CHAPTER 69

Antisocial Personality Disorder

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Antisocial personality disorder (ASPD) is the most reliably diagnosed condition among the personality disorders, yet treatment efforts are notoriously difficult. Many psychiatrists are reluctant to treat patients with ASPD because of widespread belief that such patients are always untreatable. There is increasing evidence, however, that ASPD may, in certain cases, be treatable.

In this chapter, we briefly review historical and contemporary nosological controversies regarding the ASPD construct, and summarize the general research findings for this condition. We then discuss treatment planning in detail, based on thorough assessment of the individual's personality characteristics to determine prognosis, risk management, and appropriate treatment. We conclude by evaluating the specific treatment approaches available for ASPD, drawing from our own clinical experience and the research evidence to date.

Psychodiagnostic Refinements

Before any treatment efforts are undertaken, diagnostic refinement is critical, especially determination of the degree of psychopathy, in the patient diagnosed with ASPD. The older, clinical tradition for understanding ASPD used the term *psychopathy* or *psychopathic personality* and was most thoughtfully delineated by Cleckley (1941/1976). This tradition is distinguished by attending to both manifest antisocial behavior and personality traits; the latter are described as the callous and remorseless disregard for the rights and feelings of others (Hare 1991) or aggressive narcissism (Meloy 1992). Hare (1991, 2003) and colleagues developed a reliable and valid clinical instrument for the assessment of psychopathy, the Psychopathy Checklist—Revised (PCL-R). This is a unidimen-

sional observational scale that quantifies clinical interview and historical data on the patient. Individuals scoring 30 or more on the PCL-R are considered psychopaths for research purposes (Hare 1991, 2003). In our clinical experience—consistent with research—a score in the range of 20–29 would indicate moderate psychopathy, and a score of 30 or higher would indicate severe psychopathy.

Psychopathy is not synonymous with behavioral histories of criminality or a DSM-5 categorical diagnosis of ASPD (American Psychiatric Association 2013; see Box 69–1), although it is often a correlate of both in severe cases. Notably, a substantial body of research has shown that, at most, only one of three individuals in prison with ASPD has severe psychopathy, and those with severe psychopathy have a significantly poorer treatment prognosis than do other antisocial patients with measurably fewer psychopathic traits (Hare 1991, 2003). The measurement of psychopathy and the use of other psychological tests help to delineate subgroups of antisocial individuals who have lower psychopathy scores and higher levels of anxiety, and who may show a better response to treatment (Hodgins 2007; Hodgins et al. 2010; Ulrich and Coid 2010).

Box 69–1. DSM-5 Diagnostic Criteria for Antisocial Personality Disorder

301.7 (F60.2)

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

ASPD is associated with considerable and complex comorbidity with other psychiatric conditions (Swanson et al. 1994), particularly substance misuse (Robins et al. 1991), and increased mortality through reckless behavior (Black et al. 1996). At least half of those with ASPD have co-occurring anxiety disorders (Goodwin and Hamilton 2003), and a quarter have a depressive disorder (Lenzenweger et al. 2007). The Epidemiologic Catchment Area study found that substance abuse occurred in 83.6% of individuals diagnosed with ASPD (Regier et al. 1990), although subsequent studies have reported prevalence rates of substance use disorders in ASPD ranging from 42% to 95% (Uzun et al. 2006). Co-

morbid Axis I conditions are important to diagnose, because the presence of ASPD acts as a negative moderator of treatment response when these conditions are treated by conventional approaches. Psychopathy appears, however, to be independent of most Axis I conditions, except for alcohol and other substance abuse and dependence (Hart and Hare 1989; Smith and Newman 1990).

Given the action-oriented nature of these patients and the likelihood of head injury, neurological and neuropsychological impairments also must be ruled out. Such impairments may exacerbate clinical expressions, such as the physical violence of this character pathology.

General Treatment Findings

Although the mainstay of treatment for ASPD is psychological therapy, only a small number of high-quality treatment trials have been conducted among people with ASPD, so the evidence base for effective treatments for this patient group continues to be very limited (Duggan et al. 2007; Gibbon et al. 2010; National Institute for Health and Clinical Excellence 2009; Warren et al. 2003). Furthermore, a comparative evaluation of available studies is hampered by different diagnostic criteria and conceptualizations of psychopathy versus ASPD, differences in defining and measuring outcomes, a focus on treating incarcerated patients rather than those in the community, and a focus on behavioral and symptomatic rather than structural personality change.

