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Personality disorder treatment in a forensic setting and its application to the italian scenery

Il trattamento dei disturbi di personalità nel setting forense e sue applicazioni nello scenario italiano

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Abstract
Our present work represents a review of the scientific literature currently available on effective psychotherapeutic treatments for mentally ill offenders. What has come out from the review of the scientific literature on effective treatments focused on this specific subpopulation is the necessity of highly integrated therapeutic interventions that have to me administered in synergism by different health professionals and community services. Specifically literature states that it is essential to differentiate the forensic patient treatment plan (meaning both psychiatric and penal rehabilitation, antisocial behaviours, prevention of psychiatric and antisocial relapses, intervention on relapse risk factors, work opportunities..) on at least two macro levels: one mainly "institutional" community based, that implies a network cooperation among different services, what we call an enrollment in a community program (both clinical and judiciary) and the other one strictly "clinical" focusing on psychosocial, psychological (and psychotherapeutic) interventions that involve patients themselves and, when possible, their relatives. This paper will introduce a first section on available community treatments literature data and a second one focused on effective psychotherapeutic interventions that are currently suggested for mentally ill offenders. The theoretical frameworks taken into considerations belong to the most valuable and experienced authors on treatment and assessment of forensic psychiatric patients.

Key words: forensic psychiatric patients • integrated evidence based treatments • anti-social personality disorder • psychopathy

Riassunto
Il lavoro presentato rappresenta una revisione della letteratura scientifica attuale rispetto ai trattamenti psicoterapici efficaci per pazienti psichiatrici autori di reato. Ciò che è emerso da questa revisione della letteratura scientifica rispetto ai trattamenti efficaci per tale target di pazienti, è la necessità di interventi terapeutici ad alto livello di integrazione erogati in sinergia di diverse figure professionali e servizi sul territorio. In particolare, dalla letteratura si rileva che risulta necessario differenziare il piano di trattamento (inteso come riabilitazione psichiatrica e penale - condotte antisociali, prevenzione delle recidive psichiatriche e antisociali, interventi sui fattori di rischio di recidive, riabilitazione lavorativa, ecc.) del paziente psichiatrico forense su almeno due macro livelli: uno rappresentato da interventi di tipo prettamente "istituzionale", di tipo comunitario che implicano la collaborazione di rete di diversi servizi presenti sul territorio, in pratica una "presa in carico" da parte dei servizi territoriali (di tipo giuridico e clinico); e l'altro che riguardi prettamente il piano "clinico", quindi gli interventi psicologici (e psicoterapici) e psicosociali, che coinvolgano il paziente e, ove possibile, i familiari dei pazienti stessi. Tale lavoro quindi presenterà in una prima parte i dati di letteratura sugli interventi disponibili di tipo comunitario; la seconda parte si focalizzerà sugli interventi psicoterapici efficaci attualmente disponibili con i pazienti autori di reato. Sono state prese in considerazione i riferimenti teorici degli autori più esperti nell'ambito della valutazione e trattamento dei pazienti psichiatrici autori di reato.

Parole chiave: pazienti psichiatrici forensi • trattamenti integrati evidence based • disturbo antisociale di personalità • psicopatia

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Introduction

In Italy the dismantlement of the Forensic Hospitals has modified the system of care and custody of offenders (Carabellese & Felthous, 2016) that are deemed affected by a psychiatric disorder and incompetent to stand trial.

The reference paradigm, aside from the ideology inherent to the reform, assumes that high intensive care along with psychiatric and psychosocial treatments should reduce the relapse risk in that specific population. For this reason these structures are exclusively run by health professionals and their safety should be guaranteed by similar sanitary procedures (Carabellese, 2017).

Substantially beside the noticeable care humanization established by the reform, it is necessary to evaluate weather this paradigm actually lays its ground on solid scientific basis and which treatments are electively administered to this clinical subpopulation to achieve the required efficacy both in in the sanitary and in the judiciary area.

It will be outlined a review, as exhaustive as possible, of the recent scientific literature regarding effective treatments for mentally ill offenders.

Sorting through the existing literature, it appears that the treatment approach for psychiatric patients convicted for a crime, authors of antisocial and/or violent behaviours, requires a multi-level therapeutic intervention delivered by different health care professionals and community services.

Most of the scientific literature derives from English speaking countries, with procedural models distant from the Italian reality.

It is essential to differentiate the forensic patient treatment plan (meaning both psychiatric and penal rehabilitation, antisocial behaviours, prevention of psychiatric and antisocial relapses, intervention on relapse risk factors, work opportunities) on at least two macro levels: one mainly "institutional" community based, that implies a network cooperation among different services, what we call an enrolment in a community program (both clinical and judiciary) and the other one strictly "clinical" focusing on psychosocial, psychological (and psychotherapeutic interventions that involve the patients and, when possible, their relatives.

This paper will introduce a first section on available community setting literature data and a second one on effective psychotherapeutic interventions on psychiatric offenders.

1. Forensic psychiatric community treatment

The program "Dangerous and Severe Personality Disorder" (DSPD) (Mullen, 2007) established by the British government represents a consistent and costly effort in Mental Health.

