The antisocial patient presents special problems for the interviewer. The patient’s pervasive tendencies to manipulate, lie, cheat, act irresponsibly, steal, demand special attention, hurt others and not feel guilt are disturbing to the clinician. The terms that have been applied to them in the past—psychopath and sociopath—have become pejoratives that reflect the countertransference and societal indignation that their character pathology arouses.

What is now called antisocial personality disorder was the first of the personality disorders to be described. This occurred in the nineteenth century, when psychiatric attention focused on defining the psychological attributes of the so-called criminal personality. At the beginning of the twentieth century, Kraepelin delineated a variety of psychopathic personalities, but the range of pathology in his descriptions was much broader than the current definition of antisocial personality disorder. During World War II, a frequent diagnosis given to servicemen who were discharged as unfit for duty because of their behavior was "chronic psychopathic inferiority." Cleckley’s 1941 monograph The Mask of Sanity provided the first comprehensive clinical description of the antisocial patient. He used the term psychopath and described the lying, narcissism, poor object relations, irresponsibility, and lack of remorse for violent or cruel actions characteristic of the more extreme antisocial patient. He felt that these individuals were so out of touch with reality that they were fundamentally psychotic. His term psychopath, used through the 1950s, was replaced by sociopath, which in turn was replaced by antisocial personality disorder. Each of these name changes reflects an attempt to evade the stigma attached to the category, but because the accrued stigma is based on unchanging core features of these patients’ behavior, it inevitably returns. Stone criticized the DSM-IV-TR criteria for antisocial per-
sonality disorder as narrowly behavioral and posits that the more psychodynamic concept of psychopathy as defined by Hare has several advantages. Hare's definition of psychopathy includes superficial charm, glibness, grandiosity, pathological lying, shallow affect, lack of empathy, and superego deficits such as lack of remorse or guilt and failure to accept responsibility for actions. Stone feels that Hare's psychopathy can be viewed as a distinct, more malignant subset within the larger domain of antisocial personality disorder. This subset contains the dangerous and violent repeat criminals, the serial killers, the hit men, the arsonists, and so on. Not all individuals with antisocial personality disorder meet the core criteria for Hare's psychopathy. In Stone's view antisocial personality disorder is a broad concept, and not all such individuals lack remorse or compassion; hence, it is more heterogeneous than Hare's psychopathy.

Some would suggest that antisocial individuals should be regarded as criminals, not patients, and because of their behavior belong in the hands of the legal-justice system, not in the office of the mental health practitioner. Some patients with severe antisocial personality disorder may be "untreatable" by any current psychiatric methods and use the mental health setting as just another opportunity to exploit and manipulate to further their impulsive desires. However, "antisocial" is not one simple entity but represents a continuum of psychopathology. Some antisocial persons may be responsive to clinical intervention. One of the clinician's tasks in interviewing an antisocial patient is to make an evaluation of the utility of treatment versus nontreatment while self-monitoring the sense of moral outrage that the patient's behavior and attitudes often arouses and that can easily disrupt clinical objectivity.

Genetic and constitutional factors are probably important in the etiology of antisocial personality disorder (Table 11-1). Children who manifest attention-deficit/hyperactivity disorder (ADHD), which almost certainly has a neurobiological substrate, are at significantly higher risk to develop antisocial personality disorder in adulthood. ADHD children are also significantly more likely to develop substance abuse problems in adolescence and adulthood. Substance abuse disorders frequently accompany antisocial personality disorder and may come to dominate the patient's behavior because constant craving for the drug leads to robbery, stealing, and such in order to obtain money to buy drugs. This cycle tends to be repetitive, and antisocial patients with concomitant substance abuse are often incarcerated. They constitute a significant proportion of the prison population.

It is possible that the impulsivity, irritability, and low frustration tolerance of ADHD children become the substrate around which crystal-
TABLE 11-1. DSM-IV-TR criteria for antisocial personality disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
   (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
   (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
   (3) impulsivity or failure to plan ahead
   (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
   (5) reckless disregard for safety of self or others
   (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
   (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.
C. There is evidence of conduct disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.


lizes the personality of the later antisocial patient. Most children with ADHD, however, do not go on to develop antisocial personality disorder. Conduct disorder, seen in children before the age of 15 years, is the anlage to antisocial personality disorder (Table 11–2).

Finally, it should be noted that antisocial mechanisms are found in everyone, even the most overtly conscience-ridden and morally scrupulous person. Their expression depends on context, opportunity, desire that overwhelms ego and superego controls, and so on. It is when such mechanisms become the dominant and, sometimes, only mode of behavior that we speak of antisocial personality disorder.

PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Behavior is antisocial when the gratification of basic motives is of overriding importance. The controlling and regulating functions of the ego are defective, and the individual pursues immediate gratification with
### TABLE II-2. DSM-IV-TR criteria for conduct disorder

**A.** A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

*Aggression toward people and animals*
1. Often bullies, threatens, or intimidates others
2. Often initiates physical fights
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. Has been physically cruel to people
5. Has been physically cruel to animals
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. Has forced someone into sexual activity

*Destruction of property*
8. Has deliberately engaged in fire setting with the intention of causing serious damage
9. Has deliberately destroyed others’ property (other than by fire setting)

*Deceitfulness or theft*
10. Has broken into someone else’s house, building, or car
11. Often lies to obtain goods or favors or to avoid obligations (i.e., “cons” others)
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

*Serious violations of rules*
13. Often stays out at night despite parental prohibitions, beginning before age 13 years
14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. Is often truant from school, beginning before age 13 years

**B.** The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

**C.** If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

**Code based on age at onset:**

- **312.81** Conduct disorder, childhood-onset type: onset of at least one criterion characteristic of conduct disorder prior to age 10 years
- **312.82** Conduct disorder, adolescent-onset type: absence of any criteria characteristic of conduct disorder prior to age 10 years
- **312.89** Conduct disorder, unspecified onset: age at onset is not known
TABLE 11-2. DSM-IV-TR criteria for conduct disorder (continued)

<table>
<thead>
<tr>
<th>Specify severity:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild</strong>: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others</td>
</tr>
<tr>
<td><strong>Moderate</strong>: number of conduct problems and effect on others intermediate between &quot;mild&quot; and &quot;severe&quot;</td>
</tr>
<tr>
<td><strong>Severe</strong>: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others</td>
</tr>
</tbody>
</table>


little regard for other aspects of psychic functioning, the wishes or feelings of others, moral codes or strictures, or the demands of external reality. The primary goals of antisocial behavior are to avoid the tension that results when impulses are not gratified, to avoid the anxiety that appears when frustration is imminent, and, furthermore, to protect the ego from feelings of inadequacy.

The traits of the antisocial personality are designed to ensure the gratification of impulses and to provide the security and tension relief that result. There is little regard for the demands of conscience, affectivity is shallow, and there is little capacity to tolerate anxiety. The antisocial patient's failure to develop adequate ego defenses makes it necessary for him to escape from frustration and anxiety, as compared with the neurotic person, who has mental mechanisms that control anxiety while providing partial gratification of feared impulses. The antisocial individual shuns responsibility and avoids situations that expose his affective deficit.

