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Antisocial Personality Disorder and Clinical Supervision

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Abstract

Antisocial personality disorder occurs in approximately 3% of the general population and up to 70% in inpatient and forensic populations. Professionals who counsel clients with antisocial personality disorder display higher rates of burnout and job dissatisfaction. A case illustration demonstrates how clinical supervisors can assist supervisees in understanding symptomatology, processing countertransference reactions, and developing creative interventions for treating clients.

Keywords: Antisocial personality disorder, clinical supervision, countertransference

Prevalence rates for antisocial personality disorder (ASPD) are 3.3 % in the general population and 70% for individuals in inpatient psychiatric facilities, substance abuse facilities, and the incarcerated (American Psychiatric Association [APA], 2013). The defining characteristics of ASPD are a disregard for the rights of others and a lack of empathy or remorse (APA, 2013). Individuals with ASPD are prone to being manipulative, deceitful, and superficially charming (National Institute for Health and Care Excellence [NICE], 2009). Further, they have increased impulsivity and a propensity toward anger and violence and often have difficulty adhering to cultural and institutional expectations (e.g., inpatient treatment; Lobbestael, Arntz, Cima, & Chakhssi, 2009). Many individuals with ASPD have a chronic history of institutionalization and recidivism beginning in adolescence and lasting throughout adulthood (NICE, 2009). Due to their impulsivity and maladaptive patterns of behavior, individuals with ASPD make up a disproportionate amount of individuals in the forensic population (e.g. prisoners, probationers, and parolees; APA, 2013). They are often seen in jail and prison settings (NICE, 2009) and may be mandated to counseling following incarceration (Meier & Barrowclough, 2009).

Clients diagnosed with ASPD present a unique set of challenges for counselors. The purpose of this article is to provide counseling supervisors with a framework from which to better understand the needs of counselors who work with clients having ASPD. A case illustration demonstrates how clinical supervision is an effective intervention in treating clients with this disorder.

Diagnosis and Treatment

Diagnosis of ASPD frequently requires use of a structured clinical interview (NICE, 2010) and a thorough examination of collateral information (APA, 2013), such as referral source interviews and documentation. This disorder is often misdiagnosed due to clinicians focusing on isolated incidents rather than an enduring pattern of antisocial behavior (Edens, Kelley, Lilenfeld, Skeem, & Douglas, 2014). To identify an enduring pattern of antisocial behaviors, clinicians may opt to speak with client family members, friends, and probation and parole officers when applicable. Even with a thorough examination of client history accurate diagnosis can be difficult due to clients using deceit and manipulation to evade diagnostic criteria (Thompson, Ramos, & Willett, 2014). These symptoms can be challenging in diagnosis as well as treatment.

According to Thompson et al. (2014), psychotherapy has little effect in the treatment of ASPD and actually may increase symptoms such as deceitfulness and use of charm and manipulation. Individuals with ASPD are difficult to treat due to their superficial charm and their belief that they do not need to change the way they relate to others (Perry, Presniak, & Olson, 2013). They are often entertaining, convincing, and frequently evade diagnostic assessment and treatment (Thompson et al., 2014). Individuals with ASPD may be captivating storytellers who are able to convince clinicians that they are victims of circumstance.

The limited efficacy of traditional talk therapy can be discouraging to clinicians. The therapeutic landscape relies heavily on evidence-based practices such as cognitive behavioral therapy (CBT) to increase client awareness of self defeating cognitions (e.g., “the rules don’t apply to me”) and their role in ongoing maladaptive behaviors (Substance Abuse and Mental Health Services Administration, 2014). While CBT is effective with a variety of issues, its success with clients with ASPD is limited. Traditional CBT relies on clients identifying maladaptive thoughts and behaviors and practicing new ways of thinking and behaving. Clients with ASPD avoid sharing their true thoughts or beliefs, thereby limiting treatment efficacy through a CBT approach (Roes, 2012).

One promising approach is cognitive behavioral therapy for personality disorders (CBTpd). This approach adapts concepts from CBT to address both the person and his/her environment. Cognitive behavioral therapy for personality disorders differs from traditional CBT as it places increased emphasis on the process of developing a trusting relationship between counselor and client. The focus of therapy is on daily struggles, and a specific protocol is put in place for addressing anger and violence (Davidson et al., 2010).

