Renewed Passion and New Methods in Forensic Mental Health

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Keynote Address:

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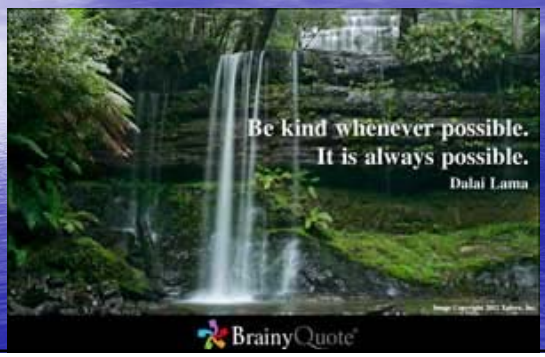
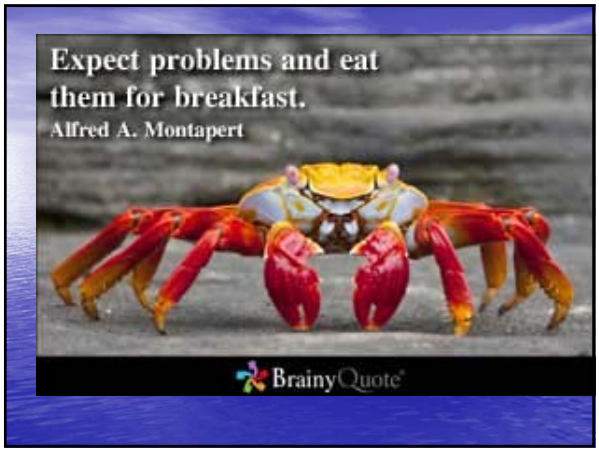
BE KIND





FORENSIC MENTAL HEALTH

- Do you know what it is? I do not know what forensic mental health is; but I love it!

Law and Mental Illness

- They are intertwined inextricably like two snakes

Forensic Assessments

- Science of Psychology/psychiatry assisting legal determinations
- Loyalty of the forensic examiner is to the truth and not to the defendant or prosecution.
- The forensic examiner is “disinterested” in the outcome.

Mental health provider in a forensic context.

- The loyalty is to the patient.
- Focused on the best outcome in terms of the welfare of the patient as well as the welfare of the society

How do you resolve the conflict?

- Can you separate “objective” assessments from empathic stance of the mental health provider?
- We have not resolved this issue.

Inherent conflicts

- Legal requirements and demands of justice
- Welfare of the society and political pressures
- Welfare of the individual

How do you change the culture?

- it easier to buy a gun than to get an appointment with a psychiatrist
- We incarcerates mentally ill people

Instead of treating them (one in five in prisons have a recent history of mental illness)

SAVE THE CHILDREN

- 15 million children suffer from a diagnosable and treatable mental illness
- 20% of children between 13 and 18 experience severe mental illness
- 7/10 in juvenile justice system have at least one mental health disorder

Mentally Disordered Offenders

- Declare them guilty and send them to jail, as they enter the system
- As they are about to leave the criminal system, after having served their time, they are held back saying that they are mentally ill and dangerous
- They spend their time at the State Hospital fighting the system instead of attending to their treatment

Two fundamental questions?

- How do we care?
- How do we teach the forensically committed person to care?

A cleaner and meaner approach?

- Can we completely separate Forensic Assessment from Forensic care?
- Can we change the way we care for the forensically committed patients?
- Can we become genuine advocates for the forensically committed patients and protect the society at the same time?

Reform the State Hospital System

- Recent attempts at reform
- DOJ and the aftermath
- A refusal to change the treatment approach
- How we refuse to change the culture
- Profound leadership problems

PRISONS INSTEAD OF HOSPITALS

- "What America has done in dealing with people with mental illness is so far short of what should be doing. America has replaced its psychiatric hospitals with prisons.." (Rep. Tim Murphy, Chair of House panel seeking mental health reform)

Forensic mental health system has a personality problem!

- A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early childhood, is stable over time, and leads to distress or impairment" (DSM-IV-TR. P.685)

How do we help the forensic patient to care?

- To care for themselves
- To care for others and the society at large

Sociopathy and Violence

- People suffering from mental illness are not naturally violent
- Violence is a major source of forensic involvement
- Antisocial stance is a major source of violence; not mental illness per se
- What are sources of violence among the mentally ill?
- Prevention of violence will reduce forensic commitments.

Can we treat Antisocial Personality Disorder?

- YES!!
- "the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment" (Allport, 1937, p.48).
- personality is the enduring, internal organization of personal experience and the resulting stylistic adaptations by the individual

The factorial and Dimensional model

- Several constitutional and psychosocial diatheses of ASPD have been identified such as autonomic and reticular arousal problems, attention deficits, cortical disinhibition, impaired functioning of prefrontal cortex, septal nuclei, and hippocampus, early attachment deficits, parental sociopathy, improper discipline, etc. as precursors of adult antisocial personality structure (Baker, Jacobson, Raine, Lozano & Bezdjian, 2007; Krampen, 2009).
- The factorial and dimensional approach has been found to have high clinical utility (Widiger & Mullins-Sweatt, 2010). The trait-based theories of personality arose in the factor-analytic tradition; and because of its mathematical and empirical base, are viewed to be trans-theoretical and trans-cultural ((Lynam & Widiger, 2007; Lowe & Widiger, 2009).

The factorial model

- Perhaps the most prominent dimensional model of personality is the Five Factor Model (FFM) (Block, 1995; Briggs, 1992). This model incorporates some elements of Eysenck's three factor model (Eysenck & Eysenck, 1970). The FFM identifies five inherent dimensions of all personality: neuroticism versus emotional stability, introversion versus extroversion, closedness versus openness, antagonism versus agreeableness , and disinhibition (impulsivity) versus conscientiousness . Costa & McCrae (1992, 1998) reported substantial convergent and discriminant validity for the FFM. The description of the Antisocial Personality Disorder in DSM-IV-TR is consistent with the Five Factor Model (Lynam, Miller, Widiger, Gaughan, Miller & Mullins-Sweat, 2011).

Utilizing the FFM, the antisocial personality structure may be prominently characterized by extroversion, antagonistic (un-empathic) interpersonal stance, inflexibility, and impulsivity.

Psychoanalytic model

- severe superego-defects. The super ego is underdeveloped and pathologically subservient to the self-serving impulses of the id, demonstrated through a general disregard for social and moral norms and through behaviors that are impulsive, excitement seeking, predatory and non-empathic.
- Defenses of externalization, projection, denial, rationalization, etc., are copiously used to repress any anxiety that may be provoked by improperly developed superego.

As a result of repeated experiences of abuse, neglect, trauma with little or inconsistent experiences of genuine nurture, the child internalizes a position that no one really cares; and if at all, it is unpredictable and therefore, must be exploited without delay.

- Additionally, the reluctant or "sterile objects" are seen as means to a self-serving end and projectively identified with hostile affects (Martens, 2008).
- The responsibility for misbehavior is almost entirely externalized. Little internal conflict and anxiety is consciously experienced with regard to self or one's behavior.
- Aggressive "Acting-Out" is used as a protective defense against anxiety (Millon, 1987). "Turning Against Others" is another Defense Mechanism employed by the antisocial personality style (Ihilevich & Gleser, 1986; Berman & McCann, 1995).

A New Developmental and Psychodyanamic Theory

- Antisocial Personality Structure is the result of a stunted internal development of an essential Psychodynamic and cognitive process
- The misunderstanding regarding "empathic deficiency"

Empathy

- Empathy is the subjective experience of sensitively understanding an object and vicariously being moved by the experience of the object
- Empathy has three components:
  - Cognitive
  - Affective
  - Vicarious caring

Three aspects of empathy

- Cognitive Empathy
  - To know and become aware of the object's thoughts, feelings, and experiences
- Affective Empathy
  -to feel in oneself what the object is feeling and experiencing.
- Caring Empathy
  -Moves the subject to experience care for the object, by vicariously experiencing what the subject is perceived to be going through.

Caring Empathy

- Moves the subject to experience care for the object, by vicariously experiencing what the subject is perceived to be going through.
- Caring empathy = sympathy
  -"affinity, association, or relationship between persons or things wherein whatever affects one similarly affects the other" Merriam Webster

Is it possible to experience the first two without experiencing the third?

- Yes!
- The antisocial person's self-serving observation of his victim is replete with cognitive empathy.
- Affective Empathy may or may not be present in ASPD
- The knowledge and awareness of the feelings of the object, do not lead to caring for the welfare of the object.
- Emotional Detachment and shallow affect
- Glibness and apparent caring.

Origin of Deficiency in Caring Empathy

- The adaptive significance of the antisocial personality style is derived from the capacity to assess and utilize the object in a self-serving manner in a world perceived as essentially hostile (Millon, 1996)
- Question: Is it adaptive?
- Yes, in a combat situation
- No in the context of productive societal living.

Primary Defenses in ASPD

Projective Identification

Externalization

Self-serving behavioral activation

Projection, the mental process of contacting, checking and verifying interpersonal reality

Projection starts with the awareness of the other, generating a hypothesis arising from internal categories (Kant).

- Is it threatening or friendly?
- Is it nurturing or harmful?
- Is it pleasurable or painful?

Projection is either confirmed or negated

- Either through feedback
- Or through internal need-structure, previous experience
- "Sibi simile cognoscitur" or "ad modum percipientis"
- Projection is followed by Introjection
- Projection as a defense

Projective Identification

- PI is the defensive process of unconsciously perceiving the hated aspects of oneself in another and rendering the object as the persecutor
- The subject unconsciously induces the object to experience and even act out the projected negative affect, and thus confirming the projection as an "objective" fact.

Failure of Introjection

When the subject is fixated at the PI level, the subject remains extraverted and pathologically fixated on the other. Introspection is thwarted.

One perceives what one has "decided" to perceive. Assimilation and no Adaptation.

An opaque and withholding response to the demands of the subject to relate to others is thwarted, thus confirming the projected hostility as true.

Projective Identification vs. Paranoid Delusions of Persecution

- Antisocial perceives the object not only as hostile and persecutory but also sees the object as an exploitable source of self-nourishment. The hostile projection renders the object not worthy of sympathy
- Paranoid person perceives the object simply as hostile and harmful; either wishes to destroy the object, be careful and avoidant.

Externalization

Externalization is the self-protective attribution of causality and responsibility to the other for the unwanted events and feeling in self.

- Externalization stems from two sources:
- Extraversion
- Projective Identification

Reactive Sociopathy

Reactive sociopathy develops in the absence of an experience of the gift of sacrificial care, which initially manifests as the capacity to "mirror" and "hold" (Kohut and Winnicott

"No one cares," is the perception, regardless of the reality of the situation.

Behavior Activation

- Behavior activation is the self-serving acting out against others (Berman & McCAnn, 1995)
- Arises from interpersonal antagonism and impulsivity
- Active Independent Stance (Millon, 1996)

"My lunch is in the hands of the one who hates me; I must grab it as soon as possible"

Summary

Caring Empathy deficit in ASPD is dynamically explained primarily in terms of PI,Externalization and Acting out against others.

