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Antisocial Personality Disorder: A Mentalizing Framework

Abstract: Antisocial personality disorder (ASPD) is a common condition with major public health implications. Yet effective treatment remains elusive. In this paper the major descriptive symptoms of ASPD are considered using a mentalizing framework. Mentalizing is the implicit or explicit perception or interpretation of the actions of others or oneself as intentional, that is, mediated by mental states or mental processes. It is considered as four intersecting dimensions: automatic/controlled or implicit/explicit; internally/externally based; self/other orientated; and cognitive/affective process. People with ASPD show problems with self/other mentalizing particularly in terms of empathic understanding of others. Their focus is biased toward external mentalizing with little regard for the internal mentalizing of others. The translation of this understanding into a clinical treatment program is discussed. The program is based on the current, evidence-based, mentalization-based treatment (MBT) for borderline personality disorder but with adaptations targeting the mentalizing difficulties of people with ASPD. A group and individual program is used. Some clinical interventions are exampled in the paper.

DEFINITION

Antisocial personality disorder (ASPD) is classified in the DSM-IV (1) as an axis II personality disorder under cluster B, together with borderline, histrionic and narcissistic personality disorder. ASPD is characterized by failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest; deception, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure; impulsiveness or failure to plan ahead; irritability and aggressiveness, as indicated by repeated physical fights or assaults; reckless disregard for safety of self or others; consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations; and lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another. For a formal diagnosis there must be evidence of conduct disorder with onset before age 15 years.

EPIDEMIOLOGY

ASPD is a common condition with the general population prevalence in men ranging from 1%–2% (2, 3) to 6% (4). Prevalence rates are

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consistently higher in men compared with women and, as would be expected, ASPD becomes increasingly common in mental health services, the judicial system, and prison settings (5). It is associated with considerable comorbidity (6), especially with other personality disorders, substance misuse (7), and other axis I conditions (8) (9) and also with increased mortality, particularly at a young age, largely because of reckless behavior (10).

PUBLIC HEALTH IMPLICATIONS

ASPD has major public health implications. Treatment for those affected by violence costs an estimated 3%−6% of the health budget in the U.K. (11), primarily due to the association with drug abuse, suicide, early unnatural death, violent crime, unemployment, homelessness, and family violence (12, 13). The disorder has a broad impact on families, relationships, and social functioning but also people with ASPD make heavy demands on social services, mental health services, and the judicial system. The disorder has a significant association with high level of imprisonment. In the U.K. prison population, the prevalence of people with ASPD has been identified as 63% male remand prisoners, 49% male sentenced prisoners, and 31% female prisoners (5). Consequently, it has a great economic cost (14).

SERVICE PROVISION

Despite the recognition of its high prevalence and level of psychiatric morbidity, there is evidence that those with ASPD continue to be rejected from services because clinicians believe that treatment is ineffective. Patients with ASPD have mental health needs and present to general mental health services and the criminal justice system but receive only brief intervention or, more likely, punishment. Crawford et al. (15) found that 96% of a study sample met criteria for anxiety disorder and 64% had evidence of alcohol misuse; 50% presented to emergency medical services and 21% were admitted to a mental health inpatient unit during the following year. Despite this, few were provided with follow-up care from mental health services when they presented. Of those that were offered some treatment, levels of alcohol and drug misuse were significantly lower over follow-up, suggesting that general psychiatric support can be useful.

People with ASPD who commit offenses may enter forensic psychiatric services only to be discharged to general mental health services where no treatment is available. More emphasis is needed to avert patients with ASPD being managed in more secure settings and to prevent patients being in-

Table 1. Personality Disorder and Mentalizing Dimensions

Dimension	Personality Disorder			
	BPD	ASPD	NPD	Paranoid
Self/other	+/+++	+/+++	+++/−	+++/−
External/ internal	+++/+	+++/+	+/+++	+/+++
Implicit/ explicit	+++/+	+++/+	++/++	++/++
Cognitive/ affective	+/+++	++/−	++/+	++/++

appropriately rejected from mainstream services. If a relatively brief and effective treatment can be offered to people with ASPD living in the community, this may reduce contact with the criminal justice system, have the potential to improve the lives of people with ASPD, improve access to services, and also reduce health and nonhealth service costs. These are the aims of a treatment program adapting mentalization-based treatment for people with ASPD, which is the topic of this paper.

