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Glen O. Gabbard, M.D.
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Antisocial personality disorder is the most reliably diagnosed condition among the personality disorders, yet treatment efforts are notoriously difficult. Therapeutic hope has not vanished, however, and one recent study indicated that almost two-thirds of psychiatrists think that "psychopathic disorder" is sometimes a treatable condition (Tennent et al. 1993). A similar finding was reported 30 years ago (Gray and Hutchison 1964).

Psychodiagnostic Refinements

The DSM-IV (American Psychiatric Association 1994) diagnosis of antisocial personality disorder continues the relatively young "social deviancy" tradition of defining chronic antisocial behavior that began with DSM-II (American Psychiatric Association 1968). The National Comorbidity Survey (Kessler et al. 1994), using DSM-III-R criteria (American Psychiatric Association 1987), found that 5.8% of males and 1.2% of females showed evidence of a lifetime risk for the disorder. Robins and Regier (1991) determined that antisocial personality disorder, as defined by DSM-III (American Psychiatric Association 1980), had an average duration of 19 years from first to last symptom. This latter finding strongly suggests that in most individuals with antisocial personality disorder, remission will occur in time, an important prognostic factor. DSM-IV criteria for antisocial personality disorder are presented in Table 84–1.

The older, "clinical" tradition for understanding antisocial personality disorder refers to the term *psychopathy* or *psychopathic personality* and was most thoughtfully delineated by Cleckley (1941/1976). It is distinguished by attending to both manifest antisocial behavior and personality traits, the latter described as the callous and remorseless disregard for the rights and feelings of others (Hare 1991), or aggressive narcissism (Meloy 1992). Hare (1991) and his colleagues developed a reliable and valid clinical instrument for the assessment of psychopathy. The 20 criteria composing the Psychopathy Checklist—Revised (PCL-R) are shown in Table 84–2.

After a diagnosis of antisocial personality disorder has been made, or when overt antisocial behaviors are shown by history that do not meet the DSM-IV threshold for the diagnosis, the severity of psychopathy should be determined by using this measure. A substantial body of research has demonstrated that only a minority of patients with antisocial personality disorder have severe psychopathy, and this latter group has a significantly poorer treatment prognosis than do patients with nonpsychopathic antisocial personality disorder (Hare 1991). Axis I conditions are also likely to accompany anti-

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Table 84–1. DSM-I

A. There is a pervas
since age 15 yea
(1) failure to cor
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(3) impulsivity or
(4) irritability and
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mistreated, or
B. The individual is at
C. There is evidence o
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D. The occurrence of a
or a manic episode.

Table 84-2. Psychopath

1. Glibness/superficial
2. Grandiose sense of s
3. Need for stimulation/
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or gu
7. Shallow affect
8. Callous/lack of empat
9. Parasitic life-style
10. Poor behavioral contro
11. Promiscuous sexual be
12. Early behavioral proble
13. Lack of realistic long-te
14. Impulsivity
15. Irresponsibility
16. Failure to accept respor
17. Many short-term marital
18. Juvenile delinquency
19. Revocation of condition
20. Criminal versatility

Source. Hare R: *The Hare Psych*
Used with permission.

social personality disorder (Robins and Regier 1991), but psychopathy as a discrete entity, or taxon (Harris et al. 1994), appears to be independent of most Axis I conditions. The exception is alcohol and other substance abuse and dependence (Hart and Hare 1989; Smith and Newman 1990).

Table 84–1. DSM-IV diagnostic criteria for antisocial personality disorder

A. There is 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 (see American Psychiatric Association 1994, p. 90) with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

Table 84-2. Psychopathy Checklist—Revised

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation/proneness to boredom
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous/lack of empathy
9. Parasitic life-style
10. Poor behavioral controls
11. Promiscuous sexual behavior
12. Early behavioral problems
13. Lack of realistic long-term goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions
17. Many short-term marital relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility

Source. Hare R: *The Hare Psychopathy Checklist—Revised Manual.* Toronto, Multi-Health Systems, 1991. Used with permission.

Most self-report psychological tests are inherently unreliable in diagnosing antisocial personality disorder because of the propensity for these patients to deceive the clinician, but there are exceptions. Both the Minnesota Multiphasic Personality Inventory—2 (Hathaway and McKinley 1989) and the Rorschach test (Exner 1993) are very helpful in understanding the current psychodynamics, personality structure, and treatability of the patient (Gacono and Meloy 1994; Pope et al. 1993).

