ANTISOCIAL PERSONALITY DISORDER: CLINICAL UNDERSTANDING, THERAPEUTIC CHALLENGES, AND EVIDENCE-INFORMED APPROACHES

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

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Abstract

Antisocial personality disorder (ASPD) represents one of the most clinically challenging and therapeutically neglected conditions within contemporary mental health practice. Despite its substantial prevalence, significant societal costs, and considerable individual suffering, ASPD has historically been regarded as untreatable, contributing to widespread therapeutic pessimism among clinicians and systematic exclusion of affected individuals from mental health services. This continuing education manual synthesizes contemporary research on the conceptualization, assessment, and treatment of ASPD, with particular attention to the psychological mechanisms that maintain the disorder, the emotional responses it evokes in clinicians, and the emerging evidence base for specialized psychotherapeutic interventions. Drawing on empirical investigations of clinician countertransference, qualitative studies of therapist experience, randomized controlled trials of psychosocial interventions, and theoretical formulations grounded in attachment theory and mentalization, this manual examines the multiple obstacles that have impeded therapeutic progress with this population. Particular emphasis is placed on mentalization-based treatment adapted for ASPD (MBT-ASPD), the Impulsive Lifestyle Counselling program, and other specialized approaches that have demonstrated promise in reducing aggression, offending, and psychosocial impairment. The manual concludes by examining implications for clinical practice, the ethical obligations of psychologists working with this underserved population, and directions for future research. Throughout, the manuscript integrates diagnostic, developmental, relational, and systemic perspectives to provide psychologists with a comprehensive understanding of ASPD that supports both clinical competence and therapeutic optimism.

Introduction

Antisocial personality disorder occupies a peculiar position within contemporary psychiatric practice. It is at once one of the most recognizable and one of the most poorly understood personality disorders, one of the most socially costly and one of the most clinically neglected. The National Institute for Health and Care Excellence (2010) noted in its clinical guidelines that "therapeutic pessimism" among health professionals toward ASPD appears repeatedly in the literature, and this pessimism has profound consequences: individuals with ASPD are frequently refused admission to mental health services, excluded from research protocols, and denied access to the kinds of specialized psychological interventions that have transformed outcomes for other personality disorders (Flaaten et al., 2024; van Dam et al., 2022). The stereotypical perception that individuals with ASPD are untreatable, or may even worsen from treatment, has been widespread for decades (Rice et al., 1992), and although this view has begun to shift in recent years, the empirical basis for effective treatment remains modest (Gibbon et al., 2020).

The clinical picture that emerges from the contemporary literature is one of a disorder characterized by pervasive disregard for the rights of others, impulsive and often aggressive behavior, deceitfulness, and a striking absence of remorse (American Psychiatric Association, 2013). Yet beneath this surface presentation lies a more complex psychological reality. Emerging developmental research suggests that a substantial proportion of individuals meeting criteria for ASPD have histories of childhood trauma, disrupted attachment, and neglect (Semiz et al., 2007; Yakeley, 2014). Neurocognitive and mentalization-based research has documented specific deficits in the recognition of others' emotional states, particularly fear, and difficulties in generating affective empathy despite intact cognitive understanding of others' minds (Bateman & Fonagy, 2016; Dolan & Fullam, 2004). The picture that results is not one of moral defect or biological determinism, but of a developmental disorder shaped by attachment disturbance, trauma, and impaired mentalization—a picture that provides the foundation for therapeutic hope.

This continuing education manual has been developed to support licensed psychologists and graduate-level clinicians in developing a sophisticated, evidence-informed, and clinically nuanced understanding of ASPD. The material integrates conceptual, empirical, and clinical

perspectives drawn from recent scholarly work on the disorder, with particular attention to the specialized psychotherapeutic approaches that have emerged in the past two decades. Rather than presenting ASPD as an intractable condition to be avoided, the manual invites clinicians to consider the disorder as a treatable, if challenging, form of psychopathology that responds to appropriate structural conditions, clinical training, and therapeutic approaches. The material also confronts directly the countertransference dynamics, systemic barriers, and diagnostic confusions that have historically impeded therapeutic engagement with this population, offering psychologists conceptual and practical tools for navigating these challenges.

The manual is organized to progress from historical and theoretical foundations through conceptual models, empirical findings, psychological mechanisms, and clinical implications. Because ASPD cannot be adequately understood without engaging the specific emotional challenges it poses to clinicians, considerable attention is devoted throughout to the phenomenon of countertransference and its management. Similarly, because system-level factors profoundly shape access to and delivery of treatment, the manual examines the organizational and cultural contexts that influence clinical work with individuals with ASPD. The overarching aim is to equip psychologists not merely with knowledge about ASPD, but with the conceptual and emotional capacities to work effectively and ethically with individuals who have historically been denied competent care.

Historical and Theoretical Foundations

The contemporary understanding of antisocial personality disorder has been shaped by a long and often contested history of conceptualization. As Pickersgill (2012) documented in his sociological analysis of the diagnosis, ASPD emerged from a tangled lineage of concepts that included moral insanity, sociopathy, and psychopathy, each carrying its own theoretical assumptions and clinical implications. Within the context of DSM-II and DSM-III, scholars argued for the existence of two distinct personality types: a more callous, low-anxiety psychopathic subtype and a more affectively driven, aggressive antisocial or sociopathic subtype. This distinction has proved consequential, as it maps onto contemporary debates about whether ASPD and psychopathy represent qualitatively different disorders or points along a shared continuum.

The evolution of the DSM criteria has moved the diagnosis of ASPD progressively toward a behavioral definition. The current DSM-5 criteria emphasize failure to obey laws and norms, deceitfulness, impulsivity, irritability and aggression, disregard for the safety of self and others, irresponsibility, and lack of remorse (American Psychiatric Association, 2013). Three of these criteria, together with a documented history of conduct disorder in childhood and an age of at least 18 years, are required for diagnosis. Yet this behaviorally anchored definition has been criticized for capturing only the surface manifestations of a deeper personality organization. As Flaaten et al. (2024) noted, the DSM-5 ASPD criteria are considerably more inclusive than the psychopathy construct as defined by the Psychopathy Checklist-Revised (PCL-R; Hare, 2003), which incorporates intrapsychic dimensions such as callousness, grandiosity, shallow affect, glibness, and manipulativeness alongside behavioral traits.

The relationship between ASPD and psychopathy has generated substantial theoretical debate. Research indicates that most individuals with psychopathy meet criteria for ASPD, but only approximately 25 to 30 percent of individuals with ASPD demonstrate significant psychopathic traits (Hare & Neumann, 2008; Ogloff et al., 2016). This asymmetry suggests that while the two constructs overlap, they are not synonymous. Wall et al. (2015) proposed that boldness—characterized by fearlessness, dominance, and low stress reactivity—represents a primary differentiator between psychopathy and ASPD without psychopathy. The triarchic psychopathy model developed by Patrick and colleagues has further refined this understanding by identifying disinhibition, meanness, and boldness as distinct dimensions that combine to produce the psychopathic phenotype (Patrick & Drislane, 2015).

Yet the field has not achieved consensus on whether these represent genuinely distinct disorders or dimensional variants of a shared underlying pathology. Some researchers, including Coid and Ullrich (2010) and Skilling et al. (2002), have argued that psychopathy represents a severe form of ASPD or that the two constructs capture the same underlying natural class. Widiger (2006) similarly proposed that psychopathy may be conceptualized as a severe variant of ASPD. Others maintain that the constructs are qualitatively distinct, differing not merely in severity but in the fundamental organization of self, affect, and interpersonal functioning. Contemporary dimensional models, including the alternative model of personality disorders in DSM-5 and the ICD-11 classification, have attempted to integrate these perspectives by locating ASPD within the trait domains of antagonism and disinhibition, with a psychopathy specifier requiring low anxiousness, withdrawal, and attention seeking (Mark et

al., 2022; Mulder, 2021).

The theoretical significance of this debate extends beyond nosology to clinical practice. As Flaaten et al. (2024) argued, using ASPD and psychopathy interchangeably can prevent appropriate treatment for both conditions and may perpetuate confusion among clinicians. De Visser et al. (2023) provided a particularly useful nuanced framework, suggesting that different pathways to antisocial behavior warrant different therapeutic approaches. For individuals with ASPD accompanied by significant psychopathic features, cognitive remediation training or risk reduction approaches may be indicated. For those whose antisocial behavior emerges from attachment-related disturbances and pervasive mistrust, trauma-focused interventions are recommended. And for individuals whose core difficulty involves impaired mentalization—difficulty understanding others from within—mentalization-based approaches offer particular promise.

Perhaps the most transformative theoretical development in recent decades has been the reconceptualization of ASPD as a developmental disorder rooted in disturbances of attachment and mentalization. This perspective, articulated most fully within the mentalization-based framework, holds that the mentalizing capacity develops in the context of early relationships with attachment figures who themselves mentalize the child. Children who grow up in secure households with caregivers capable of holding the child's mind in mind tend to develop secure attachment and robust mentalization. Conversely, children exposed to trauma, neglect, or disrupted attachment may develop impaired capacities to understand their own and others' mental states (Yakeley, 2014). Empirical support for this developmental model comes from studies such as that conducted by Semiz et al. (2007), who found that 60.8 percent of male patients diagnosed with ASPD reported at least one type of childhood traumatic experience, compared with 37.4 percent of healthy controls. Rates of childhood physical and sexual abuse, neglect, and early separation were significantly elevated in the ASPD group.