MENTALIZING

Mentalizing is the implicit or explicit perception or interpretation of the actions of others or oneself as intentional, that is, mediated by mental states or mental processes (16). It is a multidimensional construct, and breaking it down into dimensional components is helpful in understanding mentalization-based treatment (MBT) (17). Broadly speaking, mentalization can be considered as four intersecting dimensions: automatic/controlled or implicit/explicit; internally/externally based; self/other oriented; and cognitive/affective process (Table 1). Each of these dimensions possibly relates to a different neuro-biological system ("Broadening the scope of the mentalization based approach to psychopathology: mentalization as a multi-dimensional construct." Unpublished study of Luyten P, Fonagy P, Mayes LC, Vermote R, Lowyck B, Bateman A). The key to successful mentalizing is the integration of all the dimensions into a coherent whole. None of us manage to integrate all components of mentalizing all of the time, and nor should we. Normal people will, at times, move from understanding their own motives and those of others according to their consideration of what is in the mind, to explanations based on the physical environment ("I must have wanted to because I did it"; "If they behave like that, they obviously want to spoil everything"). This move from an evaluation of

mental process to a focus on physical actions as an explanation is particularly true in powerful affective states when our cognitive processes fragment in the face of a wave of emotion.

Implicit (Automatic) and Explicit (Controlled) Mentalizing

Implicit mentalization is a nonconscious, unreflective, procedural function. As Simon Baron-Cohen put it, "We mind-read all the time, effortlessly, automatically and mostly unconsciously" (18). Explicit mentalization is only likely to happen when we hit an interactive snag (19). Explicit mentalization, particularly when it is of a higher order, can be the apparent substance of psychological therapy, for example the patient is asked to reflect upon his awareness of what someone else might think about the same situation or the patient is asked to evaluate his own thoughts and appraise them more carefully against some agreed criteria. It is important to note that explicit mentalization (meta-cognition) can only be considered genuine and productive when the link between these cognitions and emotional experience is strong. This is a problem in people with ASPD, who may be asked during treatment to undertake explicit mentalizing but who do not attach any emotional salience to the understanding.

Self and Other Mentalizing

Impairments and imbalances in the capacity to reflect about oneself and others are common, and it is only when they become more extreme that they begin to cause problems. People with ASPD become expert at reading other people's minds and misuse this ability or exploit it for their own gain. Other individuals may focus on themselves and their own internal states and become experts in what others can do for them to meet their requirements. These are narcissistic characteristics. Thus excessive concentration on either the self or other leads to one-sided relationships and distortions in social interaction. Inevitably this will be reflected in how patients present for treatment and interact with their clinicians.

External and Internal Mentalizing

Internal mentalizing refers to a focus on one's own or others' internal states (i.e., thoughts, feelings, desires); external mentalizing implies a reliance on external features such as facial expression and behavior. This is not the same as the self/other dimension which relates to the actual object of focus; mentalization focused on a psychological interior

may be self or other oriented. This is discussed in relation to ASPD later.

Cognitive and affective mentalizing. The final dimension to consider relates to cognitive and emotional processing – belief, reasoning, and perspective taking on the one hand and emotional empathy, subjective self-experience, and mentalized affectivity on the other (20). A high level of mentalizing requires integration of both cognitive and affective processes. People with antisocial personality disorder invest considerable time in cognitive understanding of mental states to the detriment of both their own affective experience (21) and that of the other person.