Given the action-oriented nature of these patients and the likelihood of head injury, neurological and neuropsychological impairments must also be ruled out. Such impairments may exacerbate clinical expressions, such as the physical violence of this character pathology. Measurable intelligence is independent of psychopathy but will influence the expression of chronic antisocial behavior (Hare 1991).

General Treatment Findings

There is as yet no body of controlled empirical research concerning the treatment of patients with antisocial personality disorder or severe psychopathy. There is also no demonstrably effective treatment, although this finding does not prove the null hypothesis that no treatment will ever exist for these troublesome conditions (Ogloff et al. 1990).

A review of the research on the treatment of antisocial personality disorder in general indicates that these patients have a poor response to hospitalization. The prognosis is improved, however, if there is a treatable anxiety or depression (Gabbard and Coyne 1987). Patients with antisocial personality disorder also demonstrate a worse response to alcohol rehabilitation programs than do patients without antisocial personality disorder (Poldrugo and Forti 1988; Schuckit 1985). An early positive assessment of the helping alliance by both the patient with antisocial personality disorder and the psychotherapist is significantly related to overall treatment outcome (Gerstley et al. 1989). There is also evidence that serotonin metabolism and low platelet monoamine oxidase activity have important roles in the expression of chronic antisocial behavior (Alm et al. 1994; Lewis 1991).

A review of the treatment research concerning criminal psychopathic patients, who have the most severe form of antisocial personality disorder according to the criteria of Hare (1991) (see Table 84–2), indicates that these individuals are generally viewed as untreatable by clinical and legal professionals but are frequently segregated and referred for treatment (Quality Assurance Project 1991). In a "therapeutic community" (M. Jones 1982), they show less motivation and less clinical improvement and are discharged earlier than nonpsychopathic criminals (Ogloff et al. 1990). In one 10-year, controlled, outcome study, psychopathic individuals treated in a prison therapeutic community showed significantly more recurrences of violent offenses than did untreated psychopathic individuals (Rice et al. 1992).

Treatment Planning

Once the severity of psychopathy has been assessed in the patient with antisocial personality disorder and any other Axis I or III treatable conditions have been identified, four clinical questions should guide further psychiatric involvement with the patient:

1. Is the treatment setting secure enough to contain the relative severity of the psychopathic disturbance in the patient with antisocial personality disorder? If it is, therefore ensuring the safety of both patient and staff, 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 antisocial personality disorder and severe psychopathy, and a "not to treat" decision may entail a variety of personal dilemmas. A general clinical maxim with this personality disorder is that severity of psychopathy should be inversely related to treatment efforts and directly related to community safety and intensive supervision concerns.
2. What personality characteristics, gleaned from clinical research on patients with antisocial personality disorder or psychopathy, are relevant to the treatment planning for this particular patient?
3. What are the emotional reactions that clinicians can expect in themselves when attempting to clinically treat or help manage this patient?
4. What specific treatment approaches should be applied to this patient, given the resources available and the degree of containment necessary to effectively intervene?

Each of these latter three questions are addressed in turn in the sections that follow.

Personality Characteristics and Treatment Prognosis

Anxiety and Attachment

Laboratory evidence has supported the clinical view that psychopathic criminals do not experience anxiety and worry to the degree that nonpsychopathic criminals do (Hare and Schalling 1978; Ogloff and Wong 1990). Self-report measures of anxiety also show a robust negative correlation with one factor of psychopathy, aggressive narcissism (Hare 1991). Rorschach measures of anxiety have further validated this finding (Gacono and Meloy 1991). In comparison with male outpatients with borderline personality disorder and narcissistic personality disorder, psychopathic males are significantly less anxious (Gacono et al. 1992).

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 concern over the actions of oneself and others. As the severity of psychopathy increases in patients with antisocial personality disorder, anxiety lessens, and with it the personal discomfort that can motivate a patient to change.