The antisocial individual is relatively indifferent to his important others apart from what they can do for him. He has little concern for the security, comfort, or pleasure of others. Inner drives are experienced as urgent and overwhelming; delay or substitution does not seem possible. The feeling that results from gratifying his drives has a quality of tension relief, or satiation, rather than the more complex happiness with tender feelings toward others and increased self-esteem that characterize the neurotic individual.

Although the formal diagnosis of antisocial personality involves overt social behavior, underlying psychodynamic issues are an essential and integral part of the syndrome. An antisocial patient does not conform to social standards and participates in activities that are illegal.
or immoral, but antisocial is not merely a technical term for social misbehavior. It implies that certain developmental experiences and psychodynamic patterns have led to fixed disturbances of behavior that are antithetic to the basic moral standards of the society in which the person was raised. However, there are times and situations in which apparently antisocial behavior may be psychodynamically normal. It is therefore important to take the patient’s age and cultural background into account when evaluating his psychopathology. For example, normal adolescents will experiment with behavior that is superficially antisocial; in fact, the absence of such experimentation may be suggestive of psychopathology. Members of deprived and oppressed subcultures may be viewed by the dominant culture as exhibiting similar tendencies, because the lack of opportunity to resolve their conflicts more adaptively is associated with an increased utilization of seemingly antisocial mechanisms. Persons raised in families that are committed to lives of crime and antisocial behavior may identify with familial goals and values, with resulting patterns of criminal behavior without psychological abnormality—a pattern that was once called “dyssocial reaction.” Such individuals experience loyalty and love and can control their impulses so that they conform with the requirements of their own subculture. In each of these situations, overtly antisocial behavior does not necessarily signify that the individual has antisocial personality disorder.

Clinical Features

The antisocial individual, failing to develop control over the expression of his basic needs, retains relatively primitive impulses as his primary motives. Painful affects are poorly tolerated, and the capacity for mature pleasure and positive affectivity is impaired. Failure to develop mature ego functions is associated with inadequate or pathological object relations early in life, and adult object relations are severely disturbed. Therefore, the patient with a preponderance of antisocial mechanisms is likely to show defects not only in his basic impulses and his mode of handling them but also in his affectivity, including anxiety, guilt, and the capacity to love. His object relations are shallow and uncaring, leading to disturbances in his patterns of behavior.

Impulses

Impulses are the mental representations of needs and motives that form the driving force behind all behavior. Some antisocial patients experience their impulses as ego-syntonic—that is, they feel that they want to
act on them—but others have a subjective sense of an urgent and compelling external force. Combinations of these attitudes are common. For example, a substance abuser explains his desire for drugs by the pleasurable experiences that they offer, but he has neither the interest nor the capacity to defer the pleasure when he learns of the long-term dangers associated with it. If he is deprived of the drug, his need is experienced as more urgent. He is unable to postpone gratification because of the feeling that each opportunity may be his last and that he must take advantage of it. This philosophy of immediacy is associated with a lack of concern about the consequences of his behavior.

The antisocial individual is impatient and hedonistic, but the acts that are customarily associated with pleasure for others are more likely to bring him only a transient relief of tension. Those pleasures that he does experience have a primitive oral quality and are more related to physiological responses than to interpersonal relationships. The drink, the “hit,” the opportunity for sexual gratification, or the acquisition of property offers a temporary diminution of his inner pressure for gratification. There is no long-lasting shift in his psychic economy, no change in his perception of himself or his relationship to others. The neurotic patient who engages in a pleasurable sexual relationship develops a new attitude toward his partner, enhances his own self-esteem, and enriches his personal life in a way that lasts far longer than the effects of the physical sexual act. The antisocial patient is more likely to experience the event as a relief of a bodily need.

The patient’s inability to control or modulate his impulses leads to outbursts of aggression. These may be active or passive, and although they can be triggered by relatively minor slights, they usually involve a reaction to some frustration. The patient’s deficit in empathy and concern for others may lead to extreme cruelty and sadism, although characteristically he will have little emotional reaction to his own behavior after it is over.

Affect

Anxiety. The antisocial patient is often described as having little or no anxiety. In fact, he has a very low tolerance for anxiety, and many antisocial mechanisms are designed to forestall, defend against, or allay even minimal anxiety. The slightest threat that his needs will not be gratified leads to unbearable discomfort. He will go to great lengths to guarantee his security, but of course frequent frustrations are inevitable, and constant diffuse tension is the result. A common defense is denial, with the appearance of external composure that leads to the
erroneous claim that these patients do not experience anxiety. The patient is likely to deny not only his anxiety but also the urgent, compelling nature of his inner needs. However, this denial can be maintained only if constant gratification is available. When gratification is not available and the denial fails, anxiety, depression, rage, and impulsive behavior are common.

**Guilt.** The role of guilt is another controversial issue in the discussion of antisocial patients. In one view, there is a diminished tolerance for guilt, but in the other there is a relative lack of guilt. In our opinion, either of these features may be present, and they are integrally related in the early development of the patient. The antisocial patient experiences the more primitive precursors of guilt. He may feel shame and fear public disapproval for his unacceptable behavior, or he may become depressed if his behavior is exposed. However, he has not developed an autonomous internalized system of behavioral controls that function without the threat of discovery and that provide for regulation of impulses before they lead to overt behavior.

**Shallowness.** The affective responses of the antisocial patient have a superficial quality. This may not be apparent at first contact, and even when it is, the inexperienced interviewer may think that it is he, rather than the patient, who has failed to connect. The patient may go through all the motions, and even do so with a dramatic flair, but his feelings are unconvincing. When the patient’s sham or façade affect is penetrated, one usually finds feelings that the patient may describe as depression but that seem more like free-floating anxiety mixed with emptiness and a lack of relatedness to other people. These patients seek stimulation from the outside to fill this inner void, and any experience is better than the tense, isolated feeling that they are trying to escape.

**Object Relations**

The emotional investments of the antisocial patient are narcissistically focused on himself. Other people are transient characters in his life; they come and go, or may be replaced by substitutes, with little feeling of loss. He is most concerned with how they supply his needs, so that his primary style in interpersonal relations is ingratiating, extractive, and exploitative.

A sadomasochistic relationship typically exists between the patient and one or both of his parents or their surrogates. When the patient marries, this attitude is displaced to the spouse, who becomes both the victim and the silent partner in the patient’s antisocial behavior. As the
victim, the parent or spouse is hurt directly or indirectly. An example is
the wife of the embezzler who experiences economic hardships as a re-
sult of his behavior. A not-uncommon story is that of the wife who be-
gins a relationship through letters or e-mail with a white-collar criminal
while he was incarcerated. Upon his release from prison they marry,
and she believes her love for him will prevent future transgressions. She
gets her father to take her spouse into the family business when he
leaves jail. He promptly begins to abuse his trust and embezzles funds
from the firm. The antisocial patient’s need to punish his loved ones is
universal, and often the patient has little awareness of the amount of
rage that is discharged in this pattern.

The patient prefers to avoid controversial issues, and if he senses the
interviewer’s feelings on some issue, he will simulate a similar position
first. He has little sense of self and therefore no desire to take a stand
that will leave him feeling isolated and alone.

The antisocial person fears passivity in his personal relationships.
Much of his aggressive behavior is designed to avoid a feeling of sub-
missiveness, and many episodes of criminal violence that occur in anti-
social individuals are triggered by direct or symbolic threats that make
the patient feel passive. Antisocial prisoners are often more disturbed
by the enforced passivity of prison life than by the disruption of social
relations.

