts, so too do the conceptualisations of these categories. Twenty pages later, the reader is informed that:

“People with psychopathy […] represent a small proportion of people with antisocial personality disorder.” (NHS, p29)

Suddenly, psychopathy and ASPD are not the same. In line with much, but by no means all, clinical opinion, the NICE guidelines move to construe psychopathy as a more severe condition than ASPD. Whereas both categories refer to pathological antisociality and are considered to, on occasion, overlap, they are now implied to be ontologically distinct. This distinction is underscored when separate treatment recommendations for psychopathy are listed. Clinicians are encouraged to:

“consider cognitive and behavioural interventions (for example, programmes such as ‘reasoning and rehabilitation’) focused on reducing offending and other antisocial behaviour.” (NHS, p29)

However, earlier in the text, these same recommendations were made for individuals

“with antisocial personality disorder with a history of offending behaviour who are in community and institutional care” (NHS, p9)

To the careful reader, this (again) suggests that if there are differences between psychopathy and ASPD, these are clinically insignificant. This in turn suggests that these disorders are conceptually synonymous.

In highlighting these oscillations between different ways of thinking about ASPD and psychopathy, I have not intended to be supercilious, nor to suggest that these tensions should have
been resolved before publication of the NICE guidelines. Rather, I have aimed to draw attention to the fact that these ambiguities are now such an entrenched part of everyday psychiatric discourse that they have become invisible—even in institutional documents that, presumably, were inspected a number of times by a variety of critical readers before release. This invisibility is problematical in general, but the effacement of ontological uncertainty within institutional recommendations is a matter of special concern.

In particular, by eliding the ambiguities so characteristic of ASPD, NICE contributes to the reification of this category. Rather than noting that ASPD is a cultural artefact with a history of contestation and uncertainty, NICE instead presents this construct as a transhistorical and transcultural psychopathology that exists independently of attempts to classify and standardize it. This is in spite of many well-known and compelling arguments emanating from the social sciences and humanities for not considering DSM categories natural kinds (in particular, Rachel Cooper’s thoughtful philosophical analysis, Classifying Madness, which argues that it is unlikely that the DSM captures the natural structure of mental disorders).

Given the lack of consensus on the ontology of ASPD outlined above, we can be reasonably certain that even if the DSM formulation is a natural kind, the theoretical model of the disorder operationalised within clinical practice is unlikely to be. Care should thus be taken not to reify the category. Evidence for this comes from the analysis presented in the previous section, but also from other domains of medicine; it is well known that ambiguities are now such an entrenched part of everyday practice, clinical standards and guidelines are often used very limited and the outcomes of interventions are modest'' (NHS, p15). However, specific ways of circumventing these implications. Noting that “The evidence for the treatment of antisocial personality disorder in adult life is limited and the outcomes of interventions are modest” (NHS, p15), the guidelines highlight “the potential value of preventative measures” through “working with children and young people who are at risk, and their families” (NHS, p15; emphasis added). The identification of “vulnerable” parents is argued to be made, when appropriate, antenatally, and the characteristics of such individuals include:

- Parents with other mental health problems, or with significant drug or alcohol problems.
- Mothers younger than 18 years, particularly those with a history of maltreatment in childhood.
- Parents with a history of residential care.
- Parents with significant previous or current contact with the criminal justice system. (NHS, p15)

I do not claim that NICE is necessarily “wrong” to list these as risk factors. However, their inclusion does merit close scrutiny. For a start, these ciphers of vulnerability were synthesised from scientific studies, the cognitive authority of which again encourages their reification. Nevertheless, just because these factors have been “scientifically” derived does not neutralise the challenges that arise from the ontological ambiguity of ASPD. Setting aside the important point that the official definitions of ASPD have changed over time, and even assuming that each of the studies in question operationalised perfectly the diagnostic criteria outlined within the DSM, there is no guarantee that this matches the theoretical model of ASPD underpinning an individual clinician’s practice. Scientific research on risk factors for ASPD should, therefore, not be unproblematically incorporated into clinical work.