Attachment, or the capacity to form an emotional bond, has also been shown to be significantly less in psychopathic criminals than in nonpsychopathic criminals (Gacono and Meloy 1991). This finding is empirically consistent with the clinical literature, which has described the psychopathic individual as chronically emotionally detached (Reid

et al. 1986). Psychopathic patients are significantly more detached than are outpatients with borderline and narcissistic personality disorder (Gacono et al. 1992). It appears that chronic emotional detachment varies in severity among patients with antisocial personality disorder, is a measurable trait of the psychopathic patient with antisocial personality disorder, and is a stable characteristic that is already seen in solitary-aggressive children with conduct disorder (Gacono and Meloy 1994).

The ability to form an alliance with the therapist, a clinical measure of attachment capacity, has been shown to be a positive prognostic marker in the psychotherapeutic treatment of males with antisocial personality disorder (Gerstley et al. 1989). This ability was especially associated with decreased drug use and increased employment. 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, since an empathic capacity to inhibit aggression is nonexistent. The more severe the psychopathy, the more the patient will relate to others on the basis of power rather than affection (Meloy 1988). The psychobiological basis for this absence of anxiety and attachment is probably rooted in chronic cortical underarousal, or more specifically, a peripheral autonomic hyporeactivity to aversive stimuli, that is apparent in severely psychopathic individuals (Hare 1978).

Narcissism and Hysteria

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 antisocial personality disorder, the greater the likelihood that aggressive devaluation will be used to shore up feelings of grandiosity and repair emotional wounds. In some patients this is defensive, whereas in others there will not appear to be a core, injured sense of self. 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. Although male outpatients with narcissistic personality disorder are as self-absorbed and grandiose as are psychopathic patients, their capacity for anxiety and attachment makes them much better treatment candidates (Gacono et al. 1992).

In addition to the devaluation of others, which in some clinical cases may appear compulsive, the severity of psychopathy will determine the degree to which the patient must 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 patient's grandiose fantasies and also warding off fears of being controlled by malevolent forces outside oneself. Psychopathic criminals, moreover, appeared to be less fearful than nonpsychopathic criminals in laboratory studies in which startle probe analyses were used (Patrick et al. 1993). When the character pathology of the patient with antisocial personality disorder shows signs of weakness, there will be clinical manifestations of anxiety or depression, both of

which are positive prognostic indicators (Gabbard and Coyne 1987).

Hysteria has been linked to psychopathy in the scientific literature for a century. In the PCL-R (Hare 1991) (Table 84–2), several criteria are identified that are consistent with hysterical character: glibness and superficial charm, need for stimulation and proneness to boredom, shallow affect, and promiscuous sexual behavior. Other intrapsychic characteristics of antisocial personality disorder that are consistent with hysterical traits (Horowitz 1991) include unmodulated affect, sexual preoccupation, self-absorption, and aggressive expectations of others (Gacono and Meloy 1994). D. Shapiro (1965) termed the hysterical cognitive style *impressionistic*: "global, relatively diffuse, and lacking in sharpness, particularly in sharp detail" (p. 111).

Cognition in patients with antisocial personality disorder is characterized by moderate and pervasive formal thought disorder that appears to be psychodynamically linked to narcissism; for example, the need to self-aggrandize leads to circumstantial or tangential comments about the self that are only remotely related to the clinical task (Gacono and Meloy 1994). The hysterical aspect of psychopathy is apparent in clinical settings when the patient demonstrates evasive and impressionistic thought, minimizes and denies his or her behavior, and shows sudden, dramatic, and shallow emotional outbursts. The latter affective style is normally used by the patient with antisocial personality disorder to seek attention and control others.

Psychological Defenses

Antisocial personality disorder patients with severe psychopathy most predictably use the following psychological defenses: projection, rationalization, devaluation, denial, projective identification, omnipotence, and splitting (Gacono and Meloy 1992; Hare 1991). The psychopathic patient is usually organized at a pre-oedipal level and is unlikely to show any higher-level defenses. 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. One patient with antisocial personality disorder who was also a severe psychopath reported to his psychotherapist several homicides that he had ostensibly committed. He then sat back, smiled, and said, "You know a lot about me, doc, and sometimes when people know too much they get killed."

Higher-level or neurotic defenses, such as idealization, intellectualization, isolation, and repression, appear to be virtually absent in the antisocial personality disorder patient with severe psychopathy (Gacono 1990). Idealization of other people besides the self is a contraindication for psychopathy and a positive treatment indicator, because it signals hope and the anticipation of meaning in the future. Psychopathic patients are prone to feelings of envy toward the goodness in others and will aggress against this perceived goodness to ward off such unpleasant feelings. If neurotic defenses are present in the antisocial personality disorder patient, they suggest a diagnosis other than a psychopathic character and amenability to treatment. Internal experience will more likely be expressed with thought, rather than just through feeling and impulse.