Because he is interested only in what he can get from other people,
the antisocial individual seeks out persons of power or status. He is not
concerned with the weak or powerless unless he can earn favor from
others by displaying this interest. He frequently becomes involved with
members of the opposite sex, and his air of cool self-assurance may
make him quite attractive sexually. His dashing and exciting exterior
bears some resemblance to a romantic folk hero, and he is appealing to
those who seek exciting or glamorous romantic involvement. Here
again, however, his primary interest is extractive, and his lovers are
doomed to disappointment.

At times, the patient appears to be playing a game, and the phrase
“as if” has been used to describe this role-playing quality. This is exhib-
ited in mild form by the man at a cocktail party who makes himself
more attractive and interesting by assuming glamorous and exciting
roles. One patient would pick up women in bars and relate elaborate
descriptions of his job, social connections, and past life, varying the
story to suit the interest of each new woman. The most extreme illus-
tration occurs in the impostor syndromes in which the patient consciously
acts out a false identity. Frequently these involve prestigious or roman-
tic roles as a scientist, explorer, or entrepreneur. One of us saw an
English professor who lived a double life, traveling to Europe each summer and convincing his acquaintances there that he was a nuclear scientist working on secret projects for the government.

The patient may sometimes simulate the role of psychological health. When an individual is interviewed in some depth and is seemingly without any emotional or psychological conflicts at all, not even the stresses and strains of normal life, one should suspect an underlying antisocial disorder. Closer scrutiny may reveal deficits in affectivity and object relations. Another role that the patient may assume in the interview is that of the psychiatric patient. This usually involves claims of subjective distress. However, these are not communications of inner pain but rather attempts to deflect the conversation from the more uncomfortable topic of the patient’s interaction with his environment.

**Behavioral Patterns**

**Antisocial behavior.** Antisocial behavior includes a wide variety of disturbances, such as pathological lying, cheating, embezzling, stealing, and substance abuse. The motivational context of this behavior ranges from the apparently rational financial manipulations of the shady entrepreneur to the bizarre and highly sexualized fire setting of the pyromaniac.

The antisocial individual usually seeks to avoid punishment, but the threat of possible punishment often does not serve as an effective deterrent to his behavior. The patient’s inability to postpone gratification, poor impulse control, lack of guilt, and intolerance of anxiety contribute to an inability to consider the consequences of his actions. At the same time the usual social restraints are less important to the antisocial person; the shallowness of his object relations and his lack of tender or warm emotionality render him indifferent to the loss of social ties.

The patient often feels that he is entitled to do what he does, although he may recognize that others will not agree. He thinks that he has been unjustly treated in the past and that his current behavior will help even the balance. For example, a heroin addict who had been apprehended by the police for stealing explained that his early life was so marked by pain and deprivation that he felt he should suffer no further discomfort. He explained that he had a right to take things from others who were more privileged and that the comfort he achieved by doing so was society’s debt to him.

**Assets.** Antisocial mechanisms may also lead to useful character traits. The absence of neurotic anxiety can be associated with a calm self-control and daring behavior that superficially resemble courage.
The Antisocial Patient

and bravery. The antisocial individual may develop great skill at tasks that would cause considerable anxiety in most others. For example, antisocial traits are common in persons who pursue dangerous careers. These skills are most evident when a single episode of brilliance will suffice, and sustained goal-directed effort over a long period of time is not required. Lack of patience and susceptibility to impulsive distractions cause difficulty with long-term pursuits.

The antisocial person's social skill and smooth charm can make him successful in dealing with others, and he is master at the art of manipulating people. To the uninitiated, he does not seem to be antisocial. He has often cultivated social manners and graces to an extent that ranges from "slick" to sincerely charming. Although the antisocial individual might utilize antisocial behavior when he feels it is necessary to obtain personal gratification, ordinarily he uses his social skills in order to control the interviewer and to make the interview as friendly and comfortable as possible.

Defensive and Adaptive Techniques

In the antisocial patient, anxiety leads directly to action, in contrast to the neurotic patient, whose mental processes are designed to control and bind anxiety or to substitute symbolic action. However, there are certain psychological defenses that the antisocial individual does utilize. These involve attempts to deny anxiety and a variety of maneuvers, including isolation, displacement, projection, and rationalization, that minimize the guilt and social discomfort that he might otherwise experience.

Defenses against anxiety. The antisocial patient attempts to transfer his own anxiety to others. If he is successful, his own fear is diminished. Phobic patients also try to elicit anxiety in others, but if they are successful, they become quite anxious themselves and usually search for calmer partners whom they cannot disturb as easily. The antisocial patient, in contrast, prefers those who react most intensely, because he seems to gain some reassurance from the other person's discomfort. His provocation may begin with the opening words of the interview. One of us treated an antisocial patient who started the first interview by mentioning that he was acquainted with one of the clinician's medical school classmates and later dropped innuendoes regarding information he had concerning the clinician's earlier life. A favorite technique for evoking anxiety is to detect some weakness in the interviewer and then to focus on it. One patient asked about the clinician's fidgeting in his chair, inquiring whether he was nervous about something. This behav-
ior also occurs outside the interview. A medical student would question his colleagues about obscure details before examinations, implying that he was familiar with this material and that they were in serious trouble if they were not.

In addition to making the clinician anxious, the patient will deny his own anxiety, with the resulting picture of detachment described earlier. Antisocial individuals are relatively skillful at concealing the overt expression of emotions, and the clinician may miss the clues to underlying anxiety.

**Psychological control of guilt.** The antisocial individual copes with his discomfort about his impulsive behavior by a series of defensive maneuvers. The simplest is the patient who claims, “I didn’t do it,” denying his overt behavior. This is common, for example, in alcoholic patients, who frequently state that they drink very little and have no problem with alcohol.

Slightly more complex is the patient whose position is described by the statement “I think it was all right.” He admits the behavior but denies awareness of its social significance. This attitude is common in adolescent delinquents.

A related defense is represented by the idea “Everyone else does it.” This involves a projection of the patient’s impulses onto others. The individual with antisocial trends often feels that everyone has a gimmick and that all people are extractive and exploitative, looking out only for their own advantage. He quickly extends this view to the interviewer and may more or less directly suggest that the clinician has a good deal going. This is done in a tone of grudging admiration, often coupled with an offer of conspiratorial assistance. The patient might suggest that he could pay the clinician in cash, with the implication that the clinician cheats on his taxes.

The next step in the sequence can be characterized by the feeling “No one cares anyway.” The patient feels that others are indifferent to his behavior. This patient may claim that others expect it. For example, a college student who wanted a medical excuse from an examination even though he was not ill explained that his professor knew what was going on but wanted an official letter. Patients will frequently employ this mechanism in dealing with fees that are paid by or to third parties, such as insurance companies. They attempt to enlist the clinician’s assistance in falsifying information in order to save money, insisting, “It’s all part of the system.”

The ultimate defense in this series can be represented by the narcissistic claim of “I’m special.” The patient may include the clinician in his
"special" category, saying, "You and I aren't like the rest." Various explanations for this privileged position can be offered: that he is more gifted or intelligent, that his needs are somehow different, that he is more sensitive than others, or that his earlier experiences entitle him to special consideration.