This developmental framework has profound implications for how clinicians conceptualize the disorder. Rather than viewing individuals with ASPD as morally deficient or biologically determined to be antisocial, the developmental perspective invites understanding of their behavior as the outcome of specific developmental pathways involving attachment disturbance, trauma, and impaired mentalization. As Yakeley and Williams (2014) noted, this reframing has the potential to inform early intervention with children at risk of developing ASPD, to guide treatment for adults with the diagnosis, and to reduce the stigma that has

historically surrounded the condition. Importantly, if insecure attachment and impaired mentalization are conceptualized as reversible rather than fixed, therapeutic optimism becomes theoretically warranted.

Conceptual Models and Mechanisms

The mentalization-based framework, developed by Bateman and Fonagy and elaborated across two decades of clinical and empirical work, has provided the most influential contemporary conceptual model for understanding ASPD. Mentalization refers to "the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes" (Bateman & Fonagy, 2010). This capacity is essential for numerous domains of psychological functioning, including self-organization, affect regulation, interpersonal communication, and social relations (Bateman & Fonagy, 2016). Good mentalizing manifests in a curious, not-knowing, genuinely interested stance toward one's own and others' thoughts and feelings; in the capacity to accept that others may hold different perspectives; and in the ability to forgive others based on an understanding that mental states shape behavior.

Within this framework, individuals with ASPD present a distinctive and paradoxical mentalizing profile. As Bateman and Fonagy (2016) described, individuals with ASPD are often above average in external, cognitive, and automatic mentalizing abilities. They are skilled at reading others' behaviors, intentions, and vulnerabilities—capacities that can be deployed for manipulation or coercion. What they lack is the affective, internal dimension of mentalization: the capacity to generate how they would feel in another's situation, to experience empathy for others' suffering, or to modulate their own behavior through emotional attunement. This dissociation between cognitive and affective mentalization allows individuals with ASPD to understand others sufficiently to exploit them, while failing to be emotionally moved by their exploitation.

Research has substantiated this mentalizing profile. Dolan and Fullam (2004), in a randomized controlled study comparing offenders with ASPD (with and without psychopathy) to healthy controls, found that both offender groups performed worse than controls on subtle tests of mentalizing ability. Individuals with ASPD without psychopathy demonstrated more

marked impairments in mentalization than those with psychopathy, suggesting that the two groups differ qualitatively in their mentalizing patterns. Individuals with psychopathic traits, in contrast, showed relatively preserved recognition of basic and complex emotions from facial expressions, sometimes exceeding controls in complex emotional recognition. The core deficit in psychopathy appears to involve not the capacity to mentalize but the motivation to do so; individuals with psychopathy lack the interest in and concern for others' mental states that would motivate genuine emotional engagement.

Marsh and Blair (2008) documented in their meta-analysis that individuals with antisocial characteristics show particular deficits in the recognition of fearful emotions in others. This finding has significant clinical implications, as the capacity to recognize fear typically inhibits aggressive behavior; when a potential victim shows fear, most individuals experience an inhibitory affective response. The reduced capacity to register fear in others may contribute to the disinhibition of aggression characteristic of ASPD. More broadly, individuals with ASPD tend to treat others as objects to be manipulated rather than as human beings with their own subjective experience (Bateman & Fonagy, 2016), a pattern that both reflects and reinforces their mentalizing deficits.

The mentalization-based framework further proposes that mentalizing capacity is closely linked to the attachment system. Attachment activation—whether through relational stress, threats to identity, or interpersonal challenge—can compromise mentalizing in individuals whose developmental history has left them vulnerable. Newbury-Helps et al. (2017), in a study of offenders with ASPD, found that non-mentalizing and hypo-mentalizing were more pronounced in individuals with ASPD than in offenders without ASPD or non-offender controls. Mentalizing subscales predicted offender status, suggesting that impaired mentalization is not merely correlated with antisocial behavior but may be causally implicated. The hypothesis that emerges from this work is that threats to self or identity activate the attachment system in individuals with ASPD, which in turn impairs mentalizing capacity, lowering the threshold for aggressive or exploitative behavior toward others whose subjective experience becomes momentarily inaccessible.

This attachment-based perspective on the psychological dynamics of ASPD has been complemented by neuroscientific research on the relationships among mentalization, aggression, and psychopathy. Taubner et al. (2013) found that attachment-related mentalization moderates the relationship between psychopathic traits and proactive aggression in adolescents, suggesting that even among individuals with psychopathic

characteristics, the presence or absence of mentalizing capacity may determine whether antisocial tendencies translate into overt aggressive behavior. Schwarzer et al. (2021) similarly documented that mentalizing mediates the association between childhood emotional abuse and aggression potential in non-clinical adults. These findings suggest that mentalization may serve as both a protective factor against the development of severe antisocial pathology and a therapeutic target for intervention.

The mentalization-based framework also provides an account of the specific interpersonal patterns characteristic of ASPD. Individuals with ASPD typically show marked sensitivity to hierarchy and power, tending to organize relationships around competition and domination rather than mutual recognition (Bateman & Fonagy, 2016). This pattern reflects both their developmental experiences of insecure attachment and their impaired capacity to engage with others as autonomous subjects. In therapeutic contexts, this sensitivity manifests in resistance to perceived authority, boundary violations, and challenges to the therapist's position. Understanding these behaviors as manifestations of specific mentalizing deficits and attachment vulnerabilities, rather than as evidence of moral defect or untreatable pathology, opens therapeutic possibilities that a purely behavioral framework would foreclose.

A related concept central to contemporary understanding of ASPD is that of epistemic trust, defined as "the willingness to accept new information from another person as trustworthy, generalizable, and relevant" (Schröder-Pfeifer et al., 2018). Individuals with ASPD typically display profound epistemic mistrust, viewing information from others as potentially threatening, manipulative, or irrelevant. This epistemic vigilance is developmentally understandable—for individuals whose attachment figures were unreliable or hostile, mistrust served an adaptive function—but it becomes a significant obstacle to therapeutic engagement. Effective treatment must therefore address not only symptoms and behaviors but the underlying epistemic stance that determines whether therapeutic communication can be received and integrated.

Recent theoretical developments have extended these ideas by conceptualizing ASPD in terms of the failure to establish the "we-mode"—a shared mental state in which self and other are simultaneously present and the interpersonal field is characterized by mutual recognition (Bateman, 2022). The we-mode is understood as a prerequisite for prosocial behavior, and its disruption or absence characterizes the interpersonal life of individuals with ASPD, who tend to alternate between self-centered and other-centered stances rather than integrating them. Therapeutic interventions grounded in this framework aim to generate we-mode functioning

through carefully calibrated interventions that engage patients in genuine intersubjective exchange.

Empirical Findings Across Studies

The empirical literature on ASPD treatment remains, by consensus, insufficient. Two Cochrane reviews conducted a decade apart (Gibbon et al., 2010, 2020) have systematically examined the evidence for psychological interventions and reached similar conclusions: while some randomized controlled trials suggest that specialized psychotherapy may outperform treatment as usual, the overall evidence base is characterized by small samples, methodological heterogeneity, and insufficient replication. The 2020 Cochrane review synthesized findings from 19 randomized controlled trials comparing 18 different psychotherapies to treatment as usual, but concluded that high-quality evidence for effective treatment of ASPD remains lacking.

Despite this cautious summary, individual studies within the emerging evidence base have provided important findings. Bernstein et al. (2023) reported a randomized clinical trial comparing schema therapy to treatment as usual in offenders with personality disorders and aggression, finding that schema therapy produced more rapid improvements. Although this study focused on a broader population than ASPD specifically, its findings challenge the traditional view that individuals with severe personality pathology and violent behavior are untreatable. Similarly, the multicenter randomized controlled trial of mentalization-based treatment for offending adult males (MOAM) recently reported by Fonagy et al. (2025) demonstrated that MBT reduced individual self-defeating and interpersonally violent core features in ASPD male patients compared with probation as usual, providing the most robust evidence to date for a specific psychotherapeutic intervention for ASPD.

Preliminary studies of MBT for ASPD have consistently suggested promise. McGauley et al. (2011) reported that MBT could effectively reduce aggression in patients with ASPD, and Bateman et al. (2016) documented positive outcomes for patients with comorbid ASPD and borderline personality disorder in a randomized controlled trial of MBT versus structured clinical management. The mentalization-based treatment for adolescents with conduct disorder (MBT-CD), studied in a feasibility investigation by Hauschild et al. (2023),

demonstrated significant clinical changes and provides preliminary support for the applicability of mentalization-based approaches across the developmental spectrum of antisocial pathology.

Beyond MBT, the Impulsive Lifestyle Counselling (ILC) program has emerged as a promising brief intervention specifically targeting the impulsive antisocial behavior characteristic of ASPD, particularly in populations with co-occurring substance use disorders. Developed by Thylstrup and Hesse (2016) at the Centre for Alcohol and Drug Research at Aarhus University, the ILC is a six-session psychoeducational intervention adapted from Walters' Lifestyle Change Program. Rather than employing a criminal lifestyle framing, the program addresses "impulsive lifestyle"—the pattern of impulsive actions leading to substance use and interpersonal conflict that characterizes many individuals with ASPD.