Object Relations

There is some empirical evidence that patients with antisocial personality disorder, both severely psychopathic and nonpsychopathic, are organized at a borderline level of personality (Gacono and Meloy 1994), consistent with the clinical and theoretical literature (Kernberg 1984). Psychopathic patients produced more total primitive object relations than did nonpsychopathic individuals in several empirical Rorschach studies (Gacono and Meloy 1994). They appeared to have simultaneous developmental wishes both to symbiotically merge with the object and to be mirrored by the object, which may partially explain why they continually aggress against other people when they are also chronically emotionally detached (Meloy 1992). They appear to experience their aggressive impulses and identifications as ego-syntonic, or in league with their self image.

The treatment implications of these object relations surround the risk of violence by the patient with antisocial personality disorder. The more psychopathic he or she is, the more pleasurable, less conflicted, and perhaps more sadistic aggressive acts will be (Dietz et al. 1990). Unlike the patient with borderline personality disorder, in whom impulses to aggress against the self or others may be frightening, 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 nature of their violence, makes antisocial personality disorder patients with severe psychopathy exceedingly dangerous in a hospital milieu without appropriate security.

Affects

The emotions of the patient with antisocial personality disorder lack the subtlety, depth, and modulation of "normal" individuals. The antisocial personality disorder patient with 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, real, and meaningful other persons. The patient's emotional life is dominated by feelings of anger, sensitivities to shame or humiliation, envy, boredom, contempt, exhilaration, and pleasure through dominance. The more psychopathic the patient with antisocial personality disorder, the more apparent will be his or her limited emotional repertoire to the clinician.

Chronic cortical underarousal may be one biological substrate for this paucity of development of socialized emotions (Raine et al. 1990). Affective dysfunction in the psychopathic patient is also apparent in his or her inability to understand the emotional or connotative meaning of words (Williamson et al. 1991) and in less of a startle blink reflex in response to both pleasant and unpleasant stimuli (Patrick et al. 1993). Both male and female adults with antisocial personality disorder appear to modulate affect about as well as a 5- to 7-year-old child (Gacono and Meloy 1994). Research also indicates that patients with antisocial personality disorder are often confused by the nature and quality of their emotions, feel damaged or injured, and hold a chronic anger toward others. They also experience emotion less often than do normal males and avoid emo-

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tionality in others, which is perhaps a behavioral defense to manage what are perceived, at times, as uncontrollable feelings (Gacono and Meloy 1994).

These findings pose difficult treatment problems, but their absence in any one patient should support a more positive prognosis. Such findings in the antisocial personality disorder patient with severe psychopathy predict a nonresponsiveness to treatment modalities that depend on cognitive or emotional access to the patient, such as cognitive-behavioral relapse prevention or psychodynamic approaches that require a capacity to feel emotion in relation to the psychotherapist and talk about it. Most troublesome and difficult to detect is the psychopathic patient who imitates certain emotional states for secondary gain or to manipulate the psychotherapist. This rewarding of the clinician, often by appealing to the clinician's narcissistic belief that he or she can heal the most difficult patient, has been called "malignant pseudo-identification" (Meloy 1988, p. 139) and may be used to describe other ways in which the psychopathic patient imitates feelings, thoughts, and behaviors wished for by the treating clinician.

Superego Pathology

The touchstone of psychopathy and antisocial personality disorder 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 (Trevethan and Walker 1989), clinicians agree that this characteristic is a marker for the character pathology (Kernberg 1984; Meloy 1988; Reid et al. 1986). Minimal anxiety, attachment failure (whether biogenic or sociogenic), and cortical underarousal may be contributory substrates for the absence of internalized value in the antisocial personality disorder patient with severe psychopathy.

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, are positive prognostic signs. Certain nonpsychopathic patients with antisocial personality disorder may show evidence of harsh and punitive attitudes toward the self and assume a masochistic attitude toward the clinician. This signifies some internalized value and attachment capacity. Antisocial personality disorder 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 genuinely mentally ill patients at risk.