Programs that have the largest effect sizes adhere to the risk-need-responsivity model (Andrews 1995). These programs focus on risk (targeting those patients at greatest risk of reoffending), need (empirically established dynamic criminogenic risk factors, such as criminal attitudes, substance abuse, and impulsivity), and responsivity (delivering interventions in a manner that maximizes offender engagement in the treatment process). The effect sizes are typically one-half of the overall effects in meta-analyses of psychological interventions in general (Simon 1998).

A review of the treatment research concerning criminal psychopathic patients, who have the most severe form of ASPD according to the criteria of Hare (2003), has challenged the view that psychopathy per se is always untreatable. Salekin (2002) conducted a meta-analysis of 44 studies of a broad range of correctional treatments with various samples of psychopathic subjects and found an overall positive treatment effect. Lengthier and more intensive treatments—those including an average of at least four sessions per week of individual psychotherapy for at least 1 year—were found to be significantly more effective. However, this review was criticized for including case studies, use of therapist opinion regarding patient change, use of other measures of psychopathy than the PCL-R, and including studies that did not use recidivism as an outcome measure (Harris and Rice 2006). D'Silva et al. (2004) reviewed 10 studies of the treatment of psychopaths with high scores on the PCL-R, and found that although four studies concluded that psychopaths respond poorly to treatment, another four suggested the opposite. A more recent review by Salekin et al. (2010), which included only studies using the PCL-R for diagnosing psychopathy, showed three of eight studies with positive treatment outcomes, whereas treatment of psychopathic youths was more promising, with six of eight studies showing treatment benefits.

Another comprehensive review of the literature on rehabilitating general, psychopathic, and high-risk offenders (Skeem et al. 2009) gives rise to further optimism that intensive, targeted, appropriate psychosocial interventions based on risk-needs-responsivity principles reduce recidivism risk in some severely psychopathic individuals. The reduction in risk is more likely when cognitive-behavioral techniques are applied to address risk for recidivism, and when the treatment relationship between offender and provider is characterized by caring, fairness, and trust as well as an authoritative—not authoritarian—style. Interventions that are punitive or that focus on control and surveillance may increase risk of recidivism if not combined with rehabilitative efforts.

The Dangerous and Severe Personality Disorder (DSPD) initiative in the United Kingdom (Department of Health and Home Office 1999) illustrates the challenges of treating and researching antisocial and psychopathic patients. This ambitious pilot program for the treatment of patients with DSPD—patients assessed as posing significant risk of harm to others and whose risk is linked to their personality disorder—in specialized intensive units in selected prisons and forensic hospitals was established in the United Kingdom in 2001. Although cognitive-behavioral techniques predominated in these treatment programs, some programs also used psychodynamic ideas to both manage staff and tailor therapeutic interventions, such as using the therapeutic community model of treatment. However, despite substantial investment into research and evaluation of the programs, no high-quality trials of specific treatments or service environments were carried out, so the key question as to what treatments are effective for high-risk personality-disordered offenders remains unanswered (Völlm and Konappa 2012). The program has recently been disbanded in favor of a reconfigured national strategy for managing offenders with severe personality disorders based on a "whole systems pathway" across the criminal justice system and National Health Service (Joseph and Benefield 2012).

Treatment Planning

Once the severity of psychopathy has been assessed in the patient with ASPD and any other treatable psychiatric disorders have been identified, four clinical questions should guide further psychiatric involvement with the patient:

1. *Risk assessment:* What are the risks posed by the patient, and is the treatment setting secure enough to contain the relative severity of the psychopathic disturbance in the patient with ASPD?
2. *Personality characteristics and treatment prognosis:* What personality characteristics, gleaned from clinical research on patients with ASPD or psychopathy, are relevant to the treatment planning for this particular patient?
3. *Clinician's reactions to patient:* What are the emotional and/or countertransference reactions that the clinician can expect in himself or herself when attempting to clinically treat or help risk-manage (if no treatment is being attempted) this patient?
4. *Specific treatment approaches:* What specific treatments, if any, should be applied to this patient, given the resources available and the degree of containment necessary to effectively intervene?

Each of these questions is addressed in turn in the sections that follow.

Risk Assessment

An essential component of management of the patient with ASPD is the *setting* in which treatment is delivered, wherein containment, risk, boundaries, and disclosure of information are paramount (Meloy and Yakeley 2010). The treatment setting must be secure enough to ensure the safety of both patients and staff before treatment planning can begin, depending on the available resources. If it is not, staff may be put physically at risk by a decision to commence treatment. Political and bureaucratic pressures may be brought to bear on clinicians to "treat" currently untreatable patients with ASPD and severe psychopathy, and a "not-to-treat" decision may entail a variety of personal and professional dilemmas.