This program represents an attempt to face psychological and interpersonal challenges of psychiatric patients, affected by severe personality disorders, offenders with a high risk of relapse, that focuses primarily on reducing the risk of harming oneself and others. This broad scale project derives from the assumption that specific personality disorders could cause and support criminal behaviours.

The program states that patients with these specific psychopathological features should be correctly diagnosed and recognized as such, implying that by treating the disorder the risk of committing violent or criminal conducts decreases. Therefore the theoretical assumption that underlies it all suggests that if the criminal conduct relies on the personality disorder, treating the pathology consequently will reduce the misconducts. Cooke et all (2007) specify that individuals enrolled in the DSPD program are included when there is an acknowledged functional relationship between the personality disorder and the potential risk they represent for the entire community.

Similarly, studies that ascribe to genetic features the aetiological factors of criminal conduct, require further supporting data to acquire relevance and scientific reliability (Caspi et al, 2002).

According to this program, a crucial first step is represented by a correct assessment of the psychiatric offender showing a higher risk of relapse, specifically the following features are outlined as relevant in criminal relapse risk: being young, male, un-partnered, poorly educated with few work skills and the amount and versatility of prior criminality, having substance misuse, anti-social problems, antisocial attitudes and a criminal peer group. Being also diagnosed as psychopath indicates a higher risk of relapse and greater violence in the potential future aggressive conducts, when compared with misconducts acted by other personality disorders.

Psychopaths are identified as patients that do not modify their attitude, will not establish significative and respectful relationships with others, instead they persist on being predatory and manipulative towards others. Psychopathy level and relapse risk are measured with Psychopathy Checklist-Revised (PCL-R; Hare, 1991), the Historical Clinical Risk Management-20 (HCR-20 Webster et al, 1997) and the Violence Risk Appraisal Guide (VRAG, Quinsey et al, 2005).

The "typical" patients enrolled in the program is represented by a young man with a schizophrenic syndrome who misuses cannabis and alcohol, who is symptomatic, uncooperative with treatment, denying of illness, interpersonally callous and living a disorganised life in a high crime neighbourhood, then he is at risk of acting in an anti-social and violent manner.

The risk will be reduced by moderating or removing the substance misuse, by improving symptom control, by stable accommodation in a low crime neighbourhood, by structuring his day with meaningful activity, and working on his attitudes towards others (Mullen, 2006).

According to Cooke (2007) the clear separation of the un-

derlying personality vulnerabilities in psychopathy, and potentially their hierarchical arrangements, should allow the development of more focused and effective therapeutic interventions. Hodgins (2007) calls for an effort to identify specific treatments arguing that richer and more complete characterisations of the subtypes of persistent violent offenders would lead to the development of treatments that directly target deficits.

For example he distinguishes anti-socials who are unemotional since childhood and anti-socials who feel anxiety and/or suspiciousness. The first subgroup focuses on rewards and ignores punishments and social exclusion. The aim consists in inflicting as much pain and damages as possible to those considered adversaries. Influencing such people depends on offering them rewards they value and avoiding becoming embroiled in their hostile interpersonal relationships.

The second subgroup, anti-socials who show traits such as anxiety, suspiciousness and resentment, can be managed and guided towards rules acceptance by contemplating the possibility of losing something they care about.

Mullen (2007) reports that offenders may reduce their criminal conducts if helped in acquiring a larger repertoire of coping mechanisms and responses in the dedicated pursuit of personal goals stating that it is easier to add to the behavioural and attitudinal repertoire of the individual with personality disorder than to inhibit or remove ingrained approaches. Hope resides in Tyrer and colleagues' theory of changeability and plasticity of personality (Tyrer et al.2007).

Morgan et al (2012) reviewed about 12,154 research documents, regarding studies of the service providers to offenders with mental illness. The aim of the meta-analysis was to build a review focused on the effective treatments for offenders, taking into account all the different aspects involved (time, setting, type of intervention, research on the common risk factors that may cause offenders to dropout from specific programs**)**. Authors underlie as effective strategies those that are integrated and simultaneously target both psychiatric and forensic aspects, the strict integration of psychiatric treatments and substance abuse prevention.

Results suggest both the necessity of tailored intervention for mentally ill offenders and their effectiveness on several aspect of psychiatric, criminal and behavioural functioning. Particularly interventions with offenders with mental illness effectively reduced symptoms of distress, improving offender's ability to cope with their problems, and resulted in improved behavioural markers including institutional adjustment and behavioural functioning. Furthermore, interventions specifically designed to meet the psychiatric and criminal justice needs of offenders with mental illness have shown to produce significant reductions in psychiatric and criminal recidivism.

Among the highlighted treatment strategies the use of homework, preferential group settings as opposed to individual ones, and open admission policies that allow the admission of new treatment participants throughout the program, versus closed admission policies, appear to be the most beneficial.

Treatments are considered effective only if they target both forensic and psychiatric needs.

For the latter psychiatric rehabilitation has become the treatment of choice (Corrigan, Mueser, Bond, Drake, & Solomon, 2007) to develop offenders' fullest capacities through learning and environmental supports (Bachrach, 1992). The goal of psychiatric rehabilitation is to enable individuals to live independently by compensating for, or eliminating, functional deficits (IAPSRS, 1995).