When such patients 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. Meloy (1988) identified the following five clinical features that contraindicate treatment of any kind:

1. History of sadistic and violent behavior
2. Total absence of remorse
3. Intelligence two standard deviations from the mean
4. No history of attachments
5. Fear of predation on the part of experienced clinicians without any overtly threatening behavior by the patient

These are clinical guidelines and are not the result of controlled empirical research. The presence of a treatable Axis I condition, such as schizophrenia, in such a patient poses an ethical dilemma for the psychiatrist. Successful remission of the Axis I mental disorder may contribute to better organization of the psychopathy.

The Clinician's Reactions to the Patient

Lion (1978), Symington (1980), Strasburger (1986), Meloy (1988), and Gabbard (1994c) explored the clinician's response to the psychopathic or antisocial personality disorder patient. Table 84–3 lists eight common countertransference reactions to such a patient.

Therapeutic Nihilism

Lion (1978) used the term *therapeutic nihilism* to describe the 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 antisocial personality disorder what the patient does to others. Symington (1980) called this *condemnation*, and it psychoanalytically reflects the clinician's identification with this aspect of the patient's character.

Illusory Treatment Alliance

The opposite reaction to therapeutic nihilism is the illusion that there is a treatment alliance when, in fact, there is none. Often these perceptions on the part of the patient are the psychotherapist's own wishful projections. Although the presence of an alliance is a favorable prognostic indicator (Gerstley et al. 1989), in antisocial personality disorder patients with severe psychopathy it should not be expected. Behaviors 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). Bursten (1973) elaborated

Table 84–3. Common countertransference reactions to the patient with antisocial personality disorder

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

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 antisocial personality disorder 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 and Steadman 1994). 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 old autonomic reactions that may also signal real danger, even in the absence of an overt threat. Although there are no empirical studies of this phenomenon, it appears to be a widespread experience among clinicians working with psychopathic patients (Meloy 1988). A related clinical feature is overt sadistic triumph over the psychotherapist, or what Kernberg (1984) termed "malignant grandiosity."

Denial and Deception

Denial in the psychotherapist is most often seen in counterphobic responses to real danger. Lion and Leaff (1973) suggested that it 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 antisocial personality disorder (Gabbard 1994c), 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. It is most obvious in clinical records in forensic hospitals when a patient is referred to as having "allegedly" committed a certain crime after he or she has been tried and convicted by a judge or jury.

Deception of the patient with antisocial personality disorder 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 antisocial personality disorder. Rigorous honesty without self-disclosure is the treatment rule with antisocial personality disorder patients.

Helplessness and Guilt

The novice clinician may especially feel helpless or guilty when the patient with antisocial personality disorder 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 A. Reich (1951) called the "Midas' touch syndrome." Strasburger (1986) noted that these feelings may be transformed into rage that is passively expressed as withdrawal, or into an attempt to smother the patient with heroic treatment efforts and attention.

Devaluation and Loss of Professional Identity

If therapeutic competency is measured only through genuine change in the patient, the patient with antisocial personality disorder will be a source of continuous professional disappointment and narcissistic wounding. In long-term treatment, the psychopathic patient may stimulate 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. 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 antisocial personality disorder patient he was treating as they both stormed through the hospital with flame throwers, destroying everything in sight. No other patient will compel a psychotherapist to face their own aggressive and destructive impulses like the psychopathic antisocial personality disorder. Because these patients often hate goodness itself and will destroy the perceived goodness, such as empathy, offered by the clinician, the latter 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 1989a; Galdston 1987).

Assumption of Psychological Complexity

The most subtle countertransference reaction is the clinician's belief that the patient with antisocial personality disorder is as developmentally mature and complex as the clinician and that the patient's actual maturity has only to be facilitated by, and discovered in, treatment. This is particularly common when there is no Axis I diagnosis and the patient has an above-average IQ. Certain aspects of IQ and ego functioning are not related, and the severely psychopathic patient with a very superior IQ, through glibness and superficial charm (see Table 84–2), may mask a borderline personality organization (Kernberg 1984).

Understanding and management of these emotional reactions to patients with antisocial personality disorder, whether psychopathic or not, will not only increase staff safety, but will also contribute to diagnosis and treatment planning. Such countertransference reactions are most readily explored in individual or group supervision or in carefully led clinical staff meetings where 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. As Meloy (1988) wrote, ". . . the interpersonal encounter with the patient fundamentally defines the humanity, or lack of humanity, of the treatment: a task that is most rigorously tested when the psychopathic patient is commonly perceived, at least in part, as inhuman" (p. 340).