The National Institute for Healthcare and Clinical Excellence (2009) guidelines recommend treatment of ASPD through psychosocial and psychotherapeutic methodologies including CBTpd and medication management. Recent studies found that

antidepressants reduce aggression and increase adherence to social norms; however, more research is needed before definitive efficacy is established (Thompson et al., 2014).

Clients with ASPD benefit most when services are delivered in an engaging and nonthreatening environment through a variety of interventions (Martens, 2004). Multiple professional disciplines are recommended due to the complex issues clients with ASPD present and their involvement in multiple systems (e.g., legal, family, medical). Continued research and development of effective interventions are nonetheless needed, as clients with ASPD are disproportionately treated in underfunded settings (e.g., public psychiatric centers, prison settings) that do not address the holistic needs of the individual (NICE, 2009).

Effects on Service Providers

Clients with ASPD are challenging to counseling professionals and organizations (NICE, 2009). By adulthood, these individuals have been exposed to a variety of treatment settings and refined their skills of manipulation and evasion. Manipulation is often a survival skill learned from repeated exposure to hostile environments and is a key feature of ASPD (Bowers, 2003). While manipulation is common in clients with ASPD, the symptom is often personalized by clinicians rather than used as a means of understanding clients (Bowers, 2003). Client manipulation may therefore result in the counselor's attempt to regain a therapeutic foothold through direct confrontation or terminating the client from treatment (Hofer, 1989). Furthermore, clinicians may hold negative views of clients with ASPD, which damages the therapeutic relationship (Bowers, 2003).

The negative reactions clinicians experience when working with clients with ASPD is often a result of unresolved countertransference (Evans, 2011). The countertransference reaction is especially strong in clinicians working with these clients due to the client's interpersonal interactions involving hostility, distrust, and manipulation (Schwartz, Smith, & Chopko, 2007). While these interactions may evoke strong emotions in clinicians, they may also be a tool for better understanding and treating the client when addressed in clinical supervision (Evans, 2011).

Clinicians treating clients with ASPD are prone to being bullied, lied to, intimidated, and demeaned (Kurtz & Turner, 2007). These interactions can result in negative feelings toward clients and poor treatment provision (Evans, 2011). As already suggested, clinicians often have difficulty viewing manipulation as a symptom of the disorder and personalize the interaction (Bowers, 2003). They may also disengage from the client rather than explore their motivations for manipulation (Bowers, 2003). New counselors are especially vulnerable to manipulation (Martens, 2004). They may experience feelings of shame, embarrassment, and fear of administrative consequences when they learn they are being manipulated and, as a result, be hesitant to seek supervision and support (Bowers, 2003).

Clients with ASPD often use charm and seduction to convince clinicians that they have a special connection and thereby challenge professional boundaries. These interactions foster the counselor's need to rescue clients from their current situation (Evans, 2011). Clients present plausible arguments to project onto clinicians their belief

that nothing is wrong with them and that they are victims of circumstance (Thompson et al., 2014).

Furthermore, service providers report frustration toward their employing agency when assigned to serve clients with ASPD (Priest, Dunn, Hackett, & Wills, 2011). Often, agency policies are a poor match for the treatment needs of these clients (NICE, 2009). Agencies are challenged with serving as many clients as possible under tight time constraints. Often, new clients cannot be seen until existing clients are discharged. Service providers are faced with managing not only the needs of their clients but the changing demands of the organization. They experience feelings of vulnerability due to the challenges of working with clients with ASPD, in addition to dealing with contradictory agency policies and professional and ethical codes (Priest et al., 2011). The strain of working with challenging clients and a lack of effective treatment modalities and systemic challenges (e.g., meeting the agency/managed care guidelines for short-term treatment) leads to increased levels of stress, job dissatisfaction, and burnout (Priest et al., 2011). Breakdowns in communication between fellow staff of differing disciplines and even those within the same discipline are cited as a frequent occurrence when working with this population (Priest et al., 2011).

The chronic nature of ASPD poses another challenge. Clients with ASPD have longstanding patterns of thinking and behaving (APA, 2013). They gain trust in the therapeutic process slowly and require long-term treatment (Evans, 2011). Clinicians working with these clients report feeling frustrated due to lack of progress and often classify clients as treatment resistant or unmotivated, contributing to the cyclic stigma associated with ASPD (NICE, 2009).