In ASPD what is lacking is primarily sympathetic (caring) empathy and partially affective empathy. Cognitive empathy may be utilized as a starting point in psychotherapy.

Psychotherapy of ASPD

- Traditional Strategic Psychotherapy
  - -establish behavioral control
  - -focus more on the needs of others
  - -inhibit impulsive behavior
  - -cooperate with others
  - -take personal responsibility
  - -appreciate consequences of behavior
  - -alter deviant cognitions

-behavioral control does not necessarily change structural problems
-behavioral control may be possible in a highly structured setting
-teaching empathy to ASPD is the same as teaching a pig to sing!
-cooperate with others, yes, in a self-serving situation
-ASPD does not care about consequences other than what happens to them
-cognitions change without experience

Assessment

- 1. Arousal and related organic problems
- 2. Antisocial cognitive schema
- 3. Interpersonal antagonism (disagreeableness)
- 4. Impulsivity and dis-inhibition (Behavioral activation without appreciation of behavioral consequences)
- 5. Serious difficulty taking personal responsibility (externalization)
- .
- 6. Dissocial Affect (empathic difficulty)
- 7. Improper regulation of negative affects (anxiety, depression, anger...)
- 8. Rigidity and lack of psychological minded-ness (lack of openness to change)
- The treatment goals directly depend on the assessment of these dimensions

Therapeutic Strategies:

#1:Therapeutic contract and temporary behavioral control

- A pre-condition to successful psychotherapy is to establish adequate behavioral controls while in psychotherapy so that the individual's behavior does not interfere with the psychotherapeutic process. This may appear like an impossible dilemma. If the person can stop acting out, he would not need the therapeutic intervention; if he keeps acting out, psychotherapy cannot be accomplished! This is a false dilemma in that the opposite is true. The person may stop acting out, as he/she does have the therapeutic assistance. The goal obviously is that once the person completes the therapeutic process he/she will be able to maintain socially adaptive behavior.
- This is particularly true of inpatient settings, such as in State Forensic Hospitals. In a structured setting, as pre-condition to starting psychotherapy, the individual can successfully maintain a therapeutic and contractual obligation not to act out. Such a contract can be and need to be established at the outset once the rapport is well established. An informal observation of more than 75 individuals with ASPD diagnosis entering into such therapeutic contracts (Malancharuvil, 2011) indicated that the patients indeed did maintain fidelity to remain free of violent behavior during the psychotherapeutic course lasting six months or more

#2: Deliberate empathic approach

- Being aware that the lack of empathic abilities of ASPD provokes counter-transference of not wanting to be empathic with the client, the therapist deliberately adopts an empathic approach. In order to be empathic with the antisocial client, the therapist has to focus on the personhood of the client, beyond the behavior. The socially expected approach is to focus on the antisocial behavior, which could very well be one of the reasons for negative therapeutic results (Beier,1966)..

A therapist who adopts the theory that ASPD clients are "bad seeds" and cannot be rehabilitated may have an ethical obligation in not engaging in therapy with them. Such therapists start the relationship with a negative and relatively hopeless judgment about the very being of the client. Additionally, such an attitude reinforces the client's cognitive schema that no one cares for him and that he must fend for himself

Empathic Approach

- In order to be successful, it is imperative that the therapist believe in the possibility of helping the client (Norcross, 2002; Lively, 2005). It is part of the empathic connection with the client that the therapist adopts consciously a hopeful and caring attitude (Shamasundar, 1999).

- An empathic therapist creates a crucial modeling experience for the ASPD client and utilizes this experience as a deliberate tool for teaching what it means to be empathic. Individuals with ASPD are found to be keenly sensitive and are aware of those under their observation. (Jones, Happe, Gilbert, Burnett & Viding, 2010; Cima, Tonnaer & Hauser, 2010). ASPD has a deficit in the ability to feel sympathy than to have empathy. At the heart of psychotherapy with persons with ASPD, is giving an opportunity to experience what it means to be cared for, for their own sake. The wisdom that empathic and caring abilities stem from personal experience of being nurtured is highly relevant. One gives what one has received. (Wampold, 2007; Shedler, 2010)

Paranoid-schizoid position.

- The ASPD person also does not respect the autonomy or free agency of another human being and lacks intimacy with the other. In Kleinian terms the ASPD person is stuck at the "paranoid-schizoid" position (Klein,1957). It is in this context, the therapist deliberately decides to communicate genuine care for the individual. The crucial question is how this nurturing experience can be given in a psychotherapeutic setting to the ASPD client who is exploitative and abusive.

- The counter-transference of hopelessness and hostile feelings towards the person afflicted with the APD tends to further destroy the therapeutic alliance. The therapist reacts with a futile attempt to teach the patient empathic skills and caring attitude which is glibly rejected by the patient who takes no responsibility for himself, creating a vicious circle of mutual rejection and premature termination of the therapeutic undertaking. Cleckley (1955) suggested that sociopathy is characterized by an "absolute" incapacity for object-love

Deliberate Empathic Approach

- In successful clinical settings, it has been repeatedly demonstrated (Salekin, 2002; Malancharuvil, 2011) that individuals with an antisocial stance of "no one cares" did find out that they were indeed cared for much more than they had actually acknowledged consciously. This emphasis on finding grains of gold in a stack of abusive thistles is a powerful therapeutic strategy for restructuring the antisocial stance.
- When some of these individuals come to realize that they had failed to register or unconsciously buried the experiences of being cared for, they genuinely demonstrate an emotional "melt down" and break down in to tears. When such events happen, the therapeutic relationship itself is viewed as one of the most caring experiences by these individuals. Obviously this is not an invitation to be naively victimized and exploited by the individual.

Empathic Experience

- A positive projective identification, in which the self identifies positive feelings in the object, is a pre-condition to developing compassion and intimacy (Shamasundar, 1999). Projection is mitigated by introjection (Martens, 2008). Such introjection is achieved by getting the client to experience at least some (even one) objects as caring and nurturing. This may be resisted by the client by introjecting the object as "useful". The object needs to be perceived as more than "useful". The goal is to assist the client to experience the object as a person who cares, and eventually, as an autonomous agent in the context of an "I-Thou" relationship. This idealistic vision may be seen as unrealistic and unattainable for the ASPD. Clinical experience of those who worked with this dynamic understanding tells otherwise (Salekin, 2002; Martens, 2008).
- **Pay attention *first* to the "selfish needs" of the client instead of focusing on caring for others.**

Therapeutic Strategy #3 &4

- **Know that "adults do not change, but children do."**
- **Pay attention to the slow-moving affects.**
- Individuals with ASPD are clinically observed to be deficient in experiencing as well as dwelling on slow-moving affects, such as sorrow related to object loss and the resulting melancholy, remorse, loneliness, grief, etc. These individuals are known to express readily the fast moving emotions such as anger, excitement, overt hostility, feelings of revenge, etc. The fast moving feelings defend against the more vulnerable, slow acting, and deeper feelings. The therapist will be tempted to deal only with the easily accessible feelings of anger and hostility. Such an approach to the neglect of the deeper feelings could eventually sabotage successful restructuring of the personality style. In order to access the isolated, slow-acting emotions, the individual is helped to relax and regress to these early experiences through the anamnesis. The focus is not so much on the events per se, but their emotional, cognitive, and attitude-generating significance.

Strategy#5 & 6

- **Attacking the rigidity of the personality style**
  - After establishing the rapport and setting up the expected guidelines of the psychotherapeutic process, the therapist sets out to mitigate the underlying rigidity of the experiential-structure and resistance to change. A frontal attack is unlikely to be productive. For the ASPD afflicted person, this may be achieved through an invitation to a new and exciting experience, which requires on his part some switching of gears.
- **Longing to be loved and teaching to love**
  - -The ASPD style has repressed the inherent longing of being loved as well as the need to experience loving others (Cleckley, 1955). As they have projectively identified the undesirable feelings of hostility, hurt, and anger with the objects, they cannot expect these objects to love them (Klein, 1955).

The need to be loved

- Cleckley (1955) stated that the anti-social personality demonstrates an almost "absolute"(Cleckley,1955) "incapacity for love". Can the ASPD person experience the joy of receiving and giving love? Can this capacity be initiated or enhanced through a psychotherapeutic process? The vast majority of studies of ASPD (based on a search of several data bases) do not address this issue.
- Apart from the philosophical issue of whether human beings inherently are constituted to experience both the receiving and giving of love, from a dynamic point of view, experience of love is activated with the introjection of a nurturing, pleasurable and loveable object, starting with the soft, cuddly and nourishing mother. This absolutely necessary and unconscious introjective process is disrupted with deprivation, abuse, as well as organic processes in the ASPD.

The need to experience love

- **Reinforcing and cultivating the experience of receiving love and affection**
- The starting point is to help the client to grasp the value of love. This is achieved by connecting with the feelings of anger, and more importantly the loss and deprivation and the resulting sadness. The sense of loss and deprivation necessarily points to their conditions of possibility which is that if one never needed or desired love there will be no feelings of loss or deprivation in this regard. This may be a subtle deduction, and may need to be translated experientially.
- It is possible, as has been shown in actual clinical settings, to move the patient from a sense of loss to the appreciation of the need for the object. When an empathic therapist reminds the patient to what would have been if there were unconditional love and acceptance in their developmental years, the client is likely to contemplate it. In other words, start with the appreciation of the need or usefulness of the object, proceed with the value of being loved *by* the object and allow the patient to become tender by imagining receiving the love, leading hopefully to a longing to be loved (Gawda, 2008).

Teaching to love

- **Teaching to care for others**
- This is the most difficult aspect of working with the ASPD. The very language of the ASPD person is problematic (Gawada, 2010). Once the foundational work of relating to oneself with empathy and compassion and the longing to be loved for one's own sake is sufficiently consolidated, it is possible to introduce meaningfully the experience of caring for others. Obviously, if the ASPD person learns to love, his experience of life itself is transformed thereby creating an internal structure that is antithetical to ASPD.
- While many clinician and researcher are skeptical of such an outcome, individual clinicians may attest to the possibility of such an achievement. Given the prejudice that this cannot be done, if success is achieved, the temptation is to discount it by saying that the original diagnosis was not correct to start with or that the change is only temporary. In many ways the persons afflicted with ASPD are the modern lepers of the psychiatric world, and very many of them are removed from the society to colonies of prisons.

The hope!

- The hope for anti-social personality structure to be restructured needs to be kept alive as there are more than six million individuals in the United States alone who suffer from this malady. The whole society pays a heavy price. The prisons and State mental hospitals are heavily populated with people who are afflicted with ASPD. Psychotherapy has been found to be a highly effective tool in many other settings (Wampold, 2007; 2010).
- Psychotherapy with ASPD has not been conclusively demonstrated to be effective. Hopefully, this article will stimulate additional research in this important issue.

Thanks for listening & Participating

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BE KIND
Be kind whenever possible.
It is always possible.
Dalai Lama
BrainyQuote

Reducing violence among forensically-committed individuals in state-run psychiatric hospitals: Moving towards an integrative solution.