Specific Treatment Approaches

Despite the absence of a body of controlled outcome data, certain treatment modalities are more effective than others. The effectiveness of a modality will depend on the treatment goals, which should be conservative at best.

Pharmacotherapy

Although as yet there are no data showing that antisocial personality disorder can be altered with medication, certain symptoms and behaviors in the patient with antisocial personality disorder may respond to pharmacological intervention if medication compliance is heightened through institutional or community supervision (Meloy et al. 1990). Schizophrenic patients with antisocial personality disorder are most effectively treated with decanoate medications if there is a clinical choice. In hospital settings, the antisocial personality disorder patient who exhibits anxiety or depression, a contraindication of severe psychopathy, will show prognostic improvement if medically treated for these symptoms (Gabbard and Coyne 1987).

By far the most troublesome symptom of antisocial personality disorder is violence, which is significantly more frequent and severe in psychopathic patients with antisocial personality disorder (Hare and McPherson 1984). Eichelman (1988) delineated a rational pharmacotherapy for aggression and violence based on four biological systems (Table 84–4).

Reis (1974) labeled, and Eichelman (1992) and Meloy (1988) elaborated upon, the physiological, pharmacological, and forensic distinction between "affective" and "predatory" aggression. These psychobiologically different modes of violence are most relevant to antisocial personality disorder and psychopathy, although they are not inclusive and should not be considered a standardized clinical nosology for aggression (Eichelman and Hartwig 1993). Affective 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 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 nonpsychopathic criminals to engage in predatory violence toward strangers (Serin 1991; Williamson et al. 1987).

Appropriate pharmacological intervention with antisocial personality disorder patients or psychopathic patients involves an analysis of the mode of violence in which the patient has engaged and the selection of medications that have been shown to inhibit the relevant mode of violence. The serotonin agonists and the anticonvulsants appear to inhibit both (Eichelman 1988). In particular, serotonergic dysfunction may

Table 84–4. A rational pharmacotherapy for treating violence and aggression

Biological system	Action	Suggested medication
Gamma-aminobutyric acid system	Inhibits affective aggression	Benzodiazepines
Noradrenergic system	Enhances affective, inhibits predatory aggression	Lithium, propranolol
Serotonergic system	Inhibits affective and predatory aggression	Lithium, fluoxetine
Electrical "kindling"	Enhances affective and predatory aggression	Phenytoin, carbamazepine

Source. Data from Eichelman B: "Toward a Rational Pharmacotherapy for Aggressive and Violent Behavior." *Hospital and Community Psychiatry* 39:31–39, 1988.

account for prominent symptomatology in both psychopathic and nonpsychopathic patients with antisocial personality disorder, particularly their decreased ability to inhibit learned responses in the face of punishment; impulsivity; emotional dysregulation (Lewis 1991); assaultiveness; and dysphoria (Coccaro et al. 1989; Moss et al. 1990). Eichelman (1988) proposed that psychiatrists who pharmacologically treat violent patients address the primary illness first, initially use the most benign interventions, quantify the efficacy of their treatment (such as nursing observation scales), and institute each drug as a single variable into treatment if at all possible.

Family Therapy

Both parent management training (Patterson 1986) and structured family therapy (J. Alexander and Parsons 1982) have been shown to be effective with children with conduct disorder. There is no published research on family therapy with adult patients who have antisocial personality disorder, whether psychopathic or not. The use of family therapy when one of the participating adults is a psychopathic patient with antisocial personality disorder or a psychopathic individual who does not meet the criteria for antisocial personality disorder is ill 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.

Nonpsychopathic adults with antisocial personality disorder adults may benefit from family therapy and are most likely to be seen when the conduct-disordered child is the identified patient. Such work may have a positive impact 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). A genuine capacity to bond to the other family members, attempts to be a responsible spouse or parent, and clinical expressions of anxiety, dysphoria, or genuine affection during the treatment are positive prognostic indicators for the adults with antisocial personality disorder in family therapy. Continuous acting out, however, should be expected and monitored through collateral contacts.

