Optimal Involvement of Antisocial Patients In The Planning of Their Treatment Route: *Some Positive Effects*

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Abstract

Optimal participation of patients with antisocial personality disorder in the planning of their treatment programs, educational programs, and training (vocational, social skills, pro-social coping) programs might be beneficial for the social-emotional and moral development of patients, as well as the job satisfaction of therapists and the quality of hospital life. In this article an attempt is made to study how the effective selection of patients, in combination with the optimal involvement of motivated patients in planning their programs of treatment, education, and training, might contribute to therapeutic success and increase the well-being of patients as well as therapists.

Introduction

According to the DSM-IV (American Psychiatric Association, 1994) antisocial personality disorder (ASPD) is characterized by social maladjustment, criminality, deceitfulness, impulsivity, aggression, reckless and irresponsible behavior, and lack of remorse. But research indicates that other features such as emotional dysfunctions (Barrash et al., 2000; Herpertz & Sass, 2000; Herpertz et al., 2001; Keihl et al., 2001; Martens, 2002b), a lack of fear and associated incapacity to learn from experiences, insensitivity to punishment (Lykken, 1995), and sensation seeking (Zuckerman, 1994) are also linked to ASPD.

Patients with ASPD can be treated successfully (Kernberg, 1984, 1992; Martens, 1997, 1999, 2002a; van Marle, 1995; Salekin, 2002; Skeem et al., 2002), but this correlates with several factors:

- the availability of a variety of therapeutic approaches, as well as experienced (high profile) therapists who specialize in working with antisocial patients,
- a combination of different treatment approaches such as psychotherapy, neurologic treatment, neurofeedback therapy with psychosocial guidance/counseling, and social skills and/or vocational training (Martens, 2002a),
- the patient's favorable circumstances (friendship, impressive events, confrontation, maturation, and so on), and/or
- the patient's age (Black et al., 1995; Martens, 1997, 2000c; Robins, 1996).

Factors that lie behind the responsibility and capacities of the patient might be linked to the failure to successfully treat patients with ASPD (Martens, 2000a, 2000b).

Effective and realistic treatment planning is crucial to the treatment of ASPD. Some patients with antisocial personality disorder are involved, to some extent, in planning their treatment programs. However, Martens (1997) revealed that only a restricted group of antisocial patients (60% of the cases) received the opportunity to be involved in their therapeutic planning. Even in these cases, patients' chances to participate in the development of their treatment programs were often very limited as a result of rigid hospital regimes, a lack of experience with such matters, and fear of hospital staff. Staff members often resist the intensive participation of patients in the setting up of their treatment routes because they fear the supposed risks, such as losing control and power and being the object of manipulation. Another occasional occurrence was that hospital staff were sometimes unwilling or unable to utilize the fruitful and constructive ideas of patients because of the very limited therapeutic varieties that were available in a specific forensic psychiatric setting (Kahn et al., 2004). Martens (1997, 2004) discovered that when antisocial patients took part in setting up their treatment and education routes, it could sometimes contribute significantly to their therapeutic progress and positive outcomes. Furthermore, a willingness to plan their treatment and educational routes could also be a promising sign of potential social-emotional and moral awareness/capacities and the desire to change. This article attempts to investigate how the effective selection of patients, in combination with the optimal participation of selected patients in

the development of their treatment, educational, and training programs, might lead to increased motivation and enhanced well-being in patients and therapists, and more treatment success.

Practical Guidelines

Selection Criteria for Treatment

A keen selection process will contribute to an optimal therapeutic atmosphere, allowing patients to develop and flourish.

First, treatment should be offered only to patients who seriously want to change their behaviors/attitudes and realize that change is necessary. Insufficiently motivated patients should participate in a motivational program before forensic psychiatric treatment really starts. Patients should be given the opportunity to develop adequate motivation for treatment and attitude change within a set period of time (for instance, within a year after admission). Those patients who are permanently unmotivated should be admitted to special prison wards or institutions without expensive intensive psychiatric or psychotherapeutic treatment facilities. Only basic care should be provided to this category of patients (such as medical care for physical diseases, psychopharmacological treatment for patients with psychotic or other psychiatric co-morbidity, physical security, etc.). Unmotivated patients should remain in these prison wards or institutions unless they become motivated to change (Martens, 2000a, 2000b).

