The Treatment of Psychopathic and Antisocial Personality Disorders: A Review

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ABSTRACT
There is a considerable amount of controversy surrounding the treatment of psychopathic and antisocial personality disorders. Different methods of treatment have been tried with those diagnosed with the condition, but the lack of controlled follow-up research in this area has made it difficult to evaluate their effectiveness. What has emerged, however, is that the core elements of psychopathy make it one of the most difficult disorders to treat. This has not been helped by the fact that there is still considerable debate surrounding the aetiology of the syndrome and that it is defined by incompatible legal and clinical systems. As a consequence, the ‘treatability’ of psychopathic disorder has been questioned by a number of psychiatrists and psychologists and alternative methods of managing the disorder have been put forward.

The treatment of ‘psychopathic disorder’ has been a controversial issue among psychiatrists ever since the concept was first introduced to psychiatric nosology during the latter part of the last century. Much of this controversy stems from a lack of consensus among clinical psychiatrists and psychologists on three critical issues. The first issue concerns the nature of the psychopathic condition and the specific class of persons to whom it applies. The second issue relates to the most appropriate goals and targets for the clinical management of the disorder, the form treatment should take, and to how successful treatment outcome should be evaluated by the clinicians involved. The third issue concerns the extent to which ‘psychopathic’ behaviours are treatable and to whether evidence of psychological change during treatment implies reduced risk of re-engaging in such behaviour once treatment has culminated.

To assess treatability it is essential to first specify the nature of the disorder to be treated and, therefore, the targets of therapeutic change. Although etymologically the term ‘psychopath’ simply means psychologically damaged, it has long been used in Britain and America to refer to a socially damaged person who engages in impulsive and irresponsible behaviour, of an antisocial or deviant kind (Hare, 1985; World Health Organisation, 1992; American Psychiatric Association, 1994).

A narrower meaning of the term ‘psychopathic’ first appeared in the work of Koch (1891) who under the heading ‘Psychopathic Inferiorities’, grouped abnormal behavioural states, which he believed resulted from psychological weaknesses in the brain. Koch's work was succeeded by the writings of Schneider (1923) who in Psychopathic Personalities established psychopathy as a subclass of abnormal personality and suggested ten different forms of the psychopathic syndrome.

It was Henderson’s Psychopathic States (1939), however, that set the pattern that was to later characterise Anglo-American psychiatric delineations of the disorder, by confining attention only to the grossest forms of psychopathic abnormality and emphasising the antisocial nature of the condition. Henderson's contribution to the concept was his threefold subdivision of psychopaths into aggressive, inadequate and creative forms. Later authors such as Cleckley (1964) and McCord and McCord (1964)

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went even further by narrowing the category to aggressive psychopaths and establishing core criteria for the disorder centred around antisocial behaviours. Indeed, Cleckley’s publication of *The Mask of Sanity* (Fourth ed., 1964) has proved to be one of the most influential sources of the view that the psychopathic personality is a distinct clinical entity.

Today psychiatrists and psychologists are still debating the nature and aetiology of the psychopathic condition. In fact, since Henderson’s publication of *Psychopathic States*, numerous reclassifications of psychopathy have been put forward in the form of ‘sociopathy’ (American Psychiatric Association, 1952); ‘primary’ and ‘secondary psychopathy’ (Blackburn, 1975) and the more recent notions of ‘dissocial’ and ‘antisocial personality’, recommended in the current editions of the *International Classification of Diseases and Related Health Problems* (World Health Organisation, 1992) and the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). The last two categories, however, together with Hare's *Psychopathy Checklist* (1985) have been able to establish some validity as core diagnostic entities for psychopathy and as a result are now the most widely used classifications of the disorder (Coid, 1993).

In England and Wales, the law has accepted the medical view that antisocial behaviour may result from a psychological abnormality, distinct from mental illness, and that it may be appropriate to divert offenders suffering from this disorder to the mental health system for treatment rather than punishment. However, the statutory category of ‘psychopathic disorder’ is different from clinical classifications of the condition. In its legal use, for instance, ‘psychopathic disorder’ has no specific clinical meaning and is a generic term based solely on the presence of antisocial behaviour, as distinct from the range of features required for a clinical diagnosis of the syndrome (Higgins, 1995). Although around 25% of patients in English maximum security hospitals are detained under the legal concept of ‘psychopathic disorder’ (Harding, 1992; Dolan and Coid, 1993), psychiatrists have traditionally expressed their dissatisfaction with the definition on the grounds that it is too vague and ill defined to be a useful diagnostic category. According to Chiswick (1992), for instance, there is a lack of understanding among psychiatrists about the nature and aetiology of the disorder and there has been little in the way of legal explanation for what exactly is meant by the term. Tests with those who have been legally defined as psychopathic have also found that the disorder has a high comorbidity with other clinical syndromes, which has an important bearing on its treatment. (Blackburn, 1990; Dolan and Coid, 1993).

Few psychiatrists would deny that the controversy surrounding the classification of psychopathy has distracted from efforts to treat the syndrome. Indeed, there is a noticeable lack of research material in this area and what little there is, has yielded disappointing results. Although numerous methods of therapy have been tried with psychopathic patients, including pharmacological treatments, physical treatments, cognitive and behavioural approaches, therapeutic community approaches and individual and group psychotherapy, few have been able to bring about any great improvement in the patients concerned.

It was Cleckley, whose book *The mask of Sanity* (Fourth ed., 1964) first drew attention to the lack of success psychiatrists had in their efforts to treat the typical psychopath and to how the essential elements of the disorder made it a particularly unapproachable and difficult condition to manage. Since then more and more psychiatrists have expressed doubts about their ability to deal with this group, with an increasing number expressing concern at the level of dangerous and disruptive behaviour displayed by psychopathic patients, as well as their poor motivation for change and willingness to lie about their therapeutic progress. Higgins (1995) argues that the term psychopath has acquired a pejorative connotation within the mental health and social services. The implications are that the patient is untreatable, has no proper place in a hospital and is disliked by clinical staff. Indeed, the term is often employed in order to reject patients for treatment and for this purpose may be deliberately applied to patients with other psychiatric disorders such as schizophrenia or hypomania (Coid, 1988).

What little research is available, however, does indicate that although the core antisocial behaviours of the psychopath are difficult to manage, some of the associated behaviours displayed by the condition, and more commonly linked with other clinical syndromes, may be responsive to clinical intervention. This presents psychiatrists with an unusual treatment dilemma and begs the question of whether it is better to target the untreatable aspects of psychopathy on the grounds that they are what led to the hospital admission in the first place, or the alternative symptoms of the condition, which are known to be more responsive to intervention.
Recidivism research is further testimony to this treatment dilemma. Although the available follow-up studies of psychopathic patients do not enable us to relate outcome to specific treatments, such studies do indicate that patients with psychopathic disorder have higher recidivism rates than the mentally ill and that a history of prior criminal convictions is the factor most strongly associated with re-conviction after release (Black, 1982; Tennent and Way, 1984; Murray, 1989). It is on the basis of this evidence, that some clinicians believe that even if psychological change can be brought about during therapy, it is unlikely that this will be maintained beyond release.

Research of this kind has also fuelled the arguments of those concerned with the civil rights of patients, and in particular the ethics of detaining offenders indeterminately within the hospital regime. Indeed, if the criminal aspects of the psychopathic condition are unlikely to be alleviated with treatment, then this lends support to the argument that psychopathic offenders should be in prison rather than hospital, where sentences are predetermined (Grounds, 1987; Chiswick, 1992; Robertson, 1992). Under the present system, those psychopathic patients who are unresponsive to treatment are languishing in secure units for a much longer period than would be demanded by legal punishment for their crime.

The first chapter of this thesis considers some of the most current classifications of psychopathic disorder together with the legal category of the syndrome. The second chapter then outlines the most common treatment settings for psychopathic patients, together with the principle methods of treating the condition. Four models of treatment currently in use with psychopaths are also reviewed in this section. Chapter three then evaluates the success of these methods, by drawing on the available outcome research in this field and addressing some of the difficulties presented by psychopathic subjects. The conclusions that can be drawn from this research are then discussed, together with recommendations for the treatment of psychopathy in the future.

**CONTEMPORARY CLASSIFICATIONS OF PSYCHOPATHIC DISORDER**

**ICD-10: Dissocial Personality Disorder**

The International Classification of Diseases is one of the most long-standing diagnostic classifications of mental and physical disorders. It is a categorical classification, organised into 17 major sections, which divide conditions into types depending upon their defining features. *The ICD-10 Classification of Mental and Behavioural Disorders* (1992) is part of a series of clinical descriptions and guidelines that make up the tenth revision of the International Classification of Diseases and Related Health Problems (1992).

Disorders of personality are listed in the ICD-10 under subsection F60 to F69. In its notes on selected categories, the ICD suggests that this was not an easy category to write guidelines for, with concerns about the difference between observation and interpretation made by clinicians, as well as the number of criteria that must be filled before diagnosis can be confirmed, still unresolved by the ICD working committee. It also states that the personality disorders described are not mutually exclusive and can overlap in some of their characteristics.

Personality disorders are defined as deeply ingrained and enduring attitude and behaviour patterns that deviate markedly from the culturally expected range. They are not secondary to other mental illnesses, or attributable to gross brain damage or disease, although they may precede and coexist with other disorders. Disorders of personality are regarded as developmental conditions which tend to appear in late childhood or adolescence and continue to manifest into adulthood. Diagnosis of a personality disorder, therefore, would not usually be appropriate before the age of sixteen years, although the presence of conduct disorder during childhood or adolescence can indicate a predisposition towards the syndrome.

Dissocial personality disorder (F60.2) is grouped under the heading ‘Specific personality disorders’ along with syndromes such as Paranoid, Schizoid and Histrionic disorder. These conditions are defined as a
The classification of Dissocial personality disorder is intended to include previous diagnostic categories of sociopathic, amoral, asocial, psychopathic and sociopathic personality disorders, but excludes conduct disorder and emotionally unstable personalities. The condition is described as usually coming to attention because of a gross disparity between behaviour and the prevailing norms and is characterised by the WHO (1992) by the following signs and symptoms:

- callous unconcern for the feelings of others;
- gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;
- incapacity to maintain enduring relationships, though having no difficulty in establishing them;
- very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
- incapacity to experience guilt and to profit from experience, particularly punishment;
- marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society.

Persistent irritability may also be an associated feature.

Clear evidence is usually required of at least three of the above traits before a confident diagnosis of Dissocial personality disorder can be made.

The ICD-10 appears to have made an attempt to assemble the core personality traits of the psychopathic personality and have produced criteria which overlap with other classifications of the syndrome. Although the ICD suggests an emphasis on personality characteristics rather than types of behaviour, many of the features of dissocial personality may have to be inferred from a patient’s behaviour patterns rather than a true understanding of their underlying personality abnormalities. It has also been suggested that criterion (g), persistent irritability, demonstrates a potential for overlap with two criteria for ICD’s ‘emotionally labile personality disorder’ and does not easily distinguish an implied personality trait from an affective disturbance (Coid, 1993).

**DSM-IV: Antisocial Personality Disorder**

The *Diagnostic and Statistical Manual of Mental Disorders* is a categorical classification produced by the American psychiatric Association, which claims to provide codes and terms which are fully compatible with the ICD-10. Indeed, in its introduction the DSM-IV explains that the clinical and research drafts of the ICD-10 were thoroughly reviewed by the DSM working groups with the intention of increasing the congruence, and reducing meaningless differences in wording between the two systems.