Martens (2004) identified a lack of a “click” between clinician and client as a contributing factor to poor therapeutic outcomes (p. 55). Clients with ASPD form bonds slowly and the lack of an initial therapeutic alliance is off-putting to clinicians. Inexperienced clinicians report increased frustration with this lack of alliance and unknowingly sabotage therapy through unresolved countertransference (Schwartz et al., 2007). For example, clinicians may develop aversive reactions to meeting with clients due to manipulative tendencies and lack of treatment progress and cancel or shorten treatment sessions. Clinicians may also distrust their clients as a result of their deceitful nature, and belittle or demean them when interacting, which perpetuates mutual distrust in the therapeutic relationship. Effective rapport building and an environment of trust is crucial to treatment retention and therapeutic progress (White & Byrt, 2013).

Additionally, when in bland environments, clients with ASPD are prone to boredom leading to increased irritability and acting out behaviors (Martens, 2004). Furthermore, the impulsive nature of clients with ASPD makes them a high risk for treatment drop-out (Meier & Barrowclough, 2009). Clinicians are tasked with providing stimulating services while meeting systemic needs and maintaining a sense of personal safety. Safety in the workplace is a concern for clinicians working with a client with antisocial personality disorder (Kurtz & Turner, 2007; NICE, 2009). The volatile nature of clients with ASPD adds to the tenuous nature of treating these individuals. These clients often rely on violence and intimidation in order to meet their personal needs (Lobbetael et al., 2009). This propensity toward violence and acting-out behavior presents another professional dilemma. Placing too much emphasis on safety with these clients contributes to the stigma of ASPD (NICE, 2009). In other words, if a clinician

responds in a self-protective manner, the client's counter-response is to self-protect. Some clients with ASPD self-protect through distrustful, manipulative, or acting-out behaviors (Perry et al., 2013)

Staff members report a need for professional support when working with clients with antisocial personality disorder (Priest et al., 2011). Clinicians are frequently victims of staff splitting (e.g., client praises some staff members while discounting others) and as a result experience professional isolation, increasing anxiety, and feelings of helplessness (Davys & Beddoe, 2009; Kurtz & Turner 2007; Tennison, 2002). Breakdown in communication between staff (of differing disciplines and within the same discipline) are frequent occurrences indicating a need for communication concerns to be addressed through clinical supervision (Priest et al., 2011).

Implications for Clinical Supervision

Treatment protocols for clients with ASPD are unclear. These clients present with personal obstacles that negatively affect treatment outcomes. In addition to poor treatment outcomes, clinicians may leave sessions feeling frustrated, bullied, and antagonized (Schwartz et al., 2007) and have difficulty regaining a sense of self after working with clients with ASPD (Evans, 2011). That is, clinicians may take some time to return to their normal state of being following sessions with clients with ASPD (Evans, 2011). The emotional impact of working with clients with ASPD is often unconscious and underscores the importance of effective clinical supervision (Priest et al., 2011).

Effective clinical supervision is necessary to help clinicians explore the emotions and reactions they experience in session and how these reactions impact the treatment process (Evans, 2011). Many clinician reactions are a result of countertransference and should be addressed during clinical supervision (Kurtz & Turner, 2007). Countertransference is the unconscious generation of thoughts and emotions about clients based on clinicians' past experience with individuals or situations (Schwartz et al., 2007). These thoughts and emotions often shape counselors' interactions with clients. Approached carefully as part of the clinical supervision process, countertransference can promote a better understanding of clients with ASPD (Evans, 2011).

Clinical supervision includes demystifying the role of countertransference for clinicians. Taking the stories of clients at face value often leaves clinicians feeling duped when they learn of the true motivation of the clients with ASPD (Evans, 2011). Just as clinicians explore underlying themes with clients, effective supervision explores underlying beliefs and reactions triggered in clinicians working with clients with ASPD. Supervisors are tasked with helping clinicians understand how their reactions to clients may be similar to other people in clients' lives (Schwartz et al., 2007). In order for clinicians to reach deeper levels of connections with clients, supervisors must reach deeper connections with the clinicians (Evans, 2011).

