

CONTINUING EDUCATION COURSE READING MANUAL

Pharmacotherapy for Comorbid Antisocial Personality Disorder and Obsessive–Compulsive Disorder: Clinical Complexity, Treatment Challenges, and Psychological Considerations

A Continuing Education Reading Manual for Licensed Psychologists and Graduate-Level Clinicians

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Abstract

Obsessive–compulsive disorder (OCD) and antisocial personality disorder (ASPD) rarely occur together, and when they do, they present a clinical picture that is difficult to reconcile with contemporary conceptual models of either condition. OCD is defined by ego-dystonic intrusions and compulsive rituals performed to reduce distress, whereas ASPD is characterized by pervasive, ego-syntonic disregard for the rights of others, impulsivity, deceitfulness, and difficulty maintaining sustained treatment engagement. The apparent rarity of this comorbidity has been attributed to lower treatment-seeking among individuals with ASPD, to phenomenological incompatibility between the moral and empathic content of many OCD obsessions and the disinhibited value structure of ASPD, and to potential diagnostic

overshadowing (Cervin et al., 2021; Pena-Garijo et al., 2013; Thamby & Khanna, 2019). This manual synthesizes the available clinical and empirical literature bearing on this uncommon comorbidity, drawing on the case study by Jankovsky, Zaboski, and Pittenger (2023), which documented an 18-week trial of fluoxetine in a 26-year-old man with both diagnoses. The manuscript examines historical and conceptual foundations of both disorders, mechanisms that may account for their infrequent co-occurrence, empirical findings regarding pharmacotherapy, the psychological pathways connecting incarceration, impulsivity, and symptom worsening, and the clinical implications for psychologists collaborating with prescribers. The manual concludes by identifying research gaps and framing directions for future scholarship. Throughout, the emphasis is on giving psychologists a rigorous, integrative understanding of how personality pathology can shape both the presentation and course of OCD treatment, with particular attention to therapeutic alliance, motivation, and adherence.

1. Introduction

Obsessive–compulsive disorder is one of the most clinically recognizable conditions in psychiatric nosology. It is characterized by distress and functional impairment resulting from unwanted or intrusive thoughts, images, or impulses—termed obsessions—and by ritualistic behaviors, called compulsions, that are performed in an effort to ameliorate the anxiety and distress produced by those intrusions (American Psychiatric Association, 2013). The clinical picture is unified by an internal experience of unwantedness: the patient generally recognizes the intrusive content as foreign to their sense of self, and the compulsions as excessive or irrational, even when insight is only partial. This ego-dystonic quality is central to both the diagnosis and the treatment planning that follows from it.

Personality disorders occur frequently in individuals diagnosed with OCD, and their presence complicates both assessment and intervention (Thamby & Khanna, 2019). Some pairings, such as OCD and obsessive–compulsive personality disorder, have been extensively studied and are commonly reported in clinical practice; others, such as OCD and antisocial personality disorder, have received little scholarly attention. Indeed, the comorbidity of ASPD and OCD is described in the literature as exceptionally rare (Pena-Garijo et al., 2013). The relative absence of empirical guidance for such cases leaves clinicians with limited resources when they encounter these patients, and the situation is compounded by the well-documented

difficulty of engaging individuals with ASPD in sustained clinical treatment (Bateman, Bolton, & Fonagy, 2013; Fisher & Hany, 2023).

Fluoxetine and other selective serotonin reuptake inhibitors (SSRIs) constitute a first-line pharmacological treatment for OCD (Koran, Hanna, Hollander, Nestadt, & Simpson, 2007). Their efficacy has been established in numerous trials for OCD without comorbid personality pathology, but their utility for patients whose OCD is embedded within a personality structure marked by disinhibition, hostility, and low motivation to change is essentially unknown. In this context, the case study reported by Jankovsky, Zaboski, and Pittenger (2023) offers an unusually detailed clinical narrative and quantitative record of the trajectory of a young man with comorbid OCD and ASPD who completed 18 weeks of protocol-guided fluoxetine treatment and was reassessed one year later.

