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Case Report

Specific Challenges in the Treatment of Psychopathy: A Case Report

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Abstract

Although the literature is filled with articles pointing to the conclusion that psychopaths cannot be treated, very few articles detail actual attempts to treat. We present one therapist's effort to treat the case of a psychopathic outpatient. Treatment was complicated by the fact that the therapist was initially unaware of the patient being psychopathic. The therapist further lacked a theoretical framework to base his work on. Treatment ended with the psychopath being jailed. The lessons learned are shared in this article. Greater knowledge of the specific challenges clinicians face in the treatment of psychopathy may facilitate further work in this area.

Keywords: Psychopathy; Treatment; Case

Abbreviations

ADHD: Attention Deficit Hyperactive Disorder; GP: General Practioner; DUI: Driving Under the Influence; HCR-20: Historical, Clinical, Risk Management-20

Introduction

Treatment of psychopathy is a difficult endeavor. This is much due to the specific nature of the disorder, which easily switches the clinician's focus from the needs and suffering of the patient, to the discomfort of those who have to deal with him or her. Further, psychopaths typically lack ownership of their problems, and hence are not interested in therapy. Sometimes, as clinicians, we still get hold of such individuals. Usually when they are imprisoned, or otherwise confined. Psychopaths are occasionally admitted as outpatients. In this article we present an attempt to treat such as case. The case report is unique in its thorough report of the psychopath's behavior, to displaythe specific challenges clinicians face in the treatment of psychopathy.

Patient information

De-identified patient demographic information

The patient was a 24 years old Caucasian male referred to a Norwegian outpatient clinic for treatment of anxiety and depression, and assessment of ADHD. According to his GP, the patient was previously arrested for DUI. Other than this, he had led a law-abiding life. He was unemployed but with "some business in the private sector". The patient had a live-in girlfriend but no children. His girlfriend had one child.

Main concerns and symptoms of the patient

The patient presented as ashy and quiet man dressed in normal clothing, which were a little too big. He looked at the therapist with a trusting glance, smiled and shook hands. The only observable anomaly was the impression that the patient was not emotionally attuned to the content of the conversation. He was implicitly bragging about the expensive clothes he had at home. This was attributed to him being nervous in the new situation, with an urge to regulate the power balance. The patient answered all questions and cooperated with the therapist. He was perceived as friendly and sincere. The first meeting was not dramatic or special in any way.

The patient indicated that anxiety was his main problem, but could not specify his pain in much detail. He would occasionally mention that he had no friends, and that he thought about how his life would turn out when he got older. He sometimes described symptoms compatible with panic attacks, but according to the therapist, a licensed clinical specialist in psychology and the first author of this article, his anxiety was more of an existential type.

The patient presented an externalizing attitude towards problems that were clearly a result of his own behavior. And although the patient seemed ambivalent to treatment and displayed some antisocial traits in the initial stage of therapy, the therapist's understanding of the individual was complicated by the occasional good rapport between them. Until one day, when the patient told him about the way he *corrected* his partner, which sounded like torture in the ears of the therapist. The patient was completely calm with neutral eyes, as if he was talking about the weather. There was no drama with regard to the things he said, which was the problem. The therapist felt lured into something, a loss of control, and new premises that he wanted nothing of.

The antisociality of the patient eventually turned on the therapist. The patient asked questions that were clearly outside the limit, and seemed to enjoy the aversive reaction that followed. The most serious concern or symptoms were displayed at the end of the treatment course, when the patient informed the therapist that his partner had left him with her child. The patient transformed from a state of apparent suffering and took on an extremely threatening character. His eyes became black and hard, his glance more staring and invading. His body language changed from collapsed to calculated and effective. His voice, which was previously slow and self-pitying, suddenly became cold. The patient then informed the therapist that he had found the new home of his former partner, and that he planned to

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burn down the house with the woman and child inside. This was his concrete plan, which he would execute before the end of that day. The therapist informed the police under the pretext of taking care of some details from another office. The patient was arrested in the therapist's office. He reacted with rage, which turned into disappointment and resignation.

Medical, family, and psychosocial history

Early development and upbringing was without remarks, according to the parents. He did well the first years in school, but struggled with aggression and anxiety after this. He abused alcohol and marijuana on a regular basis at age 11. At 15, amphetamine became his drug of choice. He was diagnosed with ADHD and admitted to an in-patient psychiatric facility at the age of 13. This was due to his aggressive demeanor and acting out. His mother and father receive disability pensions and suffer from anxiety and diffuse body pain, respectively. His father was previously jailed.