In psychiatric rehabilitation there are six areas main areas of intervention of proven effectiveness (Meuser, Torrey, Lunde, singer &Drake, 2003):

1) **Collaborative psychopharmacology**: outcomes are improved when consumers are included in the medication decision- making formula (i.e., collaborate for shared decision-making).
2) **Assertive community treatment:** provision of services to consumers in their natural environment (e.g., community) rather than a clinical setting such as an outpatient clinic or psychiatric hospital.
3) **Family psychoeducation:** educate family members about mental illness and effects of mental illness, enhance interpersonal relations, and foster a supportive support system.
4) **Supported employment:** gain competitive employment and provide assistance as needed, regarding skill development and employment maintenance for job security.
5) **Illness management and recovery:** help consumers assume responsibility for their recovery such that they can manage their illness, seeking assistance as needed to obtain personally meaningful and satisfying life goals.
6) **Integrated dual disorders treatment:** service providers target issues of mental illness and substance abuse simultaneously in an integrated fashion rather than treating these issues as separate disorders.

Psychiatric rehabilitation has proven effective with psychiatric patients and preliminary findings with offenders are promising (MacKain & Mueser, 2009).

It appears also essential that treatment services, to be effective with regard to long-term functioning, originate while the offender is incarcerated (National Research Council, 2008).

Outcomes from treatments with non-mentally disordered offenders and psychosocial rehabilitation services for mentally ill patients suggest that services correctional rehabilitation oriented services would be effective for reducing criminalness whereas psychosocial rehabilitation oriented services would be effective at reducing symptoms of mental illness.

Very few treatments focused simultaneously on both psychiatric and forensic aspects, while the majority aimed to treat either AXIS I or AXIS II disorders (SDM IV-TR, APA 2000).

Regarding the indicated treatments it can be observed that the inclusion of homework, specifically homework that required the practice of new skills and behaviours, produced stronger positive effects than did programs that did not include homework or the practice of new skills and behaviours. Correctional treatments to be deemed as effective should be intensive in nature, include structured programming, incorporate cognitive–behavioural models or target criminogenic needs.

In spite of research highlighting the significance of the therapeutic relationship between the service provider and offenders, the majority of the studies reviewed did not include any discussion on the importance of this alliance.

Outcomes can be grouped into eight general categories: mental health symptoms, coping, institutional adjustment, behavioural functioning, criminal recidivism, psychiatric recidivism, treatment-related factors (e.g., therapeutic alliance), and

financial benefit; still it is not possible to firmly determine that treatments resulted in a reduction in criminal and psychiatric recidivism.

What is established though is that studies that focused both on psychiatric and forensic issues, significantly reduce criminal and psychiatric recidivism.

Main results suggest interventions with offenders with mental illness effectively reduce symptoms of distress, improving offender's ability to cope with their problems, and result in improved behavioural markers including institutional adjustment and behavioural functioning.

An effective program, after being discharged from forensic hospitals, is an assertive community treatment (ACT) model that provides psychiatric service, day treatment, and intensive psychiatric rehabilitation (i.e., psychosocial rehabilitation) services. Still it is essential that intervention programs specifically target the co-occurring issues of mental illness and criminalness.

Significant treatment for mentally ill offender should begin during incarceration and should grant continuity of care, switching from a correctional institute to a more rehabilitative one. This model is consistent with public health initiatives by contributing to lower health care costs by reducing the rate of psychiatric hospitalization (Mitton, Adair, McDougall, & Marcoux, 2005) as well as reducing access to general medical services (e.g., Gill, Mainous III, & Nsereko, 2000).

As for recovery it is intended the achievement of a greater level of independence, greater quality of life, improvement in symptoms management, in spite of the psychiatric disorder (e.g., Corrigan, 2007); it stands out as a policy shift, from a model of assisted functioning (e.g., assisted employment, assisted living) certainly applicable to offenders showing improvements in the co-occurring dimensions of mental illness and criminalness recidivism.

Outcomes form studies on the importance of therapeutic alliance between mentally ill offenders and their therapists, focused on criminal recidivism, are contradictory: DeSorcy (2017) suggests that working alliance is not significantly linked to outcomes of violent recidivism.

There is a greater likelihood of violent sexual recidivism if an individual shows specific psychopathic traits (Doren, 2008).

Other reviews examine how often and how consistently symptoms lead directly to criminal behaviour. First, crimes rarely were directly motivated by symptoms, particularly when the definition of symptoms excluded externalizing features that are not unique to Axis I illness.

Specifically, of the 429 crimes coded, 4% related directly to psychosis, 3% related directly to depression, and 10% related directly to bipolar disorder (including impulsivity). Second, within offenders, crimes varied in the degree to which they were directly motivated by symptoms. These findings suggest that programs will be most effective in reducing recidivism if they expand beyond psychiatric symptoms to address strong variable risk factors for crime like antisocial traits (Peterson,2014).