When patients declare that they are motivated for treatment, they must prove their good intentions by means of intensive preparation of their own treatment, training, and education routes. They must think about appropriate treatment modules and the precise routes that could most likely lead to their improvement. Such activities require an increase in self-investigation and correlated self-insight; only in this way will they discover treatment routes that correlate with their character strengths and flaws. Patients must then illustrate their intentions to cooperate with staff members, and eventually fellow patients, who are involved in this process. Of course, a patient is allowed to make severe mistakes, but his or her real attitude and the quality of his or her motivation should be unmistakable. In this intensive preparative process, the real nature of patients' intentions can be revealed.

It is important to know how intelligent and creative a particular patient is, and how mature his or her feelings of responsibility are; these are significant correlates of therapeutic success, improvement, and even remission (Black et al., 1995; Kernberg, 1984, 1992; Martens, 2003a; Robins, 1996). However, spiritual and moral interests are also positively related to treatment success and good outcomes for patients with ASPD (Martens, 2001b, 2003b).

It seems to be very important that patients are placed (by means of a selection process) in wards that are appropriate for them given the characters of fellow patients and the types of treatment regimes being utilized. For example, individuals who are easily influenced and/or individuals who seek rest (which is required for contemplation, self-investigation, and the processing of relevant therapeutic information) should not be placed in a ward with patients who are excessively aggressive, restless, and/or manipulative. It is also wise to separate destructive, noisy, and narrow-minded patients from those who are quiet, introspective, and intelligent (Kahn et al., 2004; Martens, 1997). Furthermore, in this selection process the dimension of the "constructive unity" of patients in a ward should be considered. The strengths of some patients in particular areas should potentially compensate for the specific limitations of other people, and vice versa. For instance, some patients are very diplomatic and socially skilled; these patients may be able to mediate conflicts and recognize the early signs of looming problems in their fellow patients (Martens, 2001a). Moreover, some antisocial patients are capable of supporting, motivating, and/or stimulating fellow patients during crisis situations. In this way, early and adequate interventions and/or the prevention of crisis situations can be realized. A well-balanced mix of characters in a ward will lead to remarkable results (Kahn et al., 2004; Martens, 1997).

An additional selection criteria for treatment is whether a patient shows clear signs of shame or guilt with regard to his or her offenses and deviant behavior. Signs of guilt and remorse are often regarded as necessary correlates of motivation for treatment. However, in some antisocial persons, self-knowledge and the need-to-change attitude are possible without feelings of shame or guilt. This is possible because of neurobiologically determined emotional (processing) dysfunctions (Barrash et al., 2000; Herpertz & Sass, 2000; Herpertz et al., 2001; Keihl et al., 2001; Martens, 2002b) that can interfere with moral emotions such as empathy and remorse. It is remarkable that such patients may demonstrate strong rational motivations for change; such motivations to change can include thoughts such as "change will be favorable for me and a possible career" and "change is the only way to save my marriage." Patients may also choose to change because they want to avoid arrest and incarceration. The quality of these rational reasons for change can only be tested in therapeutic practice (Martens, 1997).

Additional questions can help determine if a patient is ready to participate in planning his or her own treatment. These questions include the following:

- Did the patient try to change his or her attitude/behavior or seek help in the past? What were the results of those attempts? If the attitude/behavior did not change, why not? What has happened since then so that the patient is still motivated for treatment?
- Is the patient a re-offender? How did he or she behave in earlier forensic psychiatric or residential settings? Did the patient complete therapy, and how was his or her therapeutic attitude? If the patient was not seriously motivated for treatment in the past, his or her current intentions and motivations should be carefully assessed to ensure that they are substantially improved.