Defenses against failing self-esteem. The antisocial patient finds that others disapprove of his behavior. Although he may attach relatively little significance to specific other people, some general sense of respect from the world is important to him, if only in the form of an outer display of social approval. An example is the powerful organized crime figure who is active in his church. If he not able to gain this respect from others, he feels increased loneliness and diminished self-esteem. These feelings lead to defensive and reparative operations.

One of the simplest defenses is to treat his vices as virtues. This patient presents his callousness, indifference, or ruthlessness as an admirable trait. Adolescent delinquents frequently demonstrate this mechanism. It appears in milder form in the individual who brags about his numerous brief sexual relationships. Emotional isolation also serves to protect the patient from the pain of depression. It is common for the patient to become visibly more depressed as a relationship with the clinician develops and this defense diminishes.

Alcoholism and substance abuse. Environmental agents may become involved in antisocial patterns of behavior, and their secondary effects may strongly influence the resulting clinical picture. The most common examples are alcoholism and substance abuse.

The patient's life becomes organized around obtaining a drug for the resulting elevation of his mood and self-esteem. Because these effects are temporary, he experiences periodic cycles of need, consummation, satiation, and renewed need. He usually claims that the satiated state is the desirable one and that his behavior is designed to regain this experience after it has been lost. Contact with this individual suggests that the entire cycle is an integral part of his personality and that it is as necessary for him to crave and to seek gratification as it is to experience the state of satiation and euphoria that results.

Society frowns on the addict, and legal and social institutions are often harsh to the point of cruelty. By finding a magic chemical route to pleasure, the addict acts out universal unconscious fantasies of magical gratification for oral dependent needs. Anyone who openly acts out the secret and forbidden wishes of others becomes an outcast. These societal attitudes become issues in the interview, and it is common for the
patient to cast the clinician in the role of policeman or judge rather than therapist.

**Developmental Psychodynamics**

The antisocial individual’s mistrust of others begins early in life. The “normal” infant’s feelings that his needs will be met is based on his early relationship with his mother or other primary caretaker and his repeated experience that frustration and delay, however stressful, is inevitably followed by gratification and security. Although the child may respond to each frustration with anxiety and protest, this occurs within the context of repeated gratification. Furthermore, the child learns not only that needs will be met but also that this will occur in spite of angry protests directed at the need-fulfilling objects, his parents. In fact, this protest behavior disappears if it is unsuccessful, and the child whose cries bring no aid eventually stops crying and lies quietly and passively.

There are several reasons that the future antisocial individual does not follow this pathway. Early experiences may lead to the feeling that no one can be trusted and that security must be derived from some source other than a close human relationship. There may be constitutional determinants that contribute to an increased pressure from basic drives or a decreased tolerance for frustration such as is seen in the child with ADHD.

When a child has been abandoned by his parents or has drifted through a series of foster homes and child-care institutions, syndromes that resemble adult antisocial behavior may appear very early in life. There is much overt display of affection but little real feeling, and the shyness and inhibition that most children experience with strangers are absent. The child is skillful at extracting love and attention from adults, but the relationship that is so quickly established is of little importance and will quickly be severed if a more rewarding parental figure can be found. These children can be seen in child-care institutions, where their immediate and appealing charm is quickly directed to every new adult who appears on the scene. It is clearly a highly adaptive pattern of behavior for such a life, both protecting the child from the pain of repeated separations and facilitating his immediate adaptation to new social situations.

The severe ego pathology arising in the earliest years of life is further complicated at the stage of the developing conscience or superego. The capacity of the ego to mature through identification with important objects fails to develop. Furthermore, the parental figures who were associated with the deprivations of the first years of life offer patholog-
ical models for identification. The same mother whose care never led to a sense of basic trust may have social and moral attitudes that, when incorporated by the child, will lead to a distorted sense of right and wrong. The child acts out the unconscious forbidden wishes of a parent who may also be antisocial.

These defects in conscience formation can also occur in the absence of serious primary ego pathology. The concept of "superego lacunae" has been offered to describe individuals who have isolated specific disturbances in their personalities. For example, one of us knew a man who was a pillar of his community and an elder in his church but whose business success depended on selling overpriced merchandise to poor people who did not understand time payment plans. His daughter was arrested for selling drugs to her high school classmates. Although the overt behavior of her parents met the highest moral standards of society, the child perceived hidden or unconscious parental attitudes and translated them into action. If the family of a delinquent adolescent is available for a careful interview, one can frequently obtain a history of behavior patterns in the parents' earlier years that are similar to the child's current difficulties and that were overtly concealed from the child but covertly manifest in the parents' attitudes and behavior.

The peculiar attitude of the antisocial individual toward tension and anxiety may also stem from early experiences with the caretaker. The child's needs are ignored on one occasion, but on another his protests are quickly silenced by overindulgence in an attempt to placate his anger and shut him up. He grows frightened of the tension associated with his needs, because gratification is erratic and not motivated by love. At the same time, the process of getting what he wants becomes equivalent to extracting a bribe, and he feels entitled to take everything he can possibly get because he feels deprived of that which is most important: love and security. When this pattern continues into adult life, we see the ego-syntonic and guiltless extractive qualities of the antisocial individual.

As the individual with prominent antisocial tendencies enters puberty and adolescence, he frequently has less difficulty than his peers. Shifts in identity and allegiance present no problem to him, and he is not troubled by guilt in response to his defiance. His acquaintances look up to him and envy his social and personal ease. He has no close friends but is an object of admiration for many. In later years, these same friends are surprised to learn that the former big man on campus ended up friendless and a failure.

Adult life, and particularly old age, presents great problems. Marriage is frequently unsuccessful, and when it lasts, it is usually in spite of a distant and impersonal relationship with the spouse. If there are
children, they are seen as competitors or potential sources of gratification, attitudes that rarely lead to close family ties, or they too may become antisocial and partners in crime. Life is lonely and empty, and solace may be sought in drugs or alcohol.

**Differential Diagnosis**

Severe narcissistic personality disorder overlaps with antisocial personality disorder. Both are characterized by tendencies to be exploitative and unempathic to others. Kernberg has suggested that antisocial personality disorder is simply a very primitive variant of narcissistic personality disorder. Borderline personality disorder can also merge with antisocial personality disorder, although the former is usually more object-connected, albeit in a primitive manner.

Antisocial patients must be differentiated from paranoid individuals, who also have difficulty controlling their anger and may have poor reality testing. This combination can result in episodes of explosive violence. When the paranoid patient's delusional view of the world is taken into account, however, his behavior is understandable. The paranoid patient may feel guilt and remorse after an episode of rage, he may attempt to defend his behavior, or he may disown responsibility for it, but it usually takes him a long time to simmer down. In contrast, the angry outbursts of the antisocial person can disappear as suddenly as they began, and the patient may be tranquil, almost to the point of disinterest, after the episode. He cannot understand why others attribute such significance to his violence.