David Scott and his colleagues published in 2013 a review on the effectiveness of services that in the United States are strictly under Judiciary control, but administer sanitary treatments to mentally ill offenders: the so called criminal justice liaison and diversion (CJLD). According to the authors evidence indicates that these services can help to reduce criminal recidivism and improve mental health outcomes. They outline the key features of the interventions in these structures, known as *mental health court*- MCH,(Goodale 2013). Liaison services seek to identify offenders with a mental illness and link them to appropriate mental health services in the community. Most employ community psychiatric nurses to complete assessments and provide general guidance to criminal justice system staff, when required a full multidisciplinary team gets involved. These services follow a model of therapeutic jurisprudence. Key components include a separate court docket for offenders with mental disorders, a judge trained in mental health issues, and a "treatment team" of mental health and legal professionals. MHCs aim to divert offenders with mental disorders to appropriate services, encourage treatment compliance, and reduce recidivism (Petrila, 2005; Steadman, 2005; Balenko, 2001). Substance abuse represents the strongest risk factor in determining criminal recidivism and clients who had a dual diagnosis had committed more serious offenses (Hoff, 1999). Authors conclude that this service model may be an effective way to reduce time in jail for people with serious mental illness. The ACT intervention model help participants to respect treatment indications allowing them to improve their outcomes on recidivism and psychosocial functioning. Anyway authors emphasize that these treatments show more effectiveness in mentally ill offenders that did non experience detention, versus those who had.

The Swedish judiciary system introduced two modern principles: first, the attempt to abolish moral responsibility, atonement and punishment, and second the integration of psychiatric assistance into control systems (Svennerlind C, 2012).

Moving towards the Japanese system, after the 2005 reform, a psychiatric patient who commits a serious criminal offence is provided with intensive psychiatric treatment ascribing also great importance to society reintegration. The court panel, which consists of a judge and a specially qualified psychiatrist, plays a key role in the treatment procedure. Upon the agreement of the two panel members, the panel delivers a verdict that takes into account the outcome of psychiatric evaluation; possible verdicts are inpatient treatment order, outpatient treatment order (with mental health supervision), and no treatment order (Nakatani Y,2010).

Literature consistently reports that several personality disorders, Axis I diagnoses (Schizophrenia and Mood disorders) and substance abuse related disorders, are linked to different types of violent crimes. There are scarce results available on the type of interventions and effective therapeutic approaches for aggressive patients; still few available studies support the effectiveness of cognitive therapy (Ali, 2015; Kenworthy, 2008) and group therapies (Kenworthy, 2008) for aggressive behaviours.

Regarding the personality most frequently linked to psychopathic and antisocial traits and behaviours, Nioche in 2010 inquired for associations between psychopathy and personality disorders. Outcomes found out correlation mainly with the cluster B axis II (narcissistic, antisocial, histrionic, and borderline). Among those disorders, a particular link existed with the borderline personality disorder. The antisocial and paranoid personalities predicted the total score and the factor 2 of the PCL-R. Antisocial and narcissistic personalities predicted factor 1 underlining first the importance of impulsivity above all for the cluster B personality disorders and secondly, the im-

portance of considering impulsivity with antisocial (factor 2), narcissistic and paranoid characteristics. These results also outline treatment implications: the treatment may be adapted according to the comorbidities having an effect on psychopathy that is antisocial with paranoid personalities, and antisocial with narcissistic personalities.

Besides personality disorder other psychiatric diagnoses considered at risk for violent conduct are Schizophrenia and other psychotic disorders; nevertheless comorbid diseases with substance abuse and antisocial disorder appear to be more related to violent conducts. Some researchers argue that schizophrenic patients are more likely to commit crimes such as homicide, not because of actual acute symptoms, but mainly due to association with substance abuse (Richard-Devantoy, 2013).

Another well-acknowledged theory in the scientific world is that patients with psychopathic traits show higher risk of criminal recidivism (Hare, 2006), as well as it is established that patients with personality disorders and psychopathy are more frequent among men than women (Nicholls, 2005).

Regarding treatments focusing on psychopathological conditions such as those of patients diagnosed with antisocial personality disorder, borderline personality disorder and other personality disorder related to antisocial or aggressive behaviours, malignant narcissism and psychopathy, only in recent years forensic literature has started to offer intriguing hints that may lead to further researches, since, in spite of past acquisitions, it is still very scarce.

2. Psychotherapeutic interventions

The available described treatments mostly resulted out of few forensic studies.

Treatments focus mainly on borderline and antisocial personality disorders (Bateman, 2016). Bateman and Fonagy (Bateman, 2016; Bateman and Fonagy et al. 2008) focus on assessment of mentalization based treatment (MBT) in patients diagnosed with borderline personality disorder (BPD) and antisocial personality disorder (ASPD) in comorbidity with Axis I disorders (DSM-IV-TR, 2000). The most frequent comorbid psychiatric disorders in BPD are anxiety and affective disorders, with lifetime prevalence for these at approximately 85 %, followed by substance use disorders at approximately 79%. Co-existence of other psychiatric disorders in BPD ranges between 41–83% for major depression, 12–39% for dysthymia, and 39% for narcissistic personality disorder. Regarding antisocial personality disorder (ASPD), over 90% of those diagnosed with the condition have at least one other psychiatric disorder, at least 50% have co-occurring anxiety disorders and 25% have a depressive disorder. Both ASPD and BPD show particularly complex and severe form of personality disorder when high levels of both DSM Axis I and Axis II comorbidity are reported. The prevalence of individuals meeting both BPD and ASPD diagnostic criteria in British population is low (0.3 %), but it increases in forensic samples with a higher degree of dangerousness and violence.