Personality disorders are coded in DSM-IV along a separate axis (axis II) from the major mental disorders and subdivided into 11 categories (301.0 to 301.9). Personality disorder is defined as an

> enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment

(The American Psychiatric Association, 1994)

The personality disorders listed in the DSM-IV are grouped into three clusters based upon descriptive similarities.

Antisocial personality disorder is included under cluster B, together with Borderline, Histrionic and Narcissistic personality disorders. Individuals with these conditions are described as ‘dramatic,
emotional or erratic’ as opposed to the anxious and fearful nature of individuals in cluster C, or the odd and eccentric characteristics of those who make up cluster A. It is noted, however, that this clustering system has not been consistently validated and that individuals can frequently present with co-occurring personality disorders from different clusters.

Like the ICD-10, the DSM is an attempt to define categories on the basis of traits, which only when inflexible, maladaptive and cause ‘significant functional impairment or subjective distress’ constitute personality disorder. These behaviours should not be a manifestation of another mental disorder or medical condition nor should they be the psychological effects of a chemical substance. It is also pointed out that these behaviours must be distinguishable from characteristics that emerge in response to specific situational stressors and that a personality disorder should only be diagnosed when the defining characteristics appear before early adulthood.

The essential feature of Antisocial personality disorder (301.7) is the pervasive pattern of disregard for, and violation of the rights of others occurring since fifteen years of age, as indicated by the three or more of the following (A.P.A. 1994):

- failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
- deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- impulsivity or failure to plan ahead
- irritability and aggressiveness, as indicated by repeated physical fights or assaults
- reckless disregard for safety of self and others
- consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
- lack of remorse, as indicated by being indifferent to, or rationalising having hurt, mistreated, or stolen from another.

The individual must be at least eighteen years of age before a reliable diagnosis can be made and there should also be some evidence of conduct disorder in the patient concerned, with onset before fifteen years.

Several epidemiological studies have used standardised diagnostic criteria for Antisocial personality disorder, making it the most comprehensibly studied personality disorder category in this area of research from any contemporary glossary (Dolan and Coid, 1993). Although the DSM-IV criteria have sometimes been criticised for being too long and cumbersome, antisocial personality disorder is the only axis II criteria derived from empirical research and field trials have shown that it has a higher inter-rater reliability than any other axis II category (Mellsop et al, 1982).

**Hare’s Psychopathy Check-list**

Hare’s Psychopathy Check-list is a unidimensional scale of psychopathic disorder which includes both personality traits and antisocial behaviour. Hare’s notion of psychopathy is based upon the clinical concept of the psychopath provided by Cleckley in the five editions of his work, *The mask of Sanity* (Fourth ed., 1964). Cleckley believed that psychopaths suffered from a central and deep-seated semantic disorder in which meaning related, associative and elaborative processes are missing. He suggested that these deficits are well masked by a well functioning, expressive and receptive process, whereby the psychopath can express himself vividly and eloquently, often conning others with his superficial charm.

Hare added to this theory the notion that psychopaths differ from normal persons in the temporal integration of rewards and punishments. He argues that psychopathy is characterised by a relatively steep temporal gradient of fear arousal and response inhibition. This means that as the temporal remoteness of punishment increases, the amount of fear elicited by cues associated with the punishment decreases. To the extent that anticipatory fear mediates response inhibition, the psychopath is unlikely to inhibit a response for which the reward is immediate and the anticipated punishment is remote in time (Hare and Quinn, 1971).
Initially Hare took the list of 16 characteristics considered to be typical of the psychopath and applied them to a series of prisoners. After further studies, Hare expanded the preliminary PCL to a 22-item version. Two items were subsequently dropped from this list and a further item modified to create a revised version of the checklist (PCL-R) as shown below.

(a) Glibness / superficial charm
(b) Grandiose sense of self-worth
(c) Need for stimulation / proneness to boredom
(d) Pathological lying
(e) Cunning / manipulative
(f) Lack of remorse or guilt
(g) Shallow affect
(h) Callous / lack of empathy
(i) Parasitic lifestyle
(j) Poor behavioural controls
(k) Promiscuous sexual behaviour
(l) Early behavioural problems
(m) Lack of realistic, long-term goals
(n) Impulsivity
(o) Irresponsibility
(p) Failure to accept responsibility for own actions
(q) Many short-term marital relationships
(r) Juvenile delinquency
(s) Revocation of conditional release
(t) Criminal versatility

Ratings of 0-2 apply to each item, which can give a maximum possible score of 44. At a cut-off score of 30 or above, a subject would be designated a psychopath.

Recently Hare and colleagues have demonstrated by factor analysis, that the PCL and PCL-R contain two correlated factors that have distinct patterns of inter-correlations with other variables. The first factor is made up of the personality traits considered to be descriptive of the syndrome and includes items (a), (b), (d) - (h) and (p). The second factor consists of the traits that reflect socially deviant behaviour, including items (c), (i), (j), (l) - (o), (r) and (s). According to Harpur et al (1988) they represent a chronically unstable, antisocial and socially deviant lifestyle.

In comparison with the length of the ICD and DSM classifications, the PCL-R measures favourably in terms of brevity. Some authors have criticised the PCL-R, however, for including too many criteria involving criminal behaviour and excluding other personality traits that have been found relevant to psychopathic behaviour. Hare’s emphasis on obtaining information from case files, in addition to that obtained at interview also gives his classification a marked advantage over the other two scales in terms of reliability. Because psychopaths can deceive and manipulate others in prison and hospital settings as frequently as they do outside, it is unwise to use self report studies as a means of assessing the psychopath. Indeed, Hare himself observed large discrepancies between the verbal reports obtained from psychopaths in interviews and questionnaires and their documented behaviour (Hare, 1990). Hare and his colleagues have been able to demonstrate high inter-rater and test-retest reliability using both the PCL and PCL-R on prisoners and forensic psychiatric hospital in-patients, when the checklist is used by properly trained researchers (Hare, 1980).

The ICD-10, DSM-IV and Hare’s Psychopathy Checklist have been able to establish some validity as core diagnostic entities for the psychopathic syndrome. In fact on re-examination all three of these clinical classifications appear consistent with several traditional views of the personality traits and types of behaviour defining the construct of psychopathy. A series of earlier authors, for instance, have described psychopaths as selfish, lacking in shame and empathy, and having a callous disregard for other individuals, with an incapacity to maintain enduring relationships. They have also described them as unable to control their impulses or to delay gratification and as demonstrating a high propensity for lying, thrill seeking and poor judgement (McCord and McCord, 1956; Cleckley, 1964; Craft, 1966; Blackburn, 1986). Clinical practice measured by surveys with British forensic psychiatrists and prison medical officers have also confirmed very similar or overlapping features. (Davies and Feldman, 1981).
Perhaps the most distinguishable feature of the psychopath, however, appears to be their high propensity for violence and their disregard for law enforcement, which explains why a high number of those suffering with the disorder come in contact with the legal system. Indeed, early onset of antisocial behaviour, including that of conduct disorder, and engaging in activities that are grounds for arrest are central items in most classifications of the disorder. A number of researchers have paid particular attention to this feature and produced a considerable amount of evidence to demonstrate the degree of aggression and intolerance characteristic of the psychopathic condition. Williamson, Hare and Wong (1987) for instance, in an examination of the violent offences of psychopathic prisoners compared to non-psychopathic groups, found that the victims of psychopaths tended to be male and unknown, and that their violence tended to have revenge or retribution as the motive. In general psychopathic violence was callous and cold-blooded or part of an aggressive or macho display, but without the affective colouring that accompanied the violence of the non-psychopathic group (Williamson et al, 1987). In a longitudinal study of male psychopaths and their criminal careers, Hare, McPherson and Forth (1988) also found that psychopaths, as measured on the PCL-R, engage in an inordinate amount of violence and aggressive behaviour compared with other non-psychopathic criminals.

**The legal classification of ‘Psychopathic Disorder’**

Mental health legislation has existed in Britain for over two centuries and in England and Wales is revised about every twenty five years. The term ‘psychopathic personality’ was first incorporated into statute with the Mental Health Act of 1959. This saw the replacement of older notions of ‘moral insanity’ and ‘moral defect’, which had their origins in the work of Pinel (1809) and the later writings of James Prichard (1835) and Henry Maudsley (1879).

Under the current Mental Health Act 1983, which represents the consolidation of the Mental Health Act 1959 and the Mental Health (Amendment) Act 1982, ‘psychopathic disorder’ is defined as

*a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct*

(Section 1(2), Mental Health Act, 1983)

Section 1(3) of the Mental Health Act makes it clear that a person may not be dealt with under the act if suffering by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs. It also states that subjects within this definition cannot be detained in hospital unless ‘treatment is likely to alleviate or prevent deterioration’ (Section 3(2)(b), Mental Health Act, 1983). This marks a change from the 1959 Mental Health Act which included the phrase ‘and requires or is susceptible to medical treatment’ (Mental Health Act, 1959), within its definition of psychopathic disorder. It has been argued that this change reveals the doubt experienced by many psychiatrists concerning their ability to deal with this group.

The Mental Health Act can be used to bring about the compulsory detention of patients in cases where hospital admission is thought necessary, but the patient is reluctant to be detained, or for anyone suspected, charged or convicted of a criminal offence. Psychopathic disorder is one of the four categories of mental disorder in the Mental Health Act for which compulsory admission may be appropriate. In the case of offenders, the statutory concept of psychopathic disorder is not a cause of being unfit to plead or to stand trial, but may be used to lessen criminal responsibility and as mitigation to get a reduced sentence, to support a hospital order or to form the grounds for a plea of diminished responsibility in cases of homicide (Faulk, 1994). Applications can be made for the compulsory admission and detention of a patient in hospital for the purposes of assessment or treatment. In both instances an application should be founded on the written recommendations of two registered medical practitioners approved under Section 12 (2) by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder. In the case of mentally disordered offenders, it must be proved that they were suffering from a mental disorder at the time the offence was committed.

The legal category of ‘psychopathic disorder’ has been heavily criticised by a number of psychiatrists, for being too elastic and ill-defined and for making no contact with any validated psychiatric category of the condition. Arguably there has been little legal explanation of the meaning of the term ‘psychopathic disorder’ or the concepts of ‘abnormally aggressive’ or ‘seriously irresponsible conduct’. In fact the
only term that has received any clarification is the notion of ‘persistent disorder’, which means that there must have been signs that the condition has existed for a considerable period, before a patient can be classified psychopathic. (Mental Health Act Memorandum, 1983). A joint working group of the Department of Health and Home Office (1994) under the chairmanship of Dr. Reed, has pointed to the lack of knowledge about the nature and aetiology of the legal concept and the Butler Committee (Home Office and Department of Health and Social security, 1975) has even flirted with the idea of dispensing with psychopathy as a legal category altogether. Indeed, the Mental Health Act 1984 that operates in Scotland and the Mental Health Order 1986 currently in operation in Northern Ireland, omit the term from their legislation.

Tests carried out with those who have been legally defined as psychopathic have also revealed that it has a high comorbidity with other clinical conditions. Research conducted by Coid (1992), for instance, which included over 250 patients from maximum security hospitals who had been detained under the legal notion of the disorder, found that in order to encompass the full range of psychopathology exhibited by these subjects, multiple axis II personality disorder categories were required. There was an overall mean of 3.6 categories per subject and less than 10% presented with a single diagnosis of personality disorder using this classification. Coid also found that a number of subjects displayed DSM axis I syndromes (clinical syndromes) over their lifetime, with a mean of 2.7 categories. The most common condition was depressive disorder, which occurred at some time in the lives of 50% of the subjects. This was followed in descending order of frequency by dysthymia, hypomania, substance abuse disorders, schizophrenia, brief psychotic episodes and conditions such as phobia, panic attacks, and obsessive-compulsive disorder (Coid, 1992).

