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Dangerous cases: when treatment is not an option

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There are those who walk among us that have no conscience. They mouth certain feelings, but have no emotion. They do not bond to any living creatures. Because of their chronic emotional detachment and often sadistic impulse, they aggress without inhibition when their desires are thwarted. Their sole relational goal is to dominate their objects. They are the consummate "intraspecies predators" (Meloy and Meloy, 2002).

Although this sounds like fiction, it is not. Each of these assertions is supported by abundant empirical evidence. We are describing, of course, the psychopathic subject in his most severe, ontogenetic form. Psychopathy research is burgeoning, and over the past decade the world scientific literature has yielded over a thousand studies.[1] When psychopathy enters the consulting room, for the psychotherapist or psychoanalyst it is a sign of danger.

The nature of the beast

We theoretically conceive of psychopathy as a genotype, much like schizotypy (Raine *et al.*, 1995) – a stable constellation of biologically predisposed traits and behaviors which exists in various members of our species. In the context of certain social and cultural norms, psychopathy has different levels of phenotypic expression. For example, best estimates suggest that psychopathy in its most severe form is present in 1% of the world's population (Hare, 2003). However, the prevalence of antisocial personality disorder (ASPD), as most recently defined in DSM-IV-TR (American Psychiatric Association, 2000), varies considerably across cultures. In the United States, ASPD is found in 5.8% of males and 1.2% of females (Kessler *et al.*, 1994) for an average general population rate of about 3% (American Psychiatric Association, 2000). In Taiwan, ASPD rates are *20 times less* than in the United States, likely a corollary of a social emphasis on collectivism versus individualism in each respective

country (Reavis, 1998). The practical implications of these theoretical assertions and empirical findings are that the clinician should regard psychopathy, if present in a patient, as a stable, immutable aspect of his or her personality that will range in severity from mild, to moderate, to severe; and although most likely to be present in the context of a diagnosable ASPD – admittedly a rough categorization – it may also be noticed in the presence or absence of other DSM-IV-TR personality disorders. We illustrate this with a case from the first author's files.

Case A

Dr A was hired as a forensic psychiatrist in a publicly funded court clinic to perform evaluations of subjects in custody and testify in the California Superior Court. His resume was impeccable, although on interview his mannerisms were unusual and he largely avoided eye contact. As soon as Dr A began working, however, problems arose. Court personnel complained about his lateness in filing his evaluations and his unreliable and often bizarre testimony. After 2 months of incessant complaints, he was terminated from his position while on probation.

Several months later, his girlfriend won a custody battle for their young daughter, as well as a large financial settlement. Her testimony at the civil hearing was dramatic. She recounted two incidents: she and her Hispanic nanny were detained for many hours at an international airport in the United States following an anonymous phone call to authorities which indicated that the nanny was trying to illegally enter the country. She was not. The second incident was even more disconcerting. Dr A invited his girlfriend over to his home during their civil litigation, ostensibly to attempt some kind of reconciliation. He romanced her, and she consented to go to bed with him. Once in bed, he turned on the television set which displayed a police video of a sexual homicide crime scene. He told her, "this is what happens to bad girls." At the time he was consulting with the local prosecutor's office on the sexual homicide case.

Within 6 months of the settlement, Dr A was arrested for attempting to contract with an undercover police officer to have his girlfriend murdered. He was convicted of solicitation for murder, lost his medical license, and was sentenced to prison. Although he offered to provide medical services to other inmates, his generosity was declined. Prison psychologists evaluated him and diagnosed Dr A as a psychopath with prominent narcissistic and schizoid features. He successfully served his prison sentence and subsequent parole, and appears to have relocated to another state in the United States.

Dr A, although he completed the training and education to legally treat mentally and emotionally ill individuals, was an untreatable specimen himself. Other writers have documented the lengths to which professional guilds will go to protect psychopathic members of their own professions (Stewart, 1999; Vise, 2002).