Bateman highlights that in Section III of DSM 5 the two conditions share similarities in symptomatology and trait domains namely antagonism and disinhibition. Overlap includes marked impulsivity and unpredictability, difficulties with emotional regulation and controlling anger, disregard for safety of self, and behaviour that can be considered by others to appear manipulative.

These aspects can be viewed with different underlay perspectives. BPD conduct such behaviour with the intention of eliciting care and concern from others; while ASPD conduct it with the intention of gaining personal profit and power over others.

Bateman also explains the differences between the two disorders: ASPD tend to have an inflated self-image, whilst those diagnosed with BPD tend to have a negative and devalued self-image; those diagnosed with ASPD pose more of a risk to others due to their tendency towards interpersonal violence, whilst those diagnosed with BPD pose more of a risk to themselves due to their tendency to self-damaging and self-destructive behaviours; those diagnosed with ASPD tend to lack empathy and be indifferent to or contemptuous of the feelings and sufferings of others, whilst those diagnosed with BPD are more likely to display empathy.

Bateman, in spite the differences, states a specific hypothesis on the theoretical frame of the two diagnoses. Although they may be almost polar opposites, the prominent symptoms appear across diagnostic groups, and BPD in particular might be better understood as being at the core of personality pathology thus explaining the high levels of comorbidity with other personality disorders, including ASPD.

These considerations for the author strongly affect treatment. Bateman identified failures in social cognition associated with both personality disorders; in particular they both share deficits and distortions of mentalization (the process of making sense of the self and of others in terms of mental states e.g. beliefs, thoughts, feelings, desires). It appears that those with BPD do not mentalize properly in the context of attachment relationships, in which emotional arousal occludes the ability to accurately interpret their own and others' mind states particularly when the fear of real or imagined abandonment arises. Antisocial individuals show a more general and deeper impairment the BPD, including deficits in the recognition of basic emotions, and perform far worse than controls on subtle tests of mentalizing. Deficits in social cognition in general and the capacity to link mental states to behaviour in particular are commonly identified in association with antisocial behaviour. As for the ASPD aetiology, Bateman suggests the pathway to the disorder leading from an early child conduct disorder via alcohol abuse in early adolescence to compromised function (and maturational delay of the cognitive control system of which mentalization is a part.

Mentalization-Based Treatment is a psychotherapeutic intervention which specifically focuses on improving the capacity to mentalize; it has been shown to be effective for patients with BPD in reducing frequency of suicide, severe self-harm, and hospital admission as well as improving general symptomatology and social and interpersonal functioning (Bateman and Fonagy, 2009). While the presence of comorbid Axis II diagnoses appears to have a negative impact on outcomes for BPD patients undergoing standard clinical management, there has been preliminary work to suggest that MBT may be more beneficial for patients whose BPD is embedded in other Axis II personality disturbances, including that of ASPD (Bateman and Fonagy, 2013). The authors propose that mentalization model may be effective for addressing symptoms of ASPD as well as of BPD. Antisocial behaviour and violence tend to

occur, the authors explained, when an understanding of others' mental states is developmentally compromised (fragile) and prone to being lost when the attachment system is activated by perceived threats to self-esteem, such as interpersonal rejection.

Usually mentalizing reduces the risk of acting violent conducts ((Bateman and Fonagy, 2008) meaning that individuals with vulnerable mentalizing capacities can be at risk in situations of interpersonal stress.The authors support that improving the capacity to identify others' emotions and intentions may not only help social functioning but also reduce the risk of antisocial behaviour.

Mentalizing has been shown indeed to be a protective factor in people with tendency to develop violent traits (Taubner et al, 2013) and it has been shown that encouraging mentalizing also reduced school violence (Fonagy et al, 2005; Fonagy et al, 2009).

Bateman recent study (2016) compared patients with comorbid BPD and ASPD treated with MBT with those offered an outpatient structured protocol of similar intensity, but excluding mentalizing components in the United Kingdom.

Both the MBT and SCM groups presented with similar levels of anger at the beginning of treatment, but differed significantly by 18 months; while no significant changes between the two groups we measured in the interpersonal style. Self-rated hostility, however, decreased in both groups. Paranoia symptoms showed significantly more improvement at 18 months in the MBT group. Occurrence of suicide attempts, episodes of self-harm and hospital admissions registered also reduced in the group that received mantalization treatment. Anxiety and depression scales also scored significantly lower in the MBT group. MBT treated patients after 18 months show significantly higher levels of global and social functioning, as well as emotional regulation when compared to the standard care group. Authors then conclude that MBT in patients with comorbid ASPD and BPD reduce anger, hostility, paranoia, and frequency of self- harm and suicide attempts, as well as improve negative mood, general psychiatric symptoms, interpersonal problems, and social adjustment.

Another important data strongly suggest that this patient group value the intervention and adhere to the treatment protocol (dropout rates of 27% for MBT).