Joseph Malancharuvil

Violence in state-run inpatient psychiatric hospitals is a vexing and complex problem that is gaining attention from consumer advocacy groups, from governmental oversight agencies, and from the scientific community. The task of keeping individuals violence-free while they are being treated precisely for their proneness to violence is demanding and obviously complex. Violence not only tends to breed violence among the individuals being treated, but also may provoke violent counter-transference reactions in the staff. Individuals who are committed against their will to a state-run mental facility have a right to receive treatment in a nonviolent and secure atmosphere (Civil Rights of Institutionalized Persons Act, 1997). Forty-five percent of staff injuries at certain psychiatric hospitals are directly attributed to patient-to-staff violence (Beech & Leather, 2006; Johnson, 2010). There is increasing evidence that psychiatric inpatient violence can be managed and reduced substantially through committed and comprehensive approaches. The currently available projects and proposals address mostly aspects of the problem. An integrative and comprehensive approach is needed. Such an approach needs to include assessments, proactive and preventive measures, effective post-incident interventions, and ongoing program evaluation. Informed by the current literature, this article brings together aspects of violence-reduction proposals into a comprehensive and pragmatic approach that is directly applicable to psychiatric nursing in forensic settings.

Rationale for Violence Prevention Programs

Inpatient violence in psychiatric hospitals, especially in state-run facilities is a serious risk to healthcare workers (Winstanley & Whittington, 2003; Beech & Leather, 2006; Johnson, 2010). Individuals who are committed against their will into psychiatric hospital have a civil right to be protected from violence and harm (CRIPA, 1997). Individuals with severe and persistent mental illness are extremely susceptible to perceived threats of violence and breaches in security. Violence perpetrated in psychiatric wards severely interferes with the therapeutic milieu and the recovery process. The use of restraints, seclusion, or intrusive supervision, such as one-on-one supervision, creates a paradoxical situation whereby the very measures employed to protect individuals further aggravate the psychiatric conditions that provoked the aggression in the first place . Early evidence clearly indicates the importance of establishing a formal violence prevention program as an essential condition to reducing inpatient violence (Carmel & Hunter, 1989; Cooper & Mendoneca, 1991; Stevenson & Otto, 1998; Love & Hunter, 1998; Khadivi, Patel, Atkinson & Levine, 2004).

Summary Review of Current Literature

Types and Sources (Causes) of Violence

A review of published articles (utilizing several sources, including PsycINFO, Psychiatric literature, STAT!Ref Nursing, PUBMED, etc., 1980 to present,) on this subject points to the fact that violence among an inpatient psychiatric population is a multi-factorial and highly complex phenomenon in terms of risk assessment, predictability, process, causal analysis, and preventive and intervention strategies. In

addition to the traditional subdivision of violence into three broad categories of impulsive, instrumental (organized), and affectively driven (Bushman & Anderson, 2001; Nolan, Czobor, Roy, et al., 2003), literature, as well as clinical experience, suggests that several factors can be identified as the sources of violence among psychiatric patients (Fullam & Dolan, 2008; Ryan et al., 2008; Serper, Beech, Harvey, et al., 2008; McDermott, Edens, Quanbeck, et al., 2008; Quanbeck, McDermott, Lam, et al., 2007; Volavka, 1999). A theoretical model of the sources of violence among psychiatric patients may be conceptualized as follows:

(**INSERT FIGURE-1 HERE)**

1. Neuro-biological (e.g., Organic Brain Syndrome, specifically frontal lobe dysfunctions, limbic epilepsy, substance abuse, etc.)
2. Psychotic processes (e.g., command hallucinations, persecutory delusions, internal distress, mania, especially with psychotic features, fear response, etc.)
3. Instrumental violence (e.g., sociopathic dynamics of self-serving manipulation, intimidation, excitement, revenge, etc.)
4. Maladaptive and learned behavioral patterns where aggression is repeatedly reinforced as a preferred behavior to achieve certain goals
5. Environmental factors that breed and reinforce violence (e.g., crowding, noise, oppressive atmosphere, staff attitude, peer pressure such as coming from gang affiliation, bartering, borrowing, gambling, etc.)
6. Combination of factors (e.g., psychopathic individual with psychosis in a gang infested atmosphere)

A meta-analysis of over 200 studies reveals that violence is strongly associated with psychosis and its accompanying symptoms (Douglas, Guy & Hart, 2009). An earlier study by Nolan et al. (2003) suggested that 20 percent of the violent acts were directly attributed to psychotic symptoms. However, a more recent study reported that after analyzing 839 acts of inpatient assaults, 71% of the assaults were attributed to the combined contribution of impulsive (54%) and psychotically-driven (17%) dynamics (Quanbeck et al., 2007). Twenty-nine percent of the assaults were attributed to instrumental ("organized") violence. Several static factors such as gender, history of violence, and being unmarried, along with several environmental factors such as crowding, time of day, attitudes of staff, (non)therapeutic atmosphere of the wards (rule-bound, rigid, non-supportive), staff-to-patient ratio, certain antecedent events (setting events), reinforcing contingencies, etc., have been found to have positive correlation with violence on the wards (Flannery, 1994; Steinert, 2002; Woods, 2007, etc.). It is interesting to note that psychiatric patients view interpersonal aggression in psychiatric wards as largely due to internal factors, interpersonal stressors, including abusive and verbal expressions by peers and staff (Fagan-Pryor, Haber, et al., 2003; Crowner, Stepcip, et al., 1995; Duxbury, 2002).

Prediction of Violence

Early methods and psychometric instruments were notoriously impotent to improve predictability of violence beyond chance (Monahan, 1983). In the last two decades some progress has been made in this regard (Flannery, 1994; Steinert, 2002; Watts, Leese, Thomas, et al., 2003; Doyle & Dolan, 2006; Abderhalden, Needham, Dassen, et al., 2006; Daffern, 2007; Kennedy, Bresler, Witaker, et al., 2007). A 2004

study by Grevatt, Thomas-Peter, and Hughes of VRS-2 (Violence Risk Scale, 2001) and HRC-20 (Historical Clinical Review, 1997) concluded that they did not predict inpatient violence within the first 6 months of admission. It is interesting to note that the study pointed out that "imminent, repetitive violence" was mostly predicted by dynamic factors, specifically "lack of insight" and "active symptoms of mental illness," rather than static factors. In addition to these, several static factors such as gender, history of violence, and being unmarried, along with several environmental factors such as crowding, time of day, attitudes of staff, (non)therapeutic atmosphere of the wards (rule-bound, rigid, non-supportive), staff-to-patient ratio, certain antecedent events (setting events), reinforcing contingencies, etc., have been found to have positive correlation with violence on the wards (Flannery, 1994; Steinert, 2002; Woods, 2007, etc.). The most significant dynamic factors predictive of violence are current substance abuse, organic brain syndrome, psychosis, bi-polar disorder, specifically mania with psychotic features, intermittent explosive disorder, and cluster-B personality characteristics, specifically sociopathy. Appropriate risk-assessments have become a pre-condition to initiating interventions with violence-prone individuals.

Intervention Strategies

Varied intervention strategies have been tried over the years with mixed success. Psychopharmacological algorithms have been proposed and found to be partially successful in reducing the incidence of violence (Citrome, 2007; Crowner, 2000; Simon & Tardiff, 2008; Marder, 2006). Cognitive-behavioral approaches, especially the newly emerging support system called Positive Behavioral Support, are frequently applied to

treat violence-prone individuals. The Positive Behavioral Support is a system-based and cognitive-behavioral approach in which adaptive, replacement behaviors are cultivated to render the maladaptive behavioral patterns irrelevant and useless. There is emerging evidence that suggests that specialized clinics that assist violence-prone psychiatric inpatients can be an effective way to prevent violence among psychiatric inpatients (Table 1) (Malancharuvil & Williams, 2007).

(**INSERT TABLE 1 HERE**)

Results are mixed for specialty wards housing only violence-prone individuals. For example, several problems have been noted to arise in such wards, such as difficulty of recruiting and retaining nursing staff and the high clinical acuity of the atmosphere. Dialectical Behavioral Therapy units have been tried with initial data showing promising signs (Barley, Buie, Peterson, et al., 1993). Creating a non-violent culture both among staff and individuals being treated was found to be one of the crucial environmental factors that would reduce the incidence of violence in a psychiatric ward.

Strategies for Dealing with Violent Behavior

In a psychiatric inpatient setting, especially in state hospitals, strategies for dealing with violent behavior may be broadly subdivided into two essential domains: I) preventive and pro-active processes and II) post-incident interventions.

I. Preventive and Pro-active Processes

A. Risk assessments for inpatient violence at the time of admission. Forensic mental hospitals primarily admit individuals with a history of interpersonal violence stemming primarily from the dynamics of psychiatric conditions.

Traditionally they include individuals declared by the court as “not guilty by reason of insanity,” “mentally disordered offenders,” “incompetent to stand trial,” “returned from parole,” “incarcerated individuals with acute exacerbation of mental illness,” and sexually violent predators. One of the priorities at the time of admitting as well as at the time of release of these individuals is to assess them for violence-risk. However, a highly specific risk-assessment that determines the potential for in-hospital violence is also required. Such an assessment prompts the treatment teams to plan and institute the appropriate and preventive interventions. Several psychometric instruments have been recommended such as HCR-20 (Historical Clinical Review, 1997), PCL-R, PCL:SV (Psychopathy Check List), LSI-R (Level of Service Inventory-Revised), VRAG (Violence Risk Appraisal Guide), VRS-2 (Violence Risk Scale, 2001), START (Short-Term Assessment of Risk and Treatability), BVC (Broset Violence Checklist), DASA:IV (Dynamic Appraisal of Situational Aggression: Inpatient Version), OAS (Overt Aggression Scale), Actual Assault Scale, etc. (A somewhat comprehensive analysis of the utility of these instruments is provided by Michael Daffern (2007) (see also Abderhalden, Needham, Dassen, et al., 2008)). Obviously no single psychometric measure can accurately predict inpatient violence. A combination of findings should lead to a valid clinical judgment in this regard. Such a clinically determined prediction is geared towards developing meaningful preventive interventions. When it is obvious to the clinician at the very outset that there is real potential for violence, interventions should be

initiated without delay. The findings from such an assessment at the admission process could have a positive effect on the patient by developing a critical awareness and mind-set that violence is taken very seriously and not an acceptable form of behavior. Approximately 12%–18% of the newly admitted inpatients in California state hospitals are assessed to be individuals who malinger psychotic or other related symptoms, primarily to avoid criminal prosecution and/or incarceration. Some of these individuals carry an additional diagnosis of Antisocial Personality Disorder which is one source of violence, particularly instrumental violence. Assessing these individuals early and referring them to a more appropriate setting such as county jails would reduce a significant portion of violence.

