Treating Antisocial Syndromes

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Questions about treatment of offenders, especially those with antisocial personality disorder or its more malignant cousin, psychopathy, are common in our practices. The *International Handbook of Psychopathic Disorders and the Law*,[1] edited by Sass and Felthous, which is currently in press, will offer a comprehensive update on this topic. This month's column summarizes some of the research on treatment principles and describes community and experiential programs. Dr. Stephen Thorne, a clinical psychologist with a special interest in forensic evaluation, joins me in bringing it to you.

Psychopathy, Antisocial Personality, and Other Antisocial Syndromes

Understanding the differences among psychopathy, antisocial personality disorder (as defined by the DSM-IV-TR[2]), other antisocial syndromes, and simple antisocial behavior is critical for accurate clinical assessment, effective treatment or management plans, and separating real treatment opportunities from more pessimistic situations in which incarceration or other controls are the only feasible objectives. Sometimes therapeutic pessimism is justified, either because the characterologic flaw runs too deep or because appropriate programs or resources are not readily available. We will review some principles associated with limited success and, perhaps more important, specific variables that predict that success.

It is important to separate the concept of antisocial personality disorder (ASPD) from the deeper, less behavioral or empirical concept of psychopathy envisioned by Cleckley and Hare.[3–5] Some perpetrators of crimes meet criteria for ASPD but are not "psychopaths." Many clinicians believe those who barely meet ASPD criteria are able to change. Possibility of change, however, is not the same as likelihood.

During most of the past 100 years, treatment for antisocial adults was based on the premise that they could, and should, be rehabilitated or reformed. Many treatment programs were created between 1960 and 2000, some of which showed very positive outcome data.[6–15] Most of the innovative treatment programs developed between 1950 and 2000 have come and gone regardless of their level of success. Their loss seems at least partially related to the whims of popularity, but the disappearance of some was likely due to public disappointment that there was no panacea to address all antisocial syndromes and satisfy all of society's priorities: community protection, psychological change, political expediency, and lower public cost.

One longstanding key to success (and warning of failure if not heeded) has been accurate definition of the sources of the antisocial behavior and then focusing treatment on those sources. Does the perpetrator lack social education or experience, have a severe mental illness, and/or abuse or depend on drugs? Does he or she have an intellectual deficit? A personality disorder? Antisocial personality? Treatment and rehabilitation programs that limit themselves to specific groups and tailor their approaches appropriately tend to have more success than generic programs and to decrease recidivism. Blending different offender groups, and especially including those with true psychopathy or antisocial personality, frustrates treatment efforts and tends to penalize those with a better prognosis.

Treatment Objectives

There are many reasons to treat perpetrators, each of which may lead to different treatment objectives. Decreasing the interpersonal, social, and economic costs associated with antisocial behaviors is important, but the goals of lawyers, judges, politicians, and voters don't always match those of clinicians. While policy makers and/or court officials often view treatment efficacy in terms of secure containment, deterrence, reduced cor-

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rectional costs, relief of chronic prison overcrowding, or lower recidivism rates, mental health professionals may (for better or worse) tend to see therapeutic success as more individual and humanistic. Within both perspectives, however, at least one primary treatment objective is, at the core, to change the thoughts, behaviors, and predispositions that lead offenders to violate society's norms and expectations, and that increase their likelihood of recidivism.

Both policy makers and clinicians want to reduce recidivism, but there are disagreements about how that objective should be pursued. Some lean toward containment, and rehabilitation through incarceration. Many others argue that treatment beyond simple incarceration also has social value. Whatever one's philosophical bent, good studies and outcome reviews suggest optimism that appropriate treatment procedures can reduce criminal and antisocial behavior for at least some people.[16–19]

Rogers and Webster[20] wrote that clinicians stress psychological needs too highly, often recommending treatment for offenders who have "even the slightest prospect for change" (p. 22). Such a focus on personality and emotional traits with little relevance to treatment amenability and recidivism led them to argue that treatment recommendations that stem from assessment approaches are generally not evidence-based and do not adequately consider treatment goals, resource availability, and likely outcome.

What Works

Any discussion of "what works" with adult offenders should assess empirically supported principles rather than focus on specific programs whose characteristics may be unique. The basic concepts of *risk*, *need*, and *responsivity* suggest basing treatment recommendations on the ability of a program to match an offender's needs, learning style, and level of risk. The risk principle, in particular, is related to a program's ability to address an individual's pretreatment characteristics. As Lurigo[21] wrote, "offenders should be placed in specific programs that pointedly address their particular configuration of criminal propensities, problems, skills, aptitudes, and readiness for change, and make the best use of treatment dollars. This goal is easy to state but not so easy to accomplish" (p. 260).