Histrionic patients are also manipulative and extractive in personal relationships and show great variations in values or behavior according to social cues. However, the histrionic patient establishes important relationships with other people and is distressed when these do not go well. The antisocial individual views others more as vehicles for gratification and is less concerned about the disruption of specific relationships. The histrionic patient also exhibits sham emotionality and role playing. However, the roles assumed by the histrionic patient are dramatizations of unconscious fantasies, and there are consistent themes that relate to the patient's inner conflicts. The role is a vehicle for expressing and resolving a conflict, not an end in itself. It may have manipulative or extractive functions within the immediate interpersonal context, but this is only a secondary issue. The histrionic patient tries to be someone else because he rejects certain facets of himself; the antisocial person tries to be someone else because he feels that otherwise he is no one at all.
The obsessive-compulsive individual often expects disapproval, whereas the antisocial person wants the respect and admiration of others. The obsessive-compulsive person is more likely to emphasize his defiance of authority, denying his fear and submissiveness. The antisocial individual will speak of his skill or agility in getting what he wants.

**MANAGEMENT OF THE INTERVIEW**

Although the interview behavior of the antisocial patient is not as consistent as that of the obsessive-compulsive or the histrionic patient, there are specific problems in interviewing that are associated with the patient’s use of antisocial mechanisms. These occur both in antisocial characters and in others with antisocial traits.

Several major themes can be described. The patient may be charming, ingratiating, and superficially cooperative, although simultaneously evasive and dishonest. This is a common initial presentation. Later, often in response to direct confrontation by the interviewer, he can become uncooperative or overtly angry. This attitude might appear initially if the patient has been coerced to see the clinician. As the patient attempts varying methods of pursuing his goals, these established patterns may alternate.

The antisocial patient studies the interviewer from the very first moment of contact. He covertly searches for evidence that will help him to decide whether the clinician can be conned and, at the same time, mentally registers any sign of weakness or uncertainty. Although the clinician often feels on guard, he has difficulty identifying the source of the feeling. He may experience a negative reaction to the patient, or he may be overly enthusiastic and develop rescue fantasies, but he is uncertain about the reason for these responses.

Action is far more important than reflection or contemplation for the antisocial individual. A major problem in interview technique arises from the patient’s tendency to act before, or instead of, talking. He does not see how talking to another person can be of any use, unless that person is a means to some concrete end.

**The Opening Phase**

*Pre-Interview Behavior*

The antisocial patient seizes the initiative at the very first contact. When the clinician greets him in the waiting room, he may inquire, “How are you today?” and will often chat while walking into the office.
He is sensitive to the clinician's interests and attitudes, but unlike the histrionic patient, he is more interested in establishing a general atmosphere of permission and receptivity than in eliciting a specific emotional response. He may comment appreciatively on a picture on the wall or the political views suggested by a book on the clinician's shelf, comments that are aimed at disclosing something about the clinician's status or position. "Nice setup you have here" or "Have you been in this office very long?" is a typical opening remark. One patient, noticing that a Harvard diploma was displayed on the wall, said, "I see you trained in Boston." The recognition of the clinician's status was slightly disguised but nonetheless obvious.

The First Minutes

As the interview continues, there is ongoing scrutiny of the clinician and a tendency to focus on any flaws that may appear. For example, one patient began his first interview by commenting, "I noticed an article in one of the magazines in your waiting room." He went on to indicate that he agreed with the article's political views and then added, "I guess you must be much too busy to really get involved in that sort of stuff." The message was clear: the clinician was not only successful but perhaps preoccupied with his success and inconsiderate of the needs of others. These comments provide important information for the interviewer, but any attempt to reply to them early in the interview will leave the patient feeling angry, uncomfortable, and defensive.

The patient appears to be composed, pleasant, and engaging; at times he may be smooth and charming. He speaks freely, but at a level of generality that sometimes leaves the interviewer feeling that he is lost and must have missed some key material. In spite of this, every sentence is clear and relevant, and there is no suggestion of a thought disturbance. He compliments the clinician on the insightful comments he makes or the penetrating question that he raises. The patient seems to say, "We'll get along just fine." The clinician may feel pleased and flattered, or he may sense that the praise is somewhat extreme and that something is not quite right. As a rule, however, any comment on this will be met with indignant denial, the patient insisting that he could not be more sincere. It is not wise to challenge or confront the patient at this point. He does not trust the interviewer anyway, and any indication that he is not trusted himself will only make things worse. The patient’s false flattery is a product of his need to con the interviewer, which is based on his mistrust, a central theme in treatment. Mistrust can be interpreted most effectively after it has been brought into the open, and
premature confrontation is likely to encourage the patient to conceal his negative feelings. It is preferable to ignore his attempts to con the clinician until the patient has more completely exposed his suspicions.

The Chief Complaint

The clinician must establish the antisocial patient's reason for seeking treatment, a process that is not the same as eliciting the neurotic patient's chief complaint. The antisocial patient's complaints sound quite similar to those of the neurotic, but they rarely explain why he has come for help now. He may describe conflict and anxiety but seldom displays these feelings directly. If he complains of depression, he quickly shifts to expressing his frustration and irritation over a lost love object. The patient experiences more anxiety than is apparent to the clinician, and it is preferable initially to accept the patient's description of his feelings rather than to confront him with the superficial quality of his affective response.

The antisocial patient often seeks some relatively concrete goal and hopes to elicit the clinician's assistance in achieving it. If he was referred by the courts, he hopes for an acquittal or a lighter sentence; if referred by a school, he hopes to be pardoned for delinquent behavior or excused from some responsibility. Perhaps the most common situation is the patient who wants an ally in a battle with a spouse or other family member. In all these situations, the patient also experiences painful inner feelings, but he rarely comes to the clinician with any hope of help for his inner pain; he only seeks assistance in his struggle with the outside world. The therapist is perceived as a real person who can be the patient's agent rather than only a transference figure.

Exploration of the Patient's Problem

Withholding and Secrecy

The antisocial individual is frequently referred by another person or institution, and thus the clinician often has some advance information about the patient. The patient frequently does not mention that he is in trouble, thereby presenting the interviewer with a problem. If the clinician allows the interview to unfold in the usual manner, important material will not be discussed. On the other hand, if he introduces the information himself, he will have difficulty learning its emotional meaning to the patient. Also, such action is likely to be perceived by the patient as a judgment or criticism. The problem is further complicated if the patient knows that the clinician has the information. The clinician
often learns that the “confidential” correspondence he received from
the referring agency has already been seen by the patient and that the
question in the patient’s mind is not what the clinician knows but
whether he will be open about it. As with any other patient, it is essen-
tial that the clinician not keep secrets. Therefore, he refers to the infor-
mation in a general way and asks the patient to discuss it. An example
will best illustrate the problems that arise.

An adolescent male high school student was referred by his school be-
cause he had been caught stealing books from the school bookstore. He
came to the interview and discussed a variety of academic problems, not
mentioning the stolen items. After listening for a while, the clinician said,
“I understand you’ve had some difficulties with the bookstore.” The pa-
tient quite characteristically replied, “What do you know about that?” At
this point the clinician did not go into detail but replied, “I guess you
don’t feel comfortable talking to me about it,” thereby commenting on
the patient’s unwillingness to discuss the matter himself. The patient
persisted in trying to find out what the clinician already knew, and the
clinician then added, “I guess you don’t fully trust me.” This approach
shifted the interview from an attempt to find out what happened in the
bookstore—a fruitless and basically unimportant quest—to a discussion
of the patient’s mode of dealing with other people.