The pragmatic multicenter randomized controlled trial of ILC, conducted across thirteen Danish outpatient sites between 2012 and 2014, has yielded a series of significant findings. The initial report demonstrated that ILC added to treatment as usual was associated with substantially lower risk of dropout from substance use disorder treatment, with a hazard ratio of 0.063 (Thylstrup & Hesse, 2016). Participants randomized to ILC reported more days abstinent at three-month follow-up, though this effect did not persist at longer follow-up intervals (Thylstrup et al., 2015). Notably, patients who received ILC reported perceiving more help for antisocial behavior, and this perception was associated with better short-term outcomes including greater abstinence, lower dropout risk, and higher treatment satisfaction (Thylstrup et al., 2017).

The most recent report from this trial, by Hesse et al. (2022), extended the follow-up to examine criminal offending as an outcome. Using Danish national register data, the investigators followed 165 patients for one year following randomization. Patients in the ILC condition committed significantly fewer criminal offenses leading to conviction than those in treatment as usual (incidence rate ratio = 0.43, $p = .013$ in unadjusted analysis; adjusted incidence rate ratio = 0.45, $p < .001$). The effect was particularly pronounced for violent offenses (adjusted IRR = 0.19, $p = .007$) and property offenses (adjusted IRR = 0.42, $p = .010$), though no significant differences emerged for drug-related offenses or driving under the influence. These findings represent an important advance in the ASPD treatment literature, addressing directly the criticism raised in the Cochrane review that studies had failed to examine convictions as outcomes despite criminal behavior being central to the ASPD construct.

Table 1 provides a synthesis of the major intervention findings that have emerged from the recent empirical literature on ASPD treatment.

Intervention	Population	Primary Outcomes	Key Findings
MBT-ASPD (McGauley et al., 2011)	Adults with ASPD	Aggression	Reduction in aggressive behavior
MBT for comorbid ASPD/BPD (Bateman et al., 2016)	Adults with comorbid ASPD and BPD	Multiple symptom domains	MBT superior to structured clinical management in subgroup analyses
Schema Therapy (Bernstein et al., 2023)	Offenders with PD and aggression	Symptomatic improvement	ST produced more rapid improvements than TAU
MOAM MBT trial (Fonagy et al., 2025)	Male offenders with ASPD	Self-defeating and violent behavior	MBT reduced core features versus probation as usual
MBT-CD (Hauschild et al., 2023)	Adolescents with conduct disorder	Clinical symptoms	Significant clinical changes in feasibility study
ILC (Hesse et al., 2022; Thylstrup & Hesse, 2016)	Adults with ASPD and SUD	Dropout, offending	Reduced dropout, reduced total offenses, violent and property offenses

Beyond these intervention studies, an important body of empirical work has examined the emotional responses of clinicians working with individuals with ASPD. Lo Buglio et al. (2025) conducted a scoping review of studies exploring clinicians' countertransference reactions, examining 12 studies conducted primarily in Europe. Their synthesis identified consistent patterns across studies employing the Therapist Response Questionnaire (Betan et al., 2005), a validated instrument for assessing therapist countertransference. Colli et al. (2014), in a large study of 203 clinicians, found that ASPD was significantly correlated with a "criticized/mistreated" countertransference response characterized by feelings of being devalued, criticized, or repulsed. This finding was replicated by Tanzilli et al. (2016) using a refined factor structure, which separated the response into "hostile/angry" and "criticized/devalued" dimensions.

Cavalera et al. (2021) further demonstrated that antisocial factors were correlated with both hostile/angry and overwhelmed/disorganized clinician responses, even when controlling for symptom severity, treatment duration, patient age, patient education, and therapist experience. These findings suggest that the negative emotional responses evoked by ASPD are not merely artifacts of severity or other confounding variables but reflect something specific to antisocial pathology. Studies of psychopathy have found similar patterns, with Gazzillo et al. (2015) documenting that overwhelmed responses were correlated with psychopathic patterns even when controlling for overall level of personality organization, and Di Virgilio et al. (2021) finding that psychopathic traits were associated with criticized/mistreated and disengaged countertransference and negatively associated with parental/protective and positive/satisfying responses.

The qualitative literature has complemented these quantitative findings with rich descriptions of clinicians' experiences. Morken et al. (2022) conducted an autoethnographic study of four experienced MBT therapists and one social worker delivering MBT-ASPD in a Norwegian addiction medicine setting. Through focus group dialogue and thematic analysis, they identified four superordinate themes: gaining safety by getting to know patients better, gaining cooperation through clear boundaries and a non-judgmental stance, shifting inner boundaries, and timing interventions in a high-speed culture. The therapists described initial anxiety and fear of aggressive outbursts giving way to increased confidence as they became familiar with patients and observed their responsiveness. They also described being surprised by patients' motivation for change and their capacity to tolerate direct therapeutic interventions.

Aerts et al. (2023) conducted qualitative interviews with fifteen clinicians working with ASPD patients in the Netherlands, identifying several key aspects of establishing therapeutic alliance including respecting the patient's needs, regulating interpersonal dynamics, adopting a connective attitude, following the treatment process, and striving for collaborative and tailored goals. Warner and Keenan (2022), in contrast, documented more negative therapist experiences in a UK-based MBT-ASPD program, with clinicians reporting feelings of vulnerability, inadequacy, and burnout risk, which the authors attributed largely to insufficient organizational infrastructure.

Psychological Pathways and Stress Responses

The clinical work with individuals with ASPD confronts psychologists with a distinctive set of psychological pathways and stress responses that require careful understanding. At the level of the patient, ASPD is characterized by specific patterns of affect regulation, interpersonal engagement, and self-organization that shape the therapeutic encounter in ways that differ significantly from work with other personality disorders. At the level of the clinician, these same patterns evoke predictable emotional responses that, if unmanaged, can compromise both the therapist's well-being and the patient's treatment.

The interpersonal patterns of individuals with ASPD have been described in numerous clinical accounts. McWilliams (1994) noted that patients with antisocial personality typically exhibit behavioral patterns characterized by manipulation, lack of trust, cooperation difficulties, non-compliance, and defensiveness over the course of treatment. Ruszczynski (2010) observed that these patients tend to struggle to deal with challenging internal states and consequently project their internal world and problems onto their surroundings. The psychological result is a form of interpersonal engagement in which the therapist becomes not a collaborator in exploration but a container for projected affect—a container that is often experienced by the therapist as being intruded upon, exploited, or attacked.

Schwartz et al. (2007) provided important empirical documentation of the specific quality of these interpersonal encounters. Comparing therapist responses to patients with ASPD versus schizophrenia, they found that participants displayed significantly stronger feelings of being dominated by individuals with ASPD, indicating that they felt exploited, manipulated, bossed around, talked down to, and dominated. These feelings were relatively independent of therapist demographic characteristics or theoretical orientation, suggesting that they represent a fairly universal response to the interpersonal style of ASPD. The pattern is consistent with what Meloy and Yakeley (2014) described as characteristic countertransference reactions to ASPD, including therapeutic nihilism, illusory treatment alliance, fear of assault, denial and deception, helplessness and guilt, devaluation and loss of professional identity, hatred and the wish to destroy, assumption of psychological complexity, fascination, and sexual attraction.

The developmental origins of these interpersonal patterns are increasingly understood. The high rates of childhood trauma documented by Semiz et al. (2007) and others suggest that many individuals with ASPD have adapted to environments in which trust was dangerous, vulnerability was exploited, and relationships were structured around dominance and

submission rather than mutual recognition. From this developmental perspective, the interpersonal style that characterizes adult ASPD is not merely dysfunctional but represents a coherent adaptation to specific developmental conditions—an adaptation that persists into contexts where it is no longer adaptive and where it produces significant psychological suffering both for the individual and for those around them.

The stress responses evoked in clinicians by these interpersonal patterns are correspondingly distinctive. Beyond the specific countertransference reactions documented in quantitative studies, qualitative research has provided detailed descriptions of the emotional experience of working with ASPD. Morken et al. (2022) described how therapists must "endure interacting with patients who are without boundaries and often trespass the therapist level of comfort." Patients may make derogatory comments about women, ask intrusive personal or sexual questions, or discuss violence and drug use in ways that violate typical social norms. The therapists in their study described feeling entertained by the easy-going and playful tone of these interactions, but also finding themselves cognitively fatigued, losing capacity to intervene emotionally, and being drawn into what they termed the "antisocial logic" in which violence appears reasonable.

Perhaps most striking are the reports of changes in therapists' functioning outside the therapy room. Some therapists in the Morken et al. (2022) study reported becoming more externalizing and less anxious in private situations, while others reported increased fear and hypervigilance. One therapist described witnessing an aggressive incident on a playground and standing frozen rather than removing herself and her children from the situation—a response she recognized as inconsistent with her values and behavior prior to working with ASPD patients. These accounts suggest that working with ASPD may produce subtle but consequential shifts in therapists' tolerance for aggression and violence, shifts that require monitoring and supervision to prevent problematic effects on the therapist's broader life.

The stress responses that characterize this work extend beyond individual therapist experience to organizational and systemic levels. Warner and Keenan (2022) documented how clinicians in an under-resourced MBT-ASPD community program felt responsible for insufficient service infrastructure and breached their own time boundaries to support clients, risking burnout and emotional exhaustion. Their sense of professional identity was threatened, and they engaged in self-sacrifice partly to protect their sense of themselves as competent and comprehensive professionals. This account provides an important reminder that clinician stress responses are shaped not only by patient characteristics but by the

organizational and systemic contexts within which clinical work occurs.