A driving force in talk therapy is helping clients explore their emotions, thoughts, and behaviors. When working with clients with ASPD, the process is reversed, in that the reactions of clinicians are used as a tool for understanding and intervening with clients (Evans, 2011). Clients with ASPD rarely present with emotional depth, genuine thoughts, or motivations for behavioral change; therefore, the beacon for effective therapy becomes the emotions, thoughts, and reactions experienced by clinicians and processed in clinical

supervision (Schwartz et al., 2007). For example, questions like “What is this client enacting? What is the purpose for this behavior? Who needs to address this behavior, and how?” help clinicians understand clients’ motivation for behaviors and help in developing appropriate interventions (Evans, 2011, p. 148). Although these initial questions will help supervisees break through the surface level of clients’ disorder presentations, deeper-level experiences in supervision are key to deeper-level experiences in therapy. Questions that may lead to deeper-level processing include: “What emotions were you [the clinician] experiencing during this session? What do these emotions mean to you? How are these emotions familiar to you? What were you thinking during this session? How were you feeling toward the client in this session?” (Bernard & Goodyear, 2014, pp. 143–144).

Just as a clinician should not take the stories of the client with ASPD at face value, the supervisor should also look for deeper-level understanding of the therapeutic process. Taping sessions and live observation should be encouraged rather than personal reporting; however, these methods of supervision may be challenged due to the suspicious nature of clients with ASPD and can only happen after a trusting relationship has been established. Taping and live observations allow supervisors insight into therapeutic process and provide the opportunity to examine exchanges between clients and clinicians (NICE, 2009). The recording of sessions also allows for emphasis on therapeutic process rather than content during supervision.

Kagan, Schauble, Resnikoff, Danish, and Krathwohl (1969) discussed the use of interpersonal process recall (IPR) in providing an avenue for exploration of the clinician’s experience in therapy. Often, clinicians dismiss their internal reactions as unimportant, which limits the depth of the therapeutic relationship. IPR gives supervisees a safe place to explore their reactions and clients’ reactions on a deeper level. By understanding the client on a deeper level, clinicians may be better able to use creative methods of stimulating client growth (Martens, 2004).

Another method used to spark clinicians’ creativity during supervision is the use of play. Drisko (2000) posited that play in the supervisory process can create an atmosphere of creativity and excitement, which carries over to the therapeutic alliance between clinicians and clients with ASPD. Play in this context refers to creating an environment that promotes spontaneity and experimentation. Play offers the supervisee the opportunity to try new methods of thinking and behaving, which promotes development. Supervisees begin to see themselves and clients through a different lens as they grow and develop. A stimulated clinician promotes a stimulated client. Play can be utilized in clinical supervision through experiential exercises, metaphor, and continued support of the clinician throughout their developmental process.

Despite all supervisory interventions and support, clinicians working with ASPD will be manipulated. The task of clinical supervisors is to normalize the manipulation process. Clinicians will gain an understanding of clients through understanding clients’ manipulative tendencies and motivations (Bowers, 2003). This understanding is a tool for treating clients (Evans, 2011). Manipulation can be motivated by the client’s need for power, respect, safety, or unconscious drives. Supervision provides an opportunity to help supervisees view manipulation as an asset in therapy rather than a shortcoming (Bowers, 2003). Normalization of manipulation allows clinicians to avoid feelings of shame, embarrassment, and alienation.

Case Illustration

Jessica (name changed to assure anonymity) is a 28-year-old Caucasian substance abuse counselor. She recently graduated from her master's level counseling program and has been employed at an inpatient substance abuse treatment center for the past 4 months. Jessica is a Licensed Clinical Addictions Specialist Associate (LCASA) and must receive regular clinical supervision from a Certified Clinical Supervisor (CCS) for 2 years in order to receive full licensure.

Jessica is described by her supervisor as "eager" and "hardworking." She meets with her supervisor weekly. She is punctual and prepared for supervision sessions, which generally consist of case staffing, documentation review, and review of recorded counseling sessions. Jessica finds the supervision sessions helpful in her professional development. Jessica is also working with her supervisor on developing an understanding of her role in the therapeutic relationship. She reports low confidence in her abilities as a counselor and has difficulty with assertive communication.