Psychopathy should concern clinicians for three reasons: when it is severe, treatment is a waste of time and effort, and may make the character pathology worse;

the patient is likely to be emotionally dangerous; and the patient may be physically dangerous and pose a real threat to the clinician and others.

There is no body of controlled treatment outcome research, and there is, at present, no mental health treatment for psychopathy. These findings do not preclude the eventual discovery of an effective treatment regimen, but they do invite clinical caution and therapeutic skepticism if psychopathy is diagnosed in a patient seeking treatment. There are, moreover, several research studies which suggest that mental health treatment, when applied to the severely psychopathic patient, may *increase* his risk of future criminal behavior (Rice *et al.*, 1992; Seto and Barbaree, 1999). In a large prospective study of offenders in England and Wales, Hare *et al.* (2000) found that psychopaths with substantial interpersonal and affective deficiencies recidivated at a much higher rate if they had received treatment than if they had not. D'Silva *et al.* (2004) noted, however, that a negative treatment effect has not been *established*, and there is only one study of psychopathy and its effect on treatment in a non-forensic sample of patients (Skeem *et al.*, 2002); in the Skeem study, psychopathy did not diminish the treatment effect of traditional mental health care in reducing subsequent violence over the short term. Nevertheless, clinicians should keep in mind the absence of positive effects, and the presence of some negative effects of mental health treatment on psychopathy, and proceed with great caution.

The emotional danger of the psychopathic patient is a less obvious, but still serious issue. It often emerges from two inherently conflicted positions. On the one hand, the psychopath wishes to dominate his objects, and will use whatever interpersonal skills are at his disposal to do so. On the other hand, the clinician assumes that a patient has the wish and the capacity to form a therapeutic relationship based upon trust and a motivation to get better. Dominance–submission and reciprocal affection do not mix, and the clinician may become deeply disturbed as he or she gradually, or suddenly discovers the mendacity of their psychopathic patient.

The emotional life of the psychopath is developmentally pre-oedipal and pathologically narcissistic. Psycopaths do not experience emotions such as sympathy, empathy, gratitude, shared joy, guilt, or remorse. Such feelings necessitate whole object relatedness: the ability to mentally represent self and others as whole, real, meaningful, and separate individuals. Although not yet empirically measured in the childhood psychopathy literature, he may not even develop the rudimentary skills of sharing and exchanging evident in young toddlers who are just beginning to understand the presence of a separate other (Gacono and Meloy, 1994; Meloy, 1988, 2001).

His emotional life is instead characterized by part self and part object relations and accompanying feelings of boredom, exhilaration, frustration, excitement, shame, envy, and rage. Others are purely extensions of the self (Meloy, 2001), only present intrapsychically and interpersonally as sources of immediate frustration or

gratification. In other moments they do not exist, especially as constant objects of gratitude or concern.

The clinical problem is that the psychopathic patient will often imitate the more mature emotional states that he observes the psychotherapist wants him to feel. He does not identify the nuances of the clinician's emotions and desires for him through empathy, but through the vigilant activity of a predator studying the behavior of his prey. Psychopaths in the laboratory show enhanced orienting responses in certain reward situations when compared to normals (Hare, 2003). We also know through functional neuroimaging studies that they do not process emotion the way normal individuals do (Kiehl *et al.*, 2001), and clinically appear to be limbically disconnected (Meloy, 1988).

Case B

Patient B, a severe psychopath, was misdiagnosed as a narcissistic personality disorder and began intensive, psychodynamic psychotherapy. As the weeks passed, the clinician became aware that his assumptions that patient B – despite his grandiosity and sense of entitlement – experienced anxiety, formed attachments, and had a conscience were wrong. These prerequisites for successful treatment were absent. Instead, the patient became irritated, evasive, or gave absurd statements when asked to describe certain emotions he reportedly felt. The clinician sought supervision to address his disturbing recognition that the perceived emotions in his patient were only his wishful projections. Psychological testing done by a consulting psychologist confirmed his suspicions.