B. Psychopharmacological algorithms. The contribution of psychopharmacological agents to manage and treat psychosis and agitation is obvious. Several psychopharmacological algorithms have been proposed to treat violent psychiatric patients (Corrigan, Yudofsky, and Silver, 1993; Crowner, 2000; Simon & Tardiff, 2008). Haloperidol is the most commonly used anti-agitation intramuscular antipsychotic. Side effects such as acute dystonia, akathisia, and tremors make high-potency medications problematic. Lorazepam is often administered along with high-potency neuroleptics to improve sedation as well as to protect against acute dystonias and to reduce akathisia. The symptomatic use of beta blockers, Benzodiazepines and typical neuroleptics are effective mostly on a temporary basis (Crowner, 2000). Studies have shown that Risperidone was effective in reducing scores on a

hostility scale as well as incidence of violent inpatient behavior (Hirose, Ashby, & Mills, 2001). Droperidol is not advisable any more because of the QT prolongation ("black box" warning in the U.S.). Several newer medicines such as Ziprasidone, Olanzapine and Aripiprazole have a lower risk of extra-pyramidal side effects. Clozapine, while requiring close and careful monitoring of the patient, has been found to be effective in reducing aggression in psychotic patients (Volavka , Czobor , Nolan, et al., 2004; Citrome, Volavka, Czobor, Nolan, et al., 2004; Citrome, 2007; Taylor, Bitwell, Gray, et al., 1996). Of particular interest is the discovery that anti-convulsants can be effective in controlling certain types of violence (Crowner, 2000; Citrome, 2007). Obviously, psychopharmacological interventions are never sufficient to prevent violence or to treat violence. However, a carefully developed algorithm that is tailored specifically to an individual can be a powerful tool in the arsenal against inpatient violence.

C. **Therapeutic contracts with the individual and early neuro-cognitive-dynamic-behavioral interventions.** The importance of entering into a therapeutic contract with the individual as soon as possible after admission into the inpatient facility cannot be overemphasized. The following measures are especially useful:

1. Establish with the client at the very outset of treatment whether he/she has a critical awareness of the problem of interpersonal violence. Many of these individuals justify their violence through rationalizations such as self-defense, command hallucinations, etc. Those who are at the denial

stage (pre-contemplation stage of change) will require interventions such as a motivational interview to move them from denial to acknowledgement of the problem and a motivation to change their behavioral pattern (Prochaska & Norcross, 2002).

2. Once the individual has come to a critical awareness of the need to change, he/she identifies, with the assistance of functional behavior analysis, the circumstances (antecedents, setting events, environmental cues, etc.) that provoke the violent impulse.
3. Obtain a self-efficacy measure from the individuals regarding their belief about their ability to manage the violent impulse. Depending on the strength of the self-efficacy measure, discuss with the individual strategies and exercises to improve the self-efficacy. For example, if the individual states "I can't help it," the therapist needs to assist the individual to explore the source of lack of self-control, to identify strengths that he/she could build on, and to develop skills (e.g., mindfulness, deep relaxation, etc.) that improve self-efficacy. Addressing self-efficacy is an often-neglected process in behavioral interventions. As Bandura (2006) states, "Among the mechanisms of human agency, none is more central or pervasive than beliefs of personal efficacy…Whatever other factors serve as guides and motivators, they are rooted in the core belief that one has the power to effect changes by one's actions."
4. Depending on the identification of the source of violence, a well thought out neuro-cognitive restructuring plan may be developed. For example, if

arousal problems or subtle seizure activities are suspected as a source of violence, the individual may be assisted through psychopharmacological and neuro-feedback (e.g., Alpha-Theta training) procedures. In addition to these, beliefs regarding violence need to be examined and restructured. A dramatic example of an actual case of a 45-year-old man who had a repeated history of inpatient violence towards staff and fellow patients illustrates this point. With a diagnosis of paranoid type Schizophrenia, this man revealed during the motivational interview that he believed that he was a “man of peace” and attacked people out of self-defense. He attacked and injured his treating psychiatrist on the ward, believing that the psychiatrist was deliberately poisoning him with prescription medications. Through a carefully designed neuro-cognitive program, building on his core belief that he was a man of peace, the psychotherapist assisted him with adopting a behavioral pattern that was non-violent. The dynamic relationship with the psychotherapist who also trained the patient in deep relaxation technique contributed to the dramatic change, which resulted in successful discharge from the inpatient setting.

5. One of the crucial variables in the formula for successfully working with violent individuals is the dynamic and trusting relationship with a flexible psychotherapist with an integrative orientation. What has emerged in the research is that there is no single approach to this highly complex problem of violence among the psychiatric population. While it is more fashionable to use purely behavioral techniques, a dynamic approach has helped on

several occasions. An actual example is that of a 23-year-old woman who was committed to a State hospital because of Schizophrenia and violence towards young, attractive, Caucasian women. Psychopharmacological and behavioral techniques did not produce any mitigation in her behavior. In fact, this individual was so dangerous that she had to be maintained in seclusion and often in leather restraints. After over fifty serious attacks within the inpatient setting, a dynamic approach was initiated. At the assessment, it was determined that this individual was employing the defense of reaction-formation to her intense feeling of homosexual attraction to females. A carefully calibrated exploration of her homosexual attraction, which was normalized in the process of psychotherapy, produced dramatic results that resulted in her discharge from the highly structured and confining inpatient setting.

D. **Assignment of behavioral change agents and peer counselors.** There is increasing clinical and research evidence that specifically assigning trained Behavioral Change Agents (BCA) is an effective way to prevent inpatient assaults. A BCA is a person trained in essential behavioral principles and assists an individual with maladaptive behavior in applying behavioral strategies. In an inpatient setting, violence-prone individuals are often assigned to be closely supervised by a staff member who is expected to be replaced periodically (every two hours in California). This creates a problem of inconsistency as well as inefficiency. Often such intrusive supervision is to *manage* the violent behavior temporarily rather than to intervene

therapeutically to impact the targeted behavior. A BCA, on the other hand, who knows the individual and his/her treatment plan intimately focuses on assisting the individual to develop adaptive behavioral strategies. The BCA follows specific behavioral guidelines and strategies proposed by the attending treatment team. Behavioral contingencies and reinforcement schedules are faithfully followed and documented. The BCA becomes an integral and crucial member of the treatment team, providing not only consistent implementation, but also valuable feedback.

The Recovery Movement (Anthony, 1993; Frese, 2009) has been advocating the importance and usefulness of patients helping patients. The peer-counseling programs among psychiatric populations are gathering momentum across the country (Klein, Cnaan, & Whitecraft, 1998). An important stage of recovery is that one reaches out to the fellow sufferers of psychiatric challenges. The argument is that people who are at the advanced stages of recovery have much to offer by way of witnessing and by providing hope and courage to those who are still in the early or middle stages of recovery. Many individuals in the advanced stages of recovery have voluntarily sought specialized training in peer counseling and have become employed as such in psychiatric settings.

Volunteer peer counselors have to be selected with care. Several conditions have to be met prior to allowing the peer counselor to become an official participant in the recovery-journey of an individual. First, the peer counselor has to be accepted by the individual being served. Secondly, the

peer must be trained by a competent peer counselor professional. Among the essential parts of such training is to inculcate in the peer counselor that he/she needs to be careful in not interfering with the medical and psychiatric regimen, and must recognize certain complex situations that may require them to seek counsel with the attending clinicians.

E. Developing a culture of non-violence and establishing a social-learning milieu. Recovery is almost impossible in an atmosphere of constant threat and violence. Many recovering consumers of services from the traditional psychiatric wards have described their experiences in these wards as quite toxic (Deegan, 1998; Anthony, 1993; Onken & Dumont, 2002). In addition to unwittingly perpetuating a profound sense of hopelessness, the atmosphere in many of these wards has been riddled with problems of crowding, hostile attitudes and actions of peers and staff, seclusion and physical restraints, forced medications, etc. Several State hospitals have instituted milieu related reforms. There has been a national effort to reduce the use of seclusion and physical restraints. In recent years, California State hospitals, for example, have demonstrated a significant reduction in the use of physical restraints and seclusion.

A careful and systematic effort is required to create a recovery oriented milieu. Traditional psychiatric wards are based on the tenets of the "medical model" that focused on the disease (diagnosis), its course, and its treatment. Former consumers of psychiatric services in State-run psychiatric facilities have complained that the medical model's emphasis on the disease, especially

with psychiatric conditions, often produced hopelessness, further trauma, and eventual dehumanization (Frese , Knight, & Saks, 2009). Placing emotionally disturbed individuals in a crowded setting with other highly disturbed individuals can be toxic. Psychiatric rehabilitation requires an atmosphere of support, autonomy, peace, and safety. Accepting the obvious fact that the current set-up in locked facilities is generally toxic, the immediate task is to minimize this toxicity by providing the best milieu possible. The Recovery Movement specifies that such an environment should inspire hope, self-determination, and self-efficacy, collaboration, and mutual respect between the consumer, mental health staff, and the stakeholders. The entire ward atmosphere should promote the holistic view of the person with the intention of returning the individual to become a productive member of the community of his/her choice. In such a non-authoritarian and collaborative atmosphere, disputes are resolved non-violently. Attentive listening, empathic understanding of the frightening struggles of the individual afflicted with psychiatric challenges, and an emphasis on cultivating adaptive replacement behaviors would reduce and eventually eliminate interpersonal violence on such wards. An example of such an undertaking is provided by the SAFE clinic (Patton State Hospital, 2007). The SAFE clinic was designed to provide a supportive and therapeutic atmosphere during the day for those inpatients that were assessed to be in imminent danger for interpersonal violence. A program evaluation of SAFE during the last three years reported significant

reduction of violence on the part of the participants since graduation from the clinic (see Table-1).

F. Embedded Positive Behavioral Support staff as participant observers and trainers of staff. Positive Behavioral Support (PBS) has evolved into an applied science, developing from traditions of applied behavioral analysis, philosophy of recovery, person-centered values, positive programming and the normalization movement (Carr, Dunlap, Horner, et al., 2002). Tried and tested in the field of developmental disabilities and educational institutions, PBS is rapidly being introduced into other settings such as inpatient mental health institutions. While the jury is still out on valid measures of the effectiveness of PBS in such settings, the practice-based evidence is very encouraging.

Traditional behavioral treatment approaches focused on the problematic behavior, its antecedents and consequences. By managing the antecedents (stimulus control) and manipulating the reinforcing consequences (operant procedures), behavior was expected to be altered. PBS, however, emphasizes the expansion of behavioral repertoire and cultivation and reinforces positive behavior in the place of "problem behavior." The focus is shifted from the "problem" to the positive behavior. Secondly the positive behavior is cultivated in the context of milieu transformation and system change (Ruef, Poston, & Humphrey, 1999). A systematic application of PBS appears to be a highly promising system for inpatient psychiatric wards housing violence-prone individuals. A PBS team may train the staff of a ward in how to perform functional analysis of behavior, to identify functionally equivalent

replacement behaviors, and to reinforce those adaptive behaviors. The PBS team members embed themselves in the therapeutic milieu, observing the staff's behavior and providing appropriate feedback in a timely manner, eventually transforming the culture of the ward. Additionally, these experts acting as participant observers on the ward provide live examples, increasing their credibility as well as the confidence of the staff and patients.