Since normal people lose mentalizing and the process itself fluctuates naturally, for example with context and mood, it follows that personality pathology does not simply arise because of a loss of mentalizing. It occurs for a number of reasons. First, it matters how easily we lose our capacity to mentalize: some individuals, for instance, are sensitive and reactive, rapidly moving to nonmentalizing modes in a wide range of contexts. Second, it matters how quickly we regain mentalizing once it has been lost. We have suggested that a combination of frequent, rapid, and easily provoked loss of mentalizing within interpersonal relationships, with associated difficulties in regaining mentalizing and the consequent lengthy exposure to nonmentalizing modes of experience, is characteristic of borderline personality disorder (22). Third, mentalizing can become rigid, lacking flexibility. People with paranoid disorder, for example, often show rigid hyper-mentalization with regard to their own internal mental states and lack any real understanding of others (23, 24). At best they are suspicious of motives and at worst they see people as having specific malign motives and cannot be persuaded otherwise. The mental processes of people with ASPD are less rigid than those found in paranoid people. Finally, the balance of the interesting dimensions of mentalizing can be distorted. As we have mentioned, patients with narcissistic personality have a well-developed self-focus but a very limited understanding of others (25). In contrast, patients with ASPD are experts at reading the inner states of others from a cognitive perspective while being unable to identify empathically with their state, i.e., they demonstrate reasonable other/cognitive mentalizing but lack aspects of other/affective mentalizing. In addition they misuse their cognitive/other mentalizing abilities to coerce or manipulate others. It is also likely that they avoid self/affective states and so fail to develop any real understanding of their own inner world and their motives (21). Finally, people with ASPD lack the ability to read certain emotions, or perhaps even

a range of emotions, accurately. This is the externally based focus of mentalizing. While this formulation of the mentalizing problems in ASPD is speculative it forms the basis for further research and is supported to some degree by our current knowledge.

NEUROBIOLOGY

The link between ASPD and the affective and external components of mentalizing is well established both developmentally and in adults. Marsh and Blair (26) in a meta-analysis of 20 studies showed a robust link between antisocial behavior and specific deficits in recognizing fearful expressions, an external component of mentalizing. This impairment was not attributed solely to task difficulty. Failure to recognize fearful faces implies dysfunction in neural structures such as the amygdala that subserve fearful expression processing. Youths with conduct problems have been shown to have a hypo-activation of their amygdala in response to pictures normally considered emotionally arousing, particularly where a potentially painful aggressive act was depicted (27). Amygdala hyporesponsiveness may indicate a dysfunction in limbic structures leading to reduced responsiveness of the amygdala to fearful faces and consequent impairment in recognizing distress cues in others. This leads to a lack of empathy and deficient control of aggressive behavior, which would normally be inhibited by observation and empathic identification of distress in another (affective/other mentalizing). Alternatively we may see these abnormalities as reduced sensitivity to stimuli indicating threat (fearlessness). Developmentally it is likely that preferential amygdala responses to fearful faces are reserved for the modulation of vigilance primarily in threatening situations rather than subserving recognition of social cues in everyday situations. However, constitutional fearlessness would stop infants from regularly seeking their attachment figure when experiencing distress; this intersubjective experience of relating in an attachment context may be critical for the normal development of mentalizing and social cognition (28). Mentalizing inhibits unwarranted aggression. So there may be a complex interaction between constitutional fearfulness and its effect on the development of the normal inhibitory factors protecting against antisocial interaction.