Several studies have supported a "risk principle." They found that high-risk offenders placed in appropriate treatment programs, for example, community or residential programs, tend to display greater treatment effects than those with lower risk.[16–19,22,23]

Dynamic, Criminogenic, and Noncriminogenic Variables

"Dynamic" variables are those that can be changed, and are thus amenable to intervention. "Criminogenic" variables are dynamic factors assumed to be directly associated with an offender's criminal behavior. Some "static" variables, such as gender, age, and early criminal history, are commonly associated with recidivism but are not very therapeutically useful, since they cannot be altered by treatment.

Traditional clinical wisdom has said that offenders' psychological symptoms deserve as much consideration as behavioral ones. However, not all clinical needs are criminogenic (that is, cause criminal behavior). One's psychiatric symptoms may have little or no association with one's antisocial behavior. Andrews et al.[16] called such conditions and treatment needs "non-criminogenic" and said that their treatment does little to reduce recidivism. Treatment emphasis should be on the variables and needs specifically related to the individual's criminal behavior. They said, essentially, that the traditional emphasis on lowering offenders' anxiety levels, raising their self-esteem, altering their mental function, and the like is unlikely to reduce recidivism significantly and often leads to a misuse of treatment resources.

Overall, multimodal programs tailored to participants' criminogenic needs are the approaches most likely to succeed for large numbers of offenders. Such programs use cognitive and behavioral approaches, social learning, and modeling. Many individual psychotherapy approaches (e.g., psychodynamic, client-centered, insight-oriented) fare poorly in offender treatment, as do those that emphasize a military model or fear of punishment. Those approaches are often viewed as unresponsive to the criminogenic needs of offenders.[16,22–24]

Let's briefly examine two common kinds of treatment programs for antisocial syndromes.

Experiential "Boot Camp" Programs

"Experiential" treatment immerses the patient or client in an environment designed to force positive or therapeutic behavior, in the hope that positive behaviors will lead to longer term psychological or behavioral change. Many recent studies of experiential treatment programs for antisocial individuals have examined "shock incarceration" or "boot camps." Early adult boot camp programs as alternatives to incarceration were more like basic military training than treatment.[22,25] Their rise in

popularity was related to several factors, including society's desire to punish criminals while rehabilitating them.

Outcome studies have yielded mixed results. Boot camps are associated with good outcomes, but don't appear to lower recidivism on their own.[22,25,26] Studies of boot camp programs in Pennsylvania and Alabama, among others, reported economic savings and relief of prison overcrowding.[27,28] Such results support some social and political goals but may or may not be consistent with clinical and behavioral ones.

Client variables are not the only important source of outcome findings. Much of the variability in outcome among boot camp programs is related to wide and important differences in the implementation of treatment principles.[22,28] In the large MacKenzie and Souryal study,[22] estimated recidivism rates varied from 23% to 63% for rearrest, 1.3% to 13% for offense-related revocation, and 2.1% to 14.5% for technical violations. The programs with the lowest recidivism were longer, devoted more time to therapy-related programming, had high dismissal rates, and selected offenders carefully.[25]

Community Programs

Community-based correctional/treatment alternatives are often described as "intermediate" sanctions. Since their emergence in the United States in the 1970s, a great variety of such programs have been developed and tested, including intensive supervision, therapeutic group houses (see Tyce 1980,[14] Reid & Solomon 1981[10]), house arrest, electronic monitoring, and "day reporting," all of which have the goals of decreasing recidivism, reducing corrections overcrowding, and decreasing costs. The programs vary greatly. All seem to increase treatment access, but some do not reliably reduce recidivism.[29,30]

Community-based treatment programs that use empirically supported assessment and treatment techniques can decrease recidivism. A large Ohio study by Lowenkamp and Latessa[18] of 53 community programs and over 13,000 parolees suggested that using the risk principle to match offenders to appropriate treatment programs increases positive outcomes in high-risk offenders. The authors noted that offender risk level was important to treatment outcome. Both magnitude and frequency of recidivism were substantially decreased among programs treating high-risk offenders. Low-risk offenders, however, had a slight *increase* in recidivism, and moderate-risk offenders had only a slight decrease. The authors' conclusion was that low-risk offenders should usually be excluded from community programs. A later, larger Ohio study generally replicated those results, and supported the premise that residential programs in the community were more effective than nonresidential ones.[19]

In some cities, "day reporting centers" (DRCs) have been developed that offer supervision and treatment options without incarceration or residential settings. They have not been well studied, but Martin et al.[31] found that 1995–96 recidivism rates for some 1,400 clients who remained affiliated with a Cook County, Illinois DRC were significantly lower (although still substantial) than those for controls.

The Last Word

Treatment of antisocial syndromes is very difficult, but evidence-based treatment principles are associated with positive results for specific kinds of offenders. The issue is not whether or not to support offender treatment, but rather identifying offenders' criminogenic problems and needs and then advocating for appropriate treatment programs to which to refer them.

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