The antisocial patient frequently invites inquisition rather than a
psychiatric interview. He seems to be withholding or frankly lying, he
may become openly resistant or uncooperative, and the material that
does emerge may suggest antisocial or criminal behavior. The clinician
is tempted to try to piece together the truth by ingenious or coercive
questioning. The interview is not furthered by getting the goods on the
patient, and it is far more important to earn his trust and respect than to
pin down the facts. It may be helpful to interpret this dilemma to the
patient, suggesting, “I’m interested in your problem, but I see no point
in my conducting an interrogation. You seem to cast me in the role of
district attorney.” The patient is establishing a pattern of relationship
based on his past experiences with authority figures. He tries to get the
interviewer to play the role of the suspicious and mistrustful parent,
unjustly accusing and exploiting him. If the patient is successful, he
feels justified in concealing his behavior and trying to manipulate the
clinician so that he can achieve his own goals. This is the way the patient
deals with others, and he feels that it is the way they deal with him.

With most other patients, the clinician will, in time, learn about the
patient’s inner mental life. This is not the case with the typical antisocial
patient, who is unwilling or unable to share such material. In fact, he is
not even likely to tell the clinician the daily events of his external life,
let alone his fantasies. This prevents the therapist from obtaining the essential psychological information that he utilizes with other patients in understanding the psychodynamics of the treatment process. Some of these missing data may be offered by ancillary informants, such as a telephone call from one of the patient’s relatives. The therapist accepts this information and tells the patient about each call. It is mandatory that the clinician not betray the patient’s confidence in any way. However, it is not necessary for the clinician to tell the patient everything that he has learned about him if this would alienate the relative. The clinician can utilize these events to discuss the difficulties created by the patient’s withholding.

Clarification and Confrontation

As the interview progresses, the clinician directs his attention to the patient’s style of life and his mode of relating to people in general and to the interviewer in particular. The clinician must shift the discussion from those issues that the patient has volunteered to the painful feelings that he tries to avoid. This usually requires a more or less direct confrontation. Despite cautious phrasing and careful timing, a negative response frequently follows. A conflict of interest develops between the patient and the clinician. The patient wants to use the clinician to elicit an emotional reaction or to obtain some assistance in pursuing a concrete goal; the clinician wants to establish a relationship that will permit exploration of what the patient wants and how he goes about getting it.

The initial confrontation should aim at exploring the patient’s behavior or elucidating his defenses but not attacking them. For example, a young man sought consultation because of depression and somatic symptoms that were accentuated each time he was abandoned by a sexual partner. He seemed somewhat depressed during the interview but emphasized his incapacitating anxiety while discussing the reasons for his consultation. The patient seemed more interested in what he could learn about the interviewer than in relating his own problems and started the conversation by commenting, “I understand that you’re on the staff of the medical school. Do you spend a lot of time teaching up there?” These comments were made with considerable social charm, and it was easy to imagine the patient’s success as a personnel manager, his chosen profession. After some minutes the interviewer interrupted, saying, “I guess you’re more comfortable talking about me than discussing the difficulties you’ve been having in your personal life.” This is a somewhat supportive confrontation. Any more direct statement this early in the interview will interfere with the patient’s communica-
tion. For example, the question “If you’re so upset about your own problems, why do you spend so much time talking about me?” would provoke an angry or withdrawn response.

**The Patient’s Anger**

The antisocial patient’s anger may be denied behind a façade of rationalization. He will offer elaborate explanations of why his behavior has a meaning other than the obvious one. This is intended to circumvent the meaning that the interviewer has attached to it while maintaining the appearance of goodwill in the interview.

A student who was referred to the college psychiatrist after he had been caught cheating in a major examination insisted that he had only been making notes on a scrap of paper, which the proctor thought was a “crib sheet.” He went on to elaborate on how the paper came from a book of lecture notes that contained material related to the course. The psychiatrist commented, “I guess the dean didn’t completely believe your explanation or he wouldn’t have asked you to come here. What do you think he had in mind?” The student responded by further protesting his innocence and explaining why he thought that the administration might be discriminating against him. The interviewer then said, “Obviously you are the only one who knows what happened at the examination, but I’m not sure that that is really so important. Whatever actually went on, you are now in a jam. Have you thought about what to do?”

When the rationalization is both elaborate and transparent, the clinician is often tempted to reply by suggesting that so complex an explanation must be covering something. This is a fairly direct accusation of lying, and whether or not the patient is lying, it will seldom improve communication. When the clinician does want to confront the patient with an obvious lie, this can be done by comments such as “I find it hard to believe that what you say is true.” This allows the possibility of discussing why the patient’s statement is unbelievable, even if he continues to insist that it is true.

The patient may respond to the clinician’s confrontation by sullen withdrawal. He controls his angry feelings, playing the role of the injured party and thereby appealing to the guilt or sympathy of the interviewer. This was seen in a patient who frequented different hospital emergency rooms, presenting multiple somatic complaints and obtaining analgesics. She would collect prescriptions by lying about her previous medical contacts. When an intern who had seen her on a previous occasion recognized her and rather sharply questioned her about her story, she refused to speak and sat staring at the floor, at first pouting and then beginning to cry. The intern, not certain of what was going on,
immediately became warmer and more supportive, and the patient constructed still another story.

A different type of response to the interviewer’s confrontation is acceptance followed by renegotiation. The patient adopts a new tack as he learns more about the clinician, often openly admitting that what came before was “a line” and suggesting that he is now serious and straightforward. The clinician may feel flattered as the patient praises his perspicacity and insight. It is this patient’s manipulative style, his readiness to use and then to discard a line, rather than any specific tactic that is the essential point.

A physician learned that a recently hospitalized patient had become involved in an extensive net of gambling and bribery that involved several hospital employees. When confronted, the patient quickly sized up the situation and then said, “OK—you’re smart and you’re right. I got hooked into this by the attendants. The whole staff situation is really pretty rotten, but I can help you find out who’s behind it.” The patient offered to make a deal to protect himself and to placate the doctor.

The Patient’s Relatives

The antisocial person’s problems usually involve other people, and the clinician often has direct contact with the patient’s family. This may take the form of letters, e-mails, telephone calls, or interviews that may or may not include the patient. Antisocial mechanisms that may be obvious in the patient are often mirrored, although in subtler form, in other members of the family. A case involving a patient treated by one of us illustrates some of these points:

The patient, an adolescent male, entered treatment because of academic difficulties in school and conflict with his family over his use of marijuana. His parents, whom he described as “middle class and materialistic,” were divorced and lived in another city. Shortly after treatment began, the clinician received a letter from the patient’s father expressing his support for the treatment program and enclosing some insurance forms. The items that the father had already completed suggested that he was capitalizing on the similarity of his own name to that of his son to collect on a policy that did not actually cover his son. The problem became more complex when the patient started to miss sessions, insisting that whether he kept his appointments was privileged information that was not to be shared with his father. It was clear that the father would be enraged if he learned that he was paying for sessions that were not actually held. Thus the patient had enlisted the clinician in a conspiracy against the father by offering him full payment for an open hour, and the father had engaged the clinician’s assistance in extracting money from the insurance company.
Finally the clinician told the patient, “I’m not here to get paid to read a magazine.” The patient replied, “You said what happens here is confidential; you can’t tell him about my not coming.” The clinician answered, “That’s true, but if I decide you’re not motivated for treatment, we will stop. If that happens, I’ll have to tell your father that I felt further treatment was not useful.” At the same time, the clinician explored the patient’s anger at what his father was doing with the insurance. Eventually the patient and his father were seen together, and the clinician discussed the family pattern that each member practiced himself while protesting similar behavior in the other.