Growing up was *ok*, according to the patient. He could pretty much do as he would, and moved into the basement apartment at the age of 11. He was given cigarettes and alcohol by his father, and learned how to make spirits and to deceive others in trade before the age of 14. He was subjected to unpredictable and inconsistent corporal punishment from his father. He did not say much about this initially, but gave some information from time to time after a while. According to the therapist, the patient downplayed the aversive elements of his childhood. The therapist recognized this strategy from the patient's father.

Relevant past interventions and their outcome

The patient was diagnosed with ADHD in his younger years, but the accuracy of this diagnosis is disputed. Earlier interventions, which include prison, psychological treatment, medication, suspended sentencing, substance abuse treatment, anger management training and community service, did not reduce his psychopathic traits or improve his other ailments.

Diagnostic assessment

Diagnostic methods

The patient met the North-American cut-off for severe psychopathy, according to the Psychopathy Checklist-Revised [1]. Risk assessment with the HCR-20 [2] indicated a moderate to high risk of violence in his local environment, whichis elevated when the patient is restricted or influenced by drugs.

Intelligence testing indicated that the patient was equipped with normal intellectual abilities. Structured clinical assessment verified the referenced anxiety and depressive disorders. The patient further fulfilled the criteria for antisocial and borderline personality disorders, and reported several symptoms consistent with ADHD. His difficulties did not fit descriptions of any developmental disorder or syndromes. He did not receive a diagnosis of substance abuse, because of the control he exhibited in relation to this. The patient was physically healthy, according to his GP.

Diagnostic challenges

An obvious challenge to the diagnostic process was the therapist's initial lack of access to essential information about the patient. His criminal career was more extensive than first portrayed, which was later confirmed by the Norwegian correctional services. His mental difficulties were more severe than the tentative diagnoses. Irregularly attendance complicated the assessment and treatment as well.

Diagnostic reasoning and differential diagnoses

The ruthlessness of the patient was more severe than your typical offender. He once poured a casserole of boiling noodles over a fellow prisoner. He maintained the appropriateness of this, which is in accordance with the criteria for psychopathy. The simultaneous presence of anxiety and depression may seem incongruent but is reported in several case studies of psychopathic offenders [3-6]. Symptoms of ADHD are often confounded with symptoms of personality pathology and trauma, which may also be the case here. The dissocial character of the patient is not adequately explained by his substance abuse.

The patient's past experiences may explain the symptoms of psychopathy. His grandiose style may be linked to the fact that he was left to himself to a considerable amount of time as a child, which may have led to a compensatory response. He was perceived as dangerous from an early age, which he learned to appreciate as it gave him certain benefits and fame. The narcissistic rage he vents towards others could be ignited by his father's abuse, which he was unable to defend against. His lack of guilt may have occurred as a result of a feeling that his rage is highly justified. Combined with the expertise of how to swindle others, he had the tools to rule his environment without much resistance.

Prognostic characteristics

Psychopathy is traditionally associated with a poor prognosis. More recent research has focused on that the importance of applying treatments that are sufficiently adapted to the problem [7]. In line with this, a recent study demonstrates that individual *schema therapy*, which is customized to handle the relational distress of the psychopath, combined with interventions provided by nursing staff, showed significant improvements in psychopathic traits, cognitive schemas and risk-related outcomes at 3 years post treatment [8]. This gives cautious reason for optimism.

Therapeutic intervention

Types and administrations and changes in interventions

Although the overall contact between the therapist and the patient lasted for 2 years, it was impossible to establish a continuous course of treatment due to the patient's poor attendance and constantly emerging crises. The therapist focused on *providing the treatment the patient expressed that he needed*, as far as it could be judged as professionally acceptable. The therapist assumed, though, that it might prove impossible to treat the patient's anxiety, as it could be seen as a normal reaction to the many stressful events in his criminal and social life.

It became evident that the patient did not respond to cognitive therapy for his anxiety. He expressed some interest in pharmacological treatment. After trying out many medicaments to remedy his anxiety and depression, he deemed all of them ineffective. The administration of various medicines was partly executed in an effort to establish a therapeutic relationship. This was not successful, and the patient

demanded benzodiazepines and blamed the therapist when he did something criminal - as his felt that his anxiety was not properly treated. For a period of time, he managed to get benzodiazepines from several doctors. When this was discovered and terminated he blamed the doctors for his subsequent substance abuse. The therapist concluded that it would not be possible to help the patient with his anxiety at this time.