Jessica takes a person-centered approach to therapy (Rogers, 1980). She believes in being caring and approachable as a counselor. She is a strong advocate for client rights and is outspoken in her willingness to assist clients in the treatment process. Jessica often finds herself staying late to complete paperwork or to conduct impromptu individual therapy sessions. She becomes defensive in supervision sessions when professional boundaries are discussed. She subscribes to the belief that her role as a counselor is providing the environment in which her client can grow. She believes her behaviors are part of being an effective counselor. Furthermore, Jessica functions as a counselor in an interdisciplinary treatment approach. She is viewed as amicable and is liked by her peers.

Jessica is comfortable seeking the support of peers within her discipline and states that she has begun to be more assertive in communicating with treatment providers from other disciplines. Jessica describes her job as "stressful, chaotic, and rewarding."

Today, Jessica presents to her weekly supervision session looking unusually disheveled. She arrives 10 minutes late and is unprepared for the session. Jessica apologizes to Angela, her clinical supervisor, for her tardiness and states that she has had difficulty sleeping. She has been staying late to conduct treatment sessions with a new client and researching treatment resources for her new client after she gets home from work.

The supervision session begins with a case presentation. Jessica describes her new client David (name changed to assure anonymity). David is a 28-year-old Caucasian male who entered treatment 3 days ago seeking services for his ongoing use of alcohol and cocaine. He was involuntarily committed to the facility after threatening to hurt himself or someone else if he did not receive inpatient treatment. His treatment history includes eight inpatient admissions prior to this admission, with five being in the current facility and incarceration five times for larceny, breaking and entering, assault, and possession of cocaine. Prior to turning 18, David was in a juvenile detention center for 6 months for assault. He is now on probation and has an upcoming court date in 2 days.

David is homeless. Following his last treatment discharge, he was kicked out of a halfway house for his refusal to engage in continued care services through an outpatient provider, a house rule. He has a history of working in construction and has had 10 jobs in

the last 3 years. His support system consists of his mother, father, and two siblings. He describes his family relationships as “distant.”

Jessica shares that David has begun doing deep level counseling work that he states he “has not done in previous admissions.” David discussed being physically abused as a child and states that this is the first time he has felt “safe” in therapy. He describes in detail his childhood and shares accounts of his abuse with Jessica. He states that this is the first time he has shared these stories with anyone.

Jessica states that David informed her that this is the first time he has taken treatment seriously, and she is the first counselor he has truly trusted. David attributes his past refusal to go to outpatient treatment due to his lack of trust in his outpatient provider. He reports that he attempted outpatient therapy but dropped out when his counselor “was trying to get me locked up.”

David informs Jessica that other professionals in the facility dislike him due to his behaviors during past treatment. David was previously discharged for threatening staff members and assaulting another client. He states that he will not participate in group therapy sessions or attend educational groups because he does not want to be around other clients who “don’t take their recovery seriously.” He requests that Jessica meet with him for individual therapy and write a letter to postpone his court date so he can complete treatment. He informs Jessica that he is motivated to remain in treatment and “change his life.”

Jessica states that she would like to gain insight on how she can better assist David. She describes her sessions with David as “confusing.” She states she is angry at nursing staff because they refuse to work with David in a one-on-one setting, and instead conduct sessions with David amidst the treatment milieu. She believes David is being discriminated against because of his behaviors from previous treatment admissions. She states that she is having difficulty in treatment team meetings and feels attacked when she tries to advocate for David.

Supervision Interventions

Angela, Jessica’s supervisor, follows the case presentation while helping Jessica discuss objective details of David’s childhood history. She obtains auxiliary assessments from prior admissions and other facilities which support the client’s difficulty adhering to treatment recommendations and guidelines. Angela helps Jessica review these assessments in the supervision session. They also review David’s treatment plan and goals.

From the assessments and client history reports, Angela notices symptomatology consistent with ASPD. Angela and Jessica discuss this and are able to identify that David has a history of violence, chronic relapse, incarceration, and impulsivity. Angela provides Jessica with a Web site and handouts on ASPD.

Angela and Jessica then listen to the most recent taped counseling session with David. Utilizing IPR (Kagan et al., 1969), Jessica is encouraged to mentally place herself in the session with David. She is informed by Angela that the tape can be stopped at any time for comment or clarification. Jessica is encouraged to share her responses in the present tense.