In contrast amygdala hyper-responsiveness has also been observed in some individuals. They show a hyperactivation of the amygdala on seeing a hand shut in a door or a foot being stamped on (29). Here, amygdala responses in conduct-disordered youths correlated with parents' ratings of daring behavior and sadism. Increased amygdala response may indicate excitement or enjoyment of others' pain. The suggestion here is that for some individuals these images may generate an unusual level of enjoyment rather than empathetic concern. In either case, the dysfunction of emotional resonance or empathy appears to be linked to vulnerability for antisocial behavior and the clinical and theoretical exploration of this relationship appears warranted. Examining the role of empathy, the ability to understand and care about the emotions of others, in antisocial individuals Baron-Cohen found that lack of care for others led to antisocial and destructive behaviors possibly due to a partial but fundamental impairment of mentalizing, "mindreading without empathizing" (30).

More recently other researchers (e.g., 31) have suggested that antisocial actions and psychopathy may be associated with abnormal attention to socially relevant cues such as scanning the eyes, and that dysfunction in attentional mechanisms underlies emotion recognition deficits (32, 33). Lack of attention to the eyes implies a more general problem with the external component of mentalizing and loss of association and interest in links to internal mental states. This suggests there may be an extensive reduction in ability to recognize emotions in others rather than a specific diminution in ability to recognize fear. If deficits in processing emotion cues are pervasive, which would be consistent with the idea of reduced external mentalizing, there are likely to be widespread difficulties in those social and interpersonal interactions requiring empathic and emotional responsiveness. Misreading emotion cues, or more likely not even registering them, will make it more difficult to understand the subtleties of others' perspectives. Certainly the internal affective state, which is a key component of empathy and mentalizing of the other person, will remain a mystery. So, although not recognizing others' distress cues may be important (34, 35), additional, more wide-ranging problems related to social and emotional functioning may contribute to the problems facing people with ASPD. This has important clinical implications.

CLINICAL IMPLICATIONS

Effective treatment offered to patients presenting to mental health services may improve not only the life of patients but also their families by improving social function of patients and reduce costs to the health and criminal justice systems by reducing aggressive acts that bring people with ASPD into contact with the law.

Traditionally there has been a lack of confidence and considerable skepticism from clinicians regarding psychological treatments and management options of patients with ASPD because of the inherent challenges associated with working with this group (36, 37). Interventions for some of the symptoms associated with antisocial personality disorder have been developed, principally for the treatment or management of aggression. However, the relevance of anger management programs may be limited. Anger is not explicitly included in the diagnostic criteria for antisocial personality disorder, and while anger may be related to impulsivity and aggression, reducing anger may not reduce impulsivity and aggression. Equally, when delivered to offenders, anger management interventions may reduce levels of anger without having an impact on offending, aggressive, or violent behaviors if the causes of those behaviors in an individual are unrelated to anger.

Interventions have been developed with the aim of reducing offending behavior. These include a wide range of cognitive and behavioral interventions (38–40) and to a lesser extent therapeutic communities (41). Within the U.K. criminal justice system the use of cognitive and behavioral interventions such as reasoning and rehabilitation (42) and enhanced thinking skills (43) is widespread.

Only a small number of careful research studies have been conducted among people with ASPD, so the evidence base for the treatment and management of this patient group is limited (44, 45). Most studies have been done in the context of penal programs, and few have been undertaken in general mental health settings. An early review by Vennard et al. (46) concluded that CBT methods combined with training in social skills and problem solving gave the most positive results with both juvenile and adult offenders, in terms of recidivism. However, even this complex intervention did not achieve large reductions in reoffending with mixed groups of offenders. Therapeutic communities were found to have the lowest success rate (47). There is some more recent but limited evidence for the effectiveness of cognitive behavioral therapy (CBT) alone. Data from a pilot randomized controlled trial in a general mental health setting of individual CBT among men with ASPD suggested that psychological treatments may have a role to play in helping to reduce the likelihood of reoffending (48).

More specific targeting of the emotional deficits found in ASPD may be more appropriate. If the deficits are restricted to fear and sadness this suggests interventions focused on increasing understanding and internalization of these specific emotions. However the current finding of more pervasive deficits suggests training of all emotions is likely to be useful, and indeed a recent study (49) has found emotion recognition training (ERT) across emotions and modalities to be effective for reducing problematic behaviors in children with high-callous unemotional traits.