The patient required a prescription of Ritalin, but this was not given, as he had troubles with refraining form drugs and accepts being tested. As his symptoms went far beyond the experiences and behavior generally reported in cases of ADHD, the patient was not further assessed or treated with regard to this disorder.

Substance abuse treatment was attempted in the form of motivational interviewing and hospitalization, without success. The patient usually demanded immediate help, but was unable to plan ahead with regard to such treatment. The therapist used psychoeducation to inform the patient about his condition. And although the patient seemed to understand this information at an intellectual level, he was unable to change his behaviors. He would present himself as the victim in situations where he was clearly the perpetrator. Turning to the literature was of little help, as no valuable information on treatment of psychopathic patients could be found. As some sort of alliance was established, treatment was continued with the intent to explore whether it was possible to contribute with anything despite the serious condition of the patient.

The dialog often dealt with the offenses of the patient. It was evident that this was something that he liked to talk about. In fact, he seemed proud to be able to control other individuals through violence, threats and lies. He would sometimes ask the therapist about what he made of the things he talked about. He used to smile on these occasions, and tell the therapist that he knows that he feels like him from time to time. The therapist interpreted this and many other examples as *an effort to make them equal.* After some time, the therapist noted an almost imperceptible change in the way the patient approached him. The therapist was initially somewhat diplomatic in setting boundaries, as he would like to maintain the fragile treatment alliance. And although he clearly communicated that some questions would not be answered, the way the patient asked his question had an astonishingly disarming effect. At this point, the therapist regularly discussed the case with a colleague, who several times expressed her concern, as "there is nothing to gain therapeutically in these people".

The therapist found it impossible to create a position from which he could achieve some type of meaningful treatment. However, preventive measures such as psychoeducation of family members, cooperation with the local police, and supervision of probation service staff gave positive spillover effects, as the people around him no longer engaged in meaningless discussion that might trigger violence.

Follow-up and outcomes

Clinician and patient-assessed outcomes

In hindsight, the therapist found it plausible that the patient came to see him only to keep his economical allowance. Likewise, receiving prescriptions of benzodiazepines was probably also a motivating factor. This meant, according to the therapist, that the patient did not participate properly and thus should not expect improvement. The therapist also believed that the potential of change scared the patient, as he typically withdrew from the few conversations that the therapist perceived as meaningful. His overall impression was that much of the things that the patient presented were rather substance less. Treatment was abruptly terminated, and the patient is currently serving a long sentence for violence, threats, harassment, and drug related crimes. The patient potentially blames the therapist for his current situation, and is therefore not expected to give a positive evaluation of the treatment process if he were asked. The way the treatment process was ended probably resulted in further traumatization of the patient.

Adverse and unanticipated events

The patient's intent to murder his former partner was an adverse incident that the therapist was luckily able to prevent. In this, the patient emerges with a cynical ownership towards other people, while also indicating that the psychopath is not unaffected by those who are close to him.

The therapist further observed what seemed to be genuine, yet short-lived emotions, which soon became chaotic and ended with frustration and anger. Consistently, the therapist sometimes witnessed the patient behind his deficient personality structure, appearing genuinely vulnerable and suffering. This indicates that there might exist a window where it is possible to reach the psychopathic individual.

Discussion

Discussion of the strengths and limitations in the approach to this case

The strength of the present study is the nuanced portrayal of the psychopathic patient, and the thorough report of the specific challenges clinicians face in the treatment of psychopathy. Case reports provide a rich amount of information that is usually absent in studies of groups. An obvious weakness of the study is that the results are not readily generalizable.

The primary take-away lessons of this case report

Clinicians attempting to treat psychopathy must acknowledge the emotional strain that follows from the therapeutic relationship, for both the patient and the therapist. Psychopathic behavior should be understood in light of previous relational trauma. A theoretical framework with focus on the suffering of the psychopath must form the basis for all treatment, just as with any other patient. The therapist must be careful not to follow the patient's agenda, but rather relate each therapeutic intervention to the patient's underlying psychological needs. The psychopathic patient will reveal their pain in their effort to dominate or control others, or need for *agency*, and in their alternation between detachment and symbiotic striving, as *community* with others is something that the psychopath both wants and fears.

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