By far the most troublesome symptom of ASPD is violence, which is significantly more frequent in the severely psychopathic patient (Hare and McPherson 1984). Reis (1974) labeled "affective" and "predatory" aggression, and Eichelman (1992), Meloy (1988, 1997, 2006), McEllistrem (2004), Siegel and Victoroff (2009), Siever (2008), and others have elaborated upon the physiological, pharmacological, and forensic distinction between the two types. These psychobiologically different modes of violence are most relevant to ASPD and psychopathy, although they are not inclusive and should not be considered a standardized clinical nosology for aggression (Eichelman and Hartwig 1993). Affective (emotional, reactive) aggression is a mode of violence that is accompanied by high levels of sympathetic arousal and emotion (usually anger or fear) and is a reaction to an imminent threat. Predatory (instrumental) aggression is a mode of violence that is accompanied by minimal or no sympathetic arousal and is emotionless, planned, and purposeful. Research has shown that psychopathic criminals are more likely than other criminals to engage in both affective and predatory violence (Cornell et al. 1996; Serin 1991; Walsh 1999; Williamson et al. 1987; Woodworth and Porter 2002). Blair et al. (2005) noted that "no biologically based disorder other than psychopathy is associated with an increased risk of instrumental aggression" (p. 155).

Psychopathic criminals are typically three to five times more violent than nonpsychopathic criminals (Hare 2003), but even the most violent patients are not violent most of the time. Measurement of violence risk in both psychiatric and offender populations has found that psychopathy typically accounts for the largest proportion of explainable variance. We recommend such instruments as the Violence Risk Appraisal Guide (VRAG; Quinsey et al. 2006), the Classification of Violence Risk (COVR; Monahan et al. 2005), the HCR-20 Version 3 (Douglas et al. 2013), and the PCL-R. Yang et al. (2010) have found, however, that most actuarial and structured professional judgment instruments are equivalent in their moderately accurate prediction of violence risk, and should instead be selected on the basis of specific relevance to the patient's history of violence. All risk-of-violence evaluations should be individualized and will benefit from a complete biopsychosocial understanding of the patient.

Personality Characteristics and Treatment Prognosis

Anxiety and Attachment

Hodgins and colleagues emphasize the importance of co-occurring anxiety in

subtyping ASPD (De Brito and Hodgins 2009). Based on studies of children and adults, they propose that around half of individuals in the ASPD population are characterized by anxiety as well as persistent antisocial behavior, and have low levels of callous unemotional traits as children and low levels of psychopathic traits as adults. This group is more likely to have experienced physical abuse as children and resort to violence as a compensatory response to underlying emotional conflict and distress. The other half have normal to low levels of anxiety and varying levels of psychopathy, but include a subgroup with high levels of psychopathy. This group shows marked callous and unemotional traits as children, low levels of anxiety, more predatory (instrumental) violence, and less amenability to treatment. There is also suggestive research that severely psychopathic adults experienced *less abuse and neglect* as children than moderately psychopathic adults, which also supports the relative increase in biogenic contributions as degree of psychopathy increases (Felthous and Sass 2007; Raine 2013).

Anxiety is a necessary correlate of any successful mental health treatment that depends on interpersonal methods, because it marks a capacity for internalized object relations and may signal other affects. As the severity of psychopathy increases in patients with ASPD, anxiety likely lessens, and with it the personal discomfort that can motivate a patient to change.

Attachment, or the capacity to form an emotional bond, is considered to be lower in severely psychopathic criminals than in mild to moderately psychopathic criminals (Fonagy et al. 1997; Frodi et al. 2001; Gacono and Meloy 1994; Levinson and Fonagy 2004; Meloy 2002; van IJzendoorn et al. 1997). For a patient without an attachment capacity, any treatment that depends on the emotional relationship with the psychotherapist will fail and may pose an explicit danger to the professional because a lack of empathy for the therapist will not inhibit aggression. The more severe the psychopathy, the more the patient will relate to others on the basis of power rather than affection (Meloy 1988).

Narcissism

Psychopathic patients can be conceptualized as aggressive narcissists, with the attendant intrapsychic object relations, structure, and defenses that have been described in the psychoanalytic literature (Kernberg 1992; Meloy 1988). In a clinical and treatment setting, the more severe the psychopathic disturbance in the patient with ASPD, the greater the likelihood that aggressive devaluation will be used to shore up feelings of grandiosity and repair emotional wounds. In some patients, this devaluation is defensive, whereas in others, a core, injured sense of self is not apparent. This behavioral denigration of others can run the clinical spectrum from subtle verbal insults to the rape and homicide of a female staff member. It also distinguishes the psychopathic patient from the narcissistic patient, who can devalue in fantasy (Kernberg 1975) without resorting to the infliction of emotional or physical pain on others.

