

13. BÖLÜM

Antisosyal Kişilik Bozukluğu

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Yıkıcı bozukluklar, dürtü kontrol ve davranım bozuklukları (YDKDB) duygu ve davranışın bireysel kontrolündeki sorunları içeren durumlardır. YDKDB’nda kişiler, başkalarının haklarını ihlal eden (ör., saldırganlık, mülkün tahrip edilmesi) ve/veya bireyi toplumsal normlar veya otorite figürleriyle önemli çatışmalara sürükleyen davranışlar sergilerler. Ortak özellikleri dürtü kontrolündeki bozukluktur. Duygu ve davranışların özdenetiminde yaşanan sorunların altında yatan nedenleri değişkendir. YDKDB’i; disinhibisyon, kısıtlama ve daha az oranda negatif duygusallık olarak sınıflandırılan kişilik boyutları ile ilişkili dışsallaştırma spektrumuyla bağlantılandırılmıştır. Bu kişilik boyutları, bu bozukluklar arasındaki yüksek komorbiditeyi ve bunların madde kullanım bozuklukları ve antisosyal kişilik bozukluğu ile sık görülen komorbiditesini açıklayabilir (APA, 2013).

Ruhsal bozuklukları etiyolojiye göre gruplandırma girişiminde beş küme önerilmiştir. Bu kümelerden biri dışsallaştırma bozukluklarıdır (Krueger ve South, 2009). Dışsallaştırma davranışları, olumsuz duyguların öfke, saldırganlık şeklinde direk olarak ötekilere yöneltilmesi olarak tanımlanabilir (Roeser ve ark., 1998). Kişilerin özdenetim becerisinin yeterince gelişmemiş olması ile ilişkilendirilir (Cole ve ark., 1996). Dışsallaştırma spektrumunda sınıflandırılan bozukluklar çocukluk çağı yıkıcı davranım bozuklukları, erişkin antisosyal kişilik bozukluğu ve alkol, madde kullanım bozukluklarıdır (Krueger ve Markon, 2000).

Dürtüselliğin birçok tanımı vardır. Dürtüsellik, çok fazla öngörü veya bilinçli yargılama olmaksızın ve genellikle bu dürtüsel davranışların neden olduğu olumsuz sonuçları dikkate almadan iç veya dış uyarılara tepki olarak gerçekleştirilen açık

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tik ilaç tedavisinin etkinliğini değerlendiren randomize kontrollü bir çalışma yoktur, ancak vaka raporları antipsikotiklerin faydalı olabileceğini öne sürmektedir (Hirose, 2001; Walker ve ark., 2003).

Antipsikotik kullanımı yetersiz gelirse ya da kullanıma engel başka bir durum varsa selektif seretonin antagonizantları (sertralin 100-200mg/gün, fluoksetin 20mg/gün) ikinci sırada tercih edilebilirler. Selektif serotonin geri alım inhibitörü antidepressanların ASKB tedavisindeki etkinliği ile ilgili yapılmış randomize kontrollü bir çalışma olmamasına rağmen dürtüsellik, saldırganlık ya da öfke gibi davranışların tedavisi ile ilgili yapılan 3 küçük çalışmada karışık sonuçlar elde edilmiştir (Coccaro ve Kavoussi 1997; Salzman ve ark., 1995; Rinne ve ark., 2002).

Bir diğer seçenek mizaç düzenleyicilerdir (lityum karbonat ya da karbamazepin, okskarbamazepin, fenitoin gibi antikonvülanlar). Bu ilaçların bipolar bozukluk tedavisinde tavsiye edilen doz ve kan seviyelerinde kullanılması uygundur. Randomize bir çalışmada lityumun hapisanedeki mahkumlarda tehditkar davranışları ve saldırganlığı azalttığı saptanmıştır (Müller-Oerlinghausen ve Lewitzka, 2010). Farklı çalışma gruplarında yapılan randomize çalışmalarda antikonvülanların dürtüsel saldırganlığı azalttığı gözlenmiştir (Jones ve ark., 2011).

Propranolol, buspiron ve trazodon gibi ilaçlar da özellikle beyin hasarı olan hastalarda saldırganlık tedavisinde kullanılabilirler (Davis ve ark., 1995). Bağımlılık tedavisi: Metadon idamesi kötüye kullanımı engellemek ve yoksunluk belirtilerini azaltılmak amacıyla kullanılabilir. Bununla birlikte ASKB ve ek madde bağımlılığı olan bireylerde yapılan bir çalışmada suçta neden olan an-

tisoyal davranışlarda bulunma olasılığını azalttığı ve aile arasında daha az çatışmaya neden olduğu saptanmıştır (Cacciola ve ark., 1995). Bu hastalarda bağımlılık yapan veya bağımlılık potansiyeli olan ilaçlardan olabildiğince kaçınılmalıdır.

Benzodiazepinler bağımlılık potansiyeli yüksek olan ASKB olan bireylerde kullanılmamalıdır. Ayrıca bu hastalarda agresif davranışları artırabilir, borderline kişilik bozukluğu olanlarda ters yanıt oluşturabilir (Cowdry ve Gardner, 1988).

Dikkat eksikliği hiperaktivite bozukluğu (DEHB) tedavisi: ASKB ile birlikte yetişkin DEHB olan hastaların tedavisinde bağımlılık yapmayan bupropion, ya da atomoksetin gibi ilaçlar kullanılmalıdır (Westmoreland ve ark., 2011). Madde kullanım öyküsü olmayan hasta gruplarında ikinci tercih olarak metilfenidat ya da dekstroamfetamin gibi uyarıcı ilaçlar kullanılabilir. Ancak mutlaka yakın takip yapılmalıdır.

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