G. Managing setting events and escalations. Crisis of violence starts off with an initial response to a setting event, whether external or internal. In addition to trying to avoid the circumstances that provoke violence (stimulus control), it is also important to de-escalate the rising emotions. Except for what appears to be sudden and "unprovoked" violence (e.g., frontal lobe reactions), many of the violent episodes are preceded by a period of escalation during which skillful crisis intervention techniques can be employed to bring it down. The availability of a trained and prepared staff to assist in the de-escalation process can be of great help (Nijman, Merckelback, Allertz, & a Campo, 1997). Among proven techniques of de-escalation are attentive listening, giving empathic understanding of the dispute, creating a "yes set" (making statements that would evoke a response of "yes" from the agitated individual), equipping the individual with non-violent solutions to the dispute, offering time-out, and arranging with the individual to talk to someone he/she trusts (Stevenson, 1991). The best time to prepare the individual to deal with a potential crisis is when that individual is not in a crisis. The individual needs to foresee the potential crisis and develop coping plans with the assistance of a

counselor ahead of time. As a crisis is beginning to develop, the individual can be reminded of the plan that he/she had made to assist in adopting the previously determined strategy.

H. **Preventive specialty clinics or wards.** The idea of creating specialty wards for individuals with proven proneness to violence has demonstrated advantages as well as disadvantages. Unless such wards are planned and implemented with great care, they are likely to be highly problematic. The most significant advantage of having a specialty ward is the ability to create a ward milieu specifically geared towards non-violence. For example, it has been demonstrated that time of day/night can be a trigger for violence in certain wards. Such variables are better controlled and monitored in a specialty unit. Individuals are admitted into such a ward with the full disclosure of its purpose and process. This provides the individual with an expectation that there is zero tolerance for violence on the ward. It is very similar to a drug-rehabilitation inpatient program where total sobriety is expected of the participant. The individual is made fully aware that this is a positive program providing a variety of clinical, staff, and peer support to cultivate a milieu of peace with the specific purpose of developing enduring skills for non-violent dispute resolution. Individuals are assisted on these specialty wards to address the source of their violence as revealed through careful functional analysis and other assessments. Violence often develops because of earlier trauma in people's lives. For such individuals the interventions will be derived from a trauma-informed perspective also. Recent

evidence (Malancharuvil & Williams, 2007) suggests such specialty clinics are highly effective.

The outline for such a specialty ward is provided below (Malancharuvil, 2010):

Purpose. The unit provides a structured and safe environment specifically geared towards providing the best treatment available to individuals who require special assistance to manage their anger and assessed proneness to violence directed towards others.

Composition. The unit will consist of two groups of inpatients: half the population will be individuals who have been assessed to be at high risk for violence, and the other half will be peer counselors who are individuals still in treatment at the inpatient hospital and are advanced in their recovery and psychiatrically stable, preparing for discharge from the hospital within the next six months. The latter group has been selected as volunteer peer counselors who are willing to assist the former groups in adopting a non-violent approach.

Staff. Every staff member of the unit, including "floating staff," may be pre-selected and will have certification (internally produced through a specialty training program) in non-violent procedures. The staff will be provided with a Manual that provides the structure of the unit, essential elements of the clinical work, and daily management of the individuals.

Program. The structure of the unit's clinical program will be provided in a written manual. This manual will explain the specifics of the core elements of

individualized treatment, training of staff, milieu creation, methods of dealing with incidents of violence and program evaluation.

***Outcome evaluation*.** The unit's therapeutic effectiveness will be measured as follows:

1. Changes in dynamic risk factors of violence, compared to a control group that did not attend the specialty unit.
2. Incidence of physical/verbal violence **before (six months period)**, **during,** at the **completion of**, and six months **after** the specialty program.
3. Self-efficacy in managing violent impulses before and after the specialty program.
4. Quality of Life measure (satisfaction measure of the consumer).
5. Use of intrusive supervision (such as one to one), compared to a control group.
6. Staff usage (paid man hours) in comparison to a control unit.

***Specialty day clinics*.** Within the inpatient psychiatric hospital, arrangements can be made to have day-clinics that violence-prone individuals attend as a preventive (as well as post incident) measure. One such day clinic has been found to bring down the incidence of violence substantially (Table-1). The day clinic may employ educational processes, group and individual psychotherapy, Positive Behavioral Support programs, Neurofeedback (specifically Alpha-Theta relaxation training), and other modalities.

II. Post-incident Interventions

A. **Administrative segregation.** When a violent incident happens on the ward, it has been found useful to remove the perpetrator to a quiet place in order to de-escalate, reflect, and debrief. If the individual remains out of control and continues to be imminently dangerous as not to be able to voluntarily take the offer of going to a quiet place, he/she may have to be physically restrained and removed to such a place. The "quiet room" should not be on the ward for many reasons. There should be a clear message to the perpetrator of violence that regardless of how mentally incapable he/she is, violence is a crime objectively and will not be tolerated on the ward. Such an approach demonstrates to the victim as well as to the peers on the ward that interpersonal violence is a felony that requires the perpetrator to be segregated from society. Removing the individual from the ward gives the staff and peers a chance to debrief without the continuing potential escalation of the crisis. It is also important to communicate to the perpetrator as well as the witnesses that when violence is perpetrated, the community standard is to remove the person from the vicinity to a holding place assigned by the law enforcement. During the administrative segregation of the perpetrator, he is assisted to deescalate, and is then debriefed if possible. An assessment is done as to the antecedent, process, and consequences of the violent behavior. During the segregation, it is also possible for the individual to receive short-acting psychiatric medications to assist him/her in deescalating, if indicated.

B. **Debriefing of the perpetrator, victim(s), witnessing peers, and staff.**

Debriefing the perpetrator, victim(s), witnessing peers, and staff is one of the important processes that needs to take place after a violent incident on the ward. Evidence points towards the effectiveness of such procedures in reducing further incidents of violence (Stevenson & Otto, 1998). The debriefing is intended not only to assist the individuals to assimilate the traumatic event, but also to obtain facts of the violent incident so that a thorough analysis is possible of all the aspects of the incident. Such an analysis helps to figure out effective interventions with the individual, staff, peers, and especially the milieu with the specific purpose of preventing such occurrence in the future. The proposal is to debrief the entire ward after a violent incident on the ward. The therapeutic community gets together as soon as possible after the incident and has a debriefing session with the guidance of the clinical staff. During this process individuals are given an opportunity to vent their feelings and offer their analysis of the event. Discussion is held also on what measures need to be taken to prevent future incidents. During the therapeutic community meeting, it is also possible to arrange for the perpetrator of violence to come before the therapeutic community to acknowledge the error of his/her actions and to apologize for the resulting harm and disorder. The apology process also provides an opportunity for peers to develop empathy with and forgiveness for the perpetrator, as an un-forgiven event could further provoke hostility and violence.

B. Therapeutic “hearing” before a panel that includes volunteering peers.

When serious interpersonal violence occurs in the community at large, the individual is likely to be arrested, charged, and brought before a court. This happens regardless of whether the perpetrator is mentally ill. Unfortunately violence in psychiatric wards is rarely prosecuted. This sends a contradictory message to the psychiatric inpatients, precisely because they do not often appreciate the serious consequences of their violent behavior. This is also why it is important to set a process of "hearing" after violence has been perpetrated on a psychiatric ward. The therapeutic "hearing" is a process whereby the perpetrator of violence, after appropriate debriefing, is brought before a panel for a hearing regarding the behavior.

The panel may consist of the treatment team, a behavior specialist (consultant), and possibly a volunteering peer who is adequately stable and advanced in his/her psychiatric recovery. Several preparatory steps are necessary to make the hearing a therapeutic and ecologically valid event. The offender is well prepared through individual counseling to appear before the hearing. During the counseling process preceding the hearing, the individual is assisted to understand that the hearing is a therapeutic event to assist him/her to control such behavior in the future. It is impressed upon the individual that it is in his/her best interest to be utterly honest and cooperative with this process. The process starts with a short explanation of the purpose of the hearing and the expected outcomes. The individual is then heard in terms of his/her understanding and explanations of the behavior. The panel asks questions to clarify facts and related issues. Witnesses may be called to give

their accounts of the events. After this the panel retreats to a closed session to discuss and consolidate its findings and formulate recommendations. The recommendations are then shared with the individual who will be given the opportunity to evaluate and hopefully accept them voluntarily. Mostly the recommendations would be for the individual to intensify his/her therapeutic work to address the issue of violent behavior. The perpetrator may be mandated to attend and graduate from a specialty behavioral clinic that addresses how to cultivate non-violent approaches to dispute resolution. Additional assessment, functional analysis of behavior, psychotherapy, revised pharmacological interventions, and involvement with other therapeutic activities are all possible recommendations. The panel may also recommend, as a condition of returning to the ward, that the perpetrator come before the therapeutic community and apologize for the violent behavior with a commitment to engage in non-violent dispute resolutions. If the panel finds that the individual's violent behavior is maliciously instrumental and driven by clear sociopathic dynamics, it may recommend that this person be revoked to jail or prosecuted for criminal behavior. While such conclusions are likely to be rare, prosecution of willful and malicious violence on the ward should remain an option (Quanbeck, 2006). As a rule, the entire process of hearing should take less than an hour. A protocol may be developed specifying the steps of the hearing to make it more efficient.

Discussion

Interpersonal violence among involuntarily-committed psychiatric inpatients is a matter of great concern from several points of reference: protection and civil rights of involuntarily-institutionalized persons, safety of staff, milieu of recovery, cost, and human suffering. The developing evidence from research and practice indicates that inpatient violence can be substantially reduced and managed. A piecemeal approach will not suffice. A successful program in this regard calls for *comprehensive* plans supported by committed management. Such plans should include early assessment and prediction, individualized and early interventions based on careful analysis of the nature and dynamics of the type of violence, a personal commitment from the perpetrators resulting from a critical awareness of their violent tendencies, staff training, creation of a non-violent culture and milieu, and ongoing program evaluation. Research has demonstrated that any single aspect of this comprehensive approach by itself does not produce significant and lasting reduction in violence. The comprehensive models that have been presented in this article have shown impressive initial results (Table-1). Additional research and duplication of these results with appropriate scientific controls are necessary.

REFERENCES

Abderhalden, C., Needham, I., Dassen, T., Halfens, R., Haug, H., & Fisher, J. (2006). Predicting inpatient violence using an extended version of Broset-Violence-Checklist: Instrument development and clinical application. *BMC Psychiatry, 6*(17), 1–9.

Abderhalden, C., Needham, I., Dassen, T., Halfens, R., Haug, H., & Fisher, J., (2008). Structured risk assessment and violence in acute psychiatric wards: Randomized controlled trial. *British Journal of Psychiatry, 193*, 44–50.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11–24.

Bandura, A . (2006). Toward a psychology of human agency. *Perspectives on Psychological Science, 1*, 164–180.

Barley, W. D., Buie, S. E., Peterson, E. W., Hollingsworth, A. S., Griva, M., Hickerson, S. C., Lawson, J. E., & Bailey, B.J. (1993). The development of an inpatient cognitive-behavioral treatment program for borderline personality disorders. *Journal of personality Disorders, 7*(3), 232–240.

Becker, M., Love, C. C., Hunter, M. E., & Novaco, R. (Eds.). (1997). Intractability is relative: Behavior therapy in the elimination of violence in psychotic forensic patients. *Legal and Criminological Psychology, 2*(1), 89–101.

Beech, B., & Leather, P. (2006). Workplace violence in the health care sector: A review

of staff training and integration of training evaluation models. *Aggression and Violent Behavior, 11,* 27–43.