• Which co-morbid disorders are diagnosed? Many individuals with antisocial personality disorder have co-existing mental disorders such as substance abuse disorder, depression, psychotic disorder, or other personality disorders (Martens, 2000c). It might be effective to treat specific co-morbid disorders such as substance abuse or psychotic disorder before treating the main disorder (Oppenheimer et al., 2002).

• Has the antisocial behavior of the patient been determined to be neurobiological? In such cases, a combination of psychotherapy and psychopharmacological and neurofeedback treatment could be successful (Martens, 2002a).

• Does the patient demonstrate serious deceitful and unreliable behavior? Is this behavior linked to specific situations? For example, some antisocial patients show unreliable behavior only for financial reasons and not in other situations. How great is the risk that a patient will simulate therapeutic progress in order to become prematurely discharged? Is the patient aware of his or her deceitful and unreliable attitude, and does he or she want to change it? When the patient is really motivated for treatment, how will he or she try to prevent having a deceitful and unreliable attitude during therapy? Only patients who want to change their unreliable behaviors will be suitable for optimal involvement in their treatment planning.

• Is the patient a manipulator? Patients with severe manipulative tendencies who are not willing to change their attitudes are inappropriate candidates for serious participation in planning their treatment routes. Patients who want to change their manipulative attitudes can be involved in the preparation of their treatment routes, but only under specific conditions. First, the patient should clearly articulate the initiatives he or she will take to diminish his or her manipulative behavior. This can be done through specific psychotherapeutic activities and/or agreements between the patient and the therapist and other staff members. This agreement could address how the therapist would recognize and react to the first signs of manipulation, and how the patient should react so that the therapeutic process will not be seriously disturbed. For instance, a small gesture or symbolic announcement from the therapist might be enough to make the patient aware that he or she is trying to manipulate the therapist. The patient should then immediately change his or her attitude. When the patient wants to discuss or deny his or her manipulative behavior, this should take place after the session.

• Does the patient have a social network? A social network is an important predictor of social support during the planning of treatment and after discharge, a good long-term outcome, and good social integration (Martens, 1997; Reiss et al., 1996).

• Is the patient willing to accept clear rules and guidelines? For example, serious manipulation, bullying, and/or aggressive behavior will not be tolerated and must be punished (for example, by using an isolation room). The patient must stick to the therapeutic agreement and should keep his or her promises. He or she must accept the very clear structured and disciplined regime that is required for therapeutic progress in antisocial patients (Kernberg, 1984; Martens, 1997; van Marle, 1995). Patients who demonstrate harmful behavior during residence must decide how they will prevent undesirable and harmful behavior in the future and how they will compensate victims for their destructive behavior.

Effective Preparation and Guidance

All patients with ASPD who are selected for treatment should be well informed about the rules and code of conduct with regard to their planning of their treatment routes, the treatment process itself, and aftercare, and they must understand the responsibilities of each person during all phases of the treatment program. For instance, patients should know what consequences they would face if they prematurely dropped out of the treatment and exhibited a lack of loyalty to the therapists and other staff members. Selected patients who are motivated for optimal participation in the development of their programs of treatment, education, and training will be asked to develop their own ideas about the most successful route to improvement or remission. But, it will often be necessary to prepare patients for this task so that they are able to make realistic and constructive choices with respect to initiatives in specific areas such as education, training (vocational, social, coping), drama, sports, and the combination of therapeutic approaches. Specialists, who would offer information about fields in which the patients are interested, could help prepare patients for their tasks. It could also be very effective to allow fellow patients who have been successful in their planning and treatment to talk about their experiences. The period of preparation and the intensity of the guidance from hospital staff will depend on the patient's capacities (intelligence, creativity, self-salvation, initiative) and mental and emotional condition.