Talking about mentalization skill as essential to a good interpersonal, social and global functioning, several studies by Fonagy support a strong impairment in mentalization, social cognition and social sensitivity in ASPD subjects as opposed to offenders not diagnosed as ASPD.

According to Fonagy a treatment that focuses on these aspects may be effective with ASPD patients (Newbury-Helps, Feigenbaum, Fonagy, 2016).

The author also examines risk factors associated with antisocial behaviour in general and violence as mediated by intra-familiar factors, such as the quality of the parent-child relationship (Fonagy, 2004). In a developmental pathway, the risk of violence may be tied to child abuse in an attachment setting, mediated by a child ability to imagine other mental states.

The literature on Theory of Mind (ToM) in antisocial samples is limited despite evidence that the neural substrates of theory of mind task involve the same circuits implicated in the pathogenesis of antisocial behaviour(Dolan, 2004). For the majority of criminals with ASPD and psychopathy ToM abilities are relatively intact and may have an adaptive function in maintaining a criminal lifestyle. Key deficits appear to relate more to the lack of concern about the impact on potential victims than the inability to take a victim perspective. also the findings suggest that ASPDs with neurotic features may be more impaired in mentalizing ability than their low anxious psychopathic counterparts (Dolan, 2004).

Searching through recent studies Bernstein (2012) latest works contradicts the hypothesis that available treatments for offenders diagnosed with personality disorders result in discouraging outcomes. Bernstein underlies that psychopathic subjects represent an heterogeneous group both in the disorder aetiology and in the emotional distress they present. Bernstein differentiates between psychopathic patients that are emotionally unresponsive and highly emotional psychopathic patients, that, as a consequence, may be more responsive to treatment. This assumption opposes the dominant one on psychotherapies efficacy on psychopaths that may worsen their manipulative traits.

Bernstein, actually, started a still ongoing study in 2007 aimed to inquire after effective treatments for offenders with comorbid personality disorder.The author mainly focused on assessing treatment effectiveness on risk of criminal recidivism and on maladaptive personality traits, aiming to eventually, gradually, reintroduce the patient into the community. The study enrolled a sample of 100 patients diagnosed with antisocial, borderline, narcissistic, and paranoid personality disorder among seven Dutch Forensic Hospitals. Half of the sample underwent treatment with Schema Therapy and the other half underwent standard treatment *(Treatment as usual)*. The preliminary results (Bernstein, 2012) show that Schema Therapy reduces the risk of recidivism, helps to fasten the resocialization process and the patients community reintroduction, with less frequent need for supervision. Preliminary data, though encouraging, will be definitely assessed by 2018. Still Schema Therapy seems to effectively contrast the commonly shared idea that this population of patients are not treatable.The author extensively contrasts studies that suggest the psychotherapies may worsen the manipulative traits in antisocial/psychopathic conduct, arguing that often published works are biased by the assumption that these patients are not responsive to treatment, and consequently are not given specific treatments.

Another consistent data on Schema Therapy is represented by the Adherence to Treatment (Bamelis et al, 2013); it can be outlined that this intervention has moved forward, since its introduction by Jeffrey Young, so much as to prove its effectiveness in also in suicidal and self-harm behaviours.

3. How the psychotherapeutic approach to mentally ill offenders changes

As already stated, general attitude towards these patients is changing. Among the most important scientific contributions available in literature stands Kernberg's, that reflects on the possible and potential effectiveness of psychotherapeutic treatments and of social influences, once a malignant intrapsychic structure has established and consequently a pathological grandiose self-infiltrated with aggression dominates psychic function, in the absence of the moderating and maturing re-

liance on an integrated superego (Kernberg, 2004; 2006). According to Kernberg there are sufficient scientific evidences available to suggest that narcissistic personality with antisocial traits and the malignant narcissistic syndrome can be effectively treated. Similar evidences are still lacking, says Kernberg, for Antisocial Personality Disorder (ASPD).

Kernberg direct experience with these patients has lead to the standardization of a series of indications, guidelines, that regard the treatment of antisocial conducts and, especially, the prerequisites, or *conditio sine qua non*, that are mandatory to grant clinical treatment and that involve, the patient, his family and the social environment.

According to the author first it is essential to distinguish in case of severe aggressive behaviour of severe self-destructive behaviour, whether there is a life threatening risk for the patient or other figures involved, including the therapist. Kernberg suggests, if an aggressive ASPD is diagnosed, to engage the patient family, social services and the legal system for eventual warning duties. The prognosis for aggressive antisocial personality disorder is poor so the main therapeutic goal is to protect the patients himself, his family and society from his destructiveness. If a patient instead satisfies the criteria for ASPD, but does not present aggressive or exploiting behaviour that configures an immediate harm, the pressing need is for the comprehension of what lies behind the consultation request.

The request may have different genesis: it could originate by the family; it could be derived from the necessity of protecting himself from a recent lawsuit or criminal charges; the judge may ask an opinion to rule on the patient criminal responsibility; consultation is requested by the family or by community services to assess psychopathological conditions and to face the harm the patient is causing to the surrounding environment, or the patients is in a psychotic state.