The physical danger of the psychopathic patient should not be underestimated, even in the absence of a history of violence. There are many case studies which document both the affective (sudden, reactive, emotional) and predatory (planned, instrumental, emotionless) violence of psychopathic males who maintained a veneer of familial bliss and occupational success for several years prior to their commiting murders (Cahill, 1986; McGinniss, 1983; Rule, 1980). Often the motivation for the first killing is quite banal. In a recent California case, *People* v. *Scott Peterson*, a young man with many of the hallmarks of the core personality characteristics of psychopathy murdered his pregnant wife and attempted unsuccessfully to dispose of her body in the San Francisco Bay. He killed for unknown reasons, but was having an affair at the time. Peterson was eventually convicted and sentenced to death. The reporters who covered the trial were perplexed and disturbed by his complete absence of emotion throughout his court appearances. When he arrived on death row at San Quentin, he was overheard to remark, "what an adrenaline rush!" (first author's files). Both of these behaviors would be consistent with a chronic emotional detachment and a hunger for autonomic arousal noted in the clinical and empirical psychopathy literature (Hare, 2003).

In forensic research the relationship between psychopathy and violence has been well documented. When compared to non-psychopathic criminal offenders,

Table 11.1 The Hare Psychopathy Checklist: Screening Version (Hart *et al.*, 1995)

1. Superficial
2. Grandiose
3. Deceitful
4. Lacks remorse
5. Lacks empathy
6. Doesn't accept responsibility
7. Impulsive
8. Poor behavioral controls
9. Lacks goals
10. Irresponsible
11. Adolescent antisocial behavior
12. Adult antisocial behavior

psychopathic criminals are more likely to be violent (Williamson *et al.*, 1987), use a weapon (Hare *et al.*, 1988), target strangers, arouse to sadistic sexual and non-sexual themes (Levenston *et al.*, 2000), continue to be violent as they age (Hare, 2003), violently fail when conditionally released to the community (Hare, 1981), and escape from forensic hospitals (Gacono *et al.*, 1997). The presence of psychopathy is the strongest predictor of violence in both forensic (Hare, 2003) and civil mental health settings (Monahan *et al.*, 2001), and is the second strongest predictor of sexual reoffending (Harris *et al.*, 2001) – the first being sexual arousal to deviant stimuli. Research on the so-called white collar or successful psychopath, however, is in its infancy (Babiak and Hare, 2006), and other non-violent forms of aggressive predation in this population, such as economic exploitation of others, have yet to be measured.

Diagnostic issues

Psychopathy can be measured in a reliable and valid manner utilizing one of the Hare instruments (Hare, 2003). Table 11.1 lists the 12 screening criteria for psychopathy (PCL:SV, Hart *et al.*, 1995) and is a highly correlated short form of the 20-item Psychopathy Checklist-Revised (PCL-R) (Hare, 2003). The Hare instruments are quantifiable observational measures based upon clinical interview and records review, and should only be used by a qualified mental health professional with appropriate training.

We recommend the screening version for clinical practice when psychopathy is suspected. It does not require the time commitment of the PCL-R and provides the psychotherapist with an objective measure of his or her clinical concerns. Further

psychological testing may be warranted by elevated scores on the PCL:SV (>13). Gacono and Meloy (2002) provide a comprehensive guide for assessing psychopathy utilizing various tests and measures.

Unfortunately, the DSM-IV-TR (American Psychiatric Association, 2000) gives little help in the diagnosis of psychopathy since the ten personality disorders – especially Cluster B – are largely polythetic, behavioral criteria sets that have poor discriminant validity and show a comorbid relationship with many other Axis I conditions. In criminal populations, however, the severity of psychopathy does closely correlate with the number (1–7) of ASPD criteria in DSM-IV-TR that are met. In public and private non-forensic mental health settings, however, the psychopathic patient may have no overt history of criminality or violence, yet over time evidence both the interpersonal (glibness, grandiosity, pathological lying, manipulation) and affective (lack of remorse or guilt, shallow affect, callousness, failure to accept responsibility) deficiencies that are the core personality traits of the disorder. Psychological testing in such settings is critical, even though it is not often utilized by psychotherapists and psychoanalysts. The Rorschach, for example, can save a clinician many hours of wasted effort when employed as a prognostic telescope of treatment outcome (Gacono and Meloy, 1994; Weiner, 1998). An early decision not to treat based upon competent testing also avoids the sticky wicket of transference and countertransference if such a decision must be made weeks or months into the therapeutic work.