MENTALIZATION-BASED TREATMENT (MBT)

Trials of MBT have shown it to be effective for BPD. These trials have included patients with ASPD. In a trial comparing MBT with structured clinical management (SCM) for patients with BPD, a subanalysis of the data showed that MBT was more effective than SCM in patients with ASPD (Unpublished [2012] study of Bateman, A and Fonagy, P). While the effectiveness of both treatments was attenuated in people with ASPD, this suggests that people with ASPD may benefit from a more focused program on their mentalizing problems. This study also suggested that MBT was superior to SCM in patients with comorbid axis II personality disorder. If MBT is more beneficial for patients whose BPD is embedded in other personality problems, how can we explain the paradox that treatment specifically designed for BPD may be beneficial for those with additional problems beyond the target of the therapy and, if so, could it be adapted appropriately for patients with different mentalizing problems such as those outlined for ASPD. We have limited data to answer this question. We may hypothesize that first, while MBT was designed for BPD, it may have broader scope. Mentalizing is a key component of self-identity and a central aspect of interpersonal relationships and social function. Thus, improvements in mentalizing may have an impact on a range of disordered mental processes whatever the source of pathology. If PD is conceptualized as a serious impairment in interpersonal relationships, intimacy, identity, and self-direction (50), enhancing mentalizing might benefit PD as a whole, regardless of subtype.

MBT integrates cognitive and relational components of therapy and has a theoretical basis in attachment theory. MBT was developed for people with borderline personality disorder and therefore focused on mentalizing problems associated with high emotional arousal in the context of attachment relationships. Adaptation of this basic model is necessary for people with ASPD not only because their mentalizing problems differ from those found in BPD but also for a number of other descriptive reasons. First, people with ASPD are more likely to demonstrate over-control of their emotional states

within well-structured, schematic attachment relationships rather than under-control in chaotic attachment relationships, which are more commonly found in people with BPD. Second, people with ASPD tend to seek relationships that are organized hierarchically, with each person knowing his or her place, whereas people with BPD tend to struggle to reach consensus and shared respect. Third, it is specifically threats to the hierarchical order of relationships that lead to arousal within the attachment system in people with ASPD; this triggers an inhibition of mentalizing that in turn leads to fears of inability to control internal states. It has been suggested that the internal state most feared by people with ASPD are threats to self-esteem (51). Patients with ASPD inflate their self-esteem by demanding respect from others, controlling the people around them, creating an atmosphere of fear. This maintains pride, prestige, and status. Loss of status is devastating as it potentially reveals shameful internal states that threaten to overwhelm, so any threat of loss of status becomes firmly rooted as a dangerous reality that has to be dealt with by physical force. Momentary inability to mentalize, to see behind the threats to what is in the mind of the person apparently threatening them, means they have no way of keeping out a rapidly lowering self-esteem and loss of position. Emotional capacities such as guilt and love toward others and fear for the self may protect from engaging in violent behavior but the loss of mentalizing and the embryonic ability of these patients to experience such feelings prevent mobilization of these inhibitory mechanisms. Fourth, if the reduction in ability to recognize others' emotions is more pervasive than being restricted to fear and sadness, then a focus in treatment on recognition of all emotions in others is essential. Finally fear for the self is often absent and violent impulses are uninfluenced by the emotional expressions of others, which go unrecognized. Indeed the consequences and dangers of aggression become secondary.

