Antisocial Personality Disorder

Highlights from the **American Psychiatric Association 2007 Annual Meeting**

Treating Antisocial Personality Disorder: A Multi-Dimensional View

Although the DSM-IV clearly outlines the seven criteria used to diagnose antisocial personality disorder, it is a "gross categorical diagnosis", suggests Reid Meloy, PhD, University of California, San Diego. He emphasizes that to truly understand and effectively treat an individual presenting with antisocial personality disorder, clinicians must use the DSM-IV criteria in conjunction with a multi-dimensional view of the disorder.

One dimension of antisocial personality disorder that will significantly impact treatability is psychopathy. Although only 20-25% of individuals with this particular personality disorder display primary or severe psychopathy, its presence may actually hinder any effort to treat the patient. There is a negative correlation between psychopathy and treatability of antisocial personality disorder, with a greater degree of psychopathy resulting in poorer outcomes post-treatment. Furthermore, efforts to treat psychopathy, as a primary disorder, may actually yield results opposite to what would be expected, with psychopathic behaviors becoming worse as treatment progresses (Hare. *Psychiatr Clin North Am* 2006;29: 709-24).

While there are few or no treatment options for the psychopath, assessing psychopathy in the antisocial personality disorder patient has become easier. There are now a number of empirically-based assessment devices available for psychopathy evaluation. The "Hare" risk assessment instruments, including the Psychopathy Checklist (along with its Screening and Youth versions), the Antisocial Personality Disorder Screening Device and the P-SCAN (used primarily in non-clinical law enforcement settings) all provide refined, dimensional snapshots of individuals with antisocial histories. These tools may be useful when planning a course of treatment for a patient who presents with antisocial personality disorder.

Clinicians should consider, what Dr. Meloy has labeled, the "ABCs" of antisocial personality disorder. Does the patient present with ***A***nxiety? Can the patient ***B***ond in a genuine manner? When meeting with the patient, does it appear that he or she has a ***C***onscience? If any or all of these constructs are apparent, it would suggest that psychopathy is not present, thus increasing the likelihood that the patient would benefit from a clinical intervention.

If a patient scores low for psychopathy, what treatment would be available for antisocial personality disorder? Many of these patients do respond positively to anti-anxiety medications, but only if there is an aspect of anxiety related to their pathology.

Many clinicians also employ cognitive behavioral and social learning techniques to treat these patients. Although these treatments display some efficacy, clinicians should be cautious, given the effect sizes are often described as modest compared to their utility with other pathologies.

Independent of the treatment ultimately deemed appropriate for the patient, a clinician must also consider the nature of violence, given its intimate relationship with antisocial personality disorder and psychopathy. "Violence is not homogenous", states Dr. Meloy. There are two distinct, biologically dissociable forms of violence. One form, affective violence, is a reactive, unplanned form of aggression, most often a response to an imminent threat. When the threat is removed, the violence ceases. The second form of violence, predatory (or instrumental) violence, is a planned, purposeful, emotionless act of violence. Predatory violence is not reactive. In the context of antisocial personality disorder, the higher the degree of psychopathy, the greater the frequency of both affective and predatory violence.

Fortunately, pharmacological management seems to be most appropriate when addressing the violent tendencies of antisocial personality disorder patients. In order to pick the most appropriate medication, clinicians should consider which form of violence is most prevalent. Research has indicated that while phenytoin impacts affective violence, it has no effect on predatory violence. In a double-blind, placebo-controlled study, Barratt et al. (1997) demonstrated that phenytoin (200 mg in the morning and 100 mg in the evening) significantly reduced impulsive but not premeditated acts of aggression in a population of prisoners who had difficulty controlling their aggression ($p<0.05$; *J Clin Psychopharmacol*; 17:341-9). Serotonin agonists, however, appear to inhibit both forms of violence. Although medication management for violence does show some efficacy, Dr. Meloy cautions that "motivation [for treatment] is critical" in order for these pharmacological interventions to have true utility in the treatment of antisocial personality disorder.

One final consideration is the therapist's reaction, be that physical or psychological, to the patient. The notion that clinicians may experience such strong reactions to the antisocial/psychopathic patient is not without empirical support. Noting his earlier work, Dr. Meloy recalls, "individuals would experience certain physical, visceral states when they were around a psychopathic individual."

Surveying approximately 1,000 individuals employed in mental health and law enforcement in 12 states, reactions to psychopaths were assessed using two questions: a) "Have you ever interviewed a psychopathic patient based on the psychopathy criteria developed by Robert Hare and his colleagues?" and b) "Did you have a physical reaction, and, if so, can you describe it?" There was a 77.3% positive response for a physical reaction when interviewing a psychopath. The trend of this data also suggested that females had a stronger response than males ($p<0.001$), and that mental health workers had a stronger reaction than law enforcement agents (p 0.001; Meloy and Meloy. *J Threat Assess* 2002;2:21-33).

Psychologically, strong counter-transference reactions were reported in response to working with antisocial/psychopathic individuals. Clinicians need to cope with their counter-transference so they do not act out against the patient. The most common counter-transference reactions to the antisocial personality and psychopathic patient include:

- **Therapeutic Nihilism** – the patient is not treatable
- **Illusory Treatment Alliance** – an alliance when there is none
- **Fear of assault or harm** – believing the patient will act out violently
- **Hatred and wish to destroy** – identifying with the predatory violence of the patient
- **Assumption of psychological maturity** - believing the patient has insight into their pathology
- **Fascination, excitement and sexual attraction**– arousal in response to the taboo behavior of the patient

In summary, a clinician must consider the multiple dimensions of antisocial personality disorder in order to provide the most efficacious treatment for their patient. These factors include the level of psychopathy, personality disorder, the nature of violence and the clinician's reactions to the patient. Although the treatment effects with this population are modest, Dr. Meloy is optimistic about the direction of research in this area and the new understanding of antisocial personality disorder that it may yield.