Countertransference phenomenon

The clinician's reactions to the psychopathic patient often provide sensitive emotional indicators of the latter's psychopathology, and do not necessarily indicate neurotic conflict in the psychotherapist. In fact, such reactions may imply evolved adaptive strategies that have been developed to protect ourselves against the predation by such individuals (Meloy and Meloy, 2002). Such reactions should *not* be documented in the clinical record since they will be viewed by others as admittedly subjective, but they can provide an impetus for further objective testing to measure the degree of psychopathy in the patient of concern.

Lion (1978), Symington (1980), Strasburger (1986), Meloy (1988, 2001), and Gabbard (1994) have identified eight common countertransference reactions which are listed in Table 11.2. We have also added a ninth.

Therapeutic nihilism

Lion (1978) used this term to describe the clinical rejection and condemnation of all patients with any history of antisocial behavior as being completely untreatable. Instead of carefully evaluating the patient who has some psychopathic traits for evidence of conscience, anxiety, attachment, and conflict, the clinician sees him as

Table 11.2 Countertransference reactions to the psychopathic patient

1. Therapeutic nihilism (condemnation)
2. Illusory treatment alliance
3. Fear of assault or harm
4. Denial and deception
5. Helplessness and guilt
6. Devaluation and loss of professional identity
7. Hatred and the wish to destroy
8. Assumption of psychological complexity
9. Fascination and sexual attraction

a pariah and devalues him, concordantly utilizing a psychological defense that is very common in psychopathy (Racker, 1968). The clinician does to the patient what the patient does to others. Symington (1980) referred to this same countertransference reaction as *condemnation*.

Illusory treatment alliance

The opposite reaction in the clinician is the illusion that there is a treatment alliance with the patient when, in fact, none exists. As illustrated in the case B vignette above, such perceptions are often a product of the wishful projections of the clinician and the imitative skill of the patient. Meloy (1988) called this *malignant pseudoidentification*. Behaviors during psychotherapy suggest that such an alliance should be skeptically viewed, especially if the patient's psychopathy is moderate to severe. The psychopath is a chameleon, and early psychoanalytic papers on his propensity to imposture are elegant and insightful (Greenacre, 1958). Bursten (1973) described the "manipulative cycle" in the psychopathic patient wherein he successfully deceives the other person and then feels contemptuous delight. Such feelings serve to maintain his narcissistic homeostasis as he demonstrates to himself, once again, that he is cleverer than his psychotherapist. The clinician will be left feeling angry and humiliated.

Fear of assault or harm

Strasburger (1986) wrote that both reality-based and countertransference fears may co-exist when attempting to treat the psychopath. This particular reaction is an emotional defense in the clinician that is often signaled by autonomic arousal and visceral reactions, such as piloerection ("he made the hair stand up on my neck"), even in the absence of any actual violence or direct threat. Clinicians may also react autonomically to the predatory stare of the psychopath (Meloy, 1988),

which is often a fear reaction to the absence of emotion in his eyes. Although the visual communication of emotion is a quotidian experience for most individuals, it appears to be absent in psychopathy, and may eventually be measured in the laboratory. Meloy and Meloy (2002) found that over three-quarters of a large sample of professionals described such autonomic reactions when in the presence of a psychopathic subject, most commonly a dermatological event or somasthetic feeling ("he made my skin crawl"). Such reactions may portend real danger and should never be ignored.