The management of these stress responses has emerged as a central topic in the ASPD treatment literature. Hayes et al. (2018), in a meta-analytic synthesis, found that better countertransference management was associated with better treatment outcomes across psychotherapies generally. Features that facilitate countertransference management include higher levels of self-insight, conceptualizing capacities, empathy, self-integration abilities, and anxiety management. Importantly, the therapist's relationship to countertransference—rather than the presence or absence of countertransference itself—determines whether these emotional responses become therapeutic resources or obstacles.

Within specialized treatments for ASPD, explicit attention to countertransference is a defining feature. MBT-ASPD encourages therapists to engage in the "juxtaposition of their own mental states"—clearly and directly communicating to the patient what kinds of feelings different topics evoke (Bateman et al., 2013). This is particularly important when patients discuss difficult subjects in a boundaryless way, as juxtaposition can contrast their views and stimulate mentalization. The therapist thereby models authenticity and willingness to explore one's own feelings openly, while also demonstrating how mentalizing capacity can be regained after moments of failure (Karterud et al., 2020).

Morken et al. (2022) offered practical recommendations for countertransference management in MBT-ASPD, emphasizing clear procedures including peer supervision, regular communication among therapists about their reactions, the maintenance of an open and supportive mentalizing environment among clinicians, and strict adherence to the treatment format. The video-based supervision that is standard in MBT provides a structural mechanism for these processes, allowing therapists to review their own interventions and receive feedback on the quality of their mentalizing stance. Female therapists in particular may benefit from specific attention to countertransference, as the misogynistic behavior common in male ASPD patients can pose distinctive challenges to maintaining a mentalizing stance.

Mental Health Outcomes and Severity Spectrum

The clinical presentation of ASPD spans a considerable severity spectrum, from individuals whose antisocial behavior is relatively contained and whose social functioning is preserved to those whose behavior produces catastrophic consequences for themselves and others. Understanding this spectrum is essential for clinical assessment, treatment planning, and prognostic evaluation. Yet the field has struggled to develop consensus frameworks for characterizing severity, in part because different theoretical approaches emphasize different dimensions of the disorder.

The dimensional approach to personality disorders that has emerged in ICD-11 and the alternative model of DSM-5 provides one framework for severity assessment. In this approach, ASPD is characterized by trait combinations within the domains of antagonism and disinhibition, with severity determined by the degree of impairment in self and interpersonal functioning (Mark et al., 2022; Mulder, 2021). This framework has the advantage of capturing gradations of severity that categorical diagnosis obscures, and it aligns with contemporary understanding that personality pathology varies along continuous dimensions rather than falling into discrete kinds.

Within the categorical framework, however, several clinically important distinctions along the severity spectrum have been proposed. The distinction between primary and secondary psychopathy, as elaborated by Wall et al. (2015), differentiates between individuals whose antisocial behavior emerges from callousness and low stress reactivity (primary psychopathy) and those whose behavior is driven by high aggression, impulsivity, and affective reactivity (secondary psychopathy). This distinction has clinical implications, as the treatment implications differ substantially. Primary psychopathy, characterized by boldness and reduced anxiety, may be less amenable to interventions focused on emotional processing, while secondary psychopathy may respond more readily to affect-focused approaches.

De Visser et al. (2023) proposed a more differentiated framework that identifies multiple pathways to antisocial behavior, each with distinct clinical implications. Their framework distinguishes among individuals with ASPD and psychopathic features, those with attachment-related disturbances and mistrust, and those with core deficits in mentalizing others. Each pathway warrants different therapeutic emphases. For individuals with prominent psychopathic features, cognitive remediation or risk reduction approaches are recommended; the theoretical model of MBT is thought to fit psychopathy poorly (Poythress et al., 2010), and the lack of motivation to mentalize others limits the utility of mentalization-based approaches. For those with attachment-related disturbances, trauma-focused interventions may be

indicated. For those whose core difficulty involves impaired mentalization, MBT offers particular promise.

The mental health outcomes associated with ASPD are extensive and consequential. Individuals with ASPD are at substantially elevated risk for a range of comorbid conditions, including a fourfold higher risk of mood disorders, a twofold increased risk of anxiety disorders, a thirteenfold risk of substance use disorders, and a seven- to ninefold increased risk of suicide (Alegria et al., 2013; Goodwin & Hamilton, 2003; Werner et al., 2015). The high comorbidity with substance use disorders is particularly significant given the clinical presentation of many individuals with ASPD, who often present initially for substance-related concerns rather than for personality difficulties. Studies indicate correlations between ASPD and SUD as high as 90 percent (Goldstein et al., 2007), and in patient populations with SUD, ASPD appears to be the most common personality disorder, present in approximately 22 percent of cases (Verheul, 2001).

The high comorbidity between ASPD and SUD reflects shared etiological pathways, including impulsivity and reward-related mechanisms (Verheul & van den Brink, 2005). This shared etiology has important implications for treatment. Interventions that address only substance use without attention to underlying personality pathology may produce limited or short-lived effects, while interventions that address personality pathology without attention to substance use may fail to engage the presenting concerns that brought the patient to treatment. Integrated approaches that address both dimensions—such as MBT-SUD or ILC—offer theoretical and empirical advantages, though the evidence base for such integration remains modest.

The consequences of ASPD extend beyond the individual to substantial societal costs. Individuals with ASPD are overrepresented in the criminal justice system, though it is important to note that not all individuals with ASPD engage in criminal behavior (National Institute for Health and Care Excellence, 2015). The correlation between ASPD and criminal justice involvement varies across settings and populations, and clinicians working with the disorder should avoid the conflation of ASPD with criminality. Nevertheless, the elevated rates of offending among individuals with ASPD represent a significant public health and safety concern, and interventions that reduce offending—such as the ILC program studied by Hesse et al. (2022)—address both individual and societal outcomes.

The severity spectrum of ASPD also intersects with mentalizing capacity in clinically significant ways. Bateman (2022) noted that compared to other personality disorders, mentalizing failures in ASPD are more globally severe and more closely linked to attachment system activation triggered by threats to identity or self. This observation has clinical implications: interventions must be calibrated to the patient's current mentalizing capacity, which may fluctuate substantially in response to interpersonal and contextual stressors. Newbury-Helps et al. (2017) documented that non-mentalizing and hypo-mentalizing were more pronounced in offenders with ASPD than in offenders without ASPD or non-offender controls, suggesting that mentalizing deficits may serve as markers of severity within the antisocial spectrum.

Two studies have provided evidence that mentalization-based treatment may be more effective for patients with more severe personality problems. Bateman and Fonagy (2013) reported that clinical severity moderated MBT outcomes for BPD, with more severely impaired patients showing greater benefit. Kvarstein et al. (2018) replicated this finding in a study comparing MBT to psychodynamic treatment programs, again finding that patients with more severe personality problems responded particularly well to MBT. These findings, while pertaining to BPD, provide indirect support for the potential effectiveness of MBT with more severely impaired ASPD patients, though direct empirical evidence for this claim remains limited.

The gender dimension of ASPD severity deserves specific attention. ASPD is diagnosed substantially more often in men than in women, with sex ratios varying across studies but consistently showing male predominance (Alegria et al., 2013). The reasons for this gender difference are contested, with some researchers arguing that diagnostic criteria are biased toward male manifestations of antisocial behavior and others proposing genuine sex differences in prevalence. The empirical literature on treatment has largely focused on male populations, and MBT-ASPD in particular has been developed and tested primarily with male patients (Bateman et al., 2019). This limitation is significant, as it constrains generalization to female populations and leaves substantial questions about optimal treatment approaches for women with ASPD unanswered.

System-Level and Contextual Psychological Effects

The provision of clinical care to individuals with ASPD occurs within organizational and systemic contexts that profoundly shape outcomes. Understanding these contextual factors is essential for psychologists working with the disorder, as individual clinical competence is necessary but not sufficient for effective treatment. The organizational infrastructure within which treatment is delivered, the training and supervision available to clinicians, the funding models that support or constrain intensive interventions, and the broader cultural attitudes toward antisocial behavior all contribute to the actual effectiveness of clinical work.

The stark differences between forensic and non-forensic settings provide a particularly informative illustration of these contextual effects. Van Dam et al. (2022) documented that approximately 60 percent of clinicians working in regular mental health services indicated they were not motivated to work with ASPD patients, with only 12 percent expressing motivation. Among clinicians in forensic mental health settings, in contrast, 65 percent expressed motivation to work with this population. This dramatic difference cannot be attributed solely to clinical experience or training, as the study found that these variables did not fully explain the differential in motivation. Instead, the difference appears to reflect a distinct clinical culture that has developed in forensic settings, where ASPD is a common presentation, treatment is often mandated, and clinicians have developed frameworks for engagement that regular mental health settings have not.

The forensic context imposes constraints that paradoxically may facilitate rather than impede therapeutic engagement. As Lo Buglio et al. (2025) noted, in forensic contexts clinicians often lack the option to reject patients—who are typically mandated to treatment by the court—fostering continuous exposure that over time may reduce initial resistance and trepidation. This continuous exposure, combined with institutional expectations for treatment provision, produces a mindset in which forensic clinicians learn to engage with ASPD patients more intentionally and strategically. Non-forensic clinicians, who typically have more discretion about which patients to accept, may feel free to avoid these cases, perceiving them as untreatable and thereby precluding the accumulation of experience that might change this perception.