In addition to the devaluation of others, the severity of psychopathy will determine the degree to which the patient will try to control other patients and staff. This "omnipotent control" in the actual clinical setting, often felt by staff as being "under the patient's thumb" or "walking on eggshells," usually serves the purpose of stimulating the severe psychopath's grandiose fantasies and also warding off the patient's fears of being

controlled by malevolent forces outside himself or herself. When the grandiosity of the mildly to moderately psychopathic patient with ASPD is challenged by failure, there will be clinical manifestations of anxiety or depression, both of which are positive prognostic indicators (Gabbard and Coyne 1987).

Psychological Defenses

ASPD patients with severe psychopathy most predictably use the following psychological defenses: projection, devaluation, denial, projective identification, omnipotence, and splitting (Gacono and Meloy 1994; Hare 2003). For instance, projective identification is most apparent in treatment when the psychopathic patient attributes certain negative characteristics to the clinician and then attempts to control the clinician, perhaps through overt or covert intimidation. An aspect of the psychopathic patient's personality is then perceived in the clinician and viewed as a threat that must be diminished. Higher-level or neurotic defenses, such as idealization, intellectualization, isolation, sublimation, and repression, appear to be virtually absent in the patient with ASPD and severe psychopathy (Gacono 1990). If neurotic defenses are present in the patient with ASPD, they suggest amenability to treatment.

Object Relations

The severely psychopathic patient's internal representations of self are aggressive and larger than life—this person is a legend in his or her own mind. At the same time, this patient does not consider others as whole, real, and meaningful individuals deserving of respect and empathy, but instead as objects to dominate and exploit. Patients with ASPD without severe psychopathy may see themselves as injured or devalued, and their grandiosity may be defensive and easily punctured.

The treatment implications of these object relations surround the risk of violence by patients with ASPD. The more psychopathic these individuals are, the more pleasurable, less conflicted, and more sadistic their aggressive acts will be (Dietz et al. 1990; Holt et al. 1999). The psychopathic patient may wholly identify with the aggressor (A. Freud 1936/1966) and have no inhibitions. A history of violence, coupled with the predatory (instrumental) nature of their violence, makes ASPD patients with severe psychopathy very dangerous in a hospital milieu without appropriate security (Gacono et al. 1995, 1997).

Affects

The emotions of the patient with ASPD lack the subtlety, depth, and modulation of those of psychiatrically healthy individuals. The patient with ASPD and severe psychopathy appears to live in a "presocialized" emotional world, where feelings are experienced in relation to the self but not to others. Such a patient is unlikely to have a capacity to experience emotions such as reciprocal pleasure, gratitude, empathy, joy, sympathy, mutual eroticism, affection, guilt, or remorse, that depend on whole object relations. The patient's emotional life instead is dominated by feelings of anger, sensitivities to shame or humiliation, envy, boredom, contempt, exhilaration, and pleasure through dominance (sadism).

Such feelings in the patient with ASPD and severe psychopathy pose difficulties for modalities that depend on emotional access to the patient, such as cognitive-behavioral relapse prevention or psychodynamic approaches that require the patient to have a capacity to feel emotion in relation to the psychotherapist and to talk about it. Most trouble-

some and difficult to detect is the psychopathic patient's imitation of certain emotional states for secondary gain or to manipulate the psychotherapist.

Superego Pathology

The touchstone of psychopathy and ASPD has been the absence of conscience, or serious deficits in moral judgment (Cleckley 1941/1976; Hare 1991; Johnson 1949; Robins 1966). Although few controlled studies of moral development in psychopathy have been done (Hare 2003; Trevethan and Walker 1989), clinicians agree that this characteristic is a marker for the character pathology (Kernberg 1984; Meloy 1988; Reid et al. 1986).

The presence of any superego development, whether a prosocial ego ideal (a realistic, long-term goal) or clinical evidence of a socially desirable need to rationalize antisocial acts, is a positive prognostic sign. Certain mild to moderately psychopathic patients with ASPD may show evidence of harsh and punitive attitudes toward the self and assume a masochistic attitude toward the clinician. This behavior signifies some internalized value and attachment capacity. ASPD patients with severe psychopathy are likely to behave cruelly toward others and show no need to justify or rationalize their behaviors. Such individuals should not be considered for a treatment setting because they place both staff and other patients at risk.

Clinician's Reactions to Patient

Lion (1978), Symington (1980), Strasburger (1986), Meloy (1988, 2001), and Gabbard (2014) explored the clinician's response to the patient with psychopathy or ASPD. Table 69–1 lists nine common countertransference reactions to such a patient. These reactions, each of which is discussed in the following subsections, are likely to occur regardless of the treatment modality being applied and will be felt more intensely when psychopathy is more severe in the patient with ASPD. These are reactive emotions and thoughts and should not be construed as necessarily implicating a conflict in the clinician. Such subjective reactions can be used as an impetus for further objective testing, a reevaluation of the appropriateness of the selected treatment, or in some cases the cessation of treatment.