Denial and deception

Denial is most often manifest in clinicians through their counterphobic responses to real danger. It is a common defense against anxiety generated by violent patients, and has been documented in those who witness mass murderers preparing for their acts, yet do nothing (Meloy *et al.*, 2004). Sometimes clinicians will not believe that a patient has a criminal history despite the presence of a "rap sheet" and extensive documentation to the contrary. Clinicians will be heard referring to their patient as having "allegedly" committed a crime despite the fact that they have been tried and convicted by a jury.

Case C

Patient C was a psychopath and sexual sadist who was committed to a forensic hospital for the torture, rape and murder of several stranger females. During a quality assurance peer review of the patient's chart, it was noted that the diagnosis of "sexual sadism" had been removed from his Axis I DSM-IV-TR formulation. When the treating psychiatrist was asked about this omission, he said, "oh, we dropped it since he hasn't done anything sexually sadistic since he's been here at the hospital."

Deception of the psychopathic patient is most often done by the clinician when she is frightened of him and wishes to avoid his rage if she tells him the truth. It may also suggest superego problems, passive-aggressive behavior, or identification with the patient's deceptive skills. Rigorous honesty without self-disclosure is a crucial treatment parameter with such patients.

Helplessness and guilt

Clinicians beginning their careers may feel particularly helpless and guilty when an antisocial or psychopathic patient does not change despite their earnest efforts. It is difficult to accept the immutability of certain personality traits, especially when viewed through the prism of a treatment philosophy that endorses the basic goodness of human nature. Psychopaths challenge our desire to order and idealize the human experience. Sometimes such feelings originate in the clinician's narcissistic belief that they have an omnipotent ability to heal others, what Reich (1951)

referred to as the "Midas touch syndrome." Psychopaths will exploit this narcissistic vulnerability by imitating back to the psychotherapist behaviors that confirm what he admires the most: his ability to heal the patient, and perhaps unconsciously defeat the therapists who had previously failed to help the patient.

Devaluation and the loss of professional identity

If therapeutic competency is only measured through genuine change in the patient, psychopathy will be a source of continuous professional disappointment and narcissistic wounding. In institutional settings where contact with such patients is prolonged and controlled, clinicians will often report symptoms of depression and "burnout" due to their treatment failures and marginal positions of power and authority when compared to the staff responsible for security. Despite the adept management of the psychopath's contempt, it is difficult not to feel despicable and devalued because of the primitive, preverbal nature of the patient's defenses, often behaviorally manifest through belittling and aggressive gestures.

Case D

Subject D was the eighth individual to enter the young female psychologist's office on her first day of work at a maximum security prison. She felt proud and confident of her skills, establishing rapport with the inmates and keeping her professional boundaries quite clear and forthright. When subject D sat down, he ignored her questions, and began talking about how she smelled. He speculated on the nature of her perfume, looked her over, and made suggestions for improving her smell and her appearance in the custody setting so as not to sexually provoke other inmates. She felt devalued and controlled, her lips and hands began to tremble, and she could not stop the tears welling up in her eyes. She abruptly ended the interview.

Hatred and the wish to destroy

Psychopathic patients despise goodness itself, and often work hard to damage the goodness they perceive in others to manage their envious feelings. Paradoxically, a psychotherapist who is devoted to being very competent and responsible with such patients will often stimulate the most envy in them. Some clinicians will identify with the psychopathic patient's hatred and aggression to ameliorate their impact upon themselves (Gabbard, 1996). If not acted upon, such feelings in the clinician can be a source for understanding the psychopathic individual's intensity of aggression and the biogenic or sociogenic roots of such impulses. It is not uncommon for psychotherapists or psychoanalysts working with such patients to have spontaneous homicidal fantasies prior to an awareness of the affective components of their aggression toward such patients. Searles (1979) explored the clinical awareness of a wish to kill one's patient.