The most significant predictor of willingness to work with ASPD, according to van Dam et al. (2022), is perceived behavioral control—the clinician's sense of having the knowledge and skills necessary to provide effective treatment. This finding, grounded in the theory of planned behavior (Ajzen, 2013), has important implications for training and supervision. Clinicians who

feel competent to work with a challenging population are more willing to do so, and their willingness in turn produces the experience that reinforces competence. Conversely, clinicians who feel incompetent avoid the work, producing a self-reinforcing cycle of avoidance and lack of competence. Breaking this cycle requires structured training, clear treatment manuals, ongoing supervision, and organizational support—the elements that specialized treatments such as MBT-ASPD explicitly provide.

The role of clear treatment manuals in enabling clinical work with ASPD deserves particular emphasis. Unstructured treatment approaches leave clinicians without clear guidance about how to intervene in the moment-to-moment challenges that ASPD presents. Manualized treatments provide not only intervention strategies but also a shared framework that enables meaningful supervision and peer consultation. Within MBT, the specification of overarching principles (such as the not-knowing stance and the maintenance of structure) and specific interventions provides clinicians with a coherent framework for navigating clinical challenges. The video-based supervision that is standard in MBT further enables both quality control and clinician development.

Van den Bosch et al. (2018) provided an important perspective on the managerial and organizational conditions that shape treatment delivery for patients with ASPD. Their practice-focused framework emphasized that treatment effectiveness depends not merely on the specific intervention delivered but on the entire organizational context, including leadership, team functioning, training, and supervision. This perspective is supported by findings from the Netherlands documenting that organizational turmoil in an inpatient facility delivering MBT reduced effect sizes on outcomes by half, even though no changes occurred at the team or therapist level (Bales et al., 2017). The organizational and systemic context of treatment is not incidental to outcomes but constitutes an essential component of effective care.

The cultural attitudes toward ASPD that pervade both professional and lay contexts represent another important systemic influence. The therapeutic pessimism documented across multiple studies is not simply an individual clinician characteristic but a broader cultural phenomenon that shapes recruitment into the field, training curricula, funding priorities, and organizational structures. Beryl and Völlm (2018) found that the ASPD label itself could negatively affect clinicians' attitudes toward treatment outcomes, and Eren and ■ahin (2016) documented that mental health professionals considered ASPD difficult to treat compared to other personality disorders and held negative attitudes toward these patients. These attitudes function as

barriers to treatment access, as patients diagnosed with ASPD may be refused admission to services or excluded from treatment programs on the basis of their diagnosis (van Dam et al., 2022).

The reduction of stigma and pessimism requires intervention at multiple levels. At the level of individual clinicians, education about the developmental origins of ASPD—understanding it as a disorder rooted in insecure attachment and childhood trauma rather than as evidence of moral defect—can shift attitudes and increase willingness to engage. At the level of teams and organizations, the establishment of specialized services with dedicated training and supervision can concentrate expertise and create environments in which competent care becomes possible. At the level of the broader health system, funding models that support intensive, specialized interventions and that recognize the long-term societal costs of untreated ASPD can enable the development of the necessary infrastructure.

The role of family and social systems in ASPD treatment has received less attention than it warrants. NICE guidelines (2010) underline the importance of including family and caregivers in treatment, but few evidence-based programs for family involvement with ASPD have been developed. For borderline personality disorder, MBT has implemented a Family and Carers Training and Support (FACTS) program that teaches families about BPD and provides basic skills for managing common problems. Bateman et al. (2019) documented that this program reduced adverse incidents within families in a randomized controlled trial. Analogous programs for ASPD have not been developed, though the theoretical rationale for family involvement is comparable: the family environment can provide crucial collateral information, can be shaped to support rather than undermine treatment goals, and can be improved as a therapeutic outcome in its own right.

The interdisciplinary and cross-sector coordination that ASPD often requires poses distinctive systemic challenges. Individuals with ASPD may simultaneously be involved with mental health services, addiction treatment, criminal justice systems, child protective services, and social welfare agencies. Each of these systems operates with its own logic, priorities, and constraints, and coordination among them is often inadequate. The development of effective treatment approaches for ASPD requires attention not only to what happens within individual therapeutic encounters but to how these encounters are situated within and supported by broader systemic arrangements.

Clinical Implications for Psychologists

The synthesis of contemporary research on ASPD carries substantial implications for how psychologists conceptualize, assess, and treat individuals with this diagnosis. These implications extend across multiple domains of clinical practice, from initial assessment through treatment planning, moment-to-moment intervention, and management of the clinician's own responses. Rather than adopting a nihilistic stance toward this population, contemporary evidence supports a stance of cautious therapeutic optimism grounded in specific knowledge about what appears to work and the conditions under which it works.

At the level of assessment, the differentiation between ASPD with and without significant psychopathic features represents an essential clinical task. The evidence reviewed above suggests that these may represent qualitatively different presentations warranting different treatment approaches, and confusing the two can prevent appropriate care for both (Ogloff et al., 2016). Psychologists working with this population should be familiar with structured assessment tools for both constructs, including the PCL-R for psychopathy and the SCID-5-PD for ASPD. The assessment should extend beyond categorical diagnosis to include a mentalizing profile that identifies the specific combinations of mentalizing strengths and weaknesses characteristic of the individual patient. This profile provides crucial information for treatment planning, indicating which interventions are likely to prove beneficial.

The developmental history assessment deserves particular emphasis. Given the high rates of childhood trauma, neglect, and attachment disruption among individuals with ASPD, careful attention to developmental experiences is essential both for accurate case formulation and for the establishment of a therapeutic relationship. When patients recognize that their clinician is genuinely interested in understanding the developmental origins of their difficulties rather than merely cataloging their misdeeds, epistemic trust may begin to develop. The developmental frame also provides an alternative to punitive attitudes that many patients have internalized, offering the possibility of understanding rather than judgment.

In treatment planning, the current evidence supports several general principles. First, specialized psychotherapy appears to outperform treatment as usual, though the magnitude of superiority and the specific interventions that produce it remain under investigation. Second, treatment should be voluntary and collaborative in orientation, with the patient

participating actively in setting treatment goals rather than being subjected to interventions imposed from outside. Third, treatment should include both individual and group components where possible, as group therapy provides a specific arena for addressing the interpersonal difficulties characteristic of ASPD. Fourth, treatment should attend to co-occurring substance use disorders and other comorbidities, either through integrated approaches or through careful coordination among providers.

The therapeutic stance recommended across specialized treatments for ASPD has several consistent features. The clinician should be authoritative but not authoritarian—capable of maintaining boundaries and expectations while avoiding the hierarchical positioning that many patients experience as inviting resistance. The clinician should be genuinely curious about the patient's mental states, adopting a "not-knowing stance" that models the mentalizing capacity being developed while also communicating respect for the patient's autonomy. The clinician should be non-judgmental about the patient's history and behavior while remaining clear about ethical limits and the harmful consequences of certain actions. And the clinician should be transparent about their own mental states, using judicious self-disclosure to model authenticity and to contrast with the patient's teleological explanations of interpersonal events.

Aerts et al. (2023) identified several specific aspects of establishing therapeutic alliance with ASPD patients that deserve emphasis. Respecting the patient's needs, regulating interpersonal dynamics, adopting a connective attitude, following the treatment process, and striving for collaborative and tailored goals all contribute to alliance development. Importantly, these clinicians emphasized that without a strong therapeutic alliance, collaboration can be lost at any moment, leading to treatment failure. The alliance in ASPD treatment is therefore not merely a preliminary condition for therapeutic work but an ongoing accomplishment that must be continually maintained.

The management of countertransference represents perhaps the most demanding aspect of clinical work with ASPD. The evidence reviewed above indicates that specific negative countertransference responses are highly probable, largely independent of therapist characteristics, and potentially damaging both to treatment outcomes and to therapist well-being. Effective countertransference management requires several elements. First, clinicians must have adequate opportunity to become aware of their emotional responses, which supervision and peer consultation can facilitate. Second, clinicians must have frameworks for understanding these responses as containing information about the patient's internal world rather than as evidence of clinical failure. Third, clinicians must have techniques

for using countertransference within therapy in ways that stimulate rather than close down mentalizing processes.

Within MBT specifically, the mentalizing of the transference offers a technical framework for using countertransference therapeutically (Bateman & Fonagy, 2010). Rather than making transference interpretations in the classical psychoanalytic sense, the MBT clinician actively encourages the patient to focus on and work with the therapeutic relationship in the present moment, orienting the patient's attention toward another person's mind. This process can facilitate mentalization by contrasting the patient's perception of themselves with the therapist's perception of them. The therapist's countertransference is used not to formulate an interpretation but to inform the ongoing therapeutic dialogue about what is occurring in the relationship.

The clinical implications extend to the therapist's self-care and professional development. Working with ASPD produces predictable stress responses that can affect the therapist's functioning outside the therapy room. Regular supervision that specifically addresses countertransference, adequate case-mix so that ASPD does not dominate the therapist's caseload, and attention to the therapist's own attachment history and vulnerabilities all contribute to sustainable practice with this population. The isolation that many clinicians working with ASPD experience—the sense that colleagues do not understand the specific challenges or share the caseload—can be mitigated through participation in specialized teams, professional networks, and ongoing training.

The ethical dimensions of work with ASPD deserve explicit attention. Psychologists have ethical obligations to provide competent care to those who seek it, and the systematic exclusion of ASPD patients from services on the basis of diagnosis raises significant ethical concerns. As NICE guidelines (2010) emphasize, society has an ethical obligation to provide care to those suffering from mental health disorders, including those whose disorders manifest in socially problematic ways. This ethical stance does not diminish accountability for harmful behavior; individuals with ASPD, like other patients, remain responsible for their actions. But the recognition of accountability coexists with the recognition of pathology and the ethical obligation to offer treatment.