Case Report

William was admitted in a forensic psychiatric hospital at age 31 because of his violent and severely fraudulent behavior. According DSM-III-R criteria (American Psychiatric Association, 1987) he suffered from antisocial personality disorder. Neurologic assessment revealed that William also suffered from autonomic underarousal and abnormal 5-HT (5-hydroxytryptamine, serotonine) and CSF 5-HIAA (5-hydroxy indoleacetic) activity. Autonomic underarousal correlates with antisocial characteristics such as failure to conform to norms, criminality (Raine, 1996; Raine et al., 2000), lack of remorse (Fowles & Kochaska, 2000) and incapacity to learn from experiences (Lykken, 1995). 5-HT and CSF 5-HIAA dysfunctions are linked to impulsivity, and CSF 5-HIAA deficiency is also related to aggression (Martens, 2000c). William demonstrated superior intelligence but had serious social-emotional incapacities. During the selection procedure for treatment it became evident that

William had good intentions to change his attitude because he clearly suffered from the consequences of his destructive behavior. William suffered as a result of his aggressive and unreliable behavior: his wife had recently divorced him, his children and his friends turned away from him, and he was dismissed from his job.

Initially William was given information about the nature of his disorder and the neurobiological correlates of his deviant behavior; the possibilities for psychotherapeutic, neurofeedback, and psychopharmacological treatment; and the possibilities for education, training, and social-emotional and spiritual development. The second step was to initiate the process of planning his treatment, with the help of examples of other patients. The next step was to construct a useful model of external guidance that was acceptable to all parties. William then started to find out what kind of limitations and frustrations he needed to tackle first. For William, it was most urgent to reduce his aggressive and impulsive behavior, increase his social-interactional skills, and explore his spiritual and intellectual interests and capacities. For his treatment route, William chose psychoanalytic treatment and a combination of neuropharmacological treatment and neurofeedback treatment. William also decided to begin some spiritual activities and began studying medicine at a university. This appeared to be a "golden choice," because it worked very well. As a consequence of psychopharmacological treatment (d, l-fenfluramine [Pondimin] 0.2 mg/kg to 0.4 mg/kg for 3 years and then stopped) and neurofeedback treatment (for 2 years) his impulsivity and aggression were reduced to a normal level. He appeared to be a very successful student, and his self-esteem grew while his unreliable tendencies gradually disappeared. The psychoanalytic treatment gave him insight into his core problem, as well as his deep frustrations and wishes. After 6 years of treatment, William was released from forensic psychiatric treatment, finished medical school successfully, and reunited with his wife and children. Today he is a respected physician.

Positive Effects of Patients' Involvement in Their Treatment Planning

There are several possible constructive effects for patients who plan their own treatment. First, such participation increases patients' feelings of responsibly, which is linked to improvement and remission (Black et al., 1995; Martens, 1997; Robins, 1996). Patients' active participation in setting up their programs of treatment, training, and education allows them to take responsibility for their own lives. Taking such action is an indication of courage and a deep wish to change, and it might lead to inspiration, increased self-esteem, a change of self-image (transformation of a destructive self-image into a constructive self-image), the experience of self-control (internal locus of control) and control over one's own life (development, education, career, social relationships), and trust and respect for the therapist (because of his or her significant guiding and supporting role).

Participating in the planning of one's own treatment can also lead the patient to more intensive self-investigation, contemplation, and reflection on his or her place in the world and his or her relationship to other people. It may also lead patients to investigate the value of other people and the positive roles that others can play in the patients' social-emotional and moral development and well-being, which might lead to less hostile attitudes. These activities are required for finding a treatment route that is tuned-in to the patients' vulnerabilities, capacities, inabilities, frustrations, and deep wishes. Intensive self-investigation and contemplation, in turn, might correlate with a growth of self-knowledge, catharsis, social-emotional awareness, and eventually ethical and/or spiritual activities (Martens, 2001b, 2003b). This might eventually, with help of therapeutic, neurologic, and/or neurofeedback treatment, help patients realize that they need to transform their antisocial features into social ones (Martens, 2002a).

Another constructive effect could be the positive experiences of the patients. For example, patients might experience the opportunity to participate in the setting up of their treatment, in spite of their past destructive behavior, as a sign of respect and faith from the hospital staff. In this way, patients' capacities will be emphasized rather than their limitations and destructive tendencies. As a result, patients' self-images will change because they will realize that they are not identical with their antisocial disorder. In this way they may gradually discover a latent part of themselves that is constructive and prosocial. This might increase their self-confidence and positive self-image.