It is particularly important to keep the patient informed of every contact that the clinician has with the patient’s family, although the clinician may keep the details to himself. If the clinician receives a letter or an e-mail, he may show it to the patient; if he has a phone conversation, he should discuss it at the next session. If the relatives are to be seen by the clinician, it is usually advisable to have the patient present.

Relatives often use subtle devices to induce the clinician to betray the patient’s confidence. For instance, a teenager’s mother called the physician and said, “I guess Mike told you what happened with the car this weekend.” Either “Yes” or “No” betrays the patient. Instead, the clinician might reply, “Anything Mike does or does not tell me is confidential. What was it that you wanted to say?”

**Acting Out**

The antisocial individual prefers action to language or thought. When he feels anxious, he is more likely to do something than to talk about it. If his relationship with another person gives rise to uncomfortable emotions, these will appear in his behavior rather than in his report of internal mental processes. For example, a young female patient with antisocial tendencies would indulge in promiscuous sexuality shortly before her therapist’s vacations, although she persistently denied any emotional response to his leaving. It is this tendency to action that makes the standard techniques of psychotherapy difficult with this patient.

The term *acting out*, when used strictly, refers to behavior that is based on feelings that arise in the transference relationship and are then displaced onto persons in the patient’s everyday life. The purpose and result are to keep the expression of these feelings away from the therapist. Such behavior is a common resistance in all patients, but it can be particularly troublesome in the patient with antisocial tendencies. A neurotic patient also may displace his transference feelings, but he is more likely to inhibit the accompanying activity. The antisocial patient has a lower threshold for action and less restraint on his impulses. The
result is that feelings arising in the treatment situation may directly lead to inappropriate and maladaptive behavior in the outside world.

The acting out of transference feelings can also occur within the treatment without displacement to other figures. It is this acting out in the transference that produces some of the most difficult technical problems in the interview. The antisocial patient may not follow the rules of simply sitting in his chair and talking. He will frequently try to read the clinician’s mail or peruse the papers on his desk or even open his computer if the clinician is called from the room. These acts are usually concealed in the initial interview, unless the patient’s defenses are inadequate or are too quickly challenged.

In general, the role of the interviewer is to link acting-out behavior with the underlying feeling and to point out the displacements that have occurred. It is rarely useful to interdict the behavior early in treatment and almost never effective if these interpretations have not preceded the interdiction. The exception is when the behavior directly impinges on the rights or interest of the therapist. Here, as with the psychotic patient, it is not helpful to allow the patient to abuse his relationship with the doctor. The patient who cannot set his own limits requires others to assist him in this.

The Role of Interpretation

The limited value of intellectual insight into the psychodynamic mechanisms underlying pathological behavior is nowhere so clear as in the antisocial patient. This individual may be quick to understand the therapist’s interpretations, and he will frequently repeat and extend them at appropriate points in therapy. The patient is often misperceived as an excellent treatment case by beginning students.

Although the antisocial individual may be skillful in manipulating abstractions, only concrete things have emotional significance to him. The simplest comment linked to an act or a thing is far more powerful than an insight into unconscious patterns that are not connected to an immediate person or behavior in the patient’s life. The patient will make many concrete demands, asking for analgesic medication, money for a parking meter, recommendations for a restaurant in the neighborhood, or renewal of prescription for a medication written by another physician. Initially, the therapist responds to these directly, either accepting or rejecting them. At some point, when the patient has at least partially accepted the mode of treatment, the therapist will suggest that these requests have underlying psychological significance. The patient will either accept or deny this, but it will have little emotional impact.
However, if the therapist links his interpretation to a change in his own behavior, no longer gratifying the demand that he has now interpreted, the patient will respond dramatically and at times violently.

The Closing Phase

As the interview draws to a close, the antisocial patient senses the clinician's intention of stopping. He may seize the opportunity to seek some favor or permission, avoiding the necessity of full discussion. For example, a patient with addictive tendencies visited the emergency department of a general hospital during the course of his evaluation in the psychiatric clinic. He told the emergency department doctor of his anxiety since the last clinic visit and discussed his family problems. The doctor reviewed the patient's difficulties and confirmed that he had a follow-up appointment in the clinic. Just as he rose to terminate the interview, the patient said, "Oh, one more thing, Doc. I've just run out of my Valium, and I need a new prescription." The waiting room was crowded and the doctor was hurried. The patient was counting on this pressure to coerce the doctor to grant his request. There is obviously no time for exploration or interpretation in this situation, but the doctor could have replied, "Why don't you call your regular doctor in the morning and discuss a new prescription with him? I'll let him know about our talk tonight." The patient is forced to explore his behavior with his primary doctor.

The end of the interview provides an opportunity for the clinician to counteract the patient's tendency to relate to him impersonally. With the antisocial patient, as with the borderline patient, it is helpful for the clinician to foster and maintain a real relationship. Brief social amenities at the end of the interview—plans for the weekend or comments about the weather—are usually seen as a form of resistance in neurotic patients. The antisocial patient has difficulty establishing interpersonal relationships, and the clinician is not only an object for transference but also a potential primary person with whom he can safely experience personal feelings that are intense and genuine. The patient often has developed social skills in an almost hypertrophied form, but these are not connected with appropriate subjective feelings. Although it rarely occurs early in treatment, the patient should be encouraged when he does make a sincere social gesture toward the clinician.
TRANSFERENCE AND COUNTERTRANSFERENCE

The patient's need for a sadomasochistic relationship soon appears in the transference. The most common manifestation is to stimulate the clinician's hopes that the therapy will succeed. This is partially due to the fact that the patient's deep mistrust is not verbalized early in therapy, and instead the patient will often feign trust by playing the role of a good patient. As treatment progresses, it becomes apparent that the problems do not magically disappear, and the clinician is disappointed. Although the clinician is fully aware that neurotic and psychotic symptoms do not vanish quickly, he seems to expect that they will in this patient. Such attitudes ensure his disappointment. It must be remembered that deceit is a way of life for this person, and then it can be viewed as any other character trait.

Narcissistic pathology is universal in antisocial patients. As a consequence the real person of the therapist is relatively unimportant to the patient. He may forget the clinician's name or have little concern about shifting to a new clinician. The antisocial patient will show defensive interest in the clinician and possibly curiosity about his status or his therapeutic technique, but he will be strangely devoid of curiosity about the clinician's more human attributes—his family or his personal life. When he does ask questions, they are designed to shift the spotlight to the clinician, either to charm him or to make him uncomfortable rather than to know him.

If, in spite of this, an important relationship with the therapist does develop, it is difficult (if not impossible) for the patient to replace him with a substitute. When the clinician finally does become a total object for this patient, he is a real object, and the patient may retain such a relationship, if only in fantasy, for the rest of his life. If the patient does begin to recognize the therapist as a person, his problems with trust will be manifested in a different fashion. For example, he might tell his friends some personal information that the clinician has offered about himself. Here the clinician can comment, "You don't seem to consider things that go on between us as private" or "You have betrayed my confidence." This response shows the patient that the clinician really is different from his parents.