Assumption of psychological complexity

The most subtle countertransference reaction to psychopathy is the clinician's belief that the patient has the internal structure and developmental maturity of a neurotically organized individual, and it only has to be discovered in treatment. Severely psychopathic individuals are organized at a borderline level of personality *at best*, and they do not have the affective modulation, whole object relations, and tripartite structure that is evident in more treatable individuals (Gacono and Meloy, 1994; Kernberg, 1984; Meloy, 1988). This misapprehension is particularly common when evaluating a psychopathic patient who has a substantially above-average IQ and no other Axis I diagnosis. Some clinicians still adhere to the mistaken beliefs that all psychopathic patients have low self esteem, developmentally mature affects that are defended against (rather than non-existent), and a capacity for empathy and concern for others. There is abundant clinical and laboratory evidence that such is not the case (Hare, 2003).

Fascination and sexual attraction

We would add another countertransference reaction that heretofore has not been discussed: fascination and sexual attraction. Some clinicians are strongly drawn to such patients, and provide for the psychopath an idealizing countertransference that he can regale with stories of his prowess and exploits. Young mental health professionals, especially women, will often be enamored with criminal forensic work for the sensation-seeking it delivers and the unconscious identifications with psychopathy which it invites. What is forbidden is often what is most desired. If clinicians come to understand the fantasized extremes of their own aggression and hedonistic desires, this fascination will often devolve into boredom, and then the clinical task becomes maintaining interest in a patient who offers little hope for change.

When treatment is undertaken

In a perfect world, psychopathic individuals would be easily identified, not referred for mental health treatment, and all energies would focus on the safety of the unfortunate individuals living with or near them. Such is not the case. In both public and private treatment settings, prisons, jails, and outpatient practices, individuals with various degrees of psychopathy will present for treatment, and sometimes the clinician has no choice but to evaluate and attempt to treat them.

There are a number of comprehensive chapters and books on treatment recommendations for antisocial-personality-disordered and psychopathic individuals (Ashford *et al.*, 2001; Meloy, 2007; Wong and Hare, 2005) available to the reader.

We emphasize, instead, six parameters of mental health treatment for such patients, regardless of the specific treatment methods applied in the clinical work.

1. The initial diagnostic evaluation must be comprehensive, and include interview, testing, and historical data *independent* of the patient's self-report. The purpose of a careful diagnosis is to determine the severity of psychopathy – one of the Hare (2003) instruments is most useful – and individual differences within the patient that will aggravate or mitigate his psychopathic traits, which should be viewed as immutable. The clinical interview should assess the patient's capacity to form attachments, the presence or absence of anxiety, and the severity of his superego disturbance, such as his history of deception. The more severe the psychopathy, the more apparent will be the patient's chronic emotional detachment, fearlessness, and absence of any internalized values (Kernberg, 1984; Meloy, 1988).
2. Any treatable Axis I conditions, such as depression, anxiety, or substance abuse/dependence, should be identified and targeted for treatment. Substance abuse is the only Axis I disorder that appears to be comorbid with psychopathy (Hare, 2003), and other traditionally neurotic conditions, such as depression and anxiety, contraindicate a severe psychopathic disturbance, if they are genuine. The mendacity and malingering potential of the psychopathic patient should never be minimized, and psychological tests that are highly face valid – transparently communicating to the patient what is being measured – are often very useful to establish the genuineness of such neurotic conditions: psychopaths will typically endorse many more items than the truly anxious or depressed patient would on such measures.

   Some Axis I conditions, however, present a conundrum for the treating professional. For example, the paranoid schizophrenic who is also a severe psychopath is an exceedingly difficult challenge for the psychiatrist in a forensic hospital. If he or she successfully treats the Axis I condition, he or she will likely be faced with a better organized psychopath now living in the hospital. Is it medically ethical to treat such a patient subclinically to maintain a certain level of disorganization which increases the safety of other patients? Can the physician use the psychosis of the patient as a way to reduce his propensity for predatory violence? Such questions need careful consideration and are not easily answered.
3. Situational and environmental factors may aggravate the overt antisocial behaviors and need to be considered. These would normally be delineated on Axis IV of DSM-IV-TR. Careful consideration should be given to the use of alcohol or stimulants on the part of the patient to self-medicate against stressors or to simply sensation-seek in the face of a cortex that is chronically cortically underaroused (Raine, 1993). Other environmental stressors may be a product of his law breaking, and a rational discussion of his losses, such as freedom, family,

or friends, may provide some motivation for change. If the psychopath can be persuaded that his life strategies have not paid dividends, perhaps he can utilize his strengths in a prosocial manner.