The positive effects of a patient's change will impact a number of people. The new constructive attitudes of patients who are successfully involved in planning their treatment and therapy can have a significant positive impact on the attitudes of their fellow patients, on the atmosphere at the hospital ward, and on the well-being of patients and treatment staff. These positive results reduce problems of "burn out" for both staff members and patients. In turn, these positive influences on treatment staff and other patients can also have an extra stimulation effect on their planning and therapeutic progress.

Conclusions

Adequate selection and motivation of patients with antisocial personality disorder might influence all dimensions of hospital life and treatment, as well as all persons who are involved in the forensic psychiatric treatment. "Burn out" for therapists and patients often occurs when there is a lack of treatment success and/or a decrease in patients' motivation for treatment. Burn out can also result when there are limited possibilities to remove patients who are unmotivated for treatment and who spoil the atmosphere in a hospital and have bad influences on fellow patients, when there are not the necessary facilities (including support for therapists in crisis situations) and/or the specific therapeutic approaches that might be more suitable for some patients, and when qualified and/or experienced

personnel are not available.

Patients' motivation for treatment appears to be one of the most important correlates of the quality of hospital life, the job satisfaction of hospital staff, the therapeutic satisfaction of patients, and the well-being of all involved parties. Therefore, patients' motivation for treatment should be stimulated in the first phase of treatment planning. Researchers need to look into the distinctive dimensions of motivation that could be activated, stimulated, or corrected, as well as the methods that could be used to realize optimal motivation. For instance, inadequate motivation might have important neurobiological correlates and could be linked to neurobiologically determined antisocial features such as impulsivity, hostility, criminality, and/or the incapacity to learn from experiences (Martens, 2000c). Adequate neurobiological and neurofeedback treatment may lead to a reduction of these psychopathic traits and the enhancement of adequate motivation. Therapists and other staff members need to have access to professional training facilities to prepare them for the important task of motivating patients with antisocial personality disorder.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barrash, J., Tranel, D., & Anderson, S. W. (2000). Acquired personality disturbances associated with bilateral damage to the ventromedial prefrontal region. *Developmental Neuropsychology, 18*(3), 355-381.

Black, D. W., Baumgard, C. H., & Bell, S. E. (1995). A 16- to 45-year follow-up of 71 men with antisocial personality disorder. *Comprehensive Psychiatry, 36,* 130-140.

Fowles, D. C., & Kochanska, G. (2000). Temperament as a moderator of pathways in conscience in children: The contribution of electrodermal activity. *Psychophysiology, 37*(6), 788-795.

Herpertz, S. C., & Sass, H. (2000). Emotional deficiency and psychopathy. *Behavioral Sciences and the Law, 18*(5), 567-580.

Herpertz, S. C., Werth, U., Lukas, G., Qunaibi, M., Schuerkens, A., Kunert, H. J., Freese, R., Flesch, M., Mueller-Isberner, R., Osterheider, M., & Sass, H. (2001). Emotion in criminal offenders with psychopathy and borderline personality disorder. *Archives of General Psychiatry, 58*(8): 737-745.

Kahn, W., Oppenheimer, C., & Martens, W. H. J. (2004). Suggestions for improvement of therapeutic community treatment of patients with antisocial and psychopathic personality disorders. *W. Kahn Institute of Theoretical Psychiatry and Neuroscience (WKITPN) Publication 73*(1), 1-20.

Kernberg, O. F. (1984). *Severe personality disorders: psychotherapeutic strategies.* New York: Jason Aronson.

Kernberg, O. F. (1992). *Aggression in personality disorders and perversions.* New Haven:Yale University Press.

Kiehl, K. A., Smith, A. M., Hare, R. D., Mendrek, A., Forster, B. B., Brink, J., & Liddle, P. F. (2001). Limbic abnormalities in affective processing by criminal psychopaths as revealed by functional magnetic resonance imaging. *Biological Psychiatry, 50*(9), 677-684.