The patient's tendency to view the therapist as a nonperson is illustrated by the adolescent who was seeing a clinician because of chronic truancy. The patient perceived therapy as a route to increased privileges and the removal of restrictions on his freedom that his parents had imposed in an attempt to control his behavior. He came to the clinician but involved
himself only at a superficial level. His interest never deviated from the issue of when he would again be allowed to use the family car or not be grounded. He would talk about his feelings or discuss the day’s events, but always with his mind’s eye trained on his goal. When he regained the lost privileges, he abruptly stopped treatment.

It is valuable to make the patients’ concerns as explicit as possible early in the treatment. For example, when this patient said, “I feel anxious about being tied down in the house all of the time,” the clinician could have replied, “You must be annoyed about not being allowed to use the car.” This directs the interview to the issue that is most prominent in the patient’s mind. Later, the clinician could add, “I imagine you have some idea of what your parents want to happen before they’ll let you use the car again. What do you think that is?” As the discussion shifts to parental demands and the patient’s response to these, the clinician can offer his services in helping him to understand the connection between his desire and his parents’ behavior and to work out a relationship with them that will accommodate both the patient and his parents.

It is necessary to explore the parental encouragement of the patient’s behavior. Why did the father buy a fancy sports car? What traits does the mother admire in a man, and what avenues are available for the patient to emulate these? At the same time, the clinician must avoid taking sides. He must neither blame the parents, thereby relieving the patient of any sense of responsibility for his own behavior, nor scold the patient while ignoring the parents’ implicit communications. If the clinician can resolve this dilemma, the relationship with the patient shifts from that of adversary or co-conspirator to a therapeutic framework.

The antisocial patient elicits major countertransference problems in the interviewer. The clinician is confronted with suspiciousness and distrust coupled with evasion and, at times, outright deception. The patient shows little guilt or anxiety about this behavior and angrily denies it if confronted directly. Furthermore, the clinician senses that the patient is trying to manipulate him. The most common patterns of countertransference are the clinician who makes himself oblivious to the patient’s behavior; the clinician who assumes the role of the angry parent, threatening and admonishing the patient for behavior that is often linked to unacceptable impulses of the clinician himself; and the clinician who is more strongly motivated than the patient to continue treatment. If his own therapeutic success makes the patient a feather in his cap, this dream turns out to be short-lived, because the patient inevitably disappoints him. The clinician may then react to his disappointment much as the patient’s parents have done. Paradoxically, the anti-
The Antisocial Patient

A resident was evaluating a man referred by the courts after a fourth arrest for passing bad checks. The clinician was moved by the patient’s description of his early life deprivation, his desire for another chance, and his plans for schooling and vocational training. However, the clinic administrator would not support the clinician’s recommendation that the court drop the charges and refer the patient for vocational rehabilitation. Before the disagreement could be resolved, the patient had jumped bail and disappeared. The resident angrily explained the patient’s behavior as a result of the clinic’s failure to provide support and assistance. This view was modified when it was learned that the patient had continued his check-writing habits throughout the initial evaluation, although claiming to the resident that he had “gone straight.” When the patient returned, he indicated a preference for the senior clinician, whom he had met briefly during a conference and with whom he had developed good rapport. The patient was aware of the disagreement among the staff and felt more comfortable with a clinician who understood him than with one who was taken in by his subterfuges.

The antisocial patient has his own program for the interview and his own goals in mind. He presents an image of himself as he would like to appear, and he fears the humiliation that would result if this picture were challenged. He will go to great lengths and will often lie to prevent exposure and does not welcome distraction or interruption. His response to early confrontation is usually negative. This may take one of several forms, the simplest of which is angry denial. The patient insists that he does not know what the interviewer is talking about, that he is being misunderstood, and it is clear that he is quite hurt by the clinician’s failure to understand him. The patient may be both insistent and convincing, and it is not uncommon for the beginning interviewer to retreat in confusion and guilt, apologizing for his comment and letting the patient continue to control the interview.
A nurse was referred for consultation because of her extensive use of narcotics for vague abdominal pains. After she described her symptoms and her drug regimen, the clinician commented, “It sounds to me as if you have become addicted.” The patient became enraged and said that several previous doctors had sympathized with her pain and had prescribed the narcotics. His labeling of the patient as an addict had reflected a pejorative view, and he quickly became anxious and did not know how to respond when she detected this feeling and reacted to it. Now uncertain, he apologized and shifted to a more detailed discussion of her physical symptoms. Had he been more comfortable, he could have interrupted her attack and said, “You’re responding as if I just accused you of a crime. Perhaps it sounded that way, but I’m sure you know of the addiction that can develop to narcotics, and I guess I was wondering how you have been handling that.”

The example illustrates several points: first, the importance of carefully obtaining the data before making an interpretation; second, the value of searching for a phrase that will “save face” for the patient and allow a comfortable response (e.g., he could have said, “With that much use of narcotics, you must be worried that you will become addicted”); and third, the problems created by the interviewer’s countertransference.

The interviewer is often struck by the patient’s callous indifference in personal relations or his apparent comfort in violating social and ethical norms. Such responses may be elicited by material that is peripheral to the explicit theme of the interview but reveals the patient’s general attitude toward other people. A female patient revealed such a facet to her character when she was at first indifferent to and then annoyed by the friendly overtures of a small child who was in the waiting room of the clinician’s office. The clinician’s spontaneous reaction is to the lack of human feeling in the patient’s behavior. For example, one clinician, consciously unaware of his hostility, asked a patient who was being evaluated after an arrest for sexually molesting children, “Have you ever had any normal sexual feelings?” Early in an interview with a heroin addict, another clinician asked, “Do you serve any useful role in society?” Such comments reveal the interviewer’s feelings and prevent the establishment of a relationship with the patient.

The clinician who becomes inappropriately angry and judgmental, adopting a disciplinary rather than a therapeutic position, probably represents the most common countertransference response to these patients. This may follow the response just described, when the clinician who feels that he has been duped switches from blind acceptance to blind rejection. The patient is accustomed to similar responses in the outside world, and he will often work hard at provoking them in the
therapist. If they occur, he knows where he stands, and his mistrust is justified. The patient who provokes countertransference rejection by placing the clinician in the role of inquisitor is a common example.

The last form of countertransference, the encouragement of acting out, also repeats a pattern common in the parents of antisocial patients. The clinician vicariously enjoys the patient's behavior, although he may loudly condemn it. His pleasure is often revealed by the delight he has in recounting his patient's exploits in discussions with other clinicians or his fascination with the mechanical or operational details of the patient's exploits. One clinician would entertain his professional friends with anecdotes of his patient's sexual conquests. Another would explore his patient's technique of income tax evasion in great detail; the patient, sensing what was going on, would spend long periods of time tutoring the clinician in sophisticated methods of accounting. Antisocial patients are quick to sense the conspiratorial potentialities of such a situation.

CONCLUSION

Antisocial behavior is only partially explained by psychodynamic concepts. It is an unfortunate corollary that many clinicians ignore psychodynamic principles when interviewing these patients and instead utilize a style that would be more appropriate for a law enforcement officer or an anthropologist trying to make sense of an exotic and unfamiliar culture. The interview with the antisocial patient affords an opportunity to explore aspects of behavior that are often concealed for many years in neurotics and that may be too fragmented or disorganized to be understood in psychotic patients. The core psychopathology is often difficult to treat, but some of these patients experience considerable gain from psychotherapy.