The problem of inappropriate labelling is rendered acute by the resonance between the “risk factors” outlined by NICE, and everyday, mundane stereotypes of how children come to be “bad”. Research into risk does not arrive at vulnerability factors as if by magic. Hypotheses are always tested, and the degree to which they are shaped by the preconceptions of investigators should not be underestimated—not should the ways that these, in turn, might vary with social location. Again, even assuming “perfect” research, there nevertheless remains considerable potential for the further stigmatisation of already marginalised groups. The challenges of working with and around stigma have formed the focus for much positive work in psychiatry over recent years. No doubt with this in mind, the NICE guidelines are frank in their admission that the intensification of stigma is possible (NHS, p 15). However, specific ways of circumventing stigmatisation are not addressed beyond a statement asserting that clinicians should:

“take care not to intensify any stigma associated with the intervention or increase the child’s problems by labelling them as antisocial or problematic” (NHS, p15)

However, there are no recommendations or prompts for reflection regarding how this might be achieved.

In drawing on the idiom of risk, the NICE guidelines are congruent with recent scientific work that frames antisociality as a trait to which an individual is susceptible, rather than something that is pre-given by nature or society. However, while the guidelines thus refuse simplistic, deterministic models of ASPD, they nevertheless refrain from sophisticated discussion of the social, legal and ethical aspects and implications of identifying “at risk” children, nor do they acknowledge the arguably intractable scientific difficulties in doing so. Furthermore, through eliding the issues of ontological uncertainty that has so long been characteristic of personality disorder, NICE refrain from examining the degree to which these ambiguities might challenge some of the evidence for some of their more contentious recommendations. The NICE guidelines thus have the potential to contribute to the reification of ASPD, and the further stigmatisation of already marginalised individuals.

CONCLUSION

This paper has sketched out some of the ontological uncertainties characteristic of ASPD, exemplified by its opaque association with psychopathy, and identified some of the ways in which this ambiguity has sedimented within the recent NICE ASPD guidelines. It has been argued that ontological uncertainty has ethical implications. In particular, there is a danger of the reification of a historically and socially contingent category that has profound consequences for those living under its label. Of course, issues of ontological uncertainty are not unique to ASPD, or even to psychiatry. These have long been debated by sociologists and philosophers, and the literature is rich with arguments on both sides of the debate. However, as evidenced by the considerable public interest in the NICE guidelines, the question of how best to handle the issue of uncertainty has important implications for the way that it is communicated to patients and the public.

Sociologists have advanced several useful analyses of the politics of identifying “at risk” individuals over the past decade.
clinicians internationally.\textsuperscript{26} However, when pertaining to forensic mental health, the ethical corollaries of uncertainty are significant to say the least. They currently continue to demand our close attention.\textsuperscript{4}

NICE has provided a valuable set of guidelines on ASPD, synthesising a broad range of sometimes contradictory evidence and presenting its recommendations clearly and articulately. Nevertheless, the diagnosis of ASPD should be made judiciously, and authoritative institutional documents must strive to foster a psychiatric climate in which such reflexivity might flourish. Given the chance that individuals could be inappropriately labelled as “risky”, the diagnostic uncertainty surrounding what ASPD is should be highlighted and not effaced or eclipsed in the process of developing guidelines. Although the current NICE guidelines do make noteworthy efforts to prompt clinical reflection, the lack of recognition of the problematical ontology of ASPD limits the extent to which this might be effected. I therefore recommend that in any future revisions of the ASPD guidelines, NICE considers how it might more explicitly cast light on the uncertainty surrounding this disorder and its ethical, legal and social dimensions and implications.

Based on this analysis, we might also speculate about the place of ethical reflection and deliberation within NICE guidelines more generally. As an NHS body playing an important role in the governance of clinical practice, NICE must attend to the implications of its guidance. Psychiatric work will always have an ethical valence, and it is inappropriate for practice guidelines to divorce clinical recommendations from their implications. The ways NICE might foster reflexive practice while avoiding advocating managerial “ethical tick-boxing” exercises or some form of bureaucratic anticipatory ethical regulation is unclear. However, there is a pressing need for these questions to be asked and debated. As the influence of NICE within contemporary British health care increases, the necessity of engaging with the ethical implications of its guidance will become ever more significant.

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