TABLE 69–1. Common countertransference reactions to the patient with antisocial personality disorder

1. Therapeutic nihilism
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 maturity
9. Fascination, excitement, or sexual attraction

These countertransference reactions are most readily explored in individual or group supervision or in carefully led clinical staff meetings in which a wide range of emotional reactions toward patients are tolerated and accepted. Clinicians who are resistant to any understanding of their own emotional lives in relation to these patients should not be treating them and may put other mental health professionals at risk.

Therapeutic Nihilism

Lion (1978) used the term *therapeutic nihilism* to describe the clinician's rejection of all patients with an antisocial history as being completely untreatable. Instead of arriving at a treatment decision based on a clinical evaluation, including an assessment of the severity of psychopathy, the clinician devalues the patient as a member of a stereotyped class of "untouchables." The clinician does to the patient with ASPD what the patient does to others.

Illusory Treatment Alliance

The opposite of therapeutic nihilism is the illusion that there is a treatment alliance when, in fact, there is none. Perceptions of such an alliance are often the psychotherapist's own wishful projections. Behaviors by a severely psychopathic patient that suggest such an alliance should be viewed with clinical suspicion and may actually be imitations to please and manipulate the psychotherapist. The chameleon-like quality of the psychopathic patient is well documented (Greenacre 1958; Meloy 1988, 2001). Bursten (1973) elaborated on the "manipulative cycle" of the psychopathic patient, which leads to a feeling of contemptuous delight in these patients when successfully carried out. The clinician is left with feelings of humiliation and anger.

Fear of Assault or Harm

Strasburger (1986) noted that both reality-based and countertransference fears may exist in response to the ASPD patient with severe psychopathy. Real danger should not be discounted and is most readily evaluated by using contemporary measures to assess the risk of violence (Monahan et al. 2001). Countertransference fear is an atavistic response to the psychopathic patient as a predator and may be viscerally felt as "the hair standing up on my neck" or the patient "making my skin crawl." These are phylogenetically evolved autonomic reactions that may also signal real danger, even in the absence of an overt threat. They appear to be widespread among clinicians working with psychopathic patients (Meloy and Meloy 2002).

Denial and Deception

Denial in the psychotherapist is most often seen in counterphobic responses to real danger. Lion and Leaff (1973) suggested that such denial is a common defense against anxiety generated by violent patients. It may also be apparent in the unwillingness of mental health clinicians to participate in the prosecution of a psychopathic patient who has seriously injured someone (Hoge and Gutheil 1987), in the underdiagnosis of ASPD (Gabbard 2014), or in clinicians' disbelief that the patient has an antisocial history (Symington 1980) or that psychopathy even exists at all (Vaillant 1975). This reaction may lead to splitting or contentiousness among mental health staff, especially in hospital settings.

In our clinical experience, deception of the patient with ASPD is most likely to occur when the psychotherapist is frightened of the patient, especially of the patient's rage if certain limits are set surrounding treatment. It may also indicate

superego problems in the clinician, the avoidance of anxiety, passive-aggressive rejection of the patient, or an identification with the deceptive skills of the patient with ASPD. Rigorous honesty without self-disclosure is the treatment rule in working with patients with ASPD.

Helplessness and Guilt

In our experience, the novice clinician may especially feel helpless or guilty when the patient with ASPD does not change despite treatment efforts. These feelings may originate from the psychotherapist's narcissistic belief in his or her own omnipotent capacity to heal, what Reich (1951) called the "Midas touch syndrome."

Devaluation and Loss of Professional Identity

If therapeutic competency is measured only through genuine change in the patient, the patient with ASPD will be a source of continuous professional disappointment and narcissistic wounding. In long-term treatment, the psychopathic patient's intransigence may compel the clinician to question his or her own professional identity. Bursten (1973) noted that despite the psychotherapist's most adept management of the patient's contempt, it is difficult not to feel despicable and devalued because of the primitive, preverbal nature of the patient's manipulative cycle. The clinician's emotional responses to the patient may range, in this context, from retaliation and rage to indifference or submission.

Hatred and the Wish to Destroy

One psychiatric resident recalled the embarrassing dream of being with a hospitalized patient with ASPD whom he was treating as they both stormed through the hospital with flame throwers, destroying everything in sight. No other patient will compel psychotherapists to face their own aggressive and destructive impulses like the psychopath will. Because these patients often hate goodness itself and will destroy any perceived goodness (such as empathy) offered by the clinician, the clinician may react by identifying with the patient's hatred and wish to destroy. It may become a source of understanding and relating to the patient if brought into consciousness (Gabbard 1996; Galdston 1987).