For clinicians working in settings that historically have not served ASPD patients well, several concrete steps may improve practice. Development of specific competencies through training in evidence-informed approaches such as MBT-ASPD or ILC can equip clinicians for effective

work. Consultation with colleagues who have expertise with this population can support case management and countertransference processing. Advocacy within organizations for the inclusion of ASPD in service planning can address system-level barriers to access. And engagement with the broader professional community around the treatment of ASPD can contribute to the reduction of stigma and pessimism that impede care.

Future Directions and Research Gaps

Despite substantial recent progress in the conceptualization and treatment of ASPD, the field faces numerous unresolved questions and important research gaps. The identification of these gaps is essential both for guiding future investigation and for framing appropriate humility about current clinical practice. The evidence base for ASPD treatment remains, by consensus, insufficient, and psychologists working with this population must combine evidence-informed practice with recognition of the limits of current knowledge.

The most pressing research need concerns the effectiveness of specialized treatments in adequately powered randomized controlled trials. The recent MOAM trial (Fonagy et al., 2025) provides the most robust evidence to date for MBT-ASPD, and its findings that MBT reduced individual self-defeating and interpersonally violent core features represent an important advance. However, replication across settings and populations, longer follow-up periods, and comparison with other specialized approaches are needed. The ongoing German trial of MBT for adolescents with conduct disorder (Taubner et al., 2021) will provide important information about early intervention, and additional trials examining schema therapy, dialectical behavior therapy adapted for ASPD, and other approaches would enrich the evidence base.

The differential effectiveness of treatments for subgroups within the ASPD population represents another important research direction. The framework proposed by De Visser et al. (2023) suggests that different pathways to antisocial behavior may warrant different therapeutic approaches, and empirical investigation of this proposition would be valuable. Studies matching treatments to specific patient characteristics—psychopathic features, attachment style, mentalizing profile, trauma history, comorbidity patterns—could substantially advance the field beyond one-size-fits-all approaches.

Female patients with ASPD represent a critically underserved research population. The existing evidence base has focused almost exclusively on men, and the applicability of findings to women remains unknown. Given that the manifestations of ASPD may differ across genders and that women may present with distinct developmental histories, comorbidity patterns, and interpersonal contexts, dedicated research on female ASPD is needed. This research should attend not only to treatment outcomes but to fundamental questions about how ASPD is expressed and experienced in women.

The relationship between ASPD and psychopathy warrants continued investigation. The current status of the field, in which both dimensional and categorical models are defended and clinicians often use the terms interchangeably, produces confusion and impedes both research and practice. Empirical investigations that could resolve or clarify this relationship include longitudinal studies of stability and change across the two constructs, treatment studies examining differential responsiveness, and neurocognitive research examining shared and distinct mechanisms. Until these questions are resolved, careful attention to the specific construct being studied and the clinical implications of the distinction remain essential.

The mechanisms of change in ASPD treatment represent an important but understudied area. While specialized treatments have demonstrated some effectiveness, the psychological processes through which change occurs remain unclear. Process studies examining how patients change in MBT-ASPD or ILC, what specific therapist behaviors facilitate change, and what patient factors moderate treatment response would substantially advance the field. Qualitative investigations of patients' experiences of change, complementing the therapist-focused studies that have dominated the literature to date, could illuminate these processes.

The systemic and organizational conditions that support effective treatment delivery warrant dedicated research attention. Van den Bosch et al. (2018) provided an important starting framework, and Bales et al. (2017) documented the substantial effects of organizational conditions on treatment outcomes. Further research examining how team functioning, supervision structures, training protocols, and funding models shape treatment effectiveness would provide crucial information for service development. Comparative studies of forensic and non-forensic settings, examining what enables the higher motivation and engagement observed in forensic contexts, could inform improvements in regular mental health services.

Family involvement in ASPD treatment represents another important research direction. The FACTS program developed for BPD offers a model that might be adapted for ASPD, and evaluation of family-focused interventions with this population would address a significant gap in current treatment approaches. Given the substantial impact of ASPD on family members and the potential for family systems to either support or undermine treatment progress, this research direction warrants priority attention.

Prevention and early intervention represent perhaps the most promising long-term directions. The developmental understanding of ASPD as rooted in insecure attachment and childhood trauma implies that intervention with children and adolescents at risk could substantially alter developmental trajectories. NICE guidelines (2010) recommend early intervention for children with conduct disorder, and the MBT-CD approach studied by Hauschild et al. (2023) provides one framework for such intervention. Further research examining how to identify high-risk children, what interventions are most effective in altering developmental trajectories, and how to implement these interventions at scale would have substantial public health implications.

The intersection of ASPD with the criminal justice system deserves continued research attention. Most existing research has been conducted with offender populations or in forensic settings, but the applicability of findings to non-offender individuals with ASPD is unclear. Studies examining the full spectrum of ASPD presentations, including those without significant criminal justice involvement, would provide a more complete picture of the disorder and its treatment needs. The register-based approach used by Hesse et al. (2022) offers one methodological approach for examining criminal justice outcomes in treatment research, and broader use of such approaches would strengthen the evidence base.

Cultural dimensions of ASPD and its treatment remain substantially underexplored. Most existing research has been conducted in European and North American contexts, and the cross-cultural applicability of both diagnostic constructs and treatment approaches is uncertain. Studies examining how ASPD is expressed, understood, and treated across different cultural contexts would enrich both theoretical understanding and clinical practice. The high proportion of research from specific countries and settings (particularly Norway, the UK, Netherlands, and Italy in the recent literature) reflects the concentration of specialized research programs in these contexts and highlights the need for broader international investigation.

Finally, the role of pharmacological interventions in ASPD treatment remains underexplored. While psychosocial interventions have received most research attention, medications targeting specific features of ASPD—impulsivity, aggression, comorbid mood or anxiety symptoms—may play adjunctive roles in comprehensive treatment. The relative absence of pharmacological research in this population is striking and represents an important gap in the evidence base.

Conclusion

The clinical landscape of antisocial personality disorder has begun to shift meaningfully in recent years, though the transformation remains incomplete. The therapeutic pessimism that has historically pervaded work with this population is giving way to cautious optimism grounded in specific advances in conceptualization, assessment, and treatment. The mentalization-based framework has provided a coherent theoretical account of ASPD as a developmental disorder rooted in attachment disturbance and impaired mentalization, opening therapeutic possibilities that a purely behavioral framework would foreclose. The development of specialized treatments including MBT-ASPD and ILC has produced preliminary evidence that specific psychotherapeutic interventions can reduce aggression, offending, and psychosocial impairment in individuals with ASPD. The empirical investigation of clinician countertransference has documented the specific emotional challenges of this work and provided frameworks for their management.

Yet substantial obstacles remain. The evidence base for ASPD treatment is still modest, characterized by small samples, methodological heterogeneity, and insufficient replication. The confusion between ASPD and psychopathy continues to impede both research and practice. The systematic exclusion of ASPD patients from many mental health services persists, driven by clinician pessimism, organizational disincentives, and cultural attitudes that view antisocial behavior as beyond therapeutic reach. The training and supervision infrastructure needed to support competent clinical work with this population remains inadequate in most settings.

For psychologists working with individuals with ASPD, the current evidence base supports several core commitments. First, clinical work with this population is possible and can be

effective, particularly when supported by specialized training, adequate supervision, and appropriate organizational conditions. Second, effective work requires both technical competence in specific interventions and the capacity to manage the distinctive emotional challenges that ASPD evokes. Third, the developmental understanding of ASPD as rooted in attachment and mentalization difficulties provides both a theoretical foundation for treatment and an antidote to the punitive attitudes that have historically pervaded work with this population. Fourth, systemic and organizational factors profoundly shape clinical outcomes, and psychologists have both professional and ethical responsibilities to advocate for the conditions that enable competent care.

The individuals who receive an ASPD diagnosis are, in most cases, individuals who have suffered substantially in their own developmental histories and who continue to suffer in their current lives, even as their behavior produces suffering for others. The ethical obligation of psychologists to provide competent care to those who seek it applies to this population as fully as to any other. Meeting this obligation requires not only individual clinical competence but sustained engagement with the systemic conditions that determine whether such care can be delivered. The past two decades of research have provided psychologists with better tools than ever before for this work, and the coming decade will likely see further advances that make competent treatment of ASPD increasingly possible. Individuals with ASPD, like all people with mental disorders, deserve access to evidence-informed, ethically delivered psychological care. The challenge before the field is to translate the advances in understanding and treatment into consistently accessible clinical services that serve this historically underserved population.

The transformation from therapeutic pessimism to grounded optimism in the treatment of ASPD parallels a similar transformation that occurred earlier with borderline personality disorder. When BPD was once regarded as untreatable, the development and validation of specialized treatments including MBT, dialectical behavior therapy, transference-focused psychotherapy, and schema therapy transformed the clinical landscape. Today, six or more evidence-based treatments for BPD are available (Storebø et al., 2020), and patients with BPD who previously would have been denied care can access effective treatment. There is no principled reason to expect that ASPD cannot undergo a similar transformation. The theoretical frameworks are available, the initial evidence base is emerging, and specialized treatments are being developed and refined. What remains is the sustained clinical, research, and advocacy work needed to translate these advances into widely accessible services.