During IPR (Kagan et al., 1969), Jessica describes feeling “sucked in” when working with David. She reports being overwhelmed with the details in David’s stories and a triggered desire to help David get into the optimal environment for his growth. She also notices her tendency to focus on story details rather than therapeutic process. She states she is curious about David’s story and is honored to be the first therapist to hear these stories. However, she also feels anxious and sad in session as she was also a victim of childhood abuse. She discusses feeling “helpless” in that she feels she is not qualified to help David.

Angela asks Jessica to describe what she notices about David when he is sharing these stories and to explore possible motivations for David’s discussion. Jessica describes David shifting from event to event during session. She also notices a lack of emotional depth, as well as David’s weaving of his stories around his pressing legal issues. At the end of the session, she notices David asking for a letter to postpone his court date and proceeding into another story of abuse. Angela asks Jessica what she believes motivates David.

Jessica is angry when she considers that David is manipulating her to have his court date postponed. She describes feeling “cheated and used.” Angela asks Jessica to sit with these emotions in the supervision session. She then asks how these emotions may impact the therapeutic relationship. Angela and Jessica explore how David’s behavior may impact other people in his life. Jessica describes a desire to avoid David and have him discharged as soon as possible. She describes a feeling of embarrassment, and an urge to write David a letter for his court date and allow him to discharge. Jessica is able to identify how her emotional response is likely similar to that of other people in David’s life.

Angela assists Jessica in exploring David’s ability to meet his own needs. She asks Jessica to identify skills that David displays and how these skills might assist David in his recovery process. Angela and Jessica then practice interventions that will assist David in utilizing his resilience and creativity toward his early recovery and resolution of legal issues. Angela also discusses how she is often manipulated by clients and the emotions she experiences when this takes place.

To reduce the possibility of staff splitting, a follow-up supervision session with individuals from multiple disciplines (counselors, nurses, psychiatric, probation officer) who are working with David is held. The team collaborates to develop a plan to assist David in attending his court date and returning to treatment when his legal issues are resolved. A stipulation of David’s return to treatment includes his willingness to have legal resources engaged in his treatment, as well as his attendance in all scheduled group sessions. He is informed that he will meet with his assigned therapist once weekly. David’s probation officer attends David’s next treatment team meeting where the plan is presented to David and discusses legal consequences should David not adhere to treatment protocol.

Case Discussion

David’s motivation for treatment was to avoid legal issues. He used charm and played on Jessica’s desire to be an effective helper and her doubt in her own ability to help. David was able to identify an emotional reaction from Jessica regarding the topic of

abuse and used stories from his own childhood to gain leverage with Jessica to persuade her to have his court date postponed. David also discussed his lack of trust in past counselors to create the illusion that he was motivated for therapy. He identified Jessica's eagerness to help and used her desire to help him, and her own insecurities, to manipulate her into helping him meet his needs.

Angela was able to assist Jessica in exploring the thoughts and emotions triggered in her when working with David. By helping Jessica recognize the role her emotions played in her decision-making process, Angela enabled Jessica to discern the therapeutic spark from which to conduct therapy. Jessica was able to gain a clearer understanding of the motivations behind David's manipulative tendencies and how this manipulation has likely affected others in David's life. Angela also helped normalize the manipulation process by sharing how she experiences manipulative tendencies with clients.

Through the use of interdisciplinary supervision, Jessica was able to see how other professionals shared similar emotions as a result of working with David. As a team, they were able to identify a method of promoting further care for David while avoiding rescuing him from his legal consequence. The team also chose to have David's probation officer present. That presence served as a systemic intervention, by identifying consequences of acting out behavior that David has shown in the past.

Conclusion

There is a lack of consensus on effective treatment for clients with ASPD. Promising practices such as CBTpd may provide a structured clinical approach needed in treating this disorder and warrant further research. While effective treatment models for this disorder continue to evolve, clinical supervision is of utmost importance. An effective clinical supervisor will provide support, guidance, and education and will normalize the struggles of counselors working with this population. Supervision can provide supervisees an environment in which they are free to explore and experiment with creative interventions that stimulate both the clinician and the client. While there are a variety of interventions that can be utilized in supervision, helping supervisees meet their clients with a sense of support and optimism is mandatory when working with clients with ASPD. Supervisors are encouraged to monitor supervisees for excess stress, burnout, and pessimism, as these symptoms serve to exacerbate symptoms of ASPD and perpetuate poor treatment provision.

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