Assumption of Psychological Maturity

The most subtle countertransference reaction is the clinician's belief that the patient with ASPD is as developmentally mature and complex as the clinician, and that the patient's actual maturity only has to be facilitated by, and discovered in, treatment. This is particularly common when no other psychiatric disorder is present and the patient has an above-average IQ.

Fascination, Excitement, or Sexual Attraction

Some clinicians are strongly drawn to patients with ASPD or psychopathy, and provide an eager audience for these patients to regale with their prowess and exploits. Such an idealizing countertransference can also be sexualized, which may invite an exceedingly dangerous encounter, especially between a male patient with psychopathy and a female psychotherapist. Young mental health professionals will often be enamored with criminal forensic work for the sensation seeking that it promises and the un-

conscious identifications with psychopathy that it invites. What is forbidden is often what is most desired. If clinicians come to understand the fantasized extremes of their own aggressive and hedonistic desires, this fascination will often devolve into more realistic boredom, and then the clinical task becomes maintaining interest in a patient who offers little hope for change (Meloy and Reavis 2006). In one study of malingering insanity acquittees (N=18) in a large forensic hospital, most were severely psychopathic and 39% had a consensual sexual relationship with or married a female staff member (Gacono et al. 1995).

Specific Treatment Approaches

Although cognitive-behavioral and social learning techniques are the most frequently used methods for treating individuals with ASPD, there is a renewed interest in applying psychodynamic treatments for ASPD, such as a therapeutic community approach or mentalization-based treatment. Although a standardized assessment instrument such as the PCL-R should be used to measure psychopathy accurately, clinical indicators of the *absence* of severe psychopathy in the patient with ASPD include the "ABCs" of anxiety, bonding, and conscience. The effectiveness of a modality will depend on the treatment goals, which should be conservative at best.

Pharmacotherapy

Recent treatment recommendations caution against pharmacological treatment of the primary traits of ASPD. Two large meta-analyses of trials for pharmacological interventions for ASPD (Khalifa et al. 2010; National Institute for Health and Clinical Excellence 2009) concluded that there was no consistent evidence, including that from uncontrolled studies, that supported the use of any pharmacological intervention to treat the disorder or the underlying behavior and symptoms of the disorder. The authors recommended that pharmacological interventions should not be routinely used for the primary treatment of ASPD or associated behaviors of aggression, anger, and impulsivity, but should be used only for the treatment of comorbid mental disorders, in particular depression and anxiety (National Institute for Health and Clinical Excellence 2009). The authors also highlight the importance of paying attention to issues of adherence and the risks of misuse or overdose.

Family Therapy

There is increasing interest in the prevention of ASPD by targeting early interventions at individuals and families at risk of developing the condition (e.g., Brotman et al. 2007, 2008). Programs involving preschool nursery, schools, and home visiting have been shown to be effective in preventing conduct disorder in children of high-risk parents. Parent training programs and cognitive problem-solving programs may be effective for preadolescent children with conduct disorder; however, for teenage children with conduct disorder, programs need to be augmented by other interventions such as functional family therapy, systemic family therapy, multisystemic therapy, or multidimensional treatment foster care (National Institute for Health and Clinical Excellence 2009).

Virtually no published research is available on family therapy with adult parents who have ASPD, whether psychopathic or not. The use of family therapy when one of the participating adults

is a severely psychopathic patient with ASPD is not advised. Information learned by the individual from both the therapist and other family members is likely to be used to hurt and control in the service of sadism and omnipotent fantasy (Meloy 1992). Treatment efforts should focus on the physical, economic, and emotional safety of the other family members, whether spouse, children, or elderly parents; such efforts should also play an important role in custody litigation to help mitigate the intergenerational transmission of such problems.

Mild to moderately psychopathic adults with ASPD may benefit from family therapy and are most likely to be seen when a child with conduct disorder is the identified patient. Such work may also have a positive effect on the intergenerational transmission of the disorder, a likely combination of both early social learning and psychobiology (Sutker et al. 1993). Reductions in criminal recidivism as a result of family therapy have been reported (Gendreau and Ross 1987).

Milieu and Residential Therapy

The term *milieu* is used to describe any treatment method in which control of the environment surrounding the antisocial individual is the primary agent for change. Two milieu or residential approaches have been used for the treatment of ASPD: token economies and therapeutic communities.