For the practicing psychologist, the work with individuals with ASPD is unlikely ever to be easy. The countertransference challenges, the interpersonal difficulties, the systemic obstacles, and the complexity of the presentation all conspire to make this among the most demanding areas of clinical practice. But it is also among the most consequential. Individuals with ASPD suffer significantly, cause suffering to others, and impose substantial costs on society. Effective treatment that reduces this suffering and these costs represents a substantial contribution to both individual and public welfare. The psychologists who develop competence in this work, who advocate for the systems that support it, and who contribute to the ongoing accumulation of knowledge about how to treat this disorder are engaged in work of genuine significance. This continuing education manual has aimed to support psychologists in taking up this work with both the technical competence and the therapeutic optimism that it requires.

References

Aerts, J. E. M., Rijckmans, M. J. N., Bogaerts, S., & Van Dam, A. (2023). Establishing an optimal working relationship with patients with an antisocial personality disorder. Aspects and processes in the therapeutic alliance. *Psychology and Psychotherapy: Theory, Research and Practice, 96*, 999–1014. https://doi.org/10.1111/papt.12492

Ajzen, I. (2013). Theory of planned behaviour questionnaire. *Measurement Instruments Database for the Social Sciences, 2*, 1–10.

Alegria, A. A., Petry, N. M., Liu, S.-M., Blanco, C., Skodol, A. E., Grant, B., & Hasin, D. (2013). Sex differences in antisocial personality disorder: Results from the National Epidemiological Survey on Alcohol and Related Conditions. *Personality Disorders: Theory, Research, and Treatment, 4*, 214–222. https://doi.org/10.1037/a0031681

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Bales, D. L., Timman, R., Luyten, P., Busschbach, J., Verheul, R., & Hutsebaut, J. (2017). Implementation of evidence-based treatments for borderline personality disorder: The impact

of organizational changes on treatment outcome of mentalization-based treatment. *Personality and Mental Health, 11*(4), 266–277.

Bateman, A. (2022). Mentalizing and group psychotherapy: A novel treatment for antisocial personality disorder. *American Journal of Psychotherapy, 75*(1), 32–37.

Bateman, A., Bales, D., & Hutsebaut, J. (2014). *A quality manual for MBT*.

Bateman, A., Bolton, R., & Fonagy, P. (2013). Antisocial personality disorder: A mentalizing framework. *Focus, 11*, 178–186. https://doi.org/10.1176/appi.focus.11.2.178

Bateman, A., Campbell, C., & Fonagy, P. (2021). Rupture and repair in mentalization-based group psychotherapy. *International Journal of Group Psychotherapy, 71*(2), 371–392.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry, 156*, 1563–1569. https://doi.org/10.1176/ajp.156.10.1563

Bateman, A., & Fonagy, P. (2008a). Comorbid antisocial and borderline personality disorders: Mentalization-based treatment. *Journal of Clinical Psychology, 64*, 181–194.

Bateman, A., & Fonagy, P. (2008b). 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165*, 631–638.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry, 9*, 11–15.

Bateman, A., & Fonagy, P. (2013). Impact of clinical severity on outcomes of mentalisation-based treatment for borderline personality disorder. *British Journal of Psychiatry, 203*(3), 221–227.

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.

Bateman, A., Gunderson, J., & Mulder, R. (2015). Treatment of personality disorder. *The Lancet, 385*(9969), 735–743.

Bateman, A., Motz, A., & Yakeley, J. (2019). Antisocial personality disorder in community and prison settings. In A. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (2nd ed.). American Psychiatric Association Publishing.

Bateman, A., O'Connell, J., Lorenzini, N., Gardner, T., & Fonagy, P. (2016). A randomised controlled trial of mentalization-based treatment versus structured clinical management for patients with comorbid borderline personality disorder and antisocial personality disorder. *BMC Psychiatry, 16*, 304. https://doi.org/10.1186/s12888-016-1000-9

Bender, D. S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice, 11*, 73–87.

Berg, J. M., Smith, S. F., Watts, A. L., Ammirati, R., Green, S. E., & Lilienfeld, S. O. (2013). Misconceptions regarding psychopathic personality: Implications for clinical practice and research. *Neuropsychiatry, 3*, 63–74.

Bernstein, D. P., Keulen-de Vos, M., Clercx, M., De Vogel, V., Kersten, G. C., Lancel, M., et al. (2023). Schema therapy for violent PD offenders: A randomized clinical trial. *Psychological Medicine, 53*, 88–102.

Beryl, R., & Völlm, B. (2018). Attitudes to personality disorder of staff working in high-security and medium-security hospitals. *Personality and Mental Health, 12*, 25–37.

Betan, E., Heim, A. K., Zittel Conklin, C., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry, 162*(5), 890–898.

Bo, S., & Kongerslev, M. T. (2016). Teorier om psykopati. In M. K. F. Kreis, H. A. Hoff, H. Belfrage, & S. D. Hart (Eds.), *Psykopati*. Hans Reitzels Forlag.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252–260.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Cavalera, C., Boldrini, A., Merelli, A. A., Squillari, E., Politi, P., Pagnini, F., et al. (2021). Psychotherapists' emotional reactions to patients' personality trait in personality disorder treatment settings: An exploratory study. *BMC Psychology, 9*, 74.

Chanen, A. M., McCutcheon, L. K., Jovev, M., Jackson, H. J., & McGorry, P. D. (2007). Prevention and early intervention for borderline personality disorder. *Medical Journal of Australia, 187*, S18–S21.

Choi-Kain, L. W., Finch, E. F., Masland, S. R., Jenkins, J. A., & Unruh, B. T. (2017). What works in the treatment of borderline personality disorder. *Current Behavioral Neuroscience Reports, 4*, 21–30.

Choi-Kain, L. W., & Unruh, B. T. (2016). Mentalization-based treatment: A common-sense approach to borderline personality disorder. *Psychiatric Times, 33*, 1–3.

Cleckley, H. (1988). *The mask of sanity*. Mosby.

Coid, J., & Ullrich, S. (2010). Antisocial personality disorder is on a continuum with psychopathy. *Comprehensive Psychiatry, 51*, 426–433.

Colli, A., & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry, 28*, 46–56.

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *American Journal of Psychiatry, 171*, 102–108.

De Visser, D. W., Rijckmans, M., Vermunt, J. K., & Van Dam, A. (2023). Pathways to antisocial behavior: A framework to improve diagnostics and tailor therapeutic interventions. *Frontiers in Psychology, 14*, 993090.

Di Virgilio, P., De Page, L., & Titeca, P. (2021). Countertransference in forensic patients with psychosis: Associations with symptomatology, inpatient violence, and psychopathic personality traits. *Journal of Forensic Psychology Research and Practice, 22*, 1–16.

Dolan, M., & Doyle, M. (2000). Violence risk prediction. Clinical and actuarial measures and the role of the psychopathy checklist. *British Journal of Psychiatry, 177*, 303–311.

Dolan, M., & Fullam, R. (2004). Theory of mind and mentalizing ability in antisocial personality disorders with and without psychopathy. *Psychological Medicine, 34*, 1093–1102.

Dyson, H., & Brown, D. (2016). The experience of mentalization-based treatment: An interpretative phenomenological study. *Issues in Mental Health Nursing, 37*, 586–595.

Eren, N., & ■ahin, S. (2016). An evaluation of the difficulties and attitudes mental health professionals experience with people with personality disorders. *Journal of Psychiatric and Mental Health Nursing, 23*, 22–36.

Fauth, J. (2006). Toward more (and better) countertransference research. *Psychotherapy: Theory, Research, Practice, Training, 43*, 16–31.

Flaaten, E., Langfeldt, M., & Morken, K. T. E. (2024). Antisocial personality disorder and therapeutic pessimism—how can mentalization-based treatment contribute to an increased therapeutic optimism among health professionals? *Frontiers in Psychology, 15*, 1320405. https://doi.org/10.3389/fpsyg.2024.1320405

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*, 316–340.

Fonagy, P., Simes, E., Yirmiya, K., Wason, J., Barrett, B., Frater, A., et al. (2025). Mentalisation-based treatment for antisocial personality disorder in males convicted of an offence on community probation in England and Wales (MOAM): A multicentre, assessor-blinded, randomised controlled trial. *The Lancet Psychiatry, 12*, 208–219.

Fonagy, P., Yakeley, J., Gardner, T., Simes, E., McMurran, M., Moran, P., et al. (2020). Mentalization for offending adult males (MOAM): Study protocol for a randomized controlled trial to evaluate mentalization-based treatment for antisocial personality disorder in male offenders on community probation. *Trials, 21*, 1001.

Frick, P. J., & White, S. F. (2008). Research review: The importance of callous-unemotional traits for developmental models of aggressive and antisocial behavior. *Journal of Child Psychology and Psychiatry, 49*, 359–375.

Gazzillo, F., Lingiardi, V., Del Corno, F., Genova, F., Bornstein, R. F., Gordon, R. M., et al. (2015). Clinicians' emotional responses and psychodynamic diagnostic manual adult

personality disorders: A clinically relevant empirical investigation. *Psychotherapy, 52*, 238–246.

Gibbon, S., Duggan, C., Stoffers, J., Huband, N., Vollm, B. A., Ferriter, M., et al. (2010). Psychological interventions for antisocial personality disorder. *Cochrane Database of Systematic Reviews, 6*, CD007668.

Gibbon, S., Khalifa, N. R., Cheung, N. H. Y., Vollm, B. A., & McCarthy, L. (2020). Psychological interventions for antisocial personality disorder. *Cochrane Database of Systematic Reviews, 9*, CD007668.