Similar findings were also produced in a review of Oxford hospital dossiers conducted by Walker and McCabe (1973). They revealed that out of the 258 males whose dossiers mentioned psychopathy or its equivalents, only 25 contained no other psychiatric label. For these patients additional descriptions of neurosis, hysteria, addiction, schizophrenia and manic-depressive psychosis were common.

**METHODS OF TREATMENT**

**Treatment Settings**

The treatment of patients with psychopathic disorder can take place in a variety of in-patient settings, including special hospitals, regional secure units, intensive psychiatric care units and in conventional psychiatric hospitals. In addition there are approximately 600 beds with low to medium provision within the private sector (including Kneesworth House, St Andrews and Stockton Hall) which can provide long-term hospital care for offender patients who live in parts of the country which are without the resources to treat them. Due to the nature of the psychopathic condition and its link with violent behaviour, invariably these patients will be detained under civil or criminal compulsory measures. The psychiatrist may care for such patients at the initial stage of their presentation to the psychiatric services, while they are being remanded in hospital, after being arrested and charged, or while being detained under a hospital or interim hospital order (which is designed to test a patient’s co-operation with and response to treatment).

**Special hospitals**

The overwhelming majority of those under the legal category of psychopathic disorder are admitted to special hospitals and most of this group are detained under hospital orders with restrictions (Section 41, Mental Health Act, 1983), which means that only the Home Secretary or a mental health tribunal will have the authority to discharge them (Grounds, 1987). It is estimated that special hospitals admit some 170 to 200 patients annually and have a total population of 1700 patients, of which 25% come under the legal category of psychopathic disorder (Dolan and Coid, 1993; Faulk, 1994).

The ‘special hospitals’ are those hospitals in England and Wales run by the Special Hospital Services Authority, which provide an in-patient service for psychiatric patients who need to be nursed in maximum security because of their potential dangerousness. The first special hospitals in England were originally linked to the home office, but after 1948, were brought under the supervision of the department of Health. Admission to a special hospital is controlled by each hospital’s admission panel to which psychiatric reports must be submitted with the request to take a patient. The patient must be
detainable under the Mental Health Act 1983 and must be considered sufficiently dangerous to require conditions of special security.

The three special hospitals in England are Broadmoor Hospital in Berkshire, which was the first to be established in 1863, Rampton Hospital in Nottinghamshire and Ashworth Hospital in Merseyside, which was formed in 1989 from unifying Moss Side Hospital and the recently built Park Lane Hospital.

Regional secure units
Regional secure units (RSUs) are part of the forensic services provided by each regional health authority, following a recommendation made by the Butler report in 1975, that every region should provide facilities for the care of difficult and dangerous patients. RSUs, which can provide anything between 30 and 100 beds, care for those patients who are too dangerous for ordinary hospitals, but not so disturbed as to require care in a special hospital. Each unit has the capacity to prevent patients from absconding, but at the same time run a treatment programme that will include, as the patient improves, parole outside the unit. The patients in the unit will suffer principally from mental illness (mostly schizophrenia), whilst the remainder will suffer from psychopathic disorder. Around 25% of the patients will have been referred from NHS hospitals, 20% from special hospitals and 40 to 50%, from the courts and remand prisons. The rest of the patients in secure units of this kind will have been referred from the community services or ordinary prisons (Faulk, 1994). Most patients will either be on a hospital order, with or without a restriction, or treatment order (Section 3, Mental Health Act, 1983), reflecting their source of referral, and a high number will have had previous convictions and admissions to other hospitals. However, a few of the patients will be informal, such as ex-patients re-admitted voluntarily because of a brief breakdown.

Out-patient care
It is possible for patients with psychopathic disorder to receive treatment in an out-patient clinic. The Portman clinic in London is perhaps the most well known service of this kind and offers psychoanalytical out-patient treatment for adults, adolescents and children who have engaged in criminality or sexual deviation. A large proportion of the psychopathic patients who attend out-patient clinics will have had previous contact with the psychiatric services and will be receiving out-patient care as a follow-up to a period of in-patient treatment. Indeed, a high standard of after care for psychopathic patients is essential if dangerous behaviour is to be prevented in the future. Out-patient clinics, which are provided as part of regional forensic psychiatry services, can also provide care for those who, under the section 9(3) of the Criminal Justice Act 1991, are on a probation order with a condition of treatment. Out-patient psychotherapy groups, for instance, can be run jointly by psychiatrists and probation officers. Some regional secure units also have their own out-patient area, with administrative and treatment facilities.

Treatment in prisons
Although each prison governor is responsible for seeing that there is proper health care for the inmates in their establishment, not all are willing or have the means to engage in long-term therapy with those who have mental illness. This is not helped by the fact that the Health Care Centre provided by each prison is not recognised as a hospital under the meaning of the Mental Health Act and that doctors are therefore unable to treat any patient against their will, except in certain emergency situations. This means that some patients may have to remain untreated until they can be granted a transfer to a mental hospital, and yet transfers of this kind are relatively rare. Having said this, there are a few specialised prisons or wings which concentrate on treating particular disorders. Grendon Prison, for example, has a therapeutic community treatment programme for personality disorder and ‘C’ wing in Parkhurst Prison runs a programme for inmates with severe personality problems.

Assessing the needs of the patient
It is widely recommended that, on arrival at a new hospital, a careful clinical evaluation of psychopathic patients should be carried out before any strategy of treatment is formulated. Liebowitz, Stone and Turkat (1986) recommend that an initial out-patient assessment or in-patient evaluation should be scheduled to last at least 90 minutes. During this consultation the mental health professional, who will usually be the registered medical officer in charge of the patients treatment (RMO) should take an active role in obtaining the history of the present disorder. This will include an evaluation of psychiatric history, medical history, family history, personal history as well as the patients cognitive and affective
levels of functioning. Particular attention should also be paid to the patient’s criminal history and to evidence of previous behavioural disorder, including attention deficit disorder (ADD) in childhood. An assessment of these factors will rely upon a combination of interviews, psychometric measures (including the MMPI scales, repertory grids and Hare’s Psychopathy Checklist) and file information, in which records of social, psychiatric and criminal history can usually be found. Information from independent sources, including family members, court records and victims should also be sought.

It is equally important that the psychiatrist gains some impression of the extent to which the patient feels able to exert control over their behavioural dysfunction, as well as their general attitude to their antisocial conduct. This will involve an investigation of the lifestyle factors conducive to deviant behaviour, including attitudes to self and others, interpersonal style and substance abuse. Indeed, the motivation of each patient together with their personal capabilities will have an important bearing on their treatment programme. Because the goals of therapy will vary according to each patient’s particular needs, it is also important to agree upon treatment targets with each individual before treatment starts. Higgins (1995) also recommends being realistic with the patient about what can be expected from therapy.

Approaches To Treatment

The 1983 Mental Health Act provides little in the way of recommendation for the treatment of mentally disordered offenders. In fact, ‘treatment’ is simply defined as ‘nursing care, habilitation and rehabilitation under medical supervision’. However, numerous methods of treatment have been tried with psychopathic patients, the principles of which are described below. In most clinical settings an eclectic approach to therapy is preferred, which would usually involve the use of two or more of these methods.

Pharmacological treatments

The most common forms of medication used with personality disordered patients are neuroleptics, antidepressants, lithium, benzodiazepines, psychostimulants and anticonvulsants. Many treatments may take time to become effective and a substantial measure of active patient co-operation with them is necessary. The danger of violence may be immediate, so although there is no specific anti-aggression drug, reduction of arousal using the more sedative neuroleptics is often helpful and necessary during a crisis (Faulk, 1994). It has to be emphasised, however, that medication is only one aspect of patient management and is complimentary to psychological treatments.

Neuroleptics

Neuroleptics can have both a tranquilising effect on disturbed behaviour, most notably persistent tension, anger and hostility and a specific antipsychotic effect (Blackburn, 1993). Many clinicians will have had personal experience of administering neuroleptics to a range of disturbed and aggressive patients in hospital settings to control crises. Early observations by American psychoanalysts suggest that low dose neuroleptic therapy (i.e. doses lower than would normally be prescribed for schizophrenics or depressed patients) can be helpful in the reduction of anger, hostility and occasionally, behavioural disturbances, such as suicidal gestures or aggression (Dolan and Coid, 1993).

Antidepressants

Antidepressants, such as serotonergic reuptake inhibitors, tricyclics and monoamine oxidase inhibitors (MAOIs) have been used with patients who display persistent dysphoric mood and major or atypical depression, such as panic attacks, mood swings and dysthymia (Gunn and Taylor, 1993). Imipramine, one of the tricyclic antidepressants, is the most studied and is probably most effective with psychotic depression, but has also been used successfully with obsessives and patients with unusual states of pain. (Gross, 1992). In subjects with personality disorder, MAOIs, have been used to produce a reduction in certain core features including anger control, impulsivity and interpersonal sensitivity. In view of the potential serious side effects, however, a trial of MAOIs may only be appropriate, after lithium has failed.

Lithium

Lithium is often used in the treatment of psychopathic patients because it can bring about a reduction in impulsive, explosive and emotionally unstable behaviours. (Stein, 1993). In many parts of the world lithium has been described as a mood stabilising agent because of its primary action in preventing mood swings in patients with bipolar disorder (Katzung, 1982). Sheard (1971), who has conducted a number
of experiments with lithium, suggests that it is perhaps the closest to being a specific agent for the control of anger and aggressive outbursts in personality disordered patients. It should be remembered, however, that sedation is a side effect of lithium and that high levels of the drug are associated with tremor and uncoordination. It is also possible that the optimum serum level will vary among individuals and will have to be determined for each patient. It is important, therefore, that any patient taking lithium is carefully supervised (Stein, 1993).

**Benzodiazepines**

Benzodiazepines are known among clinicians to be highly effective in their control of anxiety states and insomnia. Although the available literature on the effect of benzodiazepines on psychopathic disorder is not of a high quality, a single administration of benzodiazepine for a disturbed and aggressive patient may be helpful during episodes of severe disturbance or when anxiety is overwhelming. Kalnia (1964), for instance, recommends the use of diazepam for patients who have a history of aggression and behavioural problems.

**Psychostimulants**

Psychostimulants are known to reduce feelings of tension and dysphoria in patients with disturbed behaviour. It has been suggested that stimulants are useful when the psychopathic behaviour exhibited by a patient can be understood as an adult development of childhood hyperactivity with attention deficit (Faulk, 1994). Indeed, there have been more than 100 controlled trials of stimulant drug effects in overactive children of normal intelligence, where drugs such as amphetamine and methylphenidate have been able to reduce ratings in the children’s behavioural disturbance. (Barkley, 1977; Rapaport, 1983). According to Dolan and Coid (1993), even if there is not a direct relationship between attention deficit disorder and psychopathic disorder, it is likely that the two conditions share at least some overlapping genetic components.