This manual uses that case as the empirical anchor for a broader synthesis of the literature on OCD, ASPD, and the practical challenges of pharmacological intervention when the two disorders coexist. The purpose is not to summarize the case in isolation but to embed its findings within the conceptual, theoretical, and empirical scaffolding needed by psychologists who work alongside prescribing clinicians and who are frequently asked to interpret, support, and sometimes salvage such treatments. The material is written for clinicians who have foundational familiarity with the DSM-5 categories, with SSRI pharmacology, and with cognitive-behavioral models of anxiety-spectrum disorders, and who wish to deepen their capacity to reason about complex comorbid presentations.

2. Historical and Theoretical Foundations

2.1 Obsessive–Compulsive Disorder

OCD has long been conceptualized as an anxiety-related condition characterized by the recurrence of intrusive mental content that the individual experiences as unwanted, distressing, and inconsistent with their preferred sense of self. The DSM-5 formalizes this phenomenology in its diagnostic criteria, requiring both obsessions and compulsions that produce clinically significant distress or functional impairment (American Psychiatric Association, 2013). The compulsions serve a functional purpose within the individual's internal

experience: they are performed to reduce or neutralize the anxiety triggered by the obsessions, even though they typically fail to do so in any lasting way and, over time, entrench and expand the very cycle they were intended to interrupt.

The Yale-Brown Obsessive Compulsive Scale (YBOCS), developed by Goodman and colleagues (Goodman et al., 1989), remains the standard clinician-administered instrument for quantifying OCD severity and monitoring treatment response. Its widespread use in both research and clinical practice reflects the consensus that OCD severity is best captured through structured assessment of the time occupied by obsessions and compulsions, the distress they produce, the interference they generate, the patient's resistance to them, and their perceived controllability.

The dominant treatment paradigm for OCD couples exposure-based cognitive-behavioral therapy with pharmacological intervention. SSRIs have long-standing empirical support and are recommended as first-line agents (Koran et al., 2007), typically at doses higher than those employed for depressive disorders and with a longer expected time to full response.

2.2 Antisocial Personality Disorder

Antisocial personality disorder is characterized by a pervasive pattern of disregard for and violation of the rights of others, deceitfulness, impulsivity, aggressiveness, reckless disregard for the safety of self or others, consistent irresponsibility, and lack of remorse. Its symptoms are typically ego-syntonic, meaning that individuals with ASPD do not tend to experience their traits as foreign or distressing to themselves in the way that a person with OCD experiences their intrusive thoughts (Fisher & Hany, 2023; Glenn, Johnson, & Raine, 2013). The prognosis for ASPD is generally regarded as poor, and interventions—both psychosocial and pharmacological—have historically produced limited durable change at the level of the personality disorder itself (Fisher & Hany, 2023; Matusiewicz, Hopwood, Banducci, & Lejuez, 2010).

Nevertheless, individual symptoms of ASPD are amenable to intervention. Aggression, one of the more clinically salient symptoms, has been shown to respond to atypical neuroleptics, SSRIs, and mood stabilizers (Fisher & Hany, 2023; Velotti et al., 2016). This selective responsiveness has led to what may be termed a symptom-cluster approach to ASPD: rather than attempting to alter the underlying personality organization, clinicians target specific behavioral or affective dimensions that generate the most functional impairment or that stand

in the way of engagement with other treatments.

2.3 Theoretical Points of Tension

At a conceptual level, OCD and ASPD sit in tension with one another. OCD, particularly in its harm-focused, moral, or scrupulosity subtypes, often involves fears of causing damage to others, of behaving immorally, or of acting deceitfully (Cervin et al., 2021). These fears rest on an underlying moral scaffolding in which the possibility of causing harm is intolerable. ASPD, by contrast, is characterized by a diminished responsiveness to precisely those concerns; disregard for the rights of others is a defining feature. Cervin et al. (2021), in a large factor and network analysis of 87 distinct OCD symptoms across 1,366 individuals, described how such moral and harm-related content is a coherent and central dimension of the disorder's symptom structure. The theoretical implication is that individuals whose personality structure is characterized by antisocial traits should, at the group level, be less likely to develop harm-related obsessions—if only because the moral premises that give such obsessions their affective charge are less firmly held.