Token economies have been empirically found to shape patient and staff behavior within institutions (Rice et al. 1990). A token economy is a system of behavior modification based on the principles of operant conditioning and the systematic positive reinforcement of target behavior. The reinforcers are symbols or tokens that can be exchanged for other reinforcers. Despite their declining popularity, token economies have no serious competition as a system of behavioral management in hospitals. Evidence also indicates that the more typically unstructured hospital ward may actually harm patients by promoting psychotic, aggressive, and dependent behaviors (Positano et al. 1990).

Therapeutic residential communities use peer influence as the key agent of change to help individuals acquire social skills and learn social norms. Although no trials of therapeutic communities have been reported specifically for ASPD, there are studies investigating the efficacy of therapeutic communities for general offenders in institutional and community settings. Most, however, are based on weak study designs. Lamb and Goertzel (1974) conducted a randomized controlled trial (RCT) that investigated a community alternative to prison in the United States, and prospective (Robertson and Gunn 1987) and retrospective (Marshall 1997) cohort studies have investigated the effects of therapeutic communities for prisoners treated in HM Prison Grendon in the United Kingdom. None of these studies revealed evidence to suggest that therapeutic communities were effective for general offenders. However, three well-designed RCTs have been conducted in institutional settings evaluating the evidence for therapeutic communities in substance misuse offenders (Nielson et al. 1996; Sacks et al. 2004; Wexler et al. 1999). All three studies found a relatively large reduction in reoffending. Up to half of the trial subjects were diagnosed with ASPD, and all participants reported behavior or symptoms associated with the ASPD diagnostic construct. These findings have led to the conclusion that therapeutic communities are only effective for treating ASPD if they are targeted specifically at those individ-

uals with comorbid drug misuse (National Institute for Health and Clinical Excellence 2009), and there is insufficient evidence to apply these findings to therapeutic communities targeting general offenders who do not abuse substances. However, in our opinion, given that many of the previous studies were based on weak methodology and, moreover, that up to 90% of individuals with ASPD may misuse substances, it is premature to conclude that therapeutic communities are ineffective for the treatment of ASPD in general. Enthusiasm for the model persists, and in the United Kingdom there are currently plans to extend the availability of therapeutic community treatment of high-risk offenders in prisons (Joseph and Benefield 2012).

Cognitive-Behavioral Therapy

Cognitive-behavioral techniques have been developed into specific treatment programs that have been shown to have some success in offenders with personality disorders, which are likely to include many diagnosed with ASPD. These techniques include relapse prevention programs (Andrews et al. 1990); programs combining cognitive skills with social skills and problem solving, such as Reasoning and Rehabilitation and Enhanced Thinking Skills (Friendship et al. 2002); anger and violence management programs (Saunders 1996; S. Wong and A. Gordon, The Violence Risk Scale, 2000); sex offender treatment programs (Beech et al. 1999, 2001); and treatments for psychopathic individuals (Wong and Hare 2005). Group-based cognitive-behavioral approaches may be the most effective (National Institute for Health and Clinical Excellence 2009). There is also some recent evidence for the effectiveness of cognitive-behavioral therapy in reducing antisocial behaviors and changing thinking for individuals in the community with a diagnosis of ASPD (Davidson et al. 2009).

Patients with ASPD are likely to respond to treatment if they are motivated to change and if therapy is used in a milieu or residential setting. Treatment response is most predictable in the moderately psychopathic patient with ASPD who normatively responds to aversive consequences and has felt the emotional and practical pain of his or her antisocial acts. Treatment is unlikely to have any effect on the severely psychopathic patient with ASPD because of deficits in passive avoidance learning (inhibiting new behavior when faced with punishment), the inability to foresee the long-term consequences of his or her actions, and the lack of capacity to reflect on the past.

Wong and Hare (2005) have devised guidelines for psychopathic treatment programs that are based on the risk-needs-responsivity principles (Andrews 1995) mentioned earlier in this chapter in the section "General Treatment Findings." These guidelines recommend cognitive-behavioral methods of treatment based on a modified social information processing model and the demonstrated efficacy of relapse prevention (Dowden et al. 2003). Wong and Hare (2005) argue that resources are better utilized when directed at high-risk offenders and when they target dynamic factors directly linked to criminality and violence. They spurn attempts to change the character pathology or temperament of the psychopath. A study on psychopathic individuals in an intensive high-risk sex offender program (Olver and Wong 2009) and a similar study with serious high-risk violent offenders (Olver et al. 2013) showed not only that there was progress on risk-related treatment targets but also that the more the offenders

changed, the fewer sexual and violent reconvictions they had.

When severely psychopathic individuals are ordered into forensic hospitals by the courts, strict behavioral controls should be used to manage behavior, and any clinical improvement should be viewed with great skepticism. All judicially committed patients, whether inpatient or outpatient, should be assessed for degree of psychopathy given the power of the construct to predict treatment outcome and violence risk (Hare 2003).