Bushman, B. J. & Anderson, C. A. (2001). Is it time to pull the plug on hostile versus instrumental aggression dichotomy? *Psychological Review, 108*(1), 273–279.

Carmel, H. & Hunter, M. (1989). Staff injuries from in-patient violence. *Hospital & Community Psychiatry, 40,* 41–46.

Carr, E. G., Dunlap, G., Horner, R. H., Koegel, R. L., Turnbull, A. P. Sailor, Anderson, J. L., Albin, R.W., Koegel, L. K., & Fox, L. (2002). Positive Behavior Support: Evolution of an applied science. *Journal of Positive Behavior Interventions, 4,* 4–16.

Citrome L. (2007). Comparison of intramuscular Ziprasidone, Olanzapine, or Aripiprazole for agitation: a quantitative review of efficacy and safety. *Journal of Clinical Psychiatry, 68*(12), 1876–85.

Citrome, L., Volavka, J., Czobor, P., Sheitman, B., Lindenmayer J., P., McEvoy J., Cooper, T. B., Chakos, M., & Lieberman, J. A. (2001). Effects of Clozapine, Olanzapine, Risperidone, and haloperidol on hostility among patients with schizophrenia. *Psychiatric Services, 52*(11),1510–4.

Citrome L. (2007), The psychopharmacology of violence with emphasis on schizophrenia, part 2: Long-term treatment. *Journal of Clinical Psychiatry, 68*(2), 331–2.

Cooper, A. J. & Mendoneca, J. D. (1991). Prospective study of patient assaults on nurses in provincial psychiatric hospital in Canada. *Acta Psychiatrica Scandinavic, 84,* 163–166.

Corrigan, P. W., Yudofsky, S. C., & Silver, J. M. (1993). Pharmacological and behavioral treatments for aggressive psychiatric inpatients. *Hospital* and *Community Psychiatry*. *44*(2), 125–133.

CRIPA: Civil Rights of Institutionalized Persons Act. 42 U.S. C., 1997.

Crowner, M. L. (Ed.). (2000). *Understanding and treating violent psychiatric patients.* Washington, D.C: American Psychiatric Press, Inc.

Crowner, M., Peric, G., Stepic, F., Ventura, F. (1995). Psychiatric patients' explanation for assaults. *Psychiatric Services, 46,* 614–615.

Daffern, M. (2007). The Predictive validity and practical utility of structured schemes used to assess risk for aggression in psychiatric inpatient settings. *Aggression and Violent Behavior, 12*(1), 116–130.

Deegan, P. E. (1998). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11–19.

Douglas, K. S., Guy, L. S., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. *Psychological Bulletin*, *135*(5), 679–706.

Doyle, M., & Dolan, M. (2006). Evaluating the validity of anger regulation problems, interpersonal style, and disturbed mental state for predicting inpatient violence. *Behavioral Sciences & the Law, 24*(6), 783–798.

Duxbury, J. (2002). An evaluation of staff and patient views of strategies employed to manage inpatient aggression and violence on one mental health unit: A pluralistic design. *Journal of Psychiatric and Mental Health Nursing, 9*, 325–337.

Fagan-Pryor, E. C., Haber, L. C., Dunlap, D., Nall, J. L., Stanley, G., & Wolpert, R. (2003). Patients' views of causes of aggression by patients and effective interventions. *Psychiatric Services, 54*(4), 549–553.

Flannery, Jr., R. B. (1994). Risk factors of psychiatric inpatient assaults on staff. *Journal of Mental Health Administration, 21*(1), 24–31.

Frese, F. J., III, Knight., E. L., & Saks.E. (2009). Recovery from schizophrenia: With views of psychiatrists, psychologists, and others diagnosed with this disorder. *Schizophrenia Bulletin, 35*(2), 370–380.

Fullam, R., & Dolan, M. (2008). Executive function and in-patient violence in forensic patients with schizophrenia. *British Journal of Psychiatry, 193*(3), 247–253.

Grevatt, M., Thomas-Peter, B., & Hughes, G. (2004). Violence, mental disorder, and risk assessment: Can structured clinical assessments predict the short term risk of inpatient violence? *Journal of Forensic Psychiatry & Psychology, 15*(2), 278–292.

Hirose, S., Ashby, C. R., Jr., & Millas, M. J. (2001). Effectiveness of ECT combined with Risperidone against aggression in schizophrenia. *Journal of ECT, 17*, 22–26.

Johnson, M. E. (2010). Violence and restraint reduction efforts on inpatient psychiatric units. *Issues in Mental Health Nursing, 31*(3), 181–197.

Kennedy, J., Bresler, S., Whitaker, A., & Masterson, B. (2007). Assessing violence risk in psychiatric inpatients: Useful tools. *Psychiatric Times, 24*(8), 1–2.

Khadivi, A. N., Patel, R. C., Atkinson, A. R., & Levine, J. M.. (2004). Association between seclusion and restraint and patient-related violence. *Psychiatric Services, 55*(11), 1311–312.

Klein, R., Cnaan, R., & Whitecraft, J. (1998). Significance of peer support with dually diagnosed clients: Findings from a pilot study. *Research on Social Work, 8*, 529–551.

Kraus, J. E., & Sheitman, B. B. (2004). Characteristics of violent behavior in a large state psychiatric hospital. *Psychiatric Services, 55*, 183–185.

Lidz, C., Mulvey, E., & Gardner, W. (1993). The accuracy of predictions of violence to others. *JAMA, 269*, 1007–1011.

Love, C. C., & Hunter, M. E. (1998). *Creating an inpatient violence prevention and monitoring program.* The Atascadero State Hospital Clinical Safety Project, California.

Love, C. C., & Hunter, M. (1999). The Atascadero State Hospital experience. Engaging patients in violence prevention. *Journal of Psychosocial Nursing and Mental Health Services, 37*(9), 32–36.

Malancharuvil, J. M., & Williams, J. (2007). *A manual for SAFE.* Unpublished, Patton State Hospital, California.

Malancharuvil, J. M. (2006). A manual for behavioral therapy. Unpublished, Patton State Hospital, California.

Marder, S. (2006). A review of agitation in mental illness: Treatment guidelines and current therapies. *Journal of Clinical Psychiatry, 67*(10), 13–21.

McDermott, D. E., Edens, J. F., Quanbeck, C., Busse, D., & Scott, C. L. (2008).

Examining the role of static and dynamic risk factors in the prediction of inpatient violence: Variable-and person-focused analyses. *Law and Human Behavior, 32*(4), 325–338.

McNiel, D. E., Eisner, J. P., & Binder, R. L. (2000). The relationship between command hallucinations and violence. *Psychiatric Services, 51*(10), 1288–1292.

Monahan, J. (1981). *Predicting violent behavior*. Beverly Hills, CA: Sage Publications.

Monahan, J. (1983). Risk assessment of violence among the mentally disordered: Generating useful knowledge. *International Journal of Law and Psychiatry, 11*(3), 249–257.

Monahan, J. (1996). Violence prediction: The last twenty and the next twenty years. *Criminal Justice and Behavior, 23,* 107–120.

Monahan, J., Steadman, H., Silever, E., et al. (2001). *Rethinking risk assessment: The MacArthur Study of Mental Disorder and Violence.* New York, Oxford University Press.

Nijman, H. L. I., Merkelbach, H. I. G. J., Allertz, W. F. F., & a Campo, J. M. L. G. (1997). Prevention of aggressive incidents on a closed ward. *Psychiatric Services, 48,* 694–698.

Nolan, K. A., Czobor, Pal, Roy, B. B., Platt, M. M., Shope, C. B., Citrome, L. L., & Volavka, J. (2003). Characteristics of assaultive behavior among psychiatric inpatients. *Psychiatric Services, 54* (7), 1002–1006.

Nolan, K. A., Volavka, J., Czobor, P., Sheitman, B., Lindenmayer, J. P., Citrome, L. L., McEvoy, J., & Lieberman, J. A. (2005). Aggression and psychopathology in

treatment-resistant inpatients with schizophrenia and schizoaffective disorder. *Journal of Psychiatric Research, 39*(1), 109–115.

Onken, S. J., & Dumont, J. M. (2002). Mental health recovery: What helps and what hinders? *National Association of State Mental Health Program Directors.*

Prochaska, J. O., & Norcross, J. C. (2002). Stages of change. In J. C. Norcross (Ed). *Psychotherapy relationships that work.* New York: Oxford University Press.

Quanbeck, C. D., McDermott, B. E., Lam, J., Eisenstark, H., Sokolov, G., & Scott, C. L. (2007). Categorization of aggressive acts committed by chronically assaultive state hospital patients. *Psychiatric Services, 58*(4), 521–528.

Ruef, M., Poston, D., & Humphrey, K. (1999). PBS: *Putting the "positive" into behavioral support: An introductory training packet.* Lawrence, KS: University of Kansas, Beach Center on Families and Disability.

Ryan, E., Aaron, J., Burnette, M., Warren, J., Burket, R., Aaron, T. (2008). Emotional responses of staff to assault in a pediatric state hospital. *Journal of the American Academy of Psychiatry and the Law. 36(3),* 360-368.

Ryan, E. P., Hart, V. S., Messick, D. L., Aaron, J., & Burnette, M. (2004). A prospective study of assault against staff by youths in a state psychiatric hospital. *Psychiatric Services, 55*(6), 665–670.

Serper, M., Beech, D. R., Harvey, P. D., & Dill, C. (2008). Neuropsychological and symptom predictors of aggression on the psychiatric inpatient service. *Journal of Clinical and Experimental Neuropsychology*, *30*(6), 700–709.

Simon, R., & Tardiff, K., (2008). Psychotherapeutic Interventions. *Textbook of violence*

assessment and management. Arlington, VA: American Publishing, Inc., 325–338.

Simon, R., & Tardiff, K. (2008). Inpatient settings. *Textbook of violence assessment and management.* Arlington, VA: American Publishing, Inc., 259–276.

Steinert, T. (2002). Prediction of inpatient violence. *Acta Psychiatrica Scandinavica,* Supplementum, 412, 133–141.

Stevenson, S. (1991). Heading off violence with verbal de-escalation. *Journal of Psycholosocial Nursing, 29*(9), 6–10.

Stevenson, S., & Otto, M. P. (1998) Finding ways to reduce violence in psychiatric hospitals. *Journal for Healthcare Quality, 20*(4), 27–32.

Tardiff, K. (1983). A survey of drugs used in the management of assaultive inpatients. *Bulletin of American Academy of Psychiatry and Law, 11*(3), 215–222.

Taylor, P. J., Butwell, M., Gray, C., et al. (1996). Schizophrenia, violence, Clozapine and Risperidone: A review. *British Journal of Psychiatry, 169*(3), 21–30.

Volavka, J., Czobor, P., Nolan, K., Sheitman, B., Lindenmayer, J. P., Citrome, L., McEvoy, J. P., Cooper, T. B., & Lieberman, J. A. (2004). Overt aggression and psychotic symptoms in patients with schizophrenia treated with Clozapine, Olanzapine, Risperidone, or Haloperidol. *Journal of Clinical Psychopharmacology, 24*(2), 225–8.