**Anticonvulsants**

It is now recognised among psychiatrists that anticonvulsant compounds have an important spectrum of clinical activity in both neuropsychiatric syndromes and behavioural disorder, as well as their effect on epileptic disorders (Gunn and Taylor, 1993). Carbamazepine (CBZ), for instance, which has been in use as an anticonvulsant since the 1960’s, is valuable in the treatment of dyscontrol episodes, such as angry outbursts, violence and self-mutilation, as well as the psychological problems experienced by epileptics. It has been suggested that anticonvulsants may be helpful in the treatment of psychopathy because of evidence that the behavioural dyscontrol exhibited by psychopaths could be linked to a disorder of the limbic system and that the condition is similar to the postulated syndrome of ‘episodic dyscontrol’ (Lishman, 1978). Further encouragement to use anticonvulsants has also emerged from electroencephalography (EEG) studies of psychopaths. The incidence of EEG abnormality, for instance, is thought to be highest in patients with personality disorder and behavioural abnormalities, and particularly aggressive psychopaths, who together with those who have a history of habitual aggression and explosive rage, show the highest incidence of all. (Williams, 1969).

**Physical treatments**

Physical treatments of psychopathic disorder are based upon the principle that abnormalities of brain function are a central factor in antisocial conduct. It is frequently suggested, for instance, that for some specific subgroups of patients, a neurological impairment interacts with other psychosocial factors to place patients at risk of certain forms of antisocial behaviour. Indeed, White (1964) has argued that the psychopathic personality is produced by generalised brain injury, which weakens an individuals capacity for inhibition and control and Gorenstein (1982) has implicated frontal lobe and limbic system damage in some psychopathic conduct. Views of this kind have supported the use of physical treatments of psychopathy, such as electroconvulsive therapy (ECT) and psychosurgery. ECT treatment involves placing electrodes on the patients temples and giving them an 80 to 110 volt shock lasting a fraction of a second, to produce a generalised convulsion. In cases of severe depression, bilateral ECT is preferable, because it acts relatively quickly and fewer treatments are needed. In unilateral ECT, an electrode is applied to the non-dominant side of the hemisphere, with the intention of reducing the potential side effects of memory disruption. It is not entirely clear whether electroconvulsive therapy is useful in the treatment of psychopaths, although according to Gunn and Taylor (1993) it may be helpful in circumstances where a patient has developed a severe depressive illness. Psychosurgery represents the most dramatic form of physical intervention and is by far the most controversial of the medical
approaches (Gross, 1992). Although the use of lobotomies (the partial separation of other parts of the brain from prefrontal lobes) enjoyed a brief vogue in the 1940’s, modern psychosurgery has become much more sophisticated, with very small amounts of brain tissue being destroyed in very precise locations (fractional operations). It has been suggested that for patients who are abnormally aggressive, the neural circuit connecting the amygdala and the hypothalamus should be removed, in the hope that this will reduce the subjects aggressive and assultive behaviour. However, surgery of this kind would not usually be considered until all other forms of treatment had failed, or when the patient was suffering from an obvious brain abnormality.

Behaviour therapy

Behaviour therapy, or the use of behaviour modification techniques, is an attempt to apply the results of learning theory and experimental psychology to the problems of maladaptive behaviour (Lantz and Ingram, 1984). Within such a model the patient is regarded as an individual whose antisocial behaviour has been acquired by learning or improper conditioning. Behaviour is seen, not as the product of spiritual or mental processes, but as the inevitable result of an interaction between environmental history and current environmental situations. As a consequence, behaviour therapists usually approach assessment through a functional framework, which places emphasis upon current behaviour-environment relations and which seeks to determine the personal and environmental factors of which the antisocial behaviour is considered a function. All behaviours, with the exception of organic syndromes are considered to be the outcome of these complex interactions and potentially amenable to the scientific process of prediction and control (Crawford, 1984).

The two basic types of learning central to the theoretical conceptions of behaviour therapy are classical and operant conditioning, both of which work on the principle that learning is the acquisition of a functional connection between an environmental stimulus and a subject response (Gross, 1992).

Classical conditioning applies only to reflex reactions within the autonomic nervous system. What is learned, therefore, is not a new response, but how to produce an established reflex in response to a new stimulus. The experimental work of the Russian physiologist Ivan Pavlov illustrates the importance of conditioned responses in basic learning. In his experiments with animals, Pavlov was able to demonstrate how it is possible to replace an autonomic reflex, or unconditioned stimulus (UCS) with a conditioned stimulus (CS), to produce an unconditioned reflex response (UCR). The relevance of classical conditioning to behavioural therapy, is that experimentally derived stimuli can be used to weaken or eliminate unwanted and maladaptive behaviours. It also demonstrates that it is possible to learn to inhibit or suppress an unwanted response when an unconditioned stimulus is removed (Pavlov, 1927).

Operant conditioning differs from classical conditioning in that it is concerned with voluntary rather than reflex behaviour, and to how new behaviours can be learnt by the subject concerned. The notion of operant conditioning has its origins in the work of Skinner, who having been influenced by Thorndike’s Law of Effect, developed a theory based upon the principle that behaviour is able to be shaped and modified by its consequences. Skinner suggests that there are three main learning principles for modifying behaviour. The first two are positive and negative reinforcement, both of which strengthen behaviour and make it more probable and the third is punishment, which through the presentation of aversive stimuli, weaken behaviour, making it less probable (Skinner, 1953). Further learning principles have been added to these, including avoidance, extinction, time-out, generalisation and discrimination.

In addition to the traditional techniques of operant and classical conditioning, are a range of more recent behavioural therapies which can also be usefully applied to psychopathic patients (Lantz and Ingram, 1984). One of the most widely known methods is aversion therapy, which is designed to decrease the frequency of inappropriate behaviour, feelings and fantasies. Aversion therapy can be classified as a classical conditioning procedure, whereby conditioned anxiety is produced in response to the previously pleasurable, but undesirable behaviour, or as an operant procedure, through which desirable behaviour is punished. In both instances, an aversive stimulus in the form of an electric shock, a nauseating drug, or a foul-smelling chemical, is presented contingent on the undesirable behaviour one wishes to eliminate. Covert sensitisation is a variant of aversion therapy, which makes use of unpleasant imagery rather than physically aversive stimuli. This technique involves the patient imagining the problem behaviour and then switching to an extremely unpleasant, often noxious or nauseous scene to
discourage it. Covert sensitisation together with orgasmic reconditioning, are often used with patients who exhibit problems with deviant sexual arousal.

A token economy is a particular type of behaviour modification in which the main vehicle of reinforcement is some sort of ‘token’. This can take a variety of forms, including poker chips, cigarettes, sweets, privileges or attendance to social events. The essential requirement is that the tokens are linked to a range of back-up reinforcers and thus come to acquire symbolic value in the same way that ordinary currency does. Token economies can, in theory, be applied to a range of problems, but they have been used most frequently to modify the behaviour of groups of people living in institutional settings.

A variety of behavioural techniques have also been developed which are based upon a skills deficit approach to behavioural difficulty (Crawford, 1984). This approach analyses behavioural problems not in terms of behavioural excess, but in terms of behavioural deficit. For example, rather than seeing antisocial behaviour as the consequence of a patient being too aggressive, the therapist would regard such conduct as an indication of the patient lacking the verbal skills to deal adequately with authority and resolving this inadequacy by being physically aggressive. Once a problem of this kind has been re-conceptualised, then new, more appropriate, behavioural repertoires can be constructed. (Schwartz and Goldiamond, 1975). This will involve the patient engaging in some form of skills training, which can then be applied to situations such as handling potentially aggressive encounters, controlling anger, and dealing with authority figures. Social skills training is probably the best known skills training approach, whereby patients are taught the behavioural components of social interaction, with techniques such as modelling, role-playing and feedback.

Cognitive approaches
Cognitive techniques involve questioning the patients maladaptive or irrational thoughts, and providing new cognitions to replace them (Dolan and Coid, 1993). This method of therapy regards the majority of clinical problems as disorders of thought or feeling and works on the principle that because behaviour is to a large extent controlled by the way we think, it should be possible to change maladaptive behaviour by changing the maladaptive thinking which lies behind it. One of the most well known cognitive-behavioural techniques is therapeutic modelling, which is a direct application of the theory of observational learning developed by Bandura (1971). Modelling has been used to reduce anxiety, but also to teach social skills and anger management, by using the powerful effects of social imitation. Treatment usually involves arranging for a patient to observe a competent, coping human model of behaviour, in the hope that this will be reflected in the patient’s future conduct. One of the most widely used anger management programmes is based upon procedures developed by Novaco (1975), who believed that subjects could gain control over their behaviour through a combination of cognitive restructuring and relaxation training. This approach aims to identify and modulate cognitive, behavioural and physiological responses to provocation, through various treatment techniques, including physiological monitoring, assertiveness training, reappraisal, cognitive self-control, relaxation training and self-instruction. The treatment goal is to regulate each individual’s anger, through the understanding of personal anger patterns, but also the acquisition of skills involving more adaptive alternatives to provocation. The programme can be used on an individual or group basis.

Individual and group psychotherapy
Psychodynamic psychotherapy has its origins in the work of Sigmund Freud and the principles of psychoanalysis. Where as behavioural therapy focused upon externally observable behaviour and on manipulating deviant conduct towards an agreed norm, dynamic psychotherapy is more concerned with approaching the patient empathetically and with helping them to identify and understand what is happening in their inner world, with regard to background, upbringing and personal development. Freud regarded the psychotherapeutic process as one in which those in distress could share and explore the underlying nature of their troubles and possibly change some of the determinants of these, through the experience of unrecognised forces in themselves (Brown and Pedder, 1979).

The psychodynamic approach to the management of patients with psychopathic disorder, emphasises the importance of personality structure and development, and is based upon the principle that antisocial behaviour is an expression of an underlying personality disturbance. Chronic antisocial behaviour is held to reflect distortions in development and most particularly, the patient’s primitive defences against trusting relationships. (Blackburn, 1990). According to Vaillant (1975), for example, behaviour of this
kind is representative of an individual’s immature defence against fears of dependency and intimacy, which probably result from early experiences of rejection and abuse. Anna Freud (1976) also argues that profound disorders of character are the result of harm inflicted on the ego (the rational, logical part of us that is governed by the reality principle) in the early course of development. According to Freud, damage of this type impairs the ego’s strength and therefore its capacity to contain and manage primitive anxieties and impulses.

A crucial part of psychotherapy, therefore, is helping the patient to uncover the relevant mental states and meanings behind their behaviour, allowing them to understand their feelings and maladaptive defence mechanisms. The therapeutic relationship plays an essential part in this process, because it is the therapist who directs the patient in their recall of memories and who will help the patient to understand and reintegrate this material into their present lifestyle. It is the work of the therapist to recognise similarities and patterns within the material presented and to share with the patient the meanings of these rememberings (Gunn and Taylor, 1993). This working alliance allows the patient to transfer their feelings and attitudes, developed in earlier similar experiences, to the therapeutic session. It is this process, which Freud described as transference, that provides insight for each patient and encourages them to have greater self awareness, self-control and empathy (Blackburn, 1993).

Group psychotherapy is intended to provide education, encouragement and support for its members, but also a secure environment in which information can be exchanged and opinions heard. The social nature of the group setting aims to provide each patient with an opportunity to examine their difficulties, in a situation reflecting the family and social networks in which their problems developed. Because several people are taking part, interaction is likely to be varied and complex, allowing the patient to learn greater understanding of himself and others, but also, how best to develop relationships with other patients. Multiple transferences can develop, in which a patient transfers feelings not only on to the therapist, but on to fellow patients and the group as a whole. One of the most common modes of group psychotherapy used with personality disordered patients is psychodrama, which can be used to help patients work through a block in expression or communication, or to explore a key conflict in their lives. It can be particularly helpful in a hospital setting for those who are inhibited or find verbal expression difficult. As the ‘director’ the therapist can instruct a patient to step into the protagonist’s role (role reversal), in order to foster identification and improvisation.