Psychodynamic Approaches

No evidence to date indicates that patients with psychopathy or ASPD benefit from traditional psychodynamic psychotherapy, including the expressive or supportive psychotherapies (Kernberg 1984), psychoanalysis, or various psychodynamically based group psychotherapies. Forensic psychotherapists working from a psychoanalytic perspective advocate modifications of technique in both individual and group treatments of violent and antisocial offenders. These changes include actively fostering the therapeutic alliance by avoiding silence and free association, focusing on affect and interpretations of the "here and now" rather than on unconscious conflicts and fantasies or on the transference, and using mentalization techniques such as helping the patient to connect internal states of mind to his or her behavioral actions (Meloy and Yakeley 2010; Yakeley 2010).

Forensic psychotherapy has promoted applying to antisocial offenders specific therapies that have been developed and empirically supported for the treatment of severe personality disorders. Although based on different theoretical models, such therapies include both cognitive and dynamic components. Dialectical behavior therapy (Linehan 1993), a variant of cognitive-behavioral therapy, is currently being evaluated for use with women in prisons in England and Wales. Schema-focused therapy (Young et al. 2003), an integrative therapy that brings together elements of cognitive therapy, behavioral therapy, object relations, and gestalt therapy, has been used to treat distorted antisocial cognitions in psychopathic offenders as part of a multimodal treatment program in the criminal justice system in the Netherlands (Chakhssi et al. 2010).

Mentalization-based therapy (MBT) is a psychodynamic treatment approach that integrates cognitive and relational components of therapy and has a theoretical basis in attachment theory. Trials of MBT, which have been shown to be effective for patients with borderline personality disorder (Bateman and Fonagy 1999, 2001, 2008), have included patients with ASPD. In a trial comparing MBT with structured clinical management (SCM), which included problem-solving and social skills, MBT was found to be more effective than SCM in patients with ASPD, but the effectiveness of each treatment was reduced when compared with patients without ASPD (Bateman and Fonagy 2009). MBT for ASPD targets mentalizing problems through a program of group and individual psychotherapy. A recent pilot project of MBT for violent men with a diagnosis of ASPD showed that treatment leads to a reduction in aggressive acts (McGauley et al. 2011), and plans are under way for a multi-site RCT in the United Kingdom.

Finally, psychodynamic treatment of ASPD should be differentiated from psychodynamically *understanding* the patient with ASPD. Psychodynamic understanding of the patient with ASPD (Clarkin et al. 2010; Meloy 1988) assumes that unconscious determinants play a major role in behavior. It also embraces a "levels"

(Stone and Dellis 1960) approach to both understanding and treating personality disorder. In other words, treatment efforts target, or at least acknowledge, the multiple and simultaneous levels that influence observable clinical behavior: psychobiology, unconscious psychodynamics, conscious thought, the situation, and the environment. In the case of a patient with ASPD, this conceptualization could translate into psychopharmacological intervention to minimize depression (psychobiology), the process of thinking about and discussing with staff the aggressive narcissism of the patient and its countertransference effect (psychodynamics), active treatment of the patient with relapse prevention that focuses on the internal and external motivators for antisocial acts (conscious thought), and the choice of a maximum-security milieu treatment program within which the treatment occurs (situation and environment).

Conclusion

Treatment and management of ASPD test the clinician's mettle. Although patients with ASPD rarely seek medical care for their personality disorder—only one out of seven will ever discuss their symptoms with a doctor (Robins et al. 1991)—concurrent problems may bring them into treatment, whether voluntarily or not.

The comprehensive care of the patient with ASPD involves six principles, which require that mental health professionals do the following:

1. Determine, during the initial diagnostic workup, the severity of psychopathy of the patient with ASPD, with a clinical focus on the presence of anxiety, bonding, and conscience.
2. Identify any treatable conditions, such as other mental or substance use disorders.
3. Delineate situational and environmental factors that may be aggravating or worsening the antisocial behaviors.
4. Recognize the likelihood of legal problems and potential legal entanglements, even if the patient initially denies them.
5. Begin treatment only if it is demonstrably safe and effective for both the patient and the clinician. This would generally rule out any attempts to psychiatrically treat the severely psychopathic antisocial patient with any brief, traditional treatment modality. Medical treatment of such a patient's major mental disorder, if present, will usually result in better organization of the psychopathy and may create an increased risk of predatory (instrumental) violence.
6. Pay careful attention to all countertransference reactions, because they provide important insights into the inner world of the patient with ASPD and the severity of his or her psychopathy.

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