Volavka, J. (1999). The neurobiology of violence: An update. *Journal of Neuropsychiatry & Clinical Neuroscience, 11*(3), 307–314.

Walsh, E., Gilvarry, C., Samele, C., et al. (2004). Predicting violence in schizophrenia: A prospective study. *Schizophrenia Research, 67*, 247–252.

Watts, D., Leese, M., Thomas, S., Atakan, Z., & Wykes, T. (2003). The prediction of violence in acute psychiatric units. *International Journal of Forensic Mental Health, 2*, 173–180.

Winstanley, S., & Whittington, R. (2003). Anxiety, burnout and coping styles in general hospital staff exposed to workplace aggression: A cyclical model of burnout and vulnerability to aggression. *Work & Stress*, *16,* 302–315.

Winstanley, S. (2005). Cognitive model of patient aggression towards health care staff: The patient's perspective. *Work & Stress, 19*(4), 340–350.

Woods, P., & Ashley, C. (2007). Violence and aggression: A literature review. *Journal of Psychiatry and Mental Health Nursing*, *14*(7), 652–660.

Empathy Deficiency in Antisocial Personality Disorder

- What is Personality?
- What is Personality Disorder?
- What is Antisocial Personality Disorder?

- "the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment" (Allport, 1937, p.48).
- personality is the enduring, internal organization of personal experience and the resulting stylistic adaptations by the individual.

Core Elements

- Four core elements need to be considered in this regard: experience, cognitive positions, enduring behavioral (stylistic) adaptations, and changeability.

- "A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early childhood, is stable over time, and leads to distress or impairment" (DSM-IV-TR. P.685)

The factorial and Dimensional model

- Several constitutional and psychosocial diatheses of ASPD have been identified such as autonomic and reticular arousal problems, attention deficits, cortical disinhibition, impaired functioning of prefrontal cortex, septal nuclei, and hippocampus, early attachment deficits, parental sociopathy, improper discipline, etc. as precursors of adult antisocial personality structure (Baker, Jacobson, Raine, Lozano & Bezdjian, 2007; Krampen, 2009).

- The factorial and dimensional approach has been found to have high clinical utility (Widiger & Mullins-Sweatt, 2010). The trait-based theories of personality arose in the factor-analytic tradition; and because of its mathematical and empirical base, are viewed to be trans-theoretical and trans-cultural ((Lynam & Widiger, 2007; Lowe & Widiger, 2009).

The factorial model

- Perhaps the most prominent dimensional model of personality is the Five Factor Model (FFM) (Block, 1995; Briggs, 1992). This model incorporates some elements of Eysenck's three factor model (Eysenck & Eysenck, 1970). The FFM identifies five inherent dimensions of all personality: neuroticism versus emotional stability, introversion versus extroversion, closedness versus openness, antagonism versus agreeableness , and disinhibition (impulsivity) versus conscientiousness . Costa & McCrae (1992, 1998) reported substantial convergent and discriminant validity for the FFM. The description of the Antisocial Personality Disorder in DSM-IV-TR is consistent with the Five Factor Model (Lynam, Miller, Widiger, Gaughan, Miller & Mullins-Sweat, 2011).

Utilizing the FFM, the antisocial personality structure may be prominently characterized by extroversion, antagonistic (un-empathic) interpersonal stance, inflexibility, and impulsivity.

Psychoanalytic model

- severe superego-defects. The super ego is underdeveloped and pathologically subservient to the self-serving impulses of the id, demonstrated through a general disregard for social and moral norms and through behaviors that are impulsive, excitement seeking, predatory and non-empathic.
- Defenses of externalization, projection, denial, rationalization, etc. are copiously used to repress any anxiety that may be provoked by improperly developed superego.

As a result of repeated experiences of abuse, neglect, trauma with little or inconsistent experiences of genuine nurture, the child internalizes a position that no one really cares; and if at all, it is unpredictable and therefore, must be exploited without delay.

- Additionally, the reluctant or "sterile objects" are seen as means to a self-serving end and projectively identified with hostile affects (Martens, 2008).
- The responsibility for misbehavior is almost entirely externalized. Little internal conflict and anxiety is consciously experienced with regard to self or one's behavior.
- Aggressive "Acting-Out" is used as a protective defense against anxiety (Millon, 1987). "Turning Against Others" is another Defense Mechanism employed by the antisocial personality style (Ihilevich & Gleser, 1986; Berman & McCann, 1995).

Psychoanalytic theory ctd.

- Because of the lack of empathic (perhaps more accurately, sympathic) abilities and the consequent difficulty in developing productive transference reactions, psychotherapeutic relationships are rendered sterile. Additionally, the patient easily abandons the therapeutic contract prematurely..

- The counter-transference of hopelessness and hostile feelings towards the person afflicted with the APD tends to further destroy the therapeutic alliance. The therapist reacts with a futile attempt to teach the patient empathic skills and caring attitude which is glibly rejected by the patient who takes no responsibility for himself, creating a vicious circle of mutual rejection and premature termination of the therapeutic undertaking. Cleckley (1955) suggested that sociopathy is characterized by an "absolute" incapacity for object-love

Attachment Theory and Cognitive theories

- Antisocial Personality Disorder is theorized to be a consequence of serious disruption in early attachment (Shaver, 2011; Dozier, 2008; Nottell, 2002; Holland et al., 1993). In the last ten years the position that ASPD is essentially an attachment disorder (Meloy, 2002) has gained some prominence. There is much in common between the psychoanalytically based object-relations theories and attachment theories in this regard. The common ground is that the relationship with others and the ability to feel *for* others is somehow disrupted early in the developmental stage, creating an antisocial personality style in adulthood.
- Developmental and cognitive theories are not far from the above dynamic formulation when describing the ASPD structure. The ASPD cognitive structure is described as an "active independent stance" (Millon, 1996), where one's belief is that "I must fend for myself, because no one really cares. I will not have another opportunity (as life is unpredictable) and must strike while the iron is hot". Developmentally, this is seen as a failure to move beyond the latency period of cognitive development (Kegan, 1986). At this stage (Piaget's stage of concrete operational thought), the individual has not developed the capacity for abstract reasoning and generalizations, to construct ideals, to coordinate different points of view and most importantly to de-identify one's needs from self. Hence the statement that adolescence is missing in the ASPD structure. What is striking in this formulation is the declaration that at the heart of ASPD is a cognitive developmental arrest prior to adolescence. This is entirely consistent with the psychoanalytic insight that the antisocial personality is essentially a pre-oedipal condition. The pseudo independence and the callous and exploitative attitudes towards others is a manifestation of cognitive as well as emotional maladjustment as a result of poor oedipal integration

Behavioral Approaches

- In common parlance and in practice, antisocial personality is described primarily in terms of behavior instead of seeing it as trait. On the other hand the theories that speculate on genetic, organic and structural defects (constitutional defect) try to explain antisocial personality in terms of traits and being. However, in order to diagnose antisocial personality, the psychometric measures (e.g. PCL-R) as well as phenomenological descriptions (DSM-IV-TR) tend to heavily emphasize behavioral criteria, along with some affective issues.
- It is now an accepted procedure to examine antisocial behavior in terms of static and dynamic factors which are derived from empirical associations. A history of juvenile delinquency, Attention Deficit Hyperactivity Disorder, nature and frequency of crimes committed, history of incarcerations, etc. are heavily loaded with behavioral manifestations. "As currently construed, the diagnosis of antisocial personality disorder grossly over-identifies people, particularly those with offense histories, as meeting the criteria for the diagnosis" (Ogloff, 2006). The findings that people with such past patterns are highly probable to repeat their behaviors in the future create a relatively hopeless situation for such people.

A New Developmental and Psychodyanamic Theory

- Antisocial Personality Structure is the result of a stunted internal development of an essential Psychodynamic and cognitive process
- Epistemology: How do we know what we know? How do we know what we know is true? Why the "same" reality is perceived differently by different people? Is one's "truth" is closer to the Truth than another's?

Empathy

- Empathy is the subjective experience of sensitively understanding an object and vicariously being moved by the experience of the object
- Empathy has three components:
  - Cognitive
  - Affective
  - Vicarious caring

Three aspects of empathy

- Cognitive Empathy
  - To know and become aware of the object's thoughts, feelings, and experiences
- Affective Empathy
  -to feel in oneself what the object is feeling and experiencing.
- Caring Empathy
  -Moves the subject to experience care for the object, by vicariously experiencing what the subject is perceived to be going through.

Caring Empathy

- Moves the subject to experience care for the object, by vicariously experiencing what the subject is perceived to be going through.
- Caring empathy = sympathy
  -"affinity, association, or relationship between persons or things wherein whatever affects one similarly affects the other" Merriam Webster

Is it possible to experience the first two without experiencing the third?

- Yes!
- The antisocial person's self-serving observation of his victim is replete with cognitive empathy.
- Affective Empathy may or may not be present in ASPD
- The knowledge and awareness of the feelings of the object, do not lead to caring for the welfare of the object.
- Emotional Detachment and shallow affect
- Glibness and apparent caring.

Origin of Deficiency in Caring Empathy

- The adaptive significance of the antisocial personality style is derived from the capacity to assess and utilize the object in a self-serving manner in a world perceived as essentially hostile (Millon, 1996)
- Question: Is it adaptive?
- Yes, in a combat situation
- No in the context of productive societal living.

Primary Defenses of ASPD

- Projective Identification
- Externalization
- Self-serving behavioral activation
- ##########

Projection, the mental process of contacting, checking and verifying interpersonal reality

Projection starts with the awareness of the other, generating a hypothesis arising from internal categories (Kant).

- Is it threatening or friendly?
- Is it nurturing or harmful?
- Is it pleasurable or painful?

Projection is either confirmed or negated

- Either through feedback
- Or through internal need-structure, previous experience
- "Sibi simile cognoscitur" or "ad modum percipientis"
- Projection is followed by Introjection
- Projection as a defense

Projective Identification

- PI is the defensive process of unconsciously perceiving the hated aspects of oneself in another and rendering the object as the persecutor
- The subject unconsciously induces the object to experience and even act out the projected negative affect, and thus confirming the projection as an "objective" fact.

Failure of Introjection

When the subject is fixated at the PI level, the subject remains extraverted and pathologically fixated on the other. Introspection is thwarted.

An opaque and withholding response to the demands of the subject to relate to others is thwarted, thus confirming the projected hostility as true.

Projective Identification vs. Paranoid Delusions of Persecution

- Antisocial perceives the object not only as hostile and persecutory but also sees the object as an exploitable source of self-nourishment. The hostile projection renders the object not worthy of sympathy
- Paranoid person perceives the object simply as hostile and harmful; either wishes to destroy the object, be careful and avoidant.

Externalization

Externalization is the self-protective attribution of causality and responsibility to the other for the unwanted events and feeling in self.

- Externalization stems from two sources:
- Extraversion
- Projective Identification

Reactive Sociopathy

Reactive sociopathy develops in the absence of an experience of the gift of sacrificial care, which initially manifests as the capacity to "mirror" and "hold" (Kohut and Winnicott

Behavior Activation

- Behavior activation is the self-serving acting out against others (Berman & McCAnn, 1995)
- Arises from interpersonal antagonism and impulsivity
- Active Independent Stance (Millon, 1996)

"My lunch is in the hands of the one who hates me; I must grab it as soon as possible"

Summary

Caring Empathy deficit in ASPD is dynamically explained primarily in terms of PI,Externalization and Acting out against others.