4. Legal problems and legal entanglements will likely be present, even if denied by the patient. In an outpatient forensic context, the mental health clinician may utilize law enforcement personnel (such as correctional officers, parole agents, and probation officers) and intermittent polygraph examinations to build a "containment team" inside which the psychopathic patient exists. Violations of the treatment contract or conditions of parole should be met by some loss of tangible privilege, such as the ability to travel freely, or by additional restrictions, such as increased contact with the treatment provider or the supervising officer.

   In private practice settings, the psychopathic patient's mendacity should be contained through the unusual request for permission from the patient to discuss his case with collaterals (family members, spouse, etc.) when deemed necessary by the clinician. This provides a means of truth verification, which should never be assumed if psychopathy is present in the case. Clinicians who approach treatment from the position of intersubjectivity and solely depend upon the credibility and hope of the patient to guide the work are creating a wild, if not surreal, analysis that may be both emotionally and physically dangerous.
5. Careful attention should be paid to all countertransference reactions (Table 11.2) because they provide important insights into the inner world of the patient with a psychopathic disturbance. They also will inoculate the clinician against manipulation by the patient, and frustrate his sadomasochistic goal to dominate his objects.
6. Treatment should only be undertaken if it is safe and effective for the clinician and the patient. Psychotherapists who do not measure the severity of the patient's psychopathy against their ability to remain safe – for example, attempting to treat a severely psychopathic individual in any voluntary outpatient setting – are placing themselves and other professionals in close proximity at great risk. The more severe the psychopathy, the more risk management is paramount.

Case E

Patient E began treatment at a public outpatient clinic with a psychiatric social worker. During the course of treatment, he revealed that he had committed a murder when he was younger. The therapist was frightened and shocked, but after consulting with her colleagues, realized that she had no legal obligation to investigate or report the past murder; and in fact, could not do so without violating the patient's confidentiality. She also clinically believed the patient was benefitting from the treatment.

Several months passed and the work seemed to be progressing nicely. Then one day the patient came in for his weekly psychotherapy session, sat down, and said, "it's happened again."

Events such as this are extraordinarily unusual, but emphasize the importance of recognizing that impulsive or planned criminal activity on the part of the patient, whether directed toward the clinician or others, may *eliminate the fiduciary responsibility of the clinician toward the patient, and obligate reporting to law enforcement.*[2] The first author has consulted on a number of cases in which a mental health clinician, in the throes of denial and rationalization, believed he still had a therapeutic responsibility to his patient despite the fact that he was being repeatedly criminally victimized by the same patient. In the case of Patient E, the university-affiliated clinic handled it very poorly. They consulted with their legal counsel who recommended that the patient be transferred to another mental health provider as quickly as possible.

Conclusions

Psychopathy is an immutable trait in certain patients which should give pause to the wise clinician before treatment is undertaken. It can be reliably measured, and, depending upon its severity, will have a minimal or massive impact on treatment outcome. We have discussed the nature of the beast, diagnostic issues, expectable countertransference reactions, and parameters that will help manage risk when such patients present for mental health care. Clinicians bear the burden of responsibility when deciding to treat such patients, since the psychopath, true to his character, believes he bears no responsibility at all.

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NOTES

1. PsycInfo search conducted by the first author, 1994–2004.
2. Statutes and case law concerning third party warnings and protections for violence risk vary from jurisdiction to jurisdiction. Clinicians should be thoroughly familiar with the applicable law in the geographical area where they practice.