FOCUS OF MBT FOR ASPD

In the light of the theoretical and clinical understanding of the roots of violence in people with ASPD outlined in this paper, MBT for ASPD focuses on:

1. Understanding emotional cues: external mentalizing and its link to internal states
2. Recognition of emotions in others: other/affective mentalizing
3. Exploration of sensitivity to hierarchy and authority: self/cognitive

4. Generation of an interpersonal process to understand subtleties of others' experience in relation to ones' own: self/other mentalizing
5. Explication of threats to loss of mentalizing which lead to teleological understanding of motivation: self/other mentalizing and self/affective mentalizing

Mentalizing group therapy is the core mode of treatment. Individual sessions with the group clinician are offered monthly to process problems experienced in the group. This treatment format has been outlined elsewhere (21). Group work is essential for people with ASPD. Many people with ASPD live within a subculture of barely restrained violence and implicit threats; in this regard they are more likely to be influenced by their peer group than by clinicians who they see as unlikely to understand the socio-cultural context in which they live. More importantly, group work stimulates a hierarchical process within a peer group, which can be harnessed in vivo by the clinicians to explore the participant's sensitivity to hierarchy and authority and their mentalizing distortions.

PRINCIPLES OF MBT GROUP FOR ASPD

MBT is underpinned by two main principles (52):

1. Any intervention that facilitates the development of mentalizing may be used.
2. There must be a concomitant avoidance of interactions that decrease mentalizing or maintain nonmentalizing.

These principles apply in MBT for ASPD. In addition, as a heuristic, the interventional process used for each of the 5 foci outlined above can be divided into mentalizing education and mentalizing process components. A few important clinical areas will be summarized here to illustrate aspects of MBT for ASPD.

Mentalizing education. In order to stimulate an understanding of emotional cues, a series of introductory groups includes sessions on the nature of emotion, facial expressions, and other nonverbal behaviors, including tone of voice, gesture, eye movement and gaze, and posture, along with the nature of truth telling and lying and the nonverbal signals associated with both. Sessions are provided about the form that relationships take in terms of mutuality versus hierarchy. A series of focused discussions has been developed in which patients are asked to give examples. Initially impersonal, non-intimate examples are requested to guard against harmful induction of shame. For example the

patients may be asked to talk about events that they have observed but not participated in or discuss a relationship a friend has with a partner. This request often stimulates stories about the interaction people with ASPD have with police whom they experience as targeting them and trying to triumph over them. The final session in this series of 12 sessions focuses on the treatment process itself and the difficulties that patients might encounter in treatment. This session includes discussion about what to do in situations commonly encountered in treatment, e.g., feeling diminished by another member of the group, disliking someone in the group (including the clinician), feeling misunderstood, interpersonal triggers that mobilize aggression.

Mentalizing process. The clinician facilitates an interactional group process and to do so takes a degree of authority. This authority is specified at the beginning of treatment in terms of a directive to the clinician to begin each group with a "go-around," that is, asking each patient if he has any incidents or concerns that he would like help with during the group ("Is there anything that you definitely want some help with from the group today and would not like to leave without having talked about it?"). The clinician should not be deflected from this task. All patients should have answered this question, even if only to a limited extent, during the first 10 minutes. It is explicitly recognized between the patients and the clinician that this is a position of control and authority on the part of the clinician but that it is in the service of a therapeutic task. It requires the patients to be subservient to some degree.

Once the go-around is complete, the clinician opens up the group and becomes the "servant" of the patient group while maintaining his/her authority to direct the group to keep to task. In the context of a patient starting to discuss an incident in his life, the clinician does not focus on the content of the story but more on the affect that may be expressed by the individual as he tells the story. It is important to ask the person to talk about himself and not to allow him to spend considerable time outlining the faults of others. This is common for people with ASPD but distracts from the focus, which is for the patient to identify how he feels (self-affective mentalizing) and also for the other members of the group to monitor him closely using their external mentalizing process to grasp how he feels (other-affective mentalizing). The clinician asks two questions—first, what do the others think the story-teller feels and second, what makes them suggest the person has such a feeling. Following discussion the clinician may ask for corroboration from the story-teller of the experience of the others in the group and explore differences between their sense of the story-tellers

feeling and his own identification of how he feels. This increases the links between external and internal mentalizing and encourages the participants to ask each other about internal states ("You come across as hurt but you say you are angry. Can you describe the difference between those feelings for you and if you think there is some 'hurt' in there?").