Lykken, D. (1995). *The antisocial personalities.* Hillsdale, NJ: Lawrence Erlbaum.

Martens, W. H. J. (1997) *Psychopathy and Remission.* (Doctoral thesis, Tilburg University, The Netherlands, 1997). Maastricht: Shaker Publishing, 1997.

Martens, W. H. J. (1999). Marcel – A case report of a violent sexual psychopath in remission. *International Journal of Offender Therapy and Comparative Criminology, 43*(3), 391-399.

Martens, W. H. J. (2000a). How treatable are "untreatable" forensic psychiatric patients? *International Journal of Offender Therapy and Comparative Criminology, 44*(3), 367-369.

Martens, W. H. J. (2000b). What shall we do with untreatable forensic psychiatric patients? *Medicine and Law, 20*(1), 389-396.

Martens, W. H. J. (2000c). Antisocial and psychopathic personality disorders: Causes, course and remission - a review article. *International Journal of Offender Therapy and Comparative Criminology, 44*(4), 406-430.

Martens, W. H. J. (2001a). Agitation therapy for antisocial and psychopathic personalities: an outline. *American Journal of Psychotherapy, 55*(2), 234-50.

Martens, W. H. J. (2001b). A theoretical framework of ethics therapy as a distinctive forensic therapeutic specialization. *International Journal of Offender Therapy and Comparative Criminology, 45*(3), 383-394.

Martens, W. H. J. (2002a). The hidden suffering of the psychopath. *Psychiatric Times, 19*(1), 1-16.

Martens, W. H. J. (2002b). Criminality and moral dysfunctions: Neurologic, biochemical and genetic dimensions. *International Journal of Offender Therapy and Comparative Criminology, 46*(2), 170-182.

Martens, W. H. J. (2003a). Creativity and associated remission in psychopaths. *Dynamical Psychology,* October, 1-18.

Martens, W. H. J. (2003b). Spiritual psychotherapy for non-religious patients: Some theoretical building-blocks. *Journal of Contemporary Psychotherapy, 33*(3), 205-218.

Martens, W.H.J. (2004). 14 ways to disturb the treatment of psychopaths. *Journal of Forensic Psychology Practice, 4*(3): 51-60.

Oppenheimer, C., Martens, W. H. J., & Kahn, W. (2002). Antisocial personality disorder with comorbid schizophrenia: A dangerous combination. *W. Kahn Institute of Theoretical Psychiatry and Neuroscience (WKITPN) Publication, 41*(1), 6-31

Raine, A. (1996). Autonomic nervous system factors underlying disinhibited, antisocial and violent behaviour: Biosocial perspectives and treatment implications. *Annals of the New York Academy of Sciences, 794,* 46-59.

Raine, A., Lencz, T., Bibrle, S., LaCasse, L., & Colletti, P. (2000). Reduced prefrontal grey matter volume and reduced autonomic activity in antisocial personality disorder. *Archives of General Psychiatry, 57*(2),119-127.

Reiss, D., Grubin, D., & Meux, C. (1996). Young 'psychopaths' in special hospital: Treatment and outcome. *British Journal of Psychiatry, 168*(1), 99-104.

Robins, L. N. (1996). *Deviant children grown up: A sociological and psychiatric study of sociopathic personality.* Baltimore, MD: Williams & Wilkins.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism: Clinical lore and clinical reality. *Clinical Psychology Review, 22,* 79-112.

Skeem, J. L., Monahan, J., & Mulvey, E. P. (2002). Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. *Law and Human Behavior, 26*(6), 577-603.

van Marle, H. J. C. (1995). *A closed system: A psychoanalytic framework of forensic psychiatric community treatment.* Doctoral thesis, Utrecht University, 1995. Arnhem: Gouda Quint.

Zuckerman, M. (1994). *Behavioral expressions and biosocial basis of sensation seeking.* New York: Cambridge University Press.

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