In ASPD what is lacking is primarily sympathetic (caring) empathy and partially affective empathy. Cognitive empathy may be utilized as a starting point in psychotherapy.

Psychotherapy of ASPD

- See you again! Thanks for listening!!

Psychotherapy of ASPD

- Traditional Strategic Psychotherapy
  - -establish behavioral control
  - -focus more on the needs of others
  - -inhibit impulsive behavior
  - -cooperate with others
  - -take personal responsibility
  - -appreciate consequences of behavior
  - -alter deviant cognitions

-behavioral control does not necessarily change structural problems
-behavioral control may be possible in a highly structured setting
-teaching empathy to ASPD is the same as teaching a pig to sing!
-cooperate with others, yes, in a self-serving situation
-ASPD does not care about consequences other than what happens to them
-cognitions change without experience

Assessment

- 1. Arousal and related organic problems
- 2. Antisocial cognitive schema
- 3. Interpersonal antagonism (disagreeableness)
- 4. Impulsivity and dis-inhibition (Behavioral activation without appreciation of behavioral consequences)
- 5. Serious difficulty taking personal responsibility (externalization)
- .
- 6. Dissocial Affect (empathic difficulty)
- 7. Improper regulation of negative affects (anxiety, depression, anger...)
- 8. Rigidity and lack of psychological minded-ness (lack of openness to change)
- The treatment goals directly depend on the assessment of these dimensions

Therapeutic Strategies:

#1:Therapeutic contract and temporary behavioral control

- A pre-condition to successful psychotherapy is to establish adequate behavioral controls while in psychotherapy so that the individual's behavior does not interfere with the psychotherapeutic process. This may appear like an impossible dilemma. If the person can stop acting out, he would not need the therapeutic intervention; if he keeps acting out, psychotherapy cannot be accomplished! This is a false dilemma in that the opposite is true. The person may stop acting out, as he/she does have the therapeutic assistance. The goal obviously is that once the person completes the therapeutic process he/she will be able to maintain socially adaptive behavior.
- This is particularly true of inpatient settings, such as in State Forensic Hospitals. In a structured setting, as pre-condition to starting psychotherapy, the individual can successfully maintain a therapeutic and contractual obligation not to act out. Such a contract can be and need to be established at the outset once the rapport is well established. An informal observation of more than 75 individuals with ASPD diagnosis entering into such therapeutic contracts (Malancharuvil, 2011) indicated that the patients indeed did maintain fidelity to remain free of violent behavior during the psychotherapeutic course lasting six months or more

#2: Deliberate empathic approach

- Being aware that the lack of empathic abilities of ASPD provokes counter-transference of not wanting to be empathic with the client, the therapist deliberately adopts an empathic approach. In order to be empathic with the antisocial client, the therapist has to focus on the personhood of the client, beyond the behavior. The socially expected approach is to focus on the antisocial behavior, which could very well be one of the reasons for negative therapeutic results (Beier,1966)..

A therapist who adopts the theory that ASPD clients are "bad seeds" and cannot be rehabilitated may have an ethical obligation in not engaging in therapy with them. Such therapists start the relationship with a negative and relatively hopeless judgment about the very being of the client. Additionally, such an attitude reinforces the client's cognitive schema that no one cares for him and that he must fend for himself

Empathic Approach

- In order to be successful, it is imperative that the therapist believe in the possibility of helping the client (Norcross, 2002; Lively, 2005). It is part of the empathic connection with the client that the therapist adopts consciously a hopeful and caring attitude (Shamasundar, 1999).
- An empathic therapist creates a crucial modeling experience for the ASPD client and utilizes this experience as a deliberate tool for teaching what it means to be empathic. Individuals with ASPD are found to be keenly sensitive and are aware of those under their observation. (Jones, Happe, Gilbert, Burnett & Viding, 2010; Cima, Tonnaer & Hauser, 2010). ASPD has a deficit in the ability to feel sympathy than to have empathy. At the heart of psychotherapy with persons with ASPD, is giving an opportunity to experience what it means to be cared for, for their own sake. The wisdom that empathic and caring abilities stem from personal experience of being nurtured is highly relevant. One gives what one has received. (Wampold, 2007; Shedler, 2010)

Paranoid-schizoid position.

- The ASPD person also does not respect the autonomy or free agency of another human being and lacks intimacy with the other. In Kleinian terms the ASPD person is stuck at the "paranoid-schizoid" position (Klein,1957). It is in this context, the therapist deliberately decides to communicate genuine care for the individual. The crucial question is how this nurturing experience can be given in a psychotherapeutic setting to the ASPD client who is exploitative and abusive.
- The counter-transference of hopelessness and hostile feelings towards the person afflicted with the APD tends to further destroy the therapeutic alliance. The therapist reacts with a futile attempt to teach the patient empathic skills and caring attitude which is glibly rejected by the patient who takes no responsibility for himself, creating a vicious circle of mutual rejection and premature termination of the therapeutic undertaking. Cleckley (1955) suggested that sociopathy is characterized by an "absolute" incapacity for object-love

Empathic Approach

- In successful clinical settings, it has been repeatedly demonstrated (Salekin, 2002; Malancharuvil, 2011) that individuals with an antisocial stance of "no one cares" did find out that they were indeed cared for much more than they had actually acknowledged consciously. This emphasis on finding grains of gold in a stack of abusive thistles is a powerful therapeutic strategy for restructuring the antisocial stance.
- When some of these individuals come to realize that they had failed to register or unconsciously buried the experiences of being cared for, they genuinely demonstrate an emotional "melt down" and break down in to tears. When such events happen, the therapeutic relationship itself is viewed as one of the most caring experiences by these individuals. Obviously this is not an invitation to be naively victimized and exploited by the individual.

Empathic Experience

- A positive projective identification, in which the self identifies positive feelings in the object, is a pre-condition to developing compassion and intimacy (Shamasundar, 1999). Projection is mitigated by introjection (Martens, 2008). Such introjection is achieved by getting the client to experience at least some (even one) objects as caring and nurturing. This may be resisted by the client by introjecting the object as "useful". The object needs to be perceived as more than "useful". The goal is to assist the client to experience the object as a person who cares, and eventually, as an autonomous agent in the context of an "I-Thou" relationship. This idealistic vision may be seen as unrealistic and unattainable for the ASPD. Clinical experience of those who worked with this dynamic understanding tells otherwise (Salekin, 2002; Martens, 2008).
- **Pay attention *first* to the "selfish needs" of the client instead of focusing on caring for others.**

Therapeutic Strategy #3 &4

- **Know that "adults do not change, but children do."**
- **Pay attention to the slow-moving affects.**
- Individuals with ASPD are clinically observed to be deficient in experiencing as well as dwelling on slow-moving affects, such as sorrow related to object loss and the resulting melancholy, remorse, loneliness, grief. etc. These individuals are known to express readily the fast moving emotions such as anger, excitement, overt hostility, feelings of revenge, etc. The fast moving feelings defend against the more vulnerable, slow acting, and deeper feelings. The therapist will be tempted to deal only with the easily accessible feelings of anger and hostility. Such an approach to the neglect of the deeper feelings could eventually sabotage successful restructuring of the personality style. In order to access the isolated, slow-acting emotions, the individual is helped to relax and regress to these early experiences through the anamnesis. The focus is not so much on the events per se, but their emotional, cognitive, and attitude-generating significance.

Strategy#5 & 6

- **Attacking the rigidity of the personality style**
  - After establishing the rapport and setting up the expected guidelines of the psychotherapeutic process, the therapist sets out to mitigate the underlying rigidity of the experiential-structure and resistance to change. A frontal attack is unlikely to be productive. For the ASPD afflicted person, this may be achieved through an invitation to a new and exciting experience, which requires on his part some switching of gears.
- **Longing to be loved and teaching to love**
  - -The ASPD style has repressed the inherent longing of being loved as well as the need to experience loving others (Cleckley, 1955). As they have projectively identified the undesirable feelings of hostility, hurt, and anger with the objects, they cannot expect these objects to love them (Klein, 1955).

The need to be loved

- Cleckley (1955) stated that the anti-social personality demonstrates an almost "absolute"(Cleckley,1955) "incapacity for love". Can the ASPD person experience the joy of receiving and giving love? Can this capacity be initiated or enhanced through a psychotherapeutic process? The vast majority of studies of ASPD (based on a search of several data bases) do not address this issue.
- Apart from the philosophical issue of whether human beings inherently are constituted to experience both the receiving and giving of love, from a dynamic point of view, experience of love is activated with the introjection of a nurturing, pleasurable and loveable object, starting with the soft, cuddly and nourishing mother. This absolutely necessary and unconscious introjective process is disrupted with deprivation, abuse, as well as organic processes in the ASPD.

The need to experience love

- **Reinforcing and cultivating the experience of receiving love and affection**
- The starting point is to help the client to grasp the value of love. This is achieved by connecting with the feelings of anger, and more importantly the loss and deprivation and the resulting sadness. The sense of loss and deprivation necessarily points to their conditions of possibility which is that if one never needed or desired love there will be no feelings of loss or deprivation in this regard. This may be a subtle deduction, and may need to be translated experientially.
- It is possible, as has been shown in actual clinical settings, to move the patient from a sense of loss to the appreciation of the need for the object. When an empathic therapist reminds the patient to what would have been if there were unconditional love and acceptance in their developmental years, the client is likely to contemplate it. In other words, start with the appreciation of the need or usefulness of the object, proceed with the value of being loved *by* the object and allow the patient to become tender by imagining receiving the love, leading hopefully to a longing to be loved (Gawda, 2008).

Teaching to love

- **Teaching to care for others**
- This is the most difficult aspect of working with the ASPD. The very language of the ASPD person is problematic (Gawada, 2010). Once the foundational work of relating to oneself with empathy and compassion and the longing to be loved for one's own sake is sufficiently consolidated, it is possible to introduce meaningfully the experience of caring for others. Obviously, if the ASPD person learns to love, his experience of life itself is transformed thereby creating an internal structure that is antithetical to ASPD.
- While many clinician and researcher are skeptical of such an outcome, individual clinicians may attest to the possibility of such an achievement. Given the prejudice that this cannot be done, if success is achieved, the temptation is to discount it by saying that the original diagnosis was not correct to start with or that the change is only temporary. In many ways the persons afflicted with ASPD are the modern lepers of the psychiatric world, and very many of them are removed from the society to colonies of prisons.

The hope!

- The hope for anti-social personality structure to be restructured needs to be kept alive as there are more than six million individuals in the United States alone who suffer from this malady. The whole society pays a heavy price. The prisons and State mental hospitals are heavily populated with people who are afflicted with ASPD. Psychotherapy has been found to be a highly effective tool in many other settings (Wampold, 2007; 2010).
- Psychotherapy with ASPD has not been conclusively demonstrated to be effective. Hopefully, this article will stimulate additional research in this important issue.

Thanks for listening & Participating

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