This theoretical tension may partly explain the apparent rarity of the comorbidity documented by Pena-Garijo et al. (2013). It also invites clinical humility: when the two do coexist, as in the case reported by Jankovsky et al. (2023), the interaction of these opposing structures within a single person can produce a phenomenology that is neither classically OCD nor classically ASPD but a distinctive hybrid deserving of careful conceptualization.

3. Conceptual Models and Mechanisms

3.1 Ego-Dystonic Versus Ego-Syntonic Symptom Structures

The distinction between ego-dystonic and ego-syntonic symptomatology is central to understanding both the co-occurrence and the treatment of OCD and ASPD. OCD symptoms are typically experienced as intrusive and unwanted; the patient wishes to be rid of them and, if not always cooperative with exposure-based interventions, at least understands why treatment aims at their reduction. ASPD symptoms, by contrast, tend to be experienced as consistent with the self. Impulsivity, disregard for rules, and preference for immediate reward

are not typically framed by the patient as pathology; they may instead be construed as pragmatic responses to a difficult environment or as expressions of personal style (Daum, 1994).

When both symptom structures coexist within a single patient, treatment planning must contend with a paradoxical motivational picture. The OCD symptoms provide an internal source of distress that can motivate treatment engagement; the ASPD features simultaneously undermine sustained engagement through impulsivity, low frustration tolerance, and skepticism of authority. The case reported by Jankovsky et al. (2023) illustrates this pattern with unusual clarity. The patient's OCD compulsions—balling his right hand and stroking his face three times in response to intrusive violent thoughts—were experienced as distressing and unwanted, and provided the motivational basis for entering treatment. His broader ASPD-consistent history, including repeated incarcerations, parole violations, and a stated preference for prison over compliance with the effort required by parole, indicated a very different orientation toward external structure and consequence.

3.2 The Interference of Personality Factors With Treatment

Multiple personality-related factors can impede intervention for ASPD. Thylstrup, Schrøder, Fridell, and Hesse (2017), in a secondary analysis of a randomized controlled trial of psychoeducation for outpatients with ASPD, described how anger, social conflict, conflicting value systems, and maladaptive coping mechanisms operate as barriers to therapeutic engagement. The social manipulation and lying often present in ASPD can also compromise the patient-provider relationship in ways that make accurate assessment and consistent care difficult (Bateman et al., 2013).

These interpersonal dynamics have specific implications for pharmacotherapy. Individuals with ASPD are at elevated risk for medication misuse, overdose, and illicit drug use (Black, Baumgard, & Bell, 1995), a pattern that necessitates unusual caution in prescribing psychoactive agents and in interpreting patient reports of adherence and response. A treatment orientation focused on short-term external rewards may further decrease compliance with a long-acting regimen when immediate benefit is absent (Daughters et al., 2008). Fluoxetine, like other SSRIs in the treatment of OCD, is characterized by a relatively long latency to therapeutic effect and requires sustained adherence at often high doses, features that align poorly with the reward preferences typical in ASPD.

3.3 A Symptom-Cluster Model of Comorbid Intervention

Given the recalcitrance of ASPD as a whole to intervention (Fisher & Hany, 2023), a productive conceptual model for clinicians is one in which the personality disorder is treated not as a monolithic target but as a constellation of discrete symptoms, each of which may or may not be amenable to particular interventions. Impulsivity, for example, can sometimes be addressed through contingency management, which reinforces medication consistency and can also aid in the discontinuation of problematic substance use (Gibbon et al., 2010). Aggression may respond to specific pharmacological agents, including SSRIs and mood stabilizers (Velotti et al., 2016). This symptom-cluster approach is particularly valuable when the primary presenting complaint is a comorbid condition such as OCD, because it allows the clinician to focus on the ASPD features most likely to interfere with the treatment of that comorbid condition rather than attempting to remediate the personality organization as a whole.

Figure 1 (conceptual). A conceptual model of comorbid OCD and ASPD would depict two overlapping symptom domains linked by shared risk factors (impulsivity, environmental adversity, substance use) and connected to treatment engagement by mediating variables that include therapeutic alliance, motivation, insight, and external reinforcement structure. Arrows would flow bidirectionally between OCD severity and ASPD-associated behaviors, with treatment engagement moderating the effect of pharmacotherapy on both.