Therapeutic community approaches
The therapeutic community (TC) has its origins in the changes that occurred in psychiatric hospitals after World War II, which encouraged a move away from an authoritarian doctor-patient model, to a more democratic style of staff-patient interaction (Dolan and Coid, 1993). This approach included the more active participation of patients in their own treatment as well as giving them greater responsibility for the day to day running of their hospital community. The general assumption is that the delegation of responsibility to residents in a ‘living and learning’ environment will encourage a more open expression of feelings among patients and a greater understanding and exploration of interpersonal relationships. Through a relaxing of staff-patient hierarchy and the collaboration of staff and patients in a wide range of activities, it is hoped that all interactions and relationships in the community can come under examination. The aim is that such enquiry will lead to a better understanding of deviant or unhealthy previous behaviour, which may then result in altered interpersonal behaviour and improved psychosocial functioning (Dolan and Coid, 1993). Indeed it is claimed that TCs can benefit psychological adjustment, by reducing anxiety and depression and increasing self-esteem and self-perceived conformity and independence (Blackburn, 1993).

The atmosphere in therapeutic environments of this type are usually informal and regular community meetings are held between residents and staff, in order to enhance cohesion and a sense of communalism. Perhaps the most important aspect of TCs, however, is that membership of the community and engagement in therapy are voluntary. In order for the community to function and social order to be maintained, members must feel that they have actively chosen to engage in the regime. A therapeutic community in the full sense maintains close contact with adjacent and relevant communities outside the therapeutic setting and usually practises an open door policy, with the patients coming and going freely and participating in activities according to a balance of personal choice and group pressures (Gunn and Taylor, 1993).
Although this means that secure settings cannot be therapeutic communities in this full sense, TCs can be provided as a voluntary option for patients within secure environments. In fact Special hospitals usually claim to offer ‘milieu therapy’, which is often used interchangeably with the concept of the therapeutic community. According to Blackburn (1993), the milieu therapy offered by secure settings usually includes a combination of pharmacotherapy, psychotherapy, cognitive therapy, group therapy and behavioural therapy. These elements of therapy are delivered by a wide range of staff from different professional backgrounds, so that different patients can receive different treatment packages, depending on their needs.

Treatment Models
Outlined below are four models of treatment currently in use with psychopathic patients. The models come from a variety of settings and, with the exception of physical methods, incorporate all the treatment modalities described above.

Henderson Hospital
Henderson Hospital was the first British unit to develop a patient-orientated approach to the treatment of psychopathic disorder. The hospital was set up after World War II, as a social rehabilitation unit using a group-analytic approach for 100 patients. In 1959 the unit was renamed Henderson Hospital, after Professor Henderson, who wrote *Psychopathic States* (1939), and offered combined psychotherapy and sociotherapy in a TC milieu. Henderson only accepts voluntary admissions, although about half the patients have a history of adult convictions and 20% have served a prison sentence. The hospital caters for 29 adults between the ages of 17 and 45, most of whom suffer from personality disorder and about 60% of which will meet DSM criteria for antisocial personality disorder (Norton, 1992).

At the Henderson, nurturing engagement among the patients is a paramount concern and is facilitated by the hospital’s internal organisation and operation. For example, selection is made in a group setting by residents and staff together and because residents outnumber staff by 3:1, they have a major say in who is admitted. All therapy at the Henderson is group based, from the daily community meeting, which includes all members of residents and staff, through to the small group psychotherapy (thrice weekly) and to art therapy, psychodrama and the task-centred work groups (cookery, gardening, maintenance and art work), which take place twice weekly. The daily activities are co-ordinated by the ‘Top Three’ residents, who have to have been resident for at least three months in order to be nominated to their positions (although no one is a resident at Henderson for more than a year). This includes setting the agenda for, and chairing the day’s community meeting, leading the weekly selection group and deciding when to call an emergency meeting. The community is rigidly organised and strictly adhered to. Residents know that they are expected to be in certain places at certain times, that their absence will be noted and that they will be called to account over this. Missing more than two therapy sessions in one week, for example, means that all groups the next day must be attended in full.

The Woodstock ward, Broadmoor Hospital
Woodstock is a purpose-built 25 bed secure ward within Broadmoor special hospital, first occupied by patients in October 1990. The patients on Woodstock ward are given their own room, with integral sanitation and there is communal space available for therapeutic and leisure activities, although a large amount of therapy takes place in the occupations and education department. Of the 25 patients in residence, the majority carry a 1983 Mental Health Act classification of psychopathic disorder, and will have been convicted of an violent offence (Brett, 1992). The predominant form of treatment within the ward is group therapy, which falls into two main classes: unstructured psychotherapy groups (which are psychodynamic in orientation) and structured groups (which are cognitive-behavioural in orientation). Each group meets once a week and includes between four and eight patients. The unstructured groups can be divided into supportive and more confrontational groups, for patients who are highly motivated and able to tolerate challenges to their defences. The structured groups focus on particular areas of functioning, including sex education, social skills, assertiveness training and anger control (which involves the use of Novaco’s approach). Medication is also considered and implemented if appropriate. A minority of patients are engaged in long-term, weekly, individual psychodynamic psychotherapy with psychologists and visiting psychotherapists, although the demand for such treatment is greater than can currently be met. As far as possible, treatment is seen as a partnership in which the patient can be active. Patients are given the opportunity to influence their environment and aspects of the ward regime at
weekly, fairly formal meetings with staff, although it is not always easy to grant patient requests within a maximum security setting.

**Dr Henri van der Hoeven Clinic, The Netherlands**

The van der Hoeven Clinic is a 75 bed residential facility, which provides community based treatment for patients who have been committed by penal courts, exclusively because of severe crimes (including physical abuse, rape, murder, and homicide) and because their mental disorder was considered to bear serious risk of future offence. Over 80% of the hospital’s admission are between 20 and 35 years and a high proportion of these will be psychopathic (Feldbrugge, 1992). The average length of stay is about four years. The purpose of the unit is to provide rehabilitation, which in practice, involves a tight connection between treatment and security. The hospital doors and windows are solid enough to prevent impulsive escapes, but at the same time, the clinic has neither guards nor permanent supervision of patients and some are granted freedom of movement outside the hospital. Security is considered to be a matter of collaborative effort, in everybody’s interest. Treatment in the unit is based on the TC model, in which the patient group accepts responsibility for decision making and the living tasks are shared between staff and residents. Guidelines include, not to do for patients, what they are capable of doing for themselves. Each patient is intensely involved in their own treatment planning and on a more limited scale, that of their group members. Each resident evaluates their treatment progress with a patient group each month. The most common form of treatment is group psychotherapy, in combination with educational rehabilitation and resocialisation programmes. It is hospital procedure that patients also participate in seclusions, whether these proceed quietly or require force.

**HMP Grendon Underwood**

Grendon is a maximum security prison, which was opened in 1962 and offers psychiatric treatment to recidivist offenders, with moderate to severe personality disorder (a high number of which will have incurred convictions of violence). The prison has 200 beds and referral is made after conviction by the prison medical service, with the final selection being made by Grendon staff. Patients are selected on the grounds of their intelligence, articulateness, willingness to accept the Grendon regime and evidence of some personal achievement. All inmates are voluntary and free to return to an ordinary location on request. Men are received into an assessment unit, where they are given an induction to the regime and the alternative ways of relating to staff and other inmates. Those unsuitable for treatment can be filtered out at this point. Following assessment, the inmates are randomly allocated to the four treatment wings, each of which is run as an individual TC, where patients are encouraged to participate in the organisation of their own activities and the general running of the institution. The essence of the system is to help patients to mature by giving them a high degree of responsibility, in an atmosphere less authoritarian than ordinary prisons (Gunn et al, 1978). Treatment takes place in small groups, which meet twice weekly, and in larger community meetings of 30 or 40 people living in the same wing. Most groups use a mixture of psychotherapy or group counselling, in which patients can examine themselves and work through personal relationships. The unit avoids the use of medication, except in exceptional circumstances.

**TREATMENT OUTCOME**

Although numerous methods of treatment have been tried with psychopathic patients, there are a limited number of controlled outcome studies in this area, which has made it difficult to determine which are the most effective. What little research is available, however, indicates that the nature of the psychopathic condition has made it one of the most difficult mental disorders to treat, with more and more psychiatrists and psychologists becoming increasingly pessimistic about their ability to deal with this group.

This chapter outlines the current status of outcome research into the treatment of psychopathic and antisocial personality disorder. The effects of each method of treatment will be considered in turn, using evidence derived from a number of different clinical settings.

**The effect of pharmacological treatments**

Although a number of drug studies have been conducted over the past 30 years which have monitored the effects of certain forms of medication on the mentally disordered, few of these have been carried out
with patients who display the core features of psychopathy, as defined in the ICD-10, DSM-IV, or in Hare’s Psychopathy Checklist. In fact, the only trials that have specifically addressed the treatment of patients whose characteristics resemble these core clinical features, are early studies involving psychostimulants and a small number of trials involving the use of lithium.

There are two uncontrolled studies that were carried out in the 1940’s, both of which report the positive effects of amphetamine in psychopathic patients. The first study was carried out by Hill (1944), who describes administering amphetamines to a large series of psychopaths in clinical practice. Hill was able to observe his subjects over a number of years and discovered that those who responded positively to amphetamines were patients whose behaviour was characterised by an aggressive, bad tempered and generally hostile tendency to interpersonal relationships. Response was most satisfactory in patients whose sleep was not affected by the drug and those who were able to make warm interpersonal relationships, even if these were quickly wrecked by their impulsivity and irritability. Non-responsive patients included paranoid and schizoid personalities and passive and hysterical personalities, for whom amphetamine would usually increase irritability, anxiety and insomnia (Hill, 1944).

The second study was conducted by Shorvon (1947), who describes an uncontrolled trial with an inadequate male psychopath and one aggressive male and one aggressive female psychopath. All three subjects responded positively to 20 to 40 mg of benzedrine, exhibiting a significant reduction in mood swings, rage attacks and irritability. Bed-wetting ceased in the inadequate male and the female, who was unable to control her sexual impulses, self-reported a reduction in sexual drive. Like Hill, Shorvon also noted that sleep was rarely affected in those who responded positively to treatment.

There have also been reports of the positive effects of lithium with patients whose characteristics resemble the core elements of psychopathy. In an open, multiple cross-over study conducted by Sheard (1971), for instance, which involved 12 male delinquents, characterised by repeated impulsive aggressive behaviour, aggressive episodes were found to decrease when sufficient lithium was prescribed for a high serum level. In a second study, Sheard, Marini and Bridges (1976) produced the same results with a sample of 66 young delinquent inmates, held in a correctional institution for violent crimes. The main criteria for selection were convictions for serious aggressive offences, including manslaughter, murder, rape and a history of chronic assaultive behaviour or chronic impulsive antisocial conduct. After a one month drug-free period, subjects were randomly allocated to either lithium carbonate or a placebo for the following three months. The patients’ antisocial behaviour was monitored by the number of infractions of institutional rules they committed. These were devided into major infractions, which involved threats or actual assaults and minor infractions, which consisted of less serious, non-violent offences. The researchers found that there was a significant reduction of major infractions among the active drug group.

Similar results were produced in a study conducted by Rifkin, Quilkin and Carrillo (1972), who examined the effects of lithium on a group of 21 adolescents. The study involved administering lithium for six weeks in a double-blind cross-over trial. Although the subjects were described as having an emotionally unstable character disorder, many of the characteristics of this condition include behaviours similar to the core features of psychopathy, such as chronic maladaptive behaviour patterns, poor acceptance of authority, poor work record and a tendency to manipulate. Of the 21 patients, it was judged that 14 were better on lithium, four on the placebo and that three showed no improvement.

The impact of comorbidity on pharmacological treatments

It has been suggested that if clinicians accept the classification of psychopathic disorder set out in the three most commonly used clinical categorisations, then it is not surprising that pharmacological methods with psychopathic patients have received so little attention, relative to other methods. According to the current editions of the DSM, ICD and Hare’s Psychopathy Checklist, psychopathic disorder is characterised by a gross disparity between behaviour and the prevailing social norms (World Health Organisation, 1992) and is a condition which develops over a very long period of time. This would imply that treatments that focus upon inner change and the renewal of interpersonal skills and relations would hold out more hope for the psychopath than a treatment modality whose effects are rapid and purely chemical (Dolan and Coid, 1993).

If clinicians accept the findings produced by Coid (1992) and Walker and McCabe (1973), however, which demonstrate that psychopathy has a high comorbidity with other clinical conditions, then it
becomes apparent that those diagnosed with the disorder may in fact be suffering from additional symptoms which are responsive to drug treatment.

Research suggests, for example, that low-dose neuroleptic therapy can be beneficial for patients exhibiting schizotypal features, including conceptual disorganisation, illusions, paranoid ideation and a history of short-lasting psychotic episodes. In an uncontrolled trial conducted by Brinkley et al (1979), for instance, which involved five patients with borderline personality disorder (BPD), low dosage neuroleptics were able to produce a reduction in regressive psychotic-like symptoms and paranoia. Similar results were obtained in a double-blind study conducted by Soloff et al (1986), which involved 62 in-patients, of which 43% had BPD, 6% had schizotypal personality disorder and 51% had a combination of both. The study looked to compare the effects of haloperidol with a placebo and amitriptyline. The findings indicated that haloperidol was superior to amitriptyline in the reduction of schizotypal symptoms, behavioural dyscontrol, hostility, paranoia and interpersonal sensitivity, although there were no significant differences between amitriptyline and the placebo.

Benzodiazepines have also been found effective in subjects suffering from schizophrenia and schizoid personality disorder. In a study conducted by Kalnia (1964), for example, diazepam produced a reduction in the behavioural problems among a group of 52 male prisoners with diagnoses of schizophrenia and schizoid personality disorder. The drug was associated with improvements in the violent, destructive and belligerent behaviour of 63% of the group. Similarly, in a double-blind trial conducted by Lion (1979), which involved the random allocation of 65 patients to oxazepam, chlordiazepoxide and a placebo, it was concluded that anti-anxiety drugs played a significant role in the management of explosive personalities and the reduction of paranoia and mood lability.

However, it is of some concern, with respect to the treatment of psychopathic patients, that benzodiazepines can produce unwanted disinhibitory effects in some patients. Indeed, Gardner and Cowdry (1985), who have conducted the most comprehensive evaluation of the unwanted side effects of patients who have been given alprazolam, found that out of the 12 subjects given the drug, seven responded with episodes of serious dyscontrol. In fact, due to the severity of these episodes in some subjects, including drug overdoses and severe self-mutilation, it was necessary to terminate four of the trials before the study had been completed.

Although there are numerous studies that point to the positive effect of tricyclic antidepressants and serotonergic reuptake inhibitors with patients suffering from severe depression, including the study conducted by Fava, Rosenblum and Pava (1993), which demonstrated the effectiveness of fluoxetine on major depression, studies involving patients with personality disorder (usually BPD), do not demonstrate such a dramatic response. For instance, Black, Bell and Hulbert (1988), found that in an experiment comparing 75 subjects with major depression and coexisting personality disorder, with 152 subjects with pure major depression, a good response to tricyclic treatment was produced in 64% of the subjects with pure depression compared to only 27% of those with an additional personality disorder. Charney et al (1981), in a similar retrospective case-note study, involving 160 patients with major depressive disorder, also found that for the subjects on medication, 76% of those who had pure depression, responded to tricyclic antidepressants, compared to only 36% of those who had an additional personality disorder. There is also some concern that antidepressants of this type can produce a disturbing clinical worsening among some patients with personality disorder. For example, in their investigation into the effect of amitriptyline and haloperidol in patients with BPD, Soloff, Anselum and Nathan (1986) found that some of the patients appeared progressively more hostile, and impulsive after being administered with the drug. These symptoms of demanding and assultive behaviour were different from the patients’ initial complaints and worsened with longer duration and higher doses of medication.

It has been noted, however, that trials involving the use of monoamine oxidase inhibitors with personality disordered patients have produced more positive results. In a trial with 16 female patients with borderline personality disorder, for instance, Cowdry and Gardner (1988) found that tranylcypromine improved anxiety, depression and sensitivity to rejection in the nine who completed the trial. Recently, Soloff et al (1993) also found that phenelzine was useful in the reduction of hostility and anger in patients with borderline personality disorder. Findings of this kind suggest that for those psychopathic patients who exhibit symptoms of severe depression, MAOIs may be the treatment of choice.
Outcome research involving the use of pharmacological treatments suggests that drug administration could play a role in the temporary control of violence in patients with psychopathic disorder, but also in the amelioration of other psychiatric symptoms which can be exhibited by this group. It is interesting, however, that there is currently little advocacy of the use of drug treatment with patients diagnosed with psychopathic disorder. According to Dell and Robertson (1988), for example, at the time their study was conducted, only 14% of the legal psychopaths at Broadmoor Hospital had been prescribed with medication and in response to a questionnaire administered by Tennent et al (1993) to all members of the forensic section of the Royal College of Psychiatrists, it was generally agreed that drug therapy was the least useful form of treatment for psychopathic patients. It is possible that psychiatrists are unwilling to use medication with psychopathic patients, and particularly tranquillisers, because of the ethical issues it has raised. It has been argued, for instance, that the use of this kind of ‘chemical straight jacket’ neglects the environmental causes of violence and that drugs should not be administered simply with the aim of controlling difficult behaviour. Clinicians are also aware that drugs such as lithium can produce unpleasant side effects in patients, while other forms of medication can become addictive. Particular concern has been expressed, for example, about the number of patients who become dependant on benzodiazepines, when they are prescribed over a long period.

The response to physical treatments
There are very few controlled trials which have demonstrated the effect of electroconvulsive therapy (ECT) on patients with psychopathic disorder and the few experiments that are available indicate that it is largely unhelpful in the treatment of the core antisocial elements of the condition. In an early study conducted by Green, Silverman and Geil (1944), for example, which involved administering petit mal electro-shock therapy to 24 psychopathic prisoners on an average of 11 occasions, the majority of subjects produced little or no response to treatment of this kind. Although immediately after the experiment, patients were described as sleeping better and less nervous, at six-month follow-up, only four patients were considered to have improved, while the rest were unchanged.

According to McCord (1982), there is much more conclusive evidence for the effective use of electroconvulsive therapy in the treatment of depressed patients. Indeed, in a review of the literature on ECT conducted by Fink (1978) it was discovered that for psychotic-depressive and manic patients, success rates with ECT ranged from 60 to 90% and that suicide was less frequent in ECT treated patients than among those who only received psychotherapy. It is possible, therefore, that electroconvulsive therapy could be useful for psychopathic patients who have developed severe depressive illness, although this still remains to be seen.

There are also very few controlled trials demonstrating the effective use of psychosurgery with psychopathic patients, despite the fact that it is frequently claimed that this form of treatment can reduce aggressive and assultive behaviour. Darling and Sandall (1952), for instance, indicated that surgical trauma to the prefrontal lobes decreased the aggressive behaviour of 17 out of 18 ‘antisocial’ inmates from a mental hospital, although no standard for improvement was given and Robin (1958), in a controlled follow-up study, found no evidence that leucotomy benefited psychopaths. In an experiment conducted by MacKay (1948), 20 psychopathic patients at Rampton Hospital, who exhibited violent behaviour and emotional tension, underwent leucotomy. At six months follow-up 35% were described as markedly improved, 35% as improved, 25% showed little or no response to treatment of this kind. Although immediately after the experiment, patients were described as sleeping better and less nervous, at six-month follow-up, only four patients were considered to have improved, while the rest were unchanged.

The lack of conclusive evidence for the effective use of psychosurgery with psychopathic patients, together with the high mortality rates associated with this kind of treatment and the ethical dilemma of patients undergoing such operations involuntarily, has meant that this technique has been largely abandoned by contemporary psychiatrists. However, there is still some discussion about the use of psychosurgery for patients whose psychopathy is clearly related to brain damage. Indeed, Andy (1975) has produced evidence that psychosurgery was successful with six psychopathic patients who all had congenital or acquired brain abnormality, through seizures or trauma.

The effect of behavioural and cognitive therapy
Although few studies have monitored the long-term effects of cognitive and behavioural treatments, there is evidence that an increasing number of mental health institutions are employing this type of approach with personality disordered patients. For instance, Dell and Robertson (1988) discovered that
of the 106 legal psychopaths detained in Broadmoor hospital for an average of eight years, 22% had attended a social skills group, 6% had been to relaxation therapy, 4% had been to sex behaviour modification programmes and 6% had attended anger control sessions.

Although the research available does not allow us to monitor the success of the cognitive-behavioural methods used at Broadmoor, there are a number of studies available that have evaluated the short-term effects of these methods, when they are employed as the sole or primary means of therapy. Most of these studies have had encouraging results with cognitive and behavioural treatments and advocate their use with aggressive and antisocial patients. Jones et al (1977) for example, describe the success of a short term token economy ward for military personal diagnosed with personality disorders and found that a combination of individualised contingency contracting and reinforcement with points for good appearance, work and educational achievement resulted in significantly more of those treated remaining on active duty, than untreated controls. Similarly, Moyes Tennent and Bedford (1985) found that a programme combining individualised contingency management, a token economy and social skills training, reduced the aggressive and disruptive behaviour of a group of 78 male and female adolescents with behaviour and character disorders (including aggressiveness, self mutilation, theft, absconding and disruptive behaviour). The study used a comparison group, which consisted of 63 adolescents who were accepted for treatment but not then admitted. At two year follow-up, the treatment group showed less physical aggression, a reduction in self mutilation and temper outbursts and significantly more of the treatment group were found to be living independently outside institutions.

Colman and Baker (1969) have also reported on the success of an operant-conditioning model with soldiers diagnosed with behavioural problems (including homicidal behaviour, psychotic-like states and antisocial threats and gestures). Subjects were randomly assigned to the operant-conditioning ward, or to traditional hospital treatment. The average stay on the treatment ward was 16 weeks, during which time education and social skills groups were held and work tasks carried out. Although participation in work tasks and groups was voluntary, subjects were rewarded for attendance, with points which could be turned into privileges. Out of 48 subjects, 46 remained in the study and were able to be followed-up for three months or more after discharge. 70% of these were functioning in their unit, compared to only 28% of the comparison group.

In a comprehensive experiment conducted by Crawford (1981), who compared the effects of social skills training on a group of violent subjects, with those having verbal psychotherapy and a group of waiting list controls, social skills training proved more effective than both control conditions on a range of self-report and behavioural measures. Crawford’s study is one of the few in this area to provide follow-up of the maintenance of treatment effects, and interestingly, it was found that only three measures differed significantly at follow-up, all of which were in the direction of improvement.