Goldstein, R. B., Compton, W. M., Pulay, A. J., Ruan, W. J., Pickering, R. P., Stinson, F. S., & Grant, B. F. (2007). Antisocial behavioral syndromes and DSM-IV drug use disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Drug and Alcohol Dependence, 90*, 145–158.

Goodwin, R. D., & Hamilton, S. P. (2003). Lifetime comorbidity of antisocial personality disorder and anxiety disorders among adults in the community. *Psychiatry Research, 117*, 159–166.

Hare, R. D. (2003). *Psychopathy checklist—revised*. Multi-Health Systems.

Hare, R. D., & Neumann, C. S. (2008). Psychopathy as a clinical and empirical construct. *Annual Review of Clinical Psychology, 4*, 217–246.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training, 46*, 203–219.

Hauschild, S., Kasper, L., Volkert, J., Sobanski, E., & Taubner, S. (2023). Mentalization-based treatment for adolescents with conduct disorder (MBT-CD): A feasibility study. *European Child & Adolescent Psychiatry, 32*, 2611–2622.

Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy, 55*, 496–507.

Hesse, M., del Palacio-Gonzalez, A., & Thylstrup, B. (2022). Impulsive Lifestyle Counselling versus treatment as usual to reduce offending in people with co-occurring antisocial personality disorder and substance use disorder: A post hoc analysis. *BMC Psychiatry, 22*, 392.

Hofsess, C. D., & Tracey, T. J. (2010). Countertransference as a prototype: The development of a measure. *Journal of Counseling Psychology, 57*, 52–67.

Huband, N., & Duggan, C. (2007). Working with adults with personality disorder in the community: A multi-agency interview study. *Psychiatric Bulletin, 31*, 133–137.

Inderhaug, T. S., & Karterud, S. (2015). A qualitative study of a mentalization-based group for borderline patients. *Group Analysis, 48*(2), 150–163.

Karterud, S., Folmo, E., & Kongerslev, M. T. (2020). *MBT: Mentaliseringsbasert terapi*. Gyldendal Norsk Forlag.

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. Yale University Press.

Kernberg, O. (2020). *Odio, rabbia, violenza e narcisismo*. Astrolabio.

Kvarstein, E. H., Pedersen, G., Folmo, E., Urnes, Ø., Johansen, M. S., Hummelen, B., Wilberg, T., & Karterud, S. (2018). Mentalization-based treatment or psychodynamic treatment programmes for patients with borderline personality disorder: The impact of clinical severity. *Psychology and Psychotherapy: Theory, Research and Practice, 92*, 91–111.

Leistico, A. M., Salekin, R. T., DeCoster, J., & Rogers, R. (2008). A large-scale meta-analysis relating the Hare measures of psychopathy to antisocial conduct. *Law and Human Behavior, 32*, 28–45.

Lingiardi, V., & McWilliams, N. (2015). The psychodynamic diagnostic manual—2nd edition (PDM-2). *World Psychiatry, 14*, 237–239.

Lo Buglio, G., Zaninotto, L., Göksal, R., Bayasgalan, U., Barsanti, A., Booth, B. D., et al. (2025). Exploring mental health professionals' emotional responses with individuals diagnosed with antisocial personality disorder or psychopathy: A scoping review. *Frontiers in*

Psychology, 16, 1501273.

Lonargáin, D. Ó., Hodge, S., & Line, R. (2017). Service user experiences of mentalisation-based treatment for borderline personality disorder. *Mental Health Review Journal, 22*, 16–27.

Mark, D., Roy, S., Walsh, H., & Neumann, C. S. (2022). Antisocial personality disorder. In S. K. Huprich (Ed.), *Personality disorders and pathology: Integrating clinical assessment and practice in the DSM-5 and ICD-11 era* (pp. 391–411). American Psychological Association.

Marsh, A. A., & Blair, R. J. (2008). Deficits in facial affect recognition among antisocial populations: A meta-analysis. *Neuroscience & Biobehavioral Reviews, 32*, 454–465.

McGauley, G., Yakeley, J., Williams, A., & Bateman, A. (2011). Attachment, mentalization and antisocial personality disorder: The possible contribution of mentalization-based treatment. *European Journal of Psychotherapy & Counselling, 13*, 371–393.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., et al. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*, 1365–1374.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process* (2nd ed.). Guilford Press.

Meloy, J. R. (1988). *The psychopathic mind: Origins, dynamics, and treatment*. J. Aronson.

Meloy, J. R., & Yakeley, J. (2014). Antisocial personality disorder. In G. O. Gabbard (Ed.), *Gabbard's treatments of psychiatric disorders* (5th ed.). American Psychiatric Publishing.

Morken, K. T. E., Binder, P. E., Arefjord, N., & Karterud, S. (2017a). Juggling thoughts and feelings: How do female patients with borderline symptomology and substance use disorder experience change in mentalization-based treatment? *Psychotherapy Research, 29*, 1–16.

Morken, K. T. E., Binder, P. E., Molde, H., Arefjord, N., & Karterud, S. (2017b). Mentalization based treatment for female patients with comorbid personality disorder and substance use disorder: A pilot study. *Scandinavian Psychologist, 4*.

Morken, K. T. E., Øvrebø, M., Klippenberg, C., Morvik, T., & Gikling, E. L. (2022). Antisocial personality disorder in group therapy, kindling pro-sociality and mentalizing. *Research in Psychotherapy: Psychopathology, Process and Outcome, 25*(3), 299–313. https://doi.org/10.4081/ripppo.2022.649

Mulder, R. T. (2021). ICD-11 personality disorders: Utility and implications of the new model. *Frontiers in Psychiatry, 12*, 655548.

National Institute for Health and Care Excellence. (2010). *Antisocial personality disorder: Treatment, management and prevention* [NICE guideline no. 77].

National Institute for Health and Care Excellence. (2015). *Personality disorders: Borderline and antisocial*.

Newbury-Helps, J., Feigenbaum, J., & Fonagy, P. (2017). Offenders with antisocial personality disorder display more impairments in mentalizing. *Journal of Personality Disorders, 31*, 232–255.

Ogloff, J. R. P., Campbell, R. E., & Shepherd, S. M. (2016). Disentangling psychopathy from antisocial personality disorder: An Australian analysis. *Journal of Forensic Psychology Practice, 16*, 198–215.

Ogloff, J. R., & Wood, M. (2010). The treatment of psychopathy: Clinical nihilism or steps in the right direction? In L. Malatesti & J. McMillan (Eds.), *Responsibility and psychopathy*. Oxford University Press.

Patrick, C. J., & Drislane, L. E. (2015). Triarchic model of psychopathy: Origins, operationalizations, and observed linkages with personality and general psychopathology. *Journal of Personality, 83*, 627–643.

Pickersgill, M. D. (2009). NICE guidelines, clinical practice and antisocial personality disorder: The ethical implications of ontological uncertainty. *Journal of Medical Ethics, 35*, 668–671.

Pickersgill, M. (2012). Standardising antisocial personality disorder: The social shaping of a psychiatric technology. *Sociology of Health & Illness, 34*, 544–559.

Poythress, N. G., Edens, J. F., Skeem, J. L., Lilienfeld, S. O., Douglas, K. S., Frick, P. J., et al. (2010). Identifying subtypes among offenders with antisocial personality disorder: A cluster-analytic study. *Journal of Abnormal Psychology, 119*, 389–400.

Rice, M. E., Harris, G. T., & Cormier, C. A. (1992). An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior, 16*, 399–412.

Ruszczynski, S. (2010). Becoming neglected: A perverse relationship to care. *British Journal of Psychotherapy, 26*, 22–32.

Sanz-García, A., Gesteira, C., Sanz, J., & García-Vera, M. P. (2021). Prevalence of psychopathy in the general adult population: A systematic review and meta-analysis. *Frontiers in Psychology, 151*, 661044.

Schröder-Pfeifer, P., Talia, A., Volkert, J., & Taubner, S. (2018). Developing an assessment of epistemic trust: A research protocol. *Research in Psychotherapy: Psychopathology, Process and Outcome, 21*, 330.

Schwartz, R. C., Smith, S. D., & Chopko, B. (2007). Psychotherapists' countertransference reactions toward clients with antisocial personality disorder and schizophrenia: An empirical test of theory. *American Journal of Psychotherapy, 61*, 375–393.

Schwarzer, N. H., Nolte, T., Fonagy, P., & Gingelmaier, S. (2021). Mentalizing mediates the association between emotional abuse in childhood and potential for aggression in non-clinical adults. *Child Abuse & Neglect, 115*, 105018.

Semiz, U., Basoglu, C., Ebrinc, S., & Cetin, M. (2007). Childhood trauma history and dissociative experiences among Turkish men diagnosed with antisocial personality disorder. *Social Psychiatry and Psychiatric Epidemiology, 42*, 865–873.

Skilling, T. A., Harris, G. T., Rice, M. E., & Quinsey, V. L. (2002). Identifying persistently antisocial offenders using the Hare psychopathy checklist and DSM antisocial personality disorder criteria. *Psychological Assessment, 14*, 27–38.

Stefana, A., Bulgari, V., Youngstrom, E. A., Dakanalis, A., Bordin, C., & Hopwood, C. J. (2020). Patient personality and psychotherapist reactions in individual psychotherapy setting:

A systematic review. *Clinical Psychology & Psychotherapy, 27*, 697–713.

Storebø, O. J., Stoffers-Winterling, J. M., Völlm, B. A., Kongerslