Biopsychosocial Treatment of Antisocial and Conduct-Disordered Offenders

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AS MORE RESEARCH literature is developed on the mental health treatment of offenders, it is apparent that approaches need to be explored that synthesize strategies and interventions from the fields of biology, psychology, and sociology. Many clinicians are aware of the current research that guides treatment services to use cognitive-behavioral and social learning theories and methodologies (Andrews and Bonta, 1998). This psychosocial approach, coupled with an understanding of biological bases of human behavior, symbolizes the essential components of the biopsychosocial treatment strategy.

In the 1960s and 1970s, personality disorders were often conceptualized in terms of character-based problem behavior. Diagnostic profiles of individuals who abused alcohol and were caught committing anti-social acts referred to these individuals as character disordered. Implicit in this type of description is the belief that substantial flaws exist in their ethical and moral thinking and the resulting behavior is the result of this disorder. During the 1980s and 1990s, biological research of the study of personality characteristics and temperament determined a common base that is really one and the same issue (Sperry, 1999).

Descriptions of personality disorders in the Diagnostic and Statistical Manual (DSM), Edition 1 and 2, supported the emphasis on character and the underlining psychodynamics of these individuals. The analytical community used characterological traits as one aspect of why individuals engage in certain behaviors and use specific defense mechanisms to maintain them. Recent thinking tends to view personality disorders in a much broader perspective, but includes both characterological and temperament issues. Biosocial and neurobiological conceptualizations of personality disorders have attracted considerable focus and generated a significant volume of clinical research. For example, Millon (1996) and Cloninger et al. (1993) have hypothesized that neurotransmitters and temperament greatly affect personality development and functioning. Another researcher (Stone, 1993) described the personality as a merging of both character and temperament.

The concepts of character and temperament are both significant to the theme of this article. Character refers to the psychological and social reinforcers that impact personality development. Character is therefore formed largely because of the socialization process (learned behavior) that an individual experiences. Other psychological issues also affect personality development, such as how cooperative a person may be, and his or her degree of self-concept, self-purpose, or assertiveness. All of these terms are useful for clarifying the term "character." Several authors (Horowitz, 1988; Slap, & Slap-Shelton, 1981) from psychoanalytic traditions and others from cognitive traditions (Beck, 1964; Young, 1994) have defined the logical component of the personality using the term "schema." Their views reflect the basic belief that within their life, individuals organize their view of the self, the world, their experiences, past events, and belief in the future around a central logic, or schema.

Temperament, on the other hand, refers to the genetic or innate influences on personality. While character and schema reflect the psychological dimension of personality, temperament or a personal style reflect the biological dimensions of personality. Cloninger et al. (1993) believe that temperament has four basic biological dimensions: novelty seeking, harm avoidance, reward dependence and persistence, while character is described as having three basic quantifiable dimensions: cooperativeness, self-directiveness and self-responsibility. Other researchers describe issues related to aggressive and impulsive behavior as additional dimensions of the concept of temperament (Costello 1996).

Clinicians use various methods to assess character and temperament, ranging from file review, self-report instruments, and psychological testing to clinical interviews. The importance of distinguishing between the personality factors of temperament and character prior to treatment planning phase is significant to the ultimate prognosis of any given client.

Treatment of the Anti-Social

Prior to the 1980s, the primary goal of treating the anti-social client was to change his or her character structure. The outcomes with this model were mixed at best, even among those offenders motivated for treatment. For the most part, clinicians used a more traditional psychoanalytic or psychodynamic approach and attempted to use insight-orientated strategies like clarification and interpretation.

Current treatment methods are considerably different now from earlier approaches, primarily regarding the increased focus on structure of the treatment sessions and where the clinician takes a more active role in the process (Beitman, 1991; Millon, 1996; Stone, 1993;

Sperry, 1995a; Andrews & Bonta, 1998; Sperry, 1999). Many treatment interventions approaches are based upon theories, but have been researched in clinical trials comparing them to other treatment modularities and approaches such as group therapy, family therapy, medications, and cognitive behavioral approaches. The cognitive approach (Beck, Freeman & Associates, 1990) and the interpersonal psychotherapy approach (Benjamin, 1993) have been modified for the specific treatment of personality-disordered individuals.

The pharmacological research in the treatment of personality disorders has grown rapidly during the 1990s (Silk, 1996; Sperry 1995b). Until recently, many clinicians believed that medication did not effectively treat personality disorders, but could be used on Axis 1 conditions or target behaviors like depression and insomnia. This view is changing, as a number of mental health professionals realize that a psychopharmacological approach can and should be directed to the basic dimensions that underline the personality (Siever & Davis, 1991; Silk, 1996; Sperry 1995b). A psychobiological treatment model that is based upon treating the biological core of personality disorders proposed by Siever & Davis has considerable clinical research studies advocating this model. This model focuses on four dimensions of the human personality, as follows:

- Cognitive Perceptual Organizations. This dimension is associated with a schizoid personality for which a low dose of neuroleptics might be useful in treating this disorder.
- Impulsivity and Aggression. These are issues commonly found in borderline and antisocial personality disorders, for which seratonin blockers, known as selective seratonin **reuptake** inhibitors (SSRIs) can be useful.
- Affective Instability. Borderline histrionic personalities present this problem, for which tricyclic anti-depressants or seratonin blockers may be useful.
- Anxiety and Inhibition. Particularly found in the avoidance personality disorder, for which seratonin blockers and **Monoxidase Inhibitors** (MAOI) agents may be useful.

Among mental health professionals there is a growing belief that effective treatment of personality disorders should involve a combination of treatment approaches and modalities. The integration of these approaches is particularly important (Sperry 1995a). One author (Stone 1993) has suggested the combination of three basic approaches:

- **Supportive Interventions**, which are useful in fostering a therapeutic alliance and should be augmented with psychoanalytic interventions, which are useful in resolving counter transference at the outset of treatment;
- **Cognitive Behavioral Interventions,** which are useful in the development of new attitudes and habits; and
- **Medication Management,** along with group and individual treatment sessions, which can also reduce symptoms underlying target behaviors and increase the effectiveness of treatment outcomes.

The effort to integrate the approaches as well as a combined treatment modality would not have received much support ten to fifteen years ago, but after years of relatively poor treatment outcome data with this very difficult population, the integration and combination is reflecting a shift in our underlying perception and way of thinking about these types of treatment concerns and issues (Beitman, 1991).

General Treatment Principles

The following list of treatment principles may require some clinicians to examine their own attitudes and practice style, and to rethink how they conceptualize, assess, and treat personality disorders. Individuals who are recent graduates from clinical training programs will require less examination and adjustment of their approach strategies, having received this information recently.

Principle 1: Enhancing Motivation for Change

The clients' motivation for treatment and their current level of behavioral functioning are good indicators of their treatability and prognosis (Sperry, 1995a). Readiness refers to the clients' motivation and positive expectations for benefits from engaging in the treatment process. According to Sperry, there are four levels that are important to assess regarding motivation for treatment:

- Past history of treatment success
- Compliance with treatment orders
- Ability to change behavior patterns
- Ability to change negative habits

The level of functioning can also be operationalized (Sperry, 1999) in terms of the global assessment and function scale of the Diagnostic and Statistical Manual Fourth Edition, DSM IV-TR (Sperry, 1999).

According to one author (Stone, 1993), personality disorders can be classified in terms of their treatability. According to Stone, the classification of lower amenability to treatment includes paranoid, passive aggressive, schizoid, and the anti-social personality disorders, which include conduct disorder in adolescents. Stone went on to add that patients frequently show mixtures of features of the various disorders. Often this is largely dependant on the degree to which the features of the disorders in the other category tend to be present. The client's prognosis will also depend on the dominance of the psychobiological dimensions described earlier (Siever & Davis, 1991) and how the behaviors respond to medication and psychosocial interventions.

Principle 2: Integrated Multi-Modal Treatment is Necessary

A combined treatment approach refers to adding modalities such as group, individual, family, or couple either concurrently or sequentially, whereas the integrative treatment refers to the blending of approaches and theoretical models such as social learning, psychodynamic, cognitive-behavioral, interpersonal, etc. Individualized treatment refers to the specific ways of customizing treatment modalities and approaches to fit the unique emotional needs, cognitive style, and treatment expectations of your client. Treatment delivered in the integrated method can have an additive, sometimes called synergistic, effect. The synergistic effect refers to a way of thinking mathematically conceptualized as "one plus one equals three," where an additional one is created as a result of enhancement from merging two other treatment methods. A practical example of this equation would be a cognitive-behavioral combined with a group therapy approach, which requires interpersonal skills development to be effective. Thus (1) cognitive behavioral plus (1) group therapy plus an invisible (1) interpersonal process equals (3) the enhanced treatment effect. The practicality of this view yields a belief that the lower the level of treatability, the more modalities and approaches need to be combined and blended to more effectively attempt to treat a difficult client.

Principle 3: Effective Treatment, General and Specific Treatment Goals

The treatment goals for working with personality-disordered individuals can be described as consisting of four basic levels of interventions. The four goals involve

1. reducing symptoms
2. modulating the temperament dimensions of the personality
3. reducing impaired social, occupational, and relational functioning
4. modifying character issues or underlying patterns or dimensions of the personality disorder

It should be noted that in goals two and four, the treatment emphasis is on modification of personality traits rather than radical restructuring. One author (Stone, 1993) used as an analogy of a cabinetmaker and a carpenter to illustrate the treatment goals of character and temperament. He compared the clinician working with personality-disordered individuals to a cabinetmaker who sands down the rough edges of the structure, rather than the carpenter who builds it. The patients' character and temperament remain, but treatment renders the individual easier to live with. Achieving level one and three goals are easier than achieving level two and four goals through the use of mediation and other cognitive-behavioral treatments such as thought stopping, which can quickly reduce symptoms of the targeted negative behaviors. Advice and limit setting, encouragement and environmental restructuring are also often useful in achieving higher levels of social and emotional functioning.

The most challenging and time intensive aspect of the treatment of the personality-disordered individual involves modification of character issues and the modulation of their temperament. Various interventions have been designed to modify character, whereas medications and skill training have been more effective in modulating temperament. Clinical research and practical experience (Freeman & Davis, 1997; Lineman, Drummer, Howard & Armstrong, 1993) have suggested that the modulation of temperament or interpersonal styles must come before the modification of character structures or underlying personality schemas. As discussed here, modulation refers to normalizing the cognitive style or response pattern that an individual uses when interacting with others. An example would be a modulation of one's response to criticism, which can range from anger, rage, and revenge to acceptance of the criticism as constructive, and all the attitudes and behaviors between those opposing perspectives.

When attempts are made to modify character issues before teaching a client to modulate their temperament, negative reactions to the therapist can often occur. The client reacting in this manner will often act out, or regress in a way that could lead to extremely inappropriate or violent outbursts.

Some of the behaviors that must be addressed for the personality disordered client become specific treatment targets. For example, when regarding schema (pattern) change in cognitive therapy, specific treatment goals can be stated in terms of the level of change possible or desirable. Researchers (Beck, Freeman & Associates, 1990) have postulated four levels of schema change, ranging from the maximum level of change, which is called schema reconstruction, to schema camouflage, which is the minimum level of change. Schema reconstruction may require a long-term commitment like receiving treatment in a therapeutic community or a highly structured long-term outpatient program. The schema camouflage treatment is often common in short-term interventions when working with conduct disordered adolescents and anti-social adults. Anger management and other social skills programs tend to cover up or camouflage underlying issues.

Principle 4: Diagnose and Treat Separately

It is very common for clients at different times to present behavior and symptoms of two or more personality disorders (Millon, 1996). In these instances the manifestation of each disorder may not occur simultaneously, or the features of the disorders can blend. In other words, temperament and characterological manifestations of personality disorders tend to be similar in nature to swirled ice cream of two different colors but complimentary tastes. Therefore, an overall treatment strategy for clients who have more than one personality disorder is to focus on the principle character and temperament styles and behaviors that are the most troublesome and distressing to the client, the clinician, and society. As other manifestations of the disorder appear, work with them, but return to the principle target behaviors. One important marker for determining when real change has occurred is that the separate manifestations of the different personality disorders become less pronounced and muted features of those disorders appear to blend. For example, an individual with high levels of impulsivity and aggressiveness who was successfully treated and placed in an extremely stressful situation would exhibit far less impulsive or aggressive behavior. The individual may still become angry, but with appropriate treatment learn to control impulsive and angry or severe passive-aggressive behaviors.

Stages of Treatment

Many authors have described various categorization schemes to define the change process (Beitman, 1991; Sperry 1999; Prochaska & DiClementi, 1982). With numerous available strategies to categorize the therapeutic or change process, the following is offered to simplify the categorization schemes cited earlier. This six-part categorization process of change is as follows:

- Client engagement in treatment
- Creation of a therapeutic alliance
- Identification of target behaviors and features
- Modification of maladapted patterns
- Development of positive pattern maintenance protocols (relapse plans)
- Maintenance of new patterns and modification of treatment goals if necessary

The first two issues, client engagement in treatment and creating a therapeutic alliance, refer to the process of developing a relationship with the client. This alliance process requires the client to trust, respect, and accept some influence of the provider, and for the provider to remain as empathetic as possible in order to establish a positive working relationship. This alliance is essential to the ultimate success of the therapeutic process. If change is to be achieved, a positive alliance between client and provider must be developed. If a client shows willingness to collaborate and begins to take more responsibility for making the necessary changes to improve the quality of life, consider this a positive indication that an alliance has been formed. It is for this reason that the first tasks of treatment are to develop a positive relationship with the client. With some offenders, standing up to their manipulations may be a necessary step in the development of a treatment relationship.

One of the primary issues in the engagement process is the socialization ultimately resulting in a treatment contract between provider and client. The contract could relate to the length of sessions, duration of treatment, fees (where appropriate), and a willingness to learn the basic process necessary to understand the treatment. The most important function of the engagement process is the clarification of expectations, goals, roles, responsibilities and functions for both client and provider. A key step in this stage is determining clients' readiness and motivation to treatment and, if necessary, increasing their motivation for participation and treatment. Prochaska & DiClementi (1982) describe a method of categorizing four levels of a client's motivation to change, which are:

- Pre-contemplation: a client denies need for treatment or that a problem exists;
- Contemplation: client accepts that he or she may have a problem and treatment may be necessary;
- Action: client has decided to begin making changes and actively seeks those people and experiences crucial to the process;
- Maintenance: client sustains the change, prevents relapse, and adapts successfully to new problems or different layers of old ones.

Another obvious part of the development of the engagement process is issues related to the concepts of transference and counter-transference. These issues often emerge in the engagement process in subtle and obvious ways. Frequently, personality-disordered individuals have extreme boundary problems and love to test the sincerity and integrity of anyone working with them.

The terms transference and counter-transference come out of the field of psychoanalysis and refer to the quality and type of relationship that's formed between a client and an individual working with them. Transference refers to a positive relationship that has developed, while counter-transference refers to a professional relationship with many negative components based in it.

Transference is defined as the emotional and behavioral reaction of the resident toward the staff member. A helping person represents a positive authority figure; the ideal. A healthy, trusting relationship is ideal, but not always possible with all residents. Transference develops by your position, duties and appearance. Transference is also shown by the manner used to exchange information and should be therapeutic. Encouragement and use of resident's self-disclosure in treatment planning and sessions; maintenance of appropriate boundaries (behaviors and conversation) within the resident/staff relationship is also important in the transference process.

Counter-transference is defined as unhelpful responses like rage, hatred, or physical violence, or, conversely, sympathy, self-disclosure, or inappropriate emotional/physical relationship by the staff to the resident. Resident sessions should not center on inappropriate needs or issues of the worker. Counter-transference is counter-therapeutic, and is *not* a goal in the treatment plan, determined by the treatment team. Counter-transference develops by the staff's focus on their unresolved relationships (current and past) and needs instead of on the clients'.

Staff always need to remember that residents are skilled in identifying and exploiting staff's unresolved current and past needs for their gain and almost always with disastrous personal/professional consequences for the staff person. Behavioral and emotional "triggers" are presented by the resident and responded to by the staff person. These triggers can be physical traits of the resident, behaviors similar to someone important to the staff person (either positive or negative), tone of voice and/or accent and a similar lifestyle or history.

Contemplation involves the clients beginning to think about, talk about, and hopefully understand the underlying patterns in their thinking, feeling, and behaviors. At this point, the client should begin to analyze their patterns and day-to-day behaviors, and learn to understand how these characterological patterns relate to their interpersonal styles and temperament. The next step is to understand the triggers for these patterns and determine whether or not they are willing to give them up. The approach now involves conducting a functional evaluation interview. The client receives psychological testing or screening plus a clinical interview to determine the patterns in their lives.

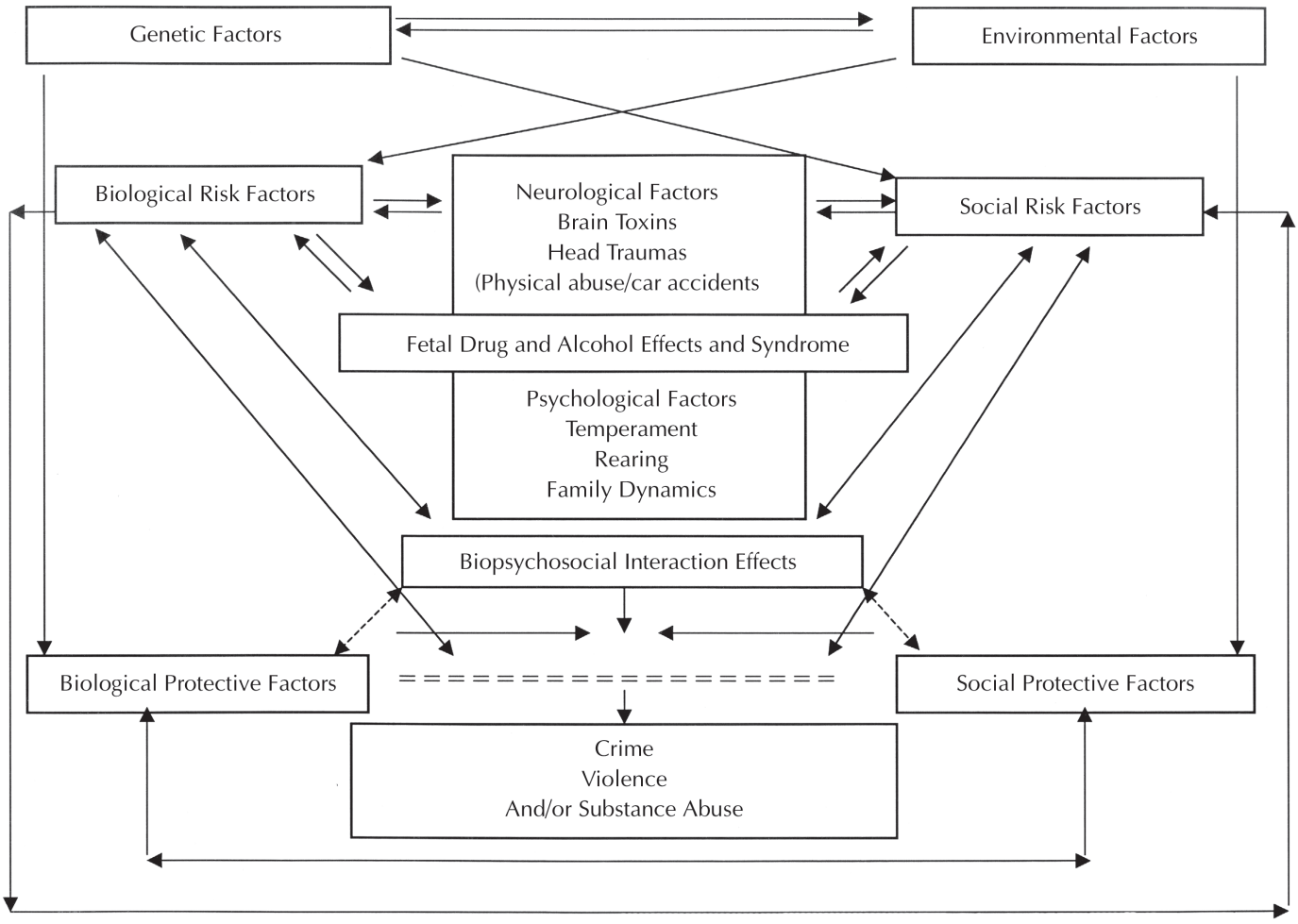
Issue four deals with the modification of the maladaptive pattern. This stage in the treatment process refers to the process of defining specific maladaptive behavior patterns that need to be modified or changed. With a personality-disordered individual, the clinical focus must often include both schemes and styles. The process that results in therapeutic change involves three steps:

- Relinquish maladaptive pattern(s)
- Enhance or develop positive adaptive pattern
- Generalize new pattern to varied situations; new pattern is generalized

A specific strategy for pattern change targets specific disorders, styles, and schemas. These maladaptive patterns are enduring, persuasive, and often inflexible, and reflect the client's core belief about their self and the world around them. When working with someone's cognitions, beliefs, and behaviors the goal of treatment is to in some way measure the change in these beliefs showing that a treated client is someone more flexible and functional. Treatment can restructure, modify, and reinterpret these underlying patterns (Laiden, Newman, Freeman & Morris, 1993). Modulation is a state in which the client perceives action in which spontaneity is experienced with pretense or exaggeration, and where coping with problems can lead to socially accepted and responsible behavior. Disordered behavioral styles are common among personality disordered individuals, and are accompanied by either an over- or under-modulation which requires a treatment goal to balance their ability to modulate both temperament and self-control issues. Many personality-disordered individuals never adequately learned these skills during their formative years, which makes it necessary to reverse their specific negative skill deficits during treatment. This is often done within individual or group therapy sessions, or psycho-educational classes where new skills can be learned and practiced.

As the new behavioral pattern becomes the standard for the client's life, the issue of preventing relapse and re-occurrence must be addressed as a formal component of treatment. As fewer treatment sessions become necessary, the issue of termination may become a therapeutic focus. When working with offenders in prisons and jails, their sentences often coincide with the direct termination of treatment. This is different for practitioners and providers who work with adolescents or adult offenders in the community. New symptoms may appear or old ones may resurface, prompting a request for one or more additional sessions, often when difficulty with separation or abandonment issues are part of the maladaptive pattern of offenders. Positive termination and separation can be a treatment goal for these clients.

Biopsychosocial Factors in Crime, Violence and Substance Abuse



The biopsychosocial approach to treatment requires tailoring the interventions to manage the client's behavior and ultimately meet their need. Treatment will be delivered in combination and hopefully yield a synergistic effect. Different treatment approaches and combinations tend to be effective in resolving different types and clusters of symptoms.

References:

Andrews, D.A., & Bonta, J. (1998) *The Psychology of Criminal Conduct.* Cincinnati, OH: Anderson Publishing Co.

Beck, A. (1964) Thinking and depression: II: Theory and therapy. *Archives of General Psychiatry,* 10, 561–571.

Cloninger, R., Svrakic, D., & Prybeck, T. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry,* 50, 975–990.

Costello, C. (Ed.). (1996). *Personality characteristics of personality disordered.* New York: Wiley.

Horowitz, M. (1988) *Introduction to psychodynamics: A new synthesis.* New York: Basic Books.

Millon, T. (1996) *Disorders of personality: DSM-IV and beyond* (2nd ed.). New York: Wiley.

Prochaska, J., & DiClementi, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy,* 19, 276–288.

Slap, J., & Slap-Shelton, L. (1981) *The schema in clinical psychoanalysis.* Hillsdale, NJ: Analytic Press.

Sperry, L. (1999) Cognitive Behavior Therapy of DSM-IV Personality Disorders: Highly Effective Interventions for the Most Common Personality Disorders. Philadelphia: Brunner/Mazel.

Stone, M. (1993). *Abnormalities of personality: Within and beyond the realm of treatment.* New York: Norton.

Young, J. (1994). *Cognitive therapy for personality disorders: A schema-focused approach* (rev. ed.) Sarasota, FL: Professional Resource Exchange.