There are also several reports of the successful use of cognitive-behavioural anger control treatment with aggressive patients. In a study conducted by Stermac (1986), for example, it was discovered that following treatment, anger control subjects reported significantly lower levels of anger and increased thresholds for provocation tolerance, than control subjects. To qualify for the study, subjects were required to have either a history of self-reported or clinically assessed anger control difficulties, or a history of aggressive behaviour. The control group were placed in twice-weekly one-hour psychoeducational group sessions and the anger control group were placed in one-hour twice weekly sessions based upon the cognitive behavioural and stress inoculation principles advocated by Novaco. The results of the study indicate that treatment was effective both in reducing self-reported anger levels and in facilitating the use of more adaptive strategies for coping with stress.

One of the problems associated with cognitive and behavioural methods of treatment, is that in line with their underlying philosophy, most programmes only target specific behavioural deficits, such as social skills and problems with anger, and very rarely address the treatment of psychological disorders in their entirety. There is also a lack of agreement among behaviourists about what constitutes an improvement in certain skills and very few of the studies in this area have provided a behavioural baseline for the evaluation of performance. It is also concerning that because of the degree of organisation and monitoring required by some cognitive-behavioural methods and most particularly the token economy, many have failed to survive in the long term. Perhaps the biggest problem with cognitive and behavioural methods, with regard to psychopathic patients, is the question of whether it is possible for subjects to transfer their behavioural training to conditions of real life. Howells (1986) has discussed this
problem in some detail, arguing that offender patients frequently receive treatment in institutions whose physical and interpersonal characteristics are entirely different from their natural environment and yet are expected to generalise their stimulus training to non-institutional settings. He adds that stimulus generalisation of this kind will be significantly reduced whenever the patient can discriminate between conditioning in which reinforcement is and is not delivered. For instance, an individual could register a difference between a confrontational situation with a member of a social skills training group and with a person in a real-life post-treatment setting. Unrealistically high standards of performance may cause confusion in the patient and evoke very different behaviour from that exhibited in the treatment session.

The response to individual and group psychotherapy

As with cognitive and behavioural methods, there have been very few evaluations of the effectiveness of psychotherapy with patients diagnosed with psychopathic disorder, even though psychodynamic therapy, and particularly group treatments, are often employed in mental health settings. Indeed, compared to the 41% of legally defined psychopaths in Broadmoor hospital who had received behavioural therapy, Dell and Robertson (1988) found that 71% of this group had been involved in group psychotherapy and 43% in individual psychotherapy. As Snowden (1995) points out, this is in spite of the fact that there are only a handful of psychotherapists working in the forensic psychiatry services.

Most psychotherapists have found that keeping psychopathic patients in out-patient psychotherapy is very difficult, unless clients are on probation, or under a court order of treatment. For instance, Carney (1977) reports the moderate success of an out-patient group programme with aggressive personality disordered male offenders, who attended as a condition of probation. After an average of 13 months treatment, significant improvements were found in ratings of community adjustment and the recidivism rate was a relatively low 28%. However, no changes were found on psychological tests administered to the group, such as the MMPI. Carney suggested that while therapy did not change personality, it did at least achieve control over violent behaviour. Woody et al (1985) found that among out-patient drug abusers undergoing psychotherapy, antisocial personality disordered patients showed little change on a variety of psychiatric and psychological measures, in comparison to antisocial personality disordered patients who were also depressed. The authors conclude that although counselling may reduce drug use, it is not beneficial to employ psychotherapy to treat opiate-dependent patients who have antisocial personality disorder alone. It is worth noting, however, that on average each patient only received 11 psychotherapy sessions, whereas most clinicians would recommend a much longer course of treatment.

Apart from a study carried out by Persons (1965) which monitors the effect of individual eclectic psychotherapy on sociopathic personalities and one or two studies that involve individual therapy as a backup to group therapy, there are no controlled experiments which evaluate the impact of individual psychotherapy on patients with psychopathic disorder. Persons’s study involved randomly assigning 12 male offenders with a diagnosis of sociopathic personality to 20 sessions of individual eclectic psychotherapy over a ten week period. Subjects were administered with self-report tests of psychopathy and anxiety before and after treatment and these were compared with the results of 40 untreated controls. Initially the scores from the two groups did not differ, but a significant effect of therapy was shown on all outcome variables after treatment.

The lack of evidence for the positive effect of individual and out-patient psychotherapy with psychopathic patients has lead most psychiatrists to consider them inappropriate for antisocial personalities and to regard group therapy as a preferable option. Indeed, far more outcome studies have been conducted using group methods and a greater number of these have had a positive effect on their subjects. In one of the largest outcome studies concerning psychotherapy with adults, for instance, Jew, Clanon and Mattocks (1972) found that imprisoned personality disordered offenders who had received group therapy had significantly better success on parole than untreated offenders. The study involved giving 257 male subjects psychoanalytically oriented group therapy over a minimum of one year, for eight hours a week. These men were matched on criminological and demographic factors with 257 men also in the prison, but who had not received therapy. During the first year of parole, the rate of parole revocation for the treated offenders was 24%, compared to a rate of 40% for the untreated group. However, at four year follow-up, the difference in the number of returns to prison had disappeared. Maas (1966) had an equally successful outcome with a group of 46 sociopathic female prison inmates. Women were randomly divided into two groups, one of which had a three month course of twice-weekly group therapy, which combined action procedures such as psychodrama with more conventional
group psychotherapy. At the end of therapy the treatment group showed significantly greater improvement on the Block Ego-Identity index.

One of the main problems with the research conducted on psychotherapy generally, is that too many of the studies are limited by very short follow-up periods and those that have followed their subjects for a long period, have found that the positive effect diminishes over time. A large number of the studies have also been conducted with groups described as 'personality disordered', which may or may not include psychopathic patients.

With regard to psychotherapy itself, there is growing concern that the degree of insight, openness and self-analysis this method requires from the patient, is simply not suited to the psychopathic personality, whose behaviour is characterised by a lack of empathy, callous unconcern and an incapacity to maintain relationships. Successful psychotherapy also requires the therapist to show acceptance of the subject, and yet the focus on the patient’s destructiveness may generate an intense countertransference reaction on their part, which can sometimes develop into a fear of the patient (Blackburn 1993).

The response to therapeutic communities
Although there are a large number of descriptive accounts of TC treatment with patients diagnosed with psychopathic disorder, in common with other treatment options, controlled outcome studies in this area are rare.

A number of the studies which review the effects of the TC model offered at the Henderson, for instance, fail to use adequate controls and rely on recidivism as the sole measure of long-term success. In an early study, Whiteley (1970) followed up 112 consecutively admitted male patients to the Henderson, who were described as suffering from psychopathic or sociopathic disorder, with no psychosis or organic mental illness. 71% of this group had been previously convicted, 42% had served a prison sentence, 47% were on probation at admission and 55% had a previous psychiatric admission. The men were studied for two years and information was obtained from the Criminal Records Office and the Ministry of Health Psychiatric Index, on all but 14 of them. 63 of the group were also followed up by personal interview. The results of the study indicated that in total, 40% of the patients had no further psychiatric admission or conviction at two year follow-up. Of those who had previous convictions, 43.6% remained free of conviction and of those who had previously been admitted to psychiatric hospital, 57.5% remained out of hospital over the two year period. Similar results were produced in a study conducted by Copas and Whitely (1976), which involved the follow-up of two cohorts of 104 and 87 male patients from Henderson Hospital. At two year follow-up, 42% and 47% of the respective cohorts had no re-conviction or hospital re-admission. Five year follow-up data was collected on the cohort of 104 patients and showed that 33.6% of the patients were free of re-conviction and admission and that 11% had had one minor relapse in the first year, but had been free of re-conviction or admission in the following four years.

Copas, O’Brien and Roberts (1984) replicated the above studies with a group of 194 male and female patients treated at Henderson for a five year follow-up period. Unlike previous studies, however, this design involved the use of a control group, made up of 51 patients referred to the Henderson, but who were not then admitted. All the subjects were diagnosed as psychopathic, sociopathic or personality disordered. As with earlier studies, outcome criteria of recidivism and hospital re-admission were used. At three year follow-up, 41% of the discharged patients were free of both admission and re-conviction, compared to 23% of the non-admitted group. At five year follow-up, the proportions were 36% and 19% respectively. Gender differences had little effect, with overall success rates for men of 36% at three years and 32% at five years and for women, 38% and 34% respectively. Further analysis of the data also showed that the success rate improved with length of stay. For example, 57% of those admitted for six months and 65% of those who stayed over nine months, did not re-offend or get re-admitted over the following five years, compared with a 19% success rate at five years for subjects who were referred but not admitted.

In one of the few studies that considers the effect of TC treatment upon psychological factors rather than recidivism or re-admission, Norris (1985) produced evidence that the majority of patients admitted to the Henderson benefit from the therapy they receive. Norris used a repertory grid technique to measure the psychological changes of 70 men and 33 women during their treatment at the Henderson, on parameters of self-esteem, percept of self, percept of ideal self, aspirations regarding rule-breaking and independence. After three-months, 60% of the patients were judged to be less rule-breaking, 75%
reported feeling more independent and 45% had increased self-esteem. Norris later found that the proportion of Henderson Hospital patients who had benefited from treatment was greater than in groups who had undergone treatment in a detention centre and a group in a voluntary trust community, although it is impossible to know whether these three groups were in fact comparable.

Similar psychological changes have also been found in patients who have undergone the TC regime at HMP Grendon. Gunn et al (1978), for instance, considered the psychological impact of therapy on 80 patients from Grendon, by comparing the MMPI scores they produced on admission with those produced just before release or after 15 months of therapy. A significant reduction was found in neurotic features, including depression and anxiety and in social introversion and hostility and those patients who completed the General Health Questionnaire within the same time scale, showed a similar decrease in pathology. The Grendon patients also exhibited a significant increase in extroversion and ego strength, as measured by the MMPI. Using semantic differential scales, the patients were also monitored for changes in attitude towards authority. The findings showed that the men’s evaluation of prison officers and doctors rose dramatically between occasions and that governors and police also improved their ratings significantly. From a clinical standpoint, the most important result was the increase in the men’s self-esteem after three months treatment at Grendon.

Recidivism research conducted with patients released from Grendon, has produced equally impressive results. A recent study carried out by Cullen (1992), for example, which followed-up 244 fixed-sentence patients released from Grendon, who had been at liberty for at least two years, found that a total of only 33.2% had been re-convicted. When groups were matched for offence type, sentence length and previous convictions, only 20% of those who had completed at least 18 months in therapy had been re-convicted within three years, compared with 40% of those who stayed less than 18 months. As was found in the study conducted by Copas et al (1984), recidivism rates were significantly lower for those who have been longer in therapy.

The rate of recidivism for patients discharged from the van der Hoeven Clinic, in The Netherlands is equally low. In an extensive study involving the follow-up of 517 patients released from the clinic between 1955 and 1980, van Emmerik (1987) found that the rate of recidivism for those who had been discharged for over five years was 52%. The recidivism rate was highest, however, among those who had transferred to other institutions, relative to those who had been conditionally discharged from the clinic. In a review of social outcome, it was also found that 63% of the conditionally discharged patients were in employment, compared with 30% of those who had been transferred.

As with so much of the treatment outcome research for psychopathic patients, most of the studies conducted with TC models are plagued with methodological shortcomings, including the inadequate use of controls, a lack of uniform criteria for improvement, short follow-up periods and an over reliance on the use of recidivism as a measure of long-term success. It is also important to note that because most therapeutic communities have developed their own personal schemes of management and selection, it is difficult to make comparisons between these models or to generalise from the findings of one setting (Dolan and Coid, 1993). The patients taken in by TCs can also be considered unrepresentative of the psychopathic population as a whole, because they are voluntary.