These patients may show a chronic tendency towards robbery or exploitation of their family, they can be chronically violent without necessarily be life threatening or they can act conducts potentially illegal. Across the Italian territory in the residential forensic facilities (REMS) a common crime is familiar aggressiveness (maltreatment). In this matter the therapist faces the responsibility of being a family consultant, but also gets involved with psychiatric services and with legal figures.

It is essential, anyhow, not to allow to the patient to take advantage or profit by therapeutic connections to protect himself by legal consequences. Similarly the clinician should take all the necessary steps to guarantee his safety, including legal aid to check on potential responsibilities, as a mandatory prerequisite before any interventions on these patients and their families.

One essential precondition to start treatment is for the clinician to get sure that the patient agrees on the necessity of stopping any social connection that may be harmful for himself or others.

Kernberg says that psychotherapy with Antisocial Personality Disorder patients that are not aggressive requires an open communication with the patient and his family on the gravity of his conditions, the prognosis and the necessity of an open communication with the entire familiar system to monitor the patient compliance, starting from the assumption that every anti-social conduct should have stopped at the beginning.

This arrangement improves the likelihood of success in managing self-harm or violence towards others and in preventing selfish gains related to the therapeutic process.

According to Kernberg the prognosis of malignant narcissism is better than the one related to ASPD. One prerequisite is the strict surveillance of antisocial behaviours, an open communication with the family and the social system, the eradication of any personal gain, and the physical, social and legal protection of the therapist.

When treating patients with severe personality disorders, another tactical approach relates to certain general priorities that need to be taken up immediately. These priorities include, in order of importance: (1) suicidal or homicidal behaviour, (2) threats to the disruption of the treatment, (3) severe acting out in the session or outside, that threatens the patient's life or the treatment, (4) dishonesty, (5) trivialization of the content of the hour.

To complete the overview on malignant narcissism, scientific literature suggests that the patient profile is liable of dimensional interventions on specific aspects.

One of the main features of the treatment is its internal consistency: for instance, no unjustified absences can be tolerate, and the aim is to progressively reduce the access of the patient to angry emotions, usually employed to inflate his self-esteem or avoid to bare pain or suffering.

These coping strategies have to be opposed favouring the access to one emotional state and in this perspective Mentalization/Metacognitive strategies seem to be preferential (Bateman and Fonagy, 2010; Fonagy 2009). Deficits in mentalization are associated with several pathological conditions (Abu-Akel and Shamay-Tsoory,2011; Bateman and Fonagy, 2010) and many mantalization based treatments resulted effective in reducing dysfunctional behaviours and in mediating the psychopathic aspects.

Trying an Interpersonal Metacognitive approach on offenders with personality disorders, it is necessary to take into account that there are still no evidences that support it, but if this is the case, the following are some of the thoughts or questions a therapist may have in mind while approaching these patients with TMI:

1) What are the psychopathological conditions that are threatening the patient's wellbeing and integrity?
2) What are the psychopathological conditions that may turn out to interfere globally with therapy and specifically with therapeutic alliance?
3) What are the psychopathological conditions that are essential in prolonging the disorder?
4) What are the psychopathological conditions that represent the main cause of subjective pain and maladaptive functioning?

In answering the first question, we have to consider that auto reflection and differentiation process are highly compromised; that patient does not have the ability to access his emotional world and does not differentiate between fantasy and reality, between intrapsychic reality and objective reality. Dissociative fantasy regulates one's mental state and counteracts the feelings of emptiness; in this perspective the subject may benefit from interventions that increase and improve the insight on his emotional world without being necessarily being frightened by it. The therapist needs to act cautiously while exploring the patients' emotional world, being at risk of elic-

iting a negative counter-transference. The main issue while working with the patients is actually the identification of the dominant primary emotion. Still, this represents the first step to undertake that is to encourage auto reflection and highlight dysfunctional coping strategies that lack of efficacy in the long term. If the access to new forms of experience is blocked the patient remains trapped in his fantasies and actively rejected by others; context rejection and the constant seeking of sensational situations will endanger the patient that will get caught in a cycle that supplies, along with other factors, the disorder persistence. These patients get often involved in serious legal situations, tend towards acting out, underestimate the risk they face and that may end up interfering with treatment.

They are often the only accountable for the lack of assistance they experience, often due to the threats they make against their lawyer or therapist.

The second question faces the psychopathological aspects that may interfere with therapy, and more specifically with therapeutic alliance. In this perspective the tendency towards deception and being manipulative are the most accounted for therapeutic alliance. The patient is in fact constantly focused on getting admired by others (including the therapist) raising in the therapist the perception of a fake alliance, along with the feeling of being constantly under deceit or exploited; on the other hand raising in the patient himself a feeling of frailty whether the therapist should get too close to his emotional world. Anyway the therapist should reach an agreement with the patient, at the beginning of the treatment, about the opportunity of checking the accuracy of the acquired information through family or other sources, also the therapist, session by session, should highlight the patient style, in the hic et nunc of the relationship, to get him to understand how his strategies are interfering with the access to deeper and authentic mental and emotional material. What de facto happens in clinical practice is that the patient gets scared, not being able to cope with negative emotions, feeling his vulnerability, and quits therapy.