Milieu and Residential Therapy

Reviews of treatment programs to reduce recidivism of convicted offenders, many of whom will usually meet the criteria for antisocial personality disorder, identify three guiding principles: 1) programs are most effective when they target moderately high-risk individuals; 2) treatment is most effective when criminogenic issues are addressed, such as antisocial values and attitudes, peer relations with other criminals, chemical dependencies, and vocational-educational deficits; and 3) treatment should teach and strengthen interpersonal skills and model prosocial attitudes (Rice et al., in press). 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. Human behavior is strongly influenced by its consequences, and this occurs regardless of whether the results are intended or the influence is deliberate. The clinician chooses to leave this to chance, or to purposefully control the environment, if he or she can, as a therapeutic tool. Three milieu or residential approaches are promising for the treatment of antisocial personality disorder.

The first approach, *token economy programs,* has been empirically found to shape patient and staff behavior within institutions (Rice et al. 1990). Although effective, such programs may be legally challenged by patients with antisocial personality disorder on the basis of an arguable constitutional right to avoid unwanted therapy. Despite their falling popularity, they have no serious competition as a system of behavioral management in hospitals. On the other hand, there is also evidence that the more typically unstructured hospital ward may actually harm patients by promoting psychotic, aggressive, and dependent behaviors (Positano et al. 1990).

The second approach, *the therapeutic community,* was originally developed by M. Jones (1956) in England a half century ago. Members of the community care for each other, follow the rules, submit to the authority of the group, and are rewarded or disciplined by the group. The primary intervention in the therapeutic community is the daily group meeting, which functions both as a psychotherapeutic and a policy-making body. Peer problem-solving is encouraged, and staff are facilitators of this largely democratic group culture. Controlled studies of therapeutic communities, although few in number, have shown modest positive effects (Harris and Rice 1994).

When offenders within therapeutic communities are classified as either psychopathic or nonpsychopathic based on the criteria of the PCL-R (Hare 1991; Table 84–2), the results are striking. Ogloff et al. (1990) found that the scores on the PCL-R were both postdictive and predictive of treatment outcome in a Canadian therapeutic community for adult male offenders. Individuals in the psychopathic group were less motivated to change their behavior and had a higher attrition rate. In contrast, individuals in the nonpsychopathic group became less angry, hostile, anxious, and depressed and were more socially at ease and more assertive in interpersonal relations.

Similarly, Ravndal and Vaglum (1991) found that antisocial aggressiveness was related to attrition among substance-abusing participants in a Norwegian therapeutic community. Rice et al. (1992) retrospectively evaluated the efficacy of a maximum-security therapeutic community in reducing both general and violent recidivism. Using a matched-group, quasi-experimental design, they found that treatment was associated

with lower recidivism, especially violent recidivism, for the nonpsychopathic patients and higher violent recidivism for the psychopathic patients, with an average follow-up of 10 years. Although the reasons for this finding are unknown, it is the first controlled study to suggest that therapeutic communities may actually be detrimental to the safety of society when severely psychopathic patients are treated.

The third approach, *wilderness programs,* uses nature as the milieu both to reinforce individual responsibility and to stimulate group cohesion. Although there are no controlled outcome studies of their effectiveness in changing antisocial personality disorder or, for that matter, criminal recidivism, it is likely that the effect size would be modest. The capacity of the subject to form an attachment or bond with the group and the experience of anxiety or fear in the face of natural danger would be favorable prognostic indicators. The severity of psychopathy would probably predict treatment failure and an absence of generalization of the newly learned, prosocial behaviors once the individual returned to the community.

Although there have been many studies purportedly to evaluate the treatment efficacy with antisocial individuals, S. Wong and Elek (1990) found that none met their six criteria for a good study: 1) a valid measure of psychopathy, 2) an assessment of diagnostic reliability, 3) a detailed description of the treatment program (Doren 1987), 4) the use of reliable and objective measures of treatment outcome, 5) a follow-up period of at least 1 year, and 6) the use of an appropriate control group. A model treatment program for high-risk offenders was proposed by the Darkstone Research Group (1992) for the Correctional Service of Canada. It included a prosocial treatment environment, the neutralization of procriminal attitudes, the involvement of nonpsychopathic offenders as prosocial models without formal authority to run the program, interpersonal skills training, emotion management skills, acceptance of personal responsibility, dissociation from criminal peers and life style, and the cessation of substance abuse. Such a program has yet to be implemented but represents the best integration of realistic methods and goals to date.

Cognitive-Behavior Therapy

Relapse prevention theory, a structured form of cognitive-behavior therapy, has been associated with successful correctional treatment programs (D. Andrews et al. 1990). The premise of the theory (Marlatt and Gordon 1985) is that the targeted behavior, in this case antisocial behavior, is learned, motivated, and reinforced by internal factors within the patient and external factors within the environment. Internal motivators encompass thoughts, feelings, perceptions, and fantasies, whereas external motivators may include alcohol or stimulants, weapons (Hunter and Love 1993), or an available pool of victims (Meloy 1988). Reinforcers may be either positive or negative and internal or external. For example, an internal positive reinforcer could be a heightened level of autonomic arousal that results from sensation-seeking behavior. A discrete antisocial behavior is preceded by a chain of events that, if not interrupted, leads to relapse. Various treatment methods arise from this model to teach the antisocial individual to implement new cognitive and behavioral strategies and to break this cognitive-behavioral chain.

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Patients with antisocial personality disorder are likely to respond to this method of treatment if they are motivated to change and it is used in a milieu or residential setting. This is most predictable in the nonpsychopathic patient with antisocial personality disorder who normatively responds to aversive consequences and has felt the emotional and practical pain of his or her antisocial acts. It is unlikely to have any impact on the severely psychopathic patient with antisocial personality disorder because of deficits in passive avoidance learning (inhibiting 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 upon the past. The cognitive deficits of the psychopathic patient, such as moderate formal thought disorder (Gacono and Meloy 1994) and impairments in understanding the connotative meaning of words (Hare 1991), would also attenuate the degree of success achieved with this mode of therapy.

Psychodynamic Approaches

There is no clinical evidence that psychopathic patients with antisocial personality disorder will benefit from any form of psychodynamic psychotherapy, including the expressive or supportive psychotherapies (Kernberg 1984), psychoanalysis, or various psychodynamically based group psychotherapies. However, psychodynamic treatment of the patient with antisocial personality disorder can be differentiated from psychodynamically understanding the patient with antisocial personality disorder, whether psychopathic or not, when other, more promising, modes of treatment are applied, such as those noted earlier. Psychodynamic understanding of the patient with antisocial personality disorder (Gabbard 1994c; Meloy 1988) assumes that unconscious determinants play a major role in behavior. It also embraces a "levels" (H. 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, and the environment. In the case of a patient with antisocial personality disorder, this conceptualization could translate into psychopharmacological intervention to minimize affective violence (psychobiology), thinking about and discussing with staff the aggressive narcissism of the patient and its countertransference impact (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 (environment). Approaches that ignore other "levels" or determinants of personality-disordered behavior are likely to fail and often are used because of the preferred treatment "philosophy" of the team leader, even in the absence of empirical data (Yochelson and Samenow 1977).

Conclusions

Treatment and management of patients with antisocial personality disorder, whether severely psychopathic or nonpsychopathic, test the clinician's mettle. Although they

rarely seek medical care for their personality disorder—only one out of seven will ever discuss their symptoms with a doctor (Robins and Regier 1991)—concurrent problems will bring them into treatment, whether voluntary or not.

The comprehensive care of the patient with antisocial personality disorder involves six principles:

1. During the initial diagnostic workup, the severity of psychopathy of the patient with antisocial personality disorder should be determined, with a clinical focus on the capacity to form attachments and any evident superego disturbance.
2. Any treatable conditions, such as Axis I mental or substance abuse disorders, should be identified.
3. Situational factors that may be aggravating or worsening the antisocial behaviors need to be delineated.
4. The mental health professional must recognize the likelihood of legal problems and potential legal entanglements, even if they are initially denied.
5. Most important, treatment should begin only if it is demonstrably safe and effective for both the patient and the clinician.
6. Careful attention should be paid to all countertransference reactions, because they provide important insights into the inner world of the patient with antisocial personality disorder.

As an anonymous Australian psychiatrist wrote,

> Basically it is symptomatic relief, clear guidelines about expected behavior, treatment of any major psychotic illness, realistically accepting them as they are and trying extremely hard not to be too frightened of them. (Quality Assurance Project 1991, p. 545)