In spite of these shortcomings, therapeutic communities are receiving an increasing amount of support as the preferred models of treatment for psychopathic patients. It appears that the humane and democratic style advocated by these systems are deemed preferable to the punitive and degrading features of many custodial institutions (Blackburn, 1993). Nevertheless, this ideological and aesthetic appeal may be at odds with rehabilitative efficiency. On closer look at the data, for instance, there are a noticeably high number of reported incidents of attempted escape by psychopathic subjects living in this type of environment, as well as dangerous and life-threatening group behaviour. In an article by Feldbrugge (1992), on the van der Hoeven Clinic, it is admitted that psychopathic patients can abuse the freedoms they are granted within TCs and that cliques have developed among patients which then result in dangerous behaviour, such as the severe incident that occurred in the early spring of 1991, in which six unsupervised patients set fire to a couch and narrowly avoided killing another patient (Feldbrugge, 1992).

TREATABILITY
There is an argument that rather than being the fault of the treatment modality itself, it is the patient’s condition that is responsible for their lack of progress in therapy and the ‘untreatable’ nature of their underlying disorder that makes it impossible to reform. The ‘untreatability’ of psychopaths has been discussed at great length by clinicians. The features of the disorder that have given rise to this argument are described below.

**The threat of danger**
The perceived risk of danger presented by psychopathic patients is central to the argument that they are ‘untreatable’. A large number of psychopathic subjects will not, in fact, exhibit any violence during their stay at any one institution. Indeed, Monahan (1984) estimates that for every three patients detained by psychiatrists on the grounds of dangerousness, only one will subsequently commit a violent act and that the severity of a patient’s disorder is a poor predictor of their potential for danger. However, staff are put under a great deal of emotional pressure at times when violence does occur, because it is they who are often the focus of a patient’s anger and hostility (Faulk, 1994). A number of clinicians have described how their perception of this risk has encroached upon the clinical management of the disorder. Brett (1992), for instance, explains how in his experience at Broadmoor Hospital, the potential risk of violence often endangered the absolute confidentiality that is normally expected between patient and therapist. Similarly, Grounds et al (1987) have suggested that some members of staff find it necessary to use defence strategies, in the form of detachment and ritualistic task performance, in order to prevent potentially dangerous transference and counter transference relationships developing between themselves and patients. Unquestionably, the necessity for defences of this kind places an unnatural distance between members of staff and their patients, which may, in turn, affect the patient’s therapeutic progress.

**Deceit**
There is some concern among clinicians that a great many of the core characteristics of psychopathy make it very difficult for the therapist to develop a rapport with those suffering from the disorder. For example, psychopathic patients have been frequently found to lie about their behaviour, which may take the form of denying or minimising the seriousness of their offence, or even deceiving members of staff about their therapeutic progress (Blackburn, 1993). Indeed, the system as it stands, positively encourages deception of this kind among patients, because it may be the only means of them ensuring a release from hospital. However, the level of deception used by the patient becomes crucial at the point where therapy relies upon a trusting and open relationship between subject and clinician. In psychotherapy, for instance, helping the patient to breakdown their primitive defences and to verbalise their intimate and uncomfortable feelings, is a prerequisite of effective therapy, without which their therapeutic progress will be significantly curtailed.

**Poor motivation**
It is equally concerning that a number of clinicians have encountered psychopathic patients who lack the motivation to change or who refuse to believe that they need to. In his review of social skills training with violent offenders, for instance, Howells (1986) suggests that the practitioner soon encounters the patient who does not regard him or herself as deficient in certain skills and who judges their own behaviour as both effective and desirable. Antisocial patients usually only enter therapy under pressure from families or the courts and even among involuntarily detained patients, attendance may be erratic and dropout rates high (Blackburn, 1993). Although in cases of this kind, group therapy can provide a suitable option, patients have been known to passively resist therapeutic involvement or to deceive the therapist with superficial gestures of enthusiasm and self-awareness.

**The Treatment Environment**
When it is considered that psychopathy is a disorder directly related to how an individual interacts with his or her social environment, it becomes immediately apparent that the environment in which that patient is treated could have a crucial bearing on their rehabilitation. It has been suggested that psychopathic patients who are required to live in prisons or hospitals which are at odds with their normal social environment will find it difficult to apply what they have learnt in therapy to situations outside that institution. Grounds et al (1987) note, for instance, that in special hospitals there is little integration of the sexes and that patients are kept away from their families, alcohol and drugs, even though these play an important role in their psychological disturbance. Indeed, numerous studies have demonstrated that psychopaths are more likely than non-psychopaths to have lifetime diagnoses of
alcoholism or drug disorder (Smith and Newman, 1990) and that these conditions probably contribute to their violent and destructive behaviour. One would think that arguments of this kind would lend support to the use of therapeutic communities with psychopathic patients, but it seems that even this environment can pose problems for those suffering with the disorder. Indeed, Whiteley (1970) has pointed out that TCs are only appropriate for a certain, very carefully selected group of subjects and most particularly those who have demonstrated their ability to cope with competition from peers and who have a relatively high capacity for occupational and interpersonal achievement.

Factors associated with re-offending

A number of studies have been conducted which compare the rate of re-offending among discharged psychopathic patients with other mentally disordered offenders and which have also isolated the determinants of recidivism within this group of offenders generally. In a five year study conducted by Black (1982), for example, which examined male discharges from Broadmoor Hospital during 1960 and 1965, it was discovered that the best predictors of low rates of recidivism were having fewer previous psychiatric admissions and fewer previous criminal convictions, while being classed as a psychopath was a positive determinant of re-conviction. In his review of studies of discharged special hospital patients, Murray (1989) also identified younger age, shorter length of stay in hospital and absolute, as opposed to conditional discharge, as correlates of subsequent re-offending. Like Black (1982), he also discovered that re-offending is more likely to occur among those diagnosed with psychopathic disorder.

Although it is impossible to relate this research to specific treatment modalities, it has been suggested that such studies indicate that it is a patient’s pre-admission criminal record that is the best indicator of their likelihood to re-offend and that hospital treatment has little or no bearing on this occurrence (Grounds, 1987; Chiswick, 1992). It is equally possible, however, that this research also indicates the desperate need for mental health institutions to review the effectiveness of the treatment methods currently in use with psychopathic patients and that, at this point in time, this area of therapy is still in its infancy.

CONCLUSION

The general criteria for recommending the transfer or discharge of a mentally disordered patient who is serving a hospital order, is that there should be sufficient psychological change (either an amelioration of psychiatric symptoms, or personality difficulties), so that the patient no longer requires protection from the public (Grounds, 1987). The research on the treatment of psychopathic patients, however, suggests that those working with this group have experienced considerable difficulty in reducing the complex spread of psychiatric symptoms and core personality deficiencies associated with this disorder.

Arguably, the research material in this area is scarce and of poor methodological quality, with few experiments using controls and adequate follow-up periods and too many relying upon recidivism statistics as a measure of success, when these are notoriously inaccurate. It has also been difficult to make comparisons between the different studies carried out in this field, because so many of them use different diagnostic criteria for their subjects and monitor their progress with incompatible assessment devices. Undoubtedly, therefore, there is an urgent need for well controlled, long-term treatment outcome research to be conducted in this area.

In spite of these shortcomings, it is easy to see from this research, and from what we know about psychopathy generally, that patients with the condition present clinicians with an unusual number of treatment difficulties. Indeed, psychopathic patients have been reported to lie about their behaviour, to minimise its seriousness, and to deceive therapists about their therapeutic progress. Although it is important not to make generalisations about patients, psychopaths have acquired such a poor reputation for themselves throughout the mental health system, that hospitals are now refusing to take them, on the grounds that they are ‘untreatable’. Some believe that the nature of the psychopathic condition is such that clinicians can not be expected to change the behaviour of those suffering with the syndrome. Arguably, psychopathy is characterised by behavioural features which, in themselves, imply the failure of the individual to respond to normal sanctions on his or her behaviour. If others have failed to effect change in the individual, perhaps then it is unreasonable to expect psychiatrists or psychologists to be able to do so.
Arguments of this kind are at the root of concerns that it is unethical to keep a psychopathic patient on an indeterminate hospital sentence, when the condition attached to release is the amelioration of their disorder. Indeed, the system as it stands has encouraged a high level of deception among psychopathic patients, who are aware that if they fail to demonstrate improvement in their psychiatric symptoms, they will languish in hospital for a far longer time than would be demanded by legal punishment for their offence.

It is suggested that although patients with the condition have psychopathology from which they suffer and should continue to be offered treatment, compulsory detention in hospital is not the appropriate way of carrying out this task (Grounds, 1987). Dell and Robertson (1988), for example, suggest that legal psychopaths should go to special hospitals only as voluntary patients and after they have been sentenced. If voluntary admission was implemented, hospitals would not be constrained to keep a patient simply because of public safety considerations and they would probably also receive better motivated individuals. Grounds (1987) and Chiswick (1992) make a similar point, arguing that if treatment is to be considered with psychopathic patients, then the preferred route is by transfer to hospital during the course of a prison sentence, which would be followed by return to prison shortly before the sentence is due to terminate. An alternative to this could be the development of more long-term treatment programmes for psychopaths inside prison settings. Either way, a system which involved greater communication between hospitals and prisons, would be far more suited to the psychopathic offender.

The difficulties encountered during treatment with psychopathic patients have partly been the fault of a lack of agreement about the aetiology of the disorder and the fact that it is defined by incompatible legal and psychiatric systems. This has meant that without proper assessment of patients diagnosed with the condition, it has been extremely difficult for clinicians to formulate an appropriate treatment programme for them. Patients within this group obviously exhibit a wide range of symptoms in varying degrees of severity, which need to be identified and targeted by the clinicians concerned.

It is possible, therefore, that if better methods of assessment were used with psychopathic patients, more effective programmes of treatment could be found for individuals suffering from the disorder. Indeed, even though no one method has been found universally affective with psychopathic patients, some patients do at least show improvements when the right treatment is identified for them. For this reason, it would also be more appropriate to use a combined and long-term treatment approach with those suffering from the disorder. Although traditional models of treatment are based on the assumption that one form of therapy can be administered to a patient for a certain period, after which time the problem is eliminated (Dolan and Coid, 1993), psychopathy clearly does not respond to this type of intervention and requires multiple methods over a long time span. In fact, one of the more positive findings of the research conducted in this area, was that longer periods of therapy often produced better results in psychopathic patients.

Effective after-care might also be helpful for psychopathic patients. Indeed, it is extremely important to make sure that the patient is able to transfer what has been learnt in therapy to their day to day encounters, and not just to assume that this will happen. In fact, follow-up research has shown that even if some degree of psychological change can be produced in therapy, this is not always maintained beyond release.

Most would agree that not all psychopaths can be deemed untreatable, until all methods of psychiatric intervention have been tried with this group. It is surprising, however, that little in the way of preventative methods have been tried with those suffering from the disorder. This is in spite of the fact that both the DSM-IV and ICD-10 regard psychopathy as a longitudinal condition, which usually manifests in childhood. This implies that psychopathic symptoms are detectable before the condition gets to the adult stage and that it might be possible to treat predispositional signs in childhood or adolescence before they have had a chance to develop. Indeed, there is a growing amount of evidence that childhood conduct problems are related to adult psychopathy. Robins (1978) and Epwright et al (1993), for example, have found that conduct disorder in childhood can predict a high level of antisocial behaviour in adulthood. Similarly, Hechtman et al (1991) have found that those who persist with attention deficit hyperactivity disorder through adolescence, have a higher risk of developing antisocial personality disorder than those who remit. Undoubtedly, this area of research requires further investigation before psychopathic disorder can be deemed untreatable.
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