Answering the third question from a TMI perspective, searching for the factors that are essential in the disorder persistence, we can consider that the written above cycle of constant admiration seek, when failed, turns for the patient in a raging search of others' admiration. The tendency to swing between seduction and anger is the maintenance factor most frequently identified in the disorder. The patient who fails in getting others' admiration or in deceiving others, turns resentful and tends to isolate himself in a world of fantasies as a coping strategy while hurting.

Finally, as for the factor that represents the main cause of subjective pain and maladaptive functioning for these patients, it seems to be the failure in manipulating others. It appears striking in them the level of social impairment; they are often clumsy both on an interpersonal and on a social level, due to the metacognitive impairment and to the scarce ability to be empathic and intimate. Let us consider their assertion of greatness and search for admiration to understand the effect they arise in others, namely of exclusion, that in turn, generates in the patient severe rage displays.

The metacognitive approach takes into account all these preconditions, focusing on relationship, interpersonal cycle and metacognitive impairment.

Regarding specific interventions on forensic psychiatric populations, besides the studies already introduced on Bernstein and Schema Therapy, on Kernberg and the Transference Focused Psychotherapy, on TMI principles, other recent studies (Rosenfeld et al, 2012; Galietta & Rosenfeld, 2012; Tomlinson & Hoaken, 2017; Tomlinson, 2018) deal with the effectiveness of dialectical behavioural treatment of Marsha Linehan adapted to forensic patients.

Particularly DBT resulted effective in reducing aggressive behaviours, anger and hostility in a sample of forensic patients (Tomlinson, 2017); it is effective on overall symptoms (Galietta & Rosenfeld, 2012); it is effective in reducing the risk of criminal recidivism up to 55%, if applied within a "Risk-Need-Responsivity" framework in residential settings (Tomlinson, 2018).

Another interesting work by Rosenfeld (2012) compared indexes of relapse in a group of psychiatric patients convicted for stalking that were enrolled in a DBT program specifically adapted for them. The results indicates that DBT treatment is effective in reducing the risk of stalking recidivism compared to patients that drop out of the DBT program and to the general data on relapse available in literature.

For ASPD patients with comorbid substance abuse guidelines suggest to consider cognitive-behavioural group therapy to address impulsivity, interpersonal difficulties and antisocial behaviours.

For ASPD patients with a history of aggressive behaviours that are in residential settings, guidelines suggest CBT group therapy that focus on the reduction of aggressive and antisocial behaviour overall.

If CBT treatments are administered id essential to assess the risk level to calibrate the treatment intensity and duration. It is also necessary to provide support and encourage patients to avoid drop outs.

For patients in residential facilities or forensic settings that meet the criteria for psychopathy or ASPD it is recommended to take into account CBT interventions based on the reduction of aggressive and antisocial behaviour overall.

As for the population of adolescents patients, the effective treatments proposed (familiar therapy, parental skill training, group CBT interventions) prove to be statistically significant in reducing aggressive behaviours. Caldwell and colleagues (2006) compared an intensive treatment program in juvenile Treatment Centres for adolescents with a group that underwent treatment as usual. The costs were higher in the first group, but there was also a significant reduction of criminal recidivism and violent crime in the adolescents that belong to the first group.

Guidelines suggest to intervene on adolescents of 17 years of age or less with a history of aggressive conducts that are in correctional facilities with CBT groups that focus on the reduction of antisocial and aggressive behaviours.

Regarding patients diagnosed with ASPD in comorbidity with substance abuse, literature data on the effectiveness of treatments that tangle substance abuse are controversial (Wolver et al, 2001; Hesselbrock, 1991; NCCMH, 2007°; 2007b). It is anyway common opinion that treating the substance abuse in comorbidity with the ASPD is effective because of its role as risk factor in ASPD relapse; treating those aspects reduce consequently criminal conduct related to ASPD and to psychopathy (NICE, 2009).

Conclusions

Considering what we have described so far we can state that the treatments to administer in a forensic setting are specific according to homogeneous diagnostic groups.

Literature especially highlights patients with dual diagnoses as the most challenging so the key features in establishing a therapeutic path are Integration, Psychiatric Treatment, Psychosocial Rehabilitation, Forensic Rehabilitation.

Differing from what is nationally deemed appropriate the complexity of those therapeutic pathways should contemplate their entitlement entirely to specialists supported by a juridical staff.

Each structure should specify which standardized instruments are employed for diagnostic assessment and to assess recidivism risk.

It appears to be mandatory the employment of appropriate tools for assessing cognitive functions, IQ, personality profile, mentalization/metacognition level (such as IVAM, Semerari et al, 2008) and psychopathy. There is no scientific evidence that treatment itself may reduce alone the relapse indexes, the only real recidivism predictor so far is PCL-R.

As for the treatment programs for patients with personality disorders it appears essential that they have a high level of structuring and intrinsic consistency both on the theoretical model they rely on that on the psychotherapeutic approach they deliver. Treatment based on mentalization (MBT) and Schema Therapy are currently showing greater scientific evidence than other treatments so approaches that enhance mentalization and metacognitive functioning should be favoured.

We wish that this may soon happen nationwide.

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