

35 Mentalization-based treatment for antisocial personality disorder

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35.1 Introduction to mentalizing

Mentalizing is the capacity to understand ourselves and others in terms of intentional mental states. It involves an awareness of mental states in oneself or in other people, particularly in respect of explaining behaviour. That mental states influence behaviour is beyond question. Beliefs, wishes, feelings and thoughts, whether inside or outside our awareness, always determine what we do. Mentalizing is not a single, self-contained attribute or skill; it is a multidimensional construct, and breaking it down into its components is helpful in understanding how we mentalize and how mentalization-based treatment (MBT) operates (Bateman & Fonagy 2012).

Broadly speaking, mentalization can be considered as constituted of four intersecting dimensions: automatic/controlled (or implicit/explicit); internally/externally based; self/other oriented; and cognitive/affective process. Each of these dimensions may relate to a different neurobiological system (Fonagy & Luyten in press). We will discuss the mentalizing dimensions in more detail below.

The key to successful mentalizing is the integration of the dimensions into a coherent whole. However, none of us manages to integrate all four 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’. Such a shift in thinking – in this case, from an evaluation of mental process to a focus on physical actions as an explanation for behaviour – is more likely to take place in powerful affective states when our cognitive processes break down in the face of a wave of emotion.

Since we all momentarily lose the capacity for mentalizing at times and the process itself fluctuates naturally, for example, with context and mood, it follows that personality pathology does not arise simply 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, and rapidly move to non-mentalizing 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 losses of mentalizing within interpersonal relationships, with associated difficulties in regaining mentalizing and a consequent lengthy exposure to non-mentalizing modes of experience, is characteristic of borderline personality disorder (BPD) (Bateman & Fonagy 2004). Third, mentalizing can become rigid, lacking flexibility. People with paranoid personality disorder, for example, often show rigid hypermentalizing with regard to their own internal mental states and lack any real understanding of others’ (Dimaggio et al. 2008, Nicolo & Nobile

2007). At best they are suspicious of others' motives, and at worst they see people as having specific malign motives and cannot be persuaded otherwise. The mental processes of people with antisocial personality disorder (ASPD) are less rigid than those of paranoid people. Finally, the balance across the dimensions of mentalizing can be distorted. Patients with narcissistic personality have a well-developed self focus but very limited understanding of others (Dimaggio et al. 2008). In contrast, psychopathic patients with ASPD are experts at reading the inner states of others from a cognitive perspective while being unable to identify empathically with others' state or be compassionate towards them; that is 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 motives (Bateman & Fonagy 2008). People with ASPD also 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.

35.1.1 The four dimensions of mentalizing

Implicit (automatic) and explicit (controlled)

Implicit mentalization is a non-conscious, unreflective, procedural function. As Simon Baron-Cohen put it, 'We mindread all the time, effortlessly, automatically, and mostly unconsciously' (Baron-Cohen 1995, p. 3). Explicit mentalization is likely to happen only when we hit an interactive snag (Allen et al. 2008). Particularly when it is of a higher order, explicit mentalizing can be the apparent substance of psychological therapy, for example, when a patient is asked to reflect upon his awareness of what someone else might think about the same situation, or asked to evaluate his own thoughts and appraise them more carefully against some agreed criteria. It is important to note that explicit mentalization 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 their thoughts – in these patients, the link between cognition and emotional experience in both self and other is tenuous. Asking a patient to consider others' mental states and to be compassionate about them can only be done meaningfully once this link has been established.

Self and other

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 psychopathy may be expert at reading other people's minds and misuse this ability or exploit it for their own gain. Other people 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 the 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. People with ASPD present with both imbalances and tend to 'fix' at one or other of the poles depending on context.

External and internal

This dimension refers to the *target* of mentalizing. Internal mentalizing is a focus on one's own or others' internal states – that is thoughts, feelings and desires. External mentalizing implies a reliance on external features such as facial expression and behaviour. 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. Relying on external cues, such as facial expression, eye movements and body posture to indicate the motives of others is a normal process and underpins many daily interactions moderately well. People with ASPD, tend to be more sensitive to external cues, particularly related to the way someone looks at them – 'the look' is a universal trigger for hostility or aggression and yet is rarely specified. It is something that is recognized when it occurs but cannot be described. However, this sensitivity to external cues does not translate into interest in the affective internal states of the other or curiosity about their underlying motives. People with ASPD assume that motives are malign unless proven otherwise and react accordingly to counter the threat. Misreading emotion cues, or more likely not even registering them, will make it more difficult for people with ASPD to understand the subtleties of others' perspectives. Certainly, the internal affective state, which is a key component of empathy and mentalizing of the other, will remain a mystery.

Individuals with ASPD have similar problems expressing affective components of their own internal states, particularly within interpersonal contexts. Identifying their own feelings, especially those associated with vulnerability, such as shame and humiliation, and expressing them within an interpersonal context is not something that people with ASPD will do naturally in the group setting of MBT, for example. However, there is one exception to this – they will express forcibly how tense they are or how 'near the edge' and explosive they feel. They will also express 'anger' and issue threats. This is less often related to the interpersonal context in the group than it is an expression of their underlying state or a feeling about organizations such as the police or housing authorities.

Cognitive and affective

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 (Jurist 2005). A high level of mentalizing requires integration of both cognitive and affective processes. People with ASPD invest considerable time in the cognitive understanding of mental states to the detriment of both their own affective experience (Bateman & Fonagy 2008) and that of the other person.

35.1.2 Prementalizing modes

When mentalizing fails, individuals often fall back on prementalizing ways of behaving, which have some parallels with the ways young children behave before they have developed their full mentalizing capacities (Bateman & Fonagy 2012). These prementalizing modes of behaviour are important for clinicians to recognize and understand, as they can cause considerable interpersonal difficulties and result in the enactment of destructive behaviours. The modes are: *psychic equivalence*, *teleological*, and *pretend* mode. These

modes of experiencing the self and others tend to re-emerge particularly whenever we lose the ability to mentalize.

In *psychic equivalence*, no alternative perspectives are possible. The suspension of the sense of 'as if' and the experience that everything is 'for real' makes the apparently exaggerated reaction of patients understandable in view of the seriousness with which they experience their own and others' thoughts and feelings. In individuals with ASPD, the superficial understanding of others based on appearance, failure to see underlying intentions, may be a profound source of difficulty. Judging people by external cues using a very rapid, implicit judgement is a substantial source of difficulty in many interpersonal contexts. What is often described as 'concrete thinking' is a consequence of mentalizing that is excessively based on external cues and is implicit and non-reflective. The extreme reactions of individuals with ASPD are understandable given their overemphasis on external indicators of internal states, unchecked by reflection, which can generate deeply disturbing expectations of the intentional states of others. To make matters worse, the absence of affective mentalizing reduces the person's capacity to imagine the pain or discomfort experienced by another. The normally functioning nature of cognitive mentalizing capacities can create a sinister impression of someone whose manipulation of the mental states of others is not limited by any kind of understanding of the affective impact their actions might have.

In the absence of an appropriate balance between cognitive and affective mentalization, thoughts and feelings can come to be almost dissociated to the point of near-meaninglessness, as the *pretend mode* re-emerges. Individuals with ASPD can sometimes appear to reflect on their own antisocial actions in this mode. The inconsequential nature of subjective reality for these individuals may enhance their capacity to act on others in a punitive and callous way. Patients with ASPD can frequently talk about the impact of their actions in a way that does not translate into a real experience of regret and mostly remains in the domain of 'empty' words. In this mode, psychotherapy can be a meaningless exercise because internal states do not carry meaning.

Early modes of conceptualizing action in terms of visible goals dominate motivation in ASPD. This is characteristic of the *teleological mode* of thinking. Within this mode there is a primacy of the physical. Experience is felt to be valid only when its consequences are apparent to all. Affection, for example, is only 'true' when accompanied by physical expression. The stereotypic depiction of a successful antisocial individual as bejewelled and driving luxury cars, with acts of loyalty demonstrated through violent attacks on enemies, may be a fantasy of scriptwriters but it is based on an appreciation of the massive value placed by antisocial individuals on appearance and social status.

35.1.3 Neurobiology

The link between ASPD and the affective and external components of mentalizing is well established both developmentally and in adults. Marsh and Blair (Marsh & Blair 2008), in a meta-analysis of 20 studies, showed a robust link between antisocial behaviour and specific deficits in recognizing fearful expressions, an external component of mentalizing. This impairment was not attributed solely to the difficulty of the task. 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 hypoactivation of the amygdala in response to pictures that are normally considered emotionally arousing, particularly images depicting a potentially painful aggressive (Jones et al. 2009). 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' expressions. This leads to a lack of empathy and deficiency in the control of aggressive behaviour, which would normally be inhibited by observing and identifying empathically with distress in another (affective/other mentalizing). Alternatively, we may see these abnormalities as reduced sensitivity to stimuli that indicate 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 the 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 (Fonagy 2003). Mentalizing inhibits unwarranted aggression. So there may be a complex interaction between constitutional fearlessness and its effect on the development of the normal inhibitory factors protecting against antisocial interaction.

In contrast, amygdala hyperresponsiveness has been observed in some individuals in response to seeing images of a hand shut in a door or a foot being stamped on (Decety et al. 2009). The amygdala responses in these conduct-disordered youths correlated with parents' ratings of their daring behaviour and sadism. The increased amygdala response may reflect excitement or even 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 (whether hyporesponsiveness or hyperresponsiveness, the dysfunction of emotional resonance or empathy appears to be linked to vulnerability for antisocial behaviour. The clinical and theoretical exploration of this relationship appears warranted. Examining the role of empathy in antisocial individuals, Baron-Cohen found that lack of care for others led to antisocial and destructive behaviours, possibly due to a partial but fundamental impairment of mentalizing – a capacity for mind-reading without empathizing (Baron-Cohen 2011).

More recently, other researchers (e.g. Dadds et al. 2011) 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. Lack of attention to the eyes implies a more general problem with the external component of mentalizing and loss of association with, 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, these individuals are likely to have widespread difficulties in 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, while not recognizing others' distress cues may be important (Blair 1995, 2006), additional, more wide-ranging problems related to social and emotional functioning may contribute to the problems people with ASPD experience. This has important clinical implications.

35.2 Mentalization-Based Treatment

MBT integrates cognitive and relational components of therapy and has a theoretical basis in attachment theory. MBT was originally developed for people with BPD and therefore

focused on mentalizing problems associated with high emotional arousal in the context of attachment relationships.

This basic model has been adapted for people with ASPD (Bateman et al. 2014) 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 characteristic of people with BPD.

Second, people with ASPD tend to seek relationships that are organized hierarchically, with each person 'knowing their place', whereas people with BPD aim for, but tend to struggle to reach, consensus and shared respect.

Third, it is, specifically, threats to the hierarchical order of relationships that lead to arousal of the attachment system in people with ASPD; this triggers inhibition of mentalizing, which in turn leads to fears about inability to control internal states. It has been suggested that the internal states most feared by people with ASPD are threats to self-esteem (Gilligan 2000). Individuals with ASPD boost their self-esteem by demanding respect from others, controlling the people around them and creating an atmosphere of fear. This maintains their pride, prestige and status. Loss of status is devastating for these individuals 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 which has to be dealt with by physical force. A momentary inability to mentalize, to see behind the threats to what is in the mind of the person who appears to be threatening them, means that these individuals have no way of averting a rapidly lowering self-esteem and loss of position. Emotional capacities such as guilt, love towards others and fear for the self may protect them from engaging in violent behaviour, but the loss of mentalizing and the rudimentary ability of these patients to experience such feelings prevent these inhibitory mechanisms from being mobilized.

Fourth, if the reduction in ability to recognize others' emotions is more pervasive, rather than being restricted to fear and sadness, then a focus in treatment on the recognition of all emotions in others is essential. Finally, fear for the self is often absent and violent impulses are not influenced by the emotional expressions of others, which go unrecognized. Indeed, the consequences and dangers of aggression become secondary considerations.

35.2.1 Aims of MBT for ASPD

1. To stimulate robust mentalizing in all dimensions in the context of hierarchical interpersonal interactions and intimate relationships.
2. To reduce aggression as the primary pathway of expression of problematic internal states.

35.2.2 Hierarchy of problems

Individuals with ASPD notoriously undermine attempts to treat them in a number of ways:

1. Their motivation varies considerably.
2. Requesting treatment often appears to have secondary motives.

3. Initially they deny problems and blame others.
4. Practical problems, e.g. crime and courts, housing, change rapidly, making focus difficult.

The clinician needs to make an agreed hierarchy of problems likely to interfere with treatment. Initially, motivation for regular attendance may be the primary problem, as this interferes considerably with continuity of sessions.

Central to the approach is an awareness that clinicians should avoid using interventions aimed at inducing guilt as a way of increasing motivation. The nascent ability for people with ASPD to feel guilt means that these feelings cannot be harnessed as powerful organizing factors. It is better for the clinician and patient to establish a mutual acceptance that they will do what they can to work on the problems important to both partners from both a practical and a psychological viewpoint, while emphasizing that the clinician has only a limited ability to influence practicalities.

35.2.3 Focus of MBT-ASPD

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

1. Understanding emotional cues - external mentalizing and its link to internal states
2. Recognizing and identifying with emotions in others – other/affective mentalizing
3. Exploring sensitivity to hierarchy and authority – self/cognitive
4. Generating an interpersonal process to understand subtleties of others’ experience in relation to one’s own – self/other mentalizing
5. Exploring and understanding threats to loss of mentalizing which lead to teleological understanding of motivation – self/other mentalizing and self/affective mentalizing.

35.2.4 Format of treatment

MBT-ASPD combines weekly group therapy with monthly individual sessions.

Treatment for each individual lasts 1 year.

In pilot studies of MBT-ASPD, two therapists ran the group. Having two therapists, rather than one, is important not only to manage risk, but also to model the ability to work together constructively whilst being respectful of differences.

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 sociocultural context in which they live. More importantly, group work stimulates a hierarchical process within a peer group, which can be harnessed in real time by the clinicians to explore the participants’ sensitivity to hierarchy and authority and their mentalizing distortions.

Trajectory of each group. The sessions are structured in the same way each week:

1. Summary of previous week and feedback from participants
2. Go around the group to establish any key areas to be covered
3. Synthesis of problems if possible
4. Focus on the first problem area.

Many groups begin with talk in pseudo-philosophical-political mode about how awful the system is, and how no-one can be trusted. In essence, this is pretend mode. Contrary to the usual exhortation about pretend mode (challenge it, and do not allow it to become embedded), it is important to allow the participants to do this at the beginning, to give them a sense of unity. However, the aim is to bring the conversation back to a focus on problem areas and/or the 'here and now' of how they are feeling as soon as possible.

1. *Summary of previous week.* The clinicians engender a culture of continuity in the group by beginning each group session with a summary of the previous session. This is a brief statement about the main themes that were discussed and an outline of remaining problems. The first part of the summary focuses on content while the second part sensitively emphasizes any problems within the group, for example, problems between participants. The aim of the summary is to increase mentalizing across time, to facilitate cohesion, and to inform patients of the themes in the context of erratic attendance. Once the clinicians have completed the summary they can ask the group members whether it is accurate and whether there is anything they would like to add. It may become possible for group members themselves to provide the summary if the culture of linking becomes embedded in the implicit mentalizing process of the group.
2. *'Go-around' of problems.* Next, the clinicians instigate a 'go-around', asking each patient in turn if there is anything they would like help with from the group during the current session. The clinicians manage the 'go-around' by clarifying the problem(s) the patient brings and then moving on to the next patient. Therapists do not explore the problems of each person at this point and do so only once all patients have been asked if they have a concern they want to discuss. Similarly, the clinicians do not allow the other patients to comment on the problems, offer advice or give solutions, or to talk about their own experience of the problem. There are several reasons to undertake a 'go-around' at the beginning of the group. First, it allows clinicians to maintain some authority within the group process; they control the group by allowing the process and content to unfold gradually rather than rapidly and/or explosively. Second, it prevents the group becoming unfocused. This is further ensured if the clinicians work towards a synthesis of some of the problems identified by the patients. Third, it encourages the patients to listen to each other and not make rapid assumptions about each other. Finally, it encourages mentalizing each other as a fundamental part of the group culture from the very beginning.
3. *Synthesis of problems.* Often the clients bring similar or overlapping problems, for example, two of them may have become angry or had fights. Sometimes participants mention so many problems in the 'go-around' that the clinicians recognize that it will be impossible to focus adequately on all of them. We therefore suggest that the clinicians work briefly towards a synthesis of the problems after the 'go-around'. This is a powerful mentalizing process: It increases sharing of problems between participants; increases the affiliative process; and maintains the authority of the clinicians, as they take charge over the process.
4. *Focus on problem area.* Once this orchestrated process is complete, the clinicians actively start the exploration of the patients' problems. One of the participants is selected to start, organizing his problem around the synthesis of patient problems if a common group problem has been identified. Often the decision about who starts is made by the other patients, who recognize that one group member has a pressing matter and point to him as the person who should begin; at other times, one patient immediately starts without deferring to the others. If no-one comes forward to start, the clinicians take authority to identify who will start by asking one of the patients to begin exploring his problem identified during the 'go-around'. From this point in the

session, the clinician must 'pace' the discussion to ensure that all the problems identified in the 'go-around' are addressed to some extent. Some clinicians suggest allocating a set time to each problem, ensuring the time is shared equally. However, this may create iatrogenic non-mentalizing by embedding teleological processes within the group.

The group is a 'slow open group'. This means that it is an ongoing group in which patients join as others leave or are discharged. This allows patient drop-out to be managed, as well as leading to a group that will eventually be made up of patients at different stages of treatment. This may be beneficial, in that patients in the later stages of treatment who feel that they have benefitted from treatment may facilitate the engagement of those who have joined more recently. Where possible, two new patients will join at the same time, and the existing members of the group should go over the principles that they covered in their MBT introduction (MBT-I; see below).

The individual sessions are also provided by the group therapists rather than being delivered by a separate therapist. The rationale for this is:

- The individual sessions are primarily to support the person with ASPD in the group.
- The peer-group interaction may be more significant as a process for change than individual therapy with a clinician.
- It minimizes the opportunity for deception about what happens in the group which may distort any discussion about the group work in individual sessions.
- It allows focus on different perceptions of events and experiences in the group by contrasting the experience of the therapist with those of the patient.
- Patients may use the individual sessions to discuss issues that they are reluctant or ashamed to talk about in the group, such as difficulties in their personal relationships, depressed or suicidal feelings, etc. Individually exploring the patient's sensitivities to talking about these issues may enable him subsequently to talk about them in the group.
- When new patients join an established group, the individual sessions may also be used to go over the psychoeducation topics and introduction to MBT covered in MBT-I (see below).

Patients are asked to complete brief outcome measures on a regular basis. The core outcome measure is the Modified Overt Aggression Scale (MOAS). This can be done at the end of each group.

35.2.5 Organization of sessions

Each group therapy session lasts for 1 hour 15 minutes. The first five groups are organized as an introduction and engagement phase. This is a modified version of the MBT Introduction (MBT-I) for BPD.

It is common for the introductory sessions to be diverted from task by people with ASPD. They attend for their own reasons, which dominate their requests in the early sessions. Commonly, they present at a time when they have social, legal and personal problems, for which they may request written statements about their psychiatric problems, support with access to benefits, help to see their children and/or partners, and so on. This can create severe problems for the clinicians, who wish to help but can easily begin to feel manipulated and diverted from task. Clinicians facing such requests are advised to tell patients that they are unable to provide any letters of support (for social, legal, and interpersonal problems) until the five MBT-I sessions are complete. The rationale for this is

that the clinicians cannot know what could be said in any such letters until this assessment and engagement period is complete.

35.2.6 Some group principles

Developing a code of conduct, with appropriate rules and boundaries, is a key task of any therapeutic group in order for its members to function together effectively, but can become a central feature in groups for ASPD. It is important that the therapists do not impose their own code of conduct on the group, but first establish the patients' moral values and sense of responsibility and fairness. Although the overt reason for each patient's referral is acts of violence that have been deemed problematic, the therapist must be seen neither to condemn nor condone these offences, but instead maintain a benign attitude of attempting to understand the patient's internal state of mind and mental precursors of violence. Although people with ASPD will defy the laws of society with no apparent compunction, breaking their own internal code of conduct may cause them to feel shame and a sense of wrongdoing.

The group therapists must set certain group principles or rules in order for the group to feel safe, but must also permit the expression of anti-authoritarian attitudes without these becoming destructive to the group, as individuals with ASPD will inevitably react against whatever rules they feel are imposed upon them. If the therapists are identified as agents of social control who arbitrarily impose 'socially acceptable' rules and regulations, the patients will inevitably oppose this and therapeutic work will become impossible.

Principles operating in the group are discussed with the patients early in treatment. These include agreement about attendance, openness, prohibition of threats and violence, refraining from contact with other patients outside of the group sessions, and commitment to thinking about others as well as themselves. At the beginning of the group the clinicians should also outline the importance of avoiding inappropriate comments that are likely to cause offence.

It is important that the clinicians explain the reasons underpinning these principles. People with ASPD are generally influenced very little by concern for others or for overall group requirements, so appealing to the patients' social generosity, for example, by suggesting that when they do not attend this affects everyone, will be ineffective. Injecting pressure through inducing guilt and/or encouraging selflessness are contra-indicated. Their experience in life has been of coercive methods and sometimes punishment, all of which have had little effect: do not recreate this in the group. The reason for encouraging attendance is so that the individuals can address their problems consistently; erratic attendance means that gains will be lost rather than consolidated. Learning from others is also increased with reliable interaction.

35.3 Conclusions

MBT-ASPD is a manualized psychotherapeutic intervention based on an understanding of ASPD as a disorder of mentalizing. Deficits in mentalizing are considered to be part of the central pathology that contributes to individuals' difficulties in managing anger within interpersonal and intimate relationships, which are at the core of the disorder. Treatment specifically targets mentalizing problems, first by using psychoeducation and then by working within peer-group interactions to explore the mentalizing distortions that govern these patients' interactions. The treatment is currently being tested in a multi-centre randomized controlled trial.

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