4. Empirical Findings Across Studies

The empirical literature bearing directly on the comorbidity of OCD and ASPD is thin. Pena-Garijo et al. (2013), in a comparative study of personality disorders in OCD relative to other anxiety disorders, documented the rarity of ASPD within OCD samples. This finding has been interpreted in several ways. It may reflect true low prevalence at the population level, in which case the theoretical incompatibility of the two symptom structures would be supported. It may also reflect an artifact of decreased treatment-seeking in ASPD populations, meaning that individuals with both conditions are underrepresented in clinical samples and are not being captured by studies that rely on treatment-seeking cohorts (Jankovsky et al., 2023).

Thamby and Khanna (2019) reviewed the broader role of personality disorders in OCD and reported that personality pathology is frequently observed among OCD patients, though the distribution across specific personality disorder categories is uneven. Cluster C disorders, particularly obsessive–compulsive personality disorder, tend to be overrepresented, while Cluster B disorders such as ASPD are notably less common. Jemal, Tessema, and Agenagnew (2022), examining Cluster B personality disorders and their associated factors in psychiatric outpatients in Southwest Ethiopia, provided cross-cultural evidence that the environmental and structural factors surrounding Cluster B pathology are influential and that treatment structure is a meaningful variable in engagement.

Regarding pharmacotherapy specifically, SSRIs are firmly established as first-line agents for OCD (Koran et al., 2007), and evidence from Velotti et al. (2016) and Fisher and Hany (2023) supports their utility for the aggression component of ASPD. There is, however, essentially no controlled empirical evidence regarding the efficacy of SSRIs in patients with the specific comorbidity of OCD and ASPD. The case study by Jankovsky et al. (2023) is thus a notable contribution to a literature that has previously been almost entirely silent on this question. In that case, an 18-week fluoxetine trial produced measurable but modest improvement in OCD symptoms, from a baseline YBOCS score of 31 (severe) to 25 by week 18 (approximately a 20% reduction), together with a more substantial reduction in generalized anxiety, from a baseline Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) score of 20 to a score of 1 at week 18. Both trajectories reversed following the patient's unilateral discontinuation of the medication, with a one-year follow-up BAI of 7 and a return of OCD symptoms toward baseline levels.

Table 1 (conceptual). A synthesis table across the sources reviewed would depict, for each study, its design, sample, primary outcome measures, and principal findings. Such a table would highlight the near-total absence of controlled trials directly targeting the OCD–ASPD comorbidity and would situate the Jankovsky et al. (2023) case within a broader literature on SSRI efficacy for OCD (Koran et al., 2007), on the modifiability of aggression in ASPD (Fisher & Hany, 2023; Velotti et al., 2016), and on psychosocial interventions for personality disorders (Gibbon et al., 2010; Matusiewicz et al., 2010).

5. Psychological Pathways and Stress Responses

The trajectory documented by Jankovsky et al. (2023) is instructive regarding the psychological pathways by which stressful environmental contexts can precipitate and shape obsessive-compulsive symptomatology, even in individuals whose broader personality organization would not obviously predict it. The patient in that case reported the onset of unwanted, persistent thoughts during his first incarceration at age 18. Specifically, he developed the belief that his sentence had been elongated and that corrections officers had forgotten to release him. The distress associated with these thoughts led to compensatory behaviors including excessive counting of letters in words. During a second prison sentence, these behaviors expanded, with repetitive actions performed in sets of three, including cleaning his cell and mopping the floor. Following a third incarceration, the pattern generalized further, producing a broad inability to purchase new items unless he already had a designated place for them.

This developmental sequence suggests that the incarceration environment—characterized by loss of control, hypervigilance, unpredictable duration, and the salience of small procedural details—served as a precipitating and reinforcing context for the emergence of compulsive rituals. From a psychological standpoint, several mechanisms are plausible. The extreme uncertainty of the incarceration environment could have activated latent vulnerabilities in inhibitory control and thought regulation, producing the initial intrusions. The compulsive behaviors that followed could then have been negatively reinforced through the transient anxiety reduction they produced, entrenching the cycle characteristic of OCD.

The subsequent morphing of aggressive tendencies into ego-dystonic fears of violence is another notable feature of the case. Whereas the patient had previously engaged in physical fights and expressed aggression outwardly, following the development of his OCD he began to experience anxiety-inducing thoughts of losing control and violently harming others through rape, stabbing, or shooting, while adamantly denying any intent to act on such thoughts (Jankovsky et al., 2023). This shift represents a psychologically significant reorganization of aggressive content: what had once been ego-syntonic and behaviorally enacted became ego-dystonic and cognitively feared. The transformation illustrates how the phenomenological structure of OCD—unwanted intrusions and compensatory rituals—can incorporate and reformulate the aggressive impulses associated with ASPD, producing a hybrid presentation in which the person is simultaneously the possessor of antisocial history and the frightened observer of his own hypothetical violent potential.

6. Mental Health Outcomes and Severity Spectrum

The severity spectrum of OCD, as captured by the YBOCS, ranges from subclinical to extreme. The Jankovsky et al. (2023) case began with a baseline YBOCS of 31, placing the patient in the severe range. The clinical significance of this score is substantial: it indicates a degree of symptom burden that consumes a large portion of daily time and imposes marked interference with functioning. The gradual reduction of the YBOCS score to 25 over 18 weeks of fluoxetine treatment represented a modest response, but one that was clinically meaningful for the patient. By week 15 he was reporting qualitative behavioral changes, including no longer feeling the need to wash objects immediately or return them to precisely the same position, and finding himself forgetting to follow through with some routine compulsions.

The BAI trajectory is also informative. Beginning at 20 (moderate anxiety), the score decreased by 8 points at week 9, five weeks after the patient reached his full 40 mg dose, and then continued to decline to a score of 1 by week 18. The differential rate of improvement between OCD and generalized anxiety is consistent with the broader clinical observation that anxiety symptoms often respond to SSRI treatment earlier and more completely than the core obsessive and compulsive symptoms of OCD, which typically require higher doses and longer durations of treatment for full response.

The severity spectrum also has implications for comorbid ASPD. Aggression exists on a continuum in ASPD, ranging from irritability to overt violence, and different points on this continuum may respond differentially to intervention (Velotti et al., 2016). Impulsivity likewise varies substantially, and its severity may be one of the most important prognostic variables for medication adherence in this population. When the impulsivity is high, the risk of discontinuation without consultation—as ultimately occurred in the Jankovsky et al. (2023) case—increases substantially.

7. System-Level and Contextual Psychological Effects

The Jankovsky et al. (2023) case cannot be adequately understood without reference to the systemic and contextual factors that shaped both its onset and its outcome. The patient's psychological trajectory unfolded within a context marked by repeated interaction with the criminal justice system, substance use, and a family environment in which his mother felt compelled to withdraw him from school at age 16 in order to prevent further legal trouble. His history of alcohol and drug abuse, including dependence on Xanax, fentanyl, and benzodiazepines, and his subsequent treatment with Suboxone and later Methadone, illustrate the intersection of ASPD-associated impulsivity with the availability and pharmacology of highly reinforcing substances. His prior brief trial of sertraline in 2008 for depressive symptoms had ended quickly, with the patient reporting that he did not perceive benefit and discontinuing on his own initiative.

At the system level, the structure of the research trial itself functioned as a therapeutic scaffold. The patient received compensation of \$275 for completing initial assessments, and additional monetary incentives for continued clinical assessments. Weekly phone calls monitored clinical changes, difficulties with the medication regimen, adverse events, and medication compliance, and treatment was overseen by a licensed and board-certified psychiatrist. Under these conditions, the patient completed the full 18 weeks of treatment without missing a dose. When this scaffolding was removed at the end of the structured trial and medication management was transferred to his primary care provider, adherence deteriorated. Formal assessments were no longer conducted; the patient's dose was increased to 60 mg per day; and, over time, as his compulsions became less frequent, he began to experience distress when he noticed himself forgetting to perform them. He ultimately discontinued fluoxetine several months after the study ended, without consulting any provider.

This trajectory illustrates several system-level psychological effects that have implications well beyond this individual case. First, the external reinforcement structure of a research trial can support engagement in a population for whom internal motivation is often insufficient, but the benefit is contingent on the continued presence of that structure. Second, the transfer of care from a specialty setting to a primary care provider represents a potentially high-risk moment for patients with ASPD, particularly when it is accompanied by a reduction in monitoring intensity. Third, symptom improvement itself can, paradoxically, become a source of distress in patients whose OCD is intertwined with a need for control. As Jankovsky et al. (2023) noted, as the patient's compulsions decreased, he became uncomfortable with his perceived

"lack of control" and felt distressed when he realized he had not performed a compulsion. This distress, coupled with ASPD-associated lack of insight (Daum, 1994) and impulsivity, contributed to the unilateral discontinuation of a treatment that had been demonstrably beneficial.

8. Clinical Implications for Psychologists

Psychologists working with patients who present with comorbid OCD and ASPD, or with any similarly complex combination of an ego-dystonic disorder and a personality disorder marked by disinhibition, face a distinctive set of clinical tasks. Several implications emerge from the material reviewed in this manual.

Assessment must be multi-method and multi-rater. Because ASPD is associated with deceitfulness and social manipulation (Bateman et al., 2013), reliance on self-report alone can produce systematically distorted data. A multi-method, multi-rater approach that combines clinician-administered measures such as the YBOCS with self-report instruments such as the BAI, structured behavioral observation, family collateral ratings when available and appropriate, and careful tracking of functional indices such as frequency of problematic behavior, reluctance to continue medication, changes in thoughts and emotions, and difficulty regulating anger can substantially improve reliability and validity (Jankovsky et al., 2023).

Therapeutic alliance must be actively cultivated and monitored. Rapport-building is a known challenge with individuals who have ASPD (Glenn et al., 2013). Where possible, minimizing the number of clinicians a patient must engage with can support the development of trust. In the Jankovsky et al. (2023) case, the research protocol allowed the patient to have a singular clinician for progress monitoring, which facilitated rapport and adherence. In routine clinical care, similar continuity should be pursued whenever feasible, and psychologists should be prepared for the alliance to be tested by manipulative or oppositional behavior.

Treatment structure and reinforcement should be built into the plan. The importance of external structure in supporting adherence for this population is well documented (Jemal et al., 2022). Where research incentives are not available, clinicians can consider contingency management strategies to reinforce medication consistency and to support the discontinuation of problematic substance use (Gibbon et al., 2010). Regular, predictable

check-ins, clear expectations, and explicit contingencies for adherence can approximate the scaffolding provided in trial settings.

Discrete ASPD symptoms should be targeted rather than the personality disorder as a whole. Given the poor prognosis for ASPD as a global entity (Fisher & Hany, 2023), a symptom-focused strategy is more tractable. Impulsivity, aggression, and substance use are amenable to specific interventions and, when addressed, reduce interference with the treatment of comorbid conditions such as OCD (Jankovsky et al., 2023).

Anticipate paradoxical distress at symptom reduction. OCD patients whose symptoms are intertwined with a need for control may experience the reduction of compulsions as itself distressing, at least transiently. Preparing patients for this possibility, framing it as a predictable feature of recovery, and providing structured support during the period of symptom reduction can reduce the risk of unilateral discontinuation.

Coordinate closely with prescribers and transitions of care. The transfer of medication management from a specialty setting to a primary care provider is a vulnerable moment, particularly for patients with ASPD. Psychologists can play a valuable role in ensuring that these transitions are accompanied by explicit communication about ongoing monitoring needs, and in maintaining continuity of psychological contact even when pharmacological management shifts.

Recognize the limits of pharmacotherapy in this population. Even a well-conducted SSRI trial may produce only modest improvement in OCD when personality pathology is present, and the durability of that improvement may depend heavily on factors outside the pharmacological intervention itself. Realistic expectations and careful monitoring of both symptomatic and functional outcomes are essential.

9. Future Directions and Research Gaps

The literature bearing on the comorbidity of OCD and ASPD is remarkably sparse, and several research gaps merit attention. First, controlled studies of SSRI efficacy in this specific comorbid population are absent. The case report by Jankovsky et al. (2023) is a valuable but singular contribution; its findings cannot be generalized without further systematic

investigation. Prospective cohort studies and, where ethically feasible, randomized controlled trials that intentionally recruit patients with both conditions would substantially advance the field.

Second, the mechanisms underlying the apparent rarity of the comorbidity deserve investigation. It is not established whether the low observed prevalence reflects true low co-occurrence, artifacts of decreased treatment-seeking in ASPD populations, or phenomenological incompatibilities between the moral content of many OCD obsessions and the value structure of ASPD (Cervin et al., 2021; Pena-Garijo et al., 2013). Epidemiological studies that use community-based rather than treatment-seeking samples could clarify this question.

Third, the psychological pathways connecting incarceration, trauma, and OCD onset warrant systematic study. The temporal association between the patient's incarcerations and the development and elaboration of his obsessive-compulsive symptoms in the Jankovsky et al. (2023) case is striking and suggests that carceral environments may function as precipitating contexts for OCD in vulnerable individuals. Research on OCD onset within incarcerated populations could illuminate these mechanisms and inform intervention.

Fourth, the paradoxical experience of distress at symptom reduction—the discomfort that some OCD patients experience when they realize they are no longer performing their compulsions—deserves further conceptualization. This phenomenon has implications for treatment adherence, for the design of relapse prevention programs, and for the education of both patients and prescribers.

Fifth, the effectiveness of contingency management and other behavioral scaffolds in supporting pharmacological adherence in patients with ASPD merits controlled investigation. Gibbon et al. (2010), in their Cochrane review of psychological interventions for antisocial personality disorder, identified this general area as one in need of more rigorous study.

Sixth, methodological advances in the assessment of ASPD severity within OCD research would allow for more nuanced analysis. In the Jankovsky et al. (2023) case, only OCD and anxiety symptomatology were systematically measured, and the authors acknowledged that variables such as ASPD severity may have been overlooked. Standardized ASPD severity measures included in OCD trials would allow for the analysis of interactions between personality pathology and treatment response.

Finally, the field would benefit from qualitative research on the subjective experience of patients with this comorbidity. Understanding how such patients construe their own symptoms, their treatment, and their relationships with providers could inform the development of more effective engagement strategies.

10. Conclusion

The comorbidity of obsessive–compulsive disorder and antisocial personality disorder is uncommon and clinically challenging. The disorders sit in structural tension with one another: OCD is characterized by ego-dystonic intrusions and effortful, distressing rituals, while ASPD is characterized by ego-syntonic disinhibition and disregard for the constraints that would inhibit such behavior in most individuals. When they coexist, they produce a clinical picture that requires careful conceptualization and creative intervention.

The case reported by Jankovsky, Zaboski, and Pittenger (2023) illustrates both the potential and the limits of SSRI monotherapy in this population. Fluoxetine at 40 mg per day, delivered within a structured research protocol with weekly monitoring and monetary incentives for continued participation, produced a modest but clinically meaningful reduction in OCD symptoms and a substantial reduction in generalized anxiety over 18 weeks. Yet the patient ultimately discontinued the medication without consulting his providers, and at one-year follow-up his symptoms had returned toward baseline. The trajectory speaks to the importance of external structure, therapeutic alliance, and continuity of care in supporting adherence in this population, and it underscores the difficulty of sustaining pharmacological benefit when the scaffolding of a research protocol is withdrawn.

For psychologists, the material reviewed in this manual carries several core lessons. Comorbid OCD and ASPD is rare but not impossible; when encountered, it deserves a multi-method assessment approach, a symptom-cluster conceptualization of the personality pathology, an intentionally cultivated therapeutic alliance, and a treatment plan that includes explicit structure and reinforcement. Pharmacotherapy can be helpful, but its benefits are contingent on adherence, which in this population cannot be assumed. Coordination with prescribers, particularly during transitions of care, is essential. And clinicians must be prepared for the paradoxical possibility that symptomatic improvement itself may become a

source of distress for a patient whose OCD is intertwined with a need for control.

Understanding how comorbidity impacts pharmacotherapy outcomes is, as Jankovsky et al. (2023) observed, a crucial step for developing treatment plans for patients with uncommon symptom presentations. Although studies of ASPD treatment efficacy remain scarce (Matusiewicz et al., 2010), the available evidence suggests that patients with ASPD and OCD may still experience meaningful symptom reduction if the intervention is well structured. Providers should be prepared for barriers including treatment noncompliance, particularly in settings without adequate external incentive structures, and should approach these cases with a combination of clinical humility, methodological rigor, and creative use of the psychological, pharmacological, and behavioral tools at their disposal.

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