Some treatments for ASPD use interventions with the aim of stimulating an individual to consider the effect of his actions on others, for example restorative justice programs and victim impact programs. MBT for ASPD does not involve the victims of crime and is more concerned with helping the individual manage violent impulses. This is mentioned here primarily because clinicians may naturally ask patients about their thoughts of the "other's" (victim) experience or, in the case of incidents with the police and others in the justice system, about their motives. This type of intervention is problematic in people with ASPD because they do not experience mental pain and internal affective states, for example guilt, associated with the other's state of mind. Such interventions are a more useful intervention in patients in whom conflict, when engendered by recognition of painful experience of the other, is aversive through a process of empathic identification. This ability may be present in some patients with less severe ASPD but more commonly it is only rudimentary; the experience of the other person, in so far as it affects the other person, is of little interest to people with ASPD. Attempts to generate conflict and guilt in ASPD, for example by asking patients in group therapy to think about the victim, are therefore relatively ineffective in inducing change and may be harmful to some degree by maintaining nonmentalizing. Instead, as discussed earlier, participants are asked not so much to consider their effect on others but more to consider the emotions of others and how they have come to their opinion. In effect the patient has to describe his external mentalizing evidence, that is what has been noticed about the others' behavior, appearance, eye movement. This is followed by work on linking that evidence to the internal state of the other person and reappraising it if necessary. While external mentalizing evidence allows inferences about internal states of others, it is only explicit mentalizing process that can confirm or disconfirm suppositions.

Challenging teleological explanations. Finally, understanding motivation of others and giving meaning to relationships is commonly based on teleological explanation. People with ASPD experience underlying motivations according to outcomes in the physical world. Teleological understanding is a nonmentalizing process and yet has

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CLINICAL EXAMPLE

The clinician explained that he felt anxious and somewhat frightened when one of the patients was making threats toward another patient.

Threatening patient: You have no need to be frightened.

Clinician: But I feel that way.

Patient: No you don't. You just say you are. If you were frightened you would have got out of the room.

Clinician: I was scared but not frightened enough to run out.

Patient: Then that is your problem. You don't need to be frightened like a nancy boy.

Clinician: What is it that makes you say I don't need to be scared.

Patient: Look. Answer this question – did I stand up?

Clinician: I am not sure what that has to do with how I feel.

Patient: Answer the question. Did I stand up?

Clinician: No

Patient: Well that tells you.

Clinician (puzzled): What?

Patient: You only need to feel frightened if I stand up. Have I ever stood up in a session? No so you don't need to feel frightened.

In this episode the patient has no empathic identification with the clinician's emotional state and dismisses his feeling as being unnecessary and without foundation. The feeling of the clinician would have credence for the patient only if there was a change in the physical world, namely that the patient stands up.

This episode was explored further at the insistence of the clinician as it illustrated the lack of mentalizing of the affective state of the other person, in this case the clinician, and the failure to identify with the clinician's internal state and respond empathically.

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considerable persuasive power for people with ASPD. What happens in the physical world has more meaning than what is going on in the mind and motivations are understood in terms of what occurs in the physical world rather than what is expressed emotionally. One patient talking about his girlfriend stated, "I know that she loves me because she does what she is told. She is well trained and I always make sure that she performs." Such statements need to be explored or challenged according to MBT principles. One principle defined in the original manual for BPD is the juxtaposition of the clinician's mental states with those of the patient. This can be especially important when patients in the group deny emotional states in others.

CONCLUSIONS

MBT for ASPD is based on a mentalizing understanding of the psychological problems of people with ASPD. The clinical interventions follow from this theoretical framework. Whether it will be effective in helping a neglected group of patients remains to be seen and it is currently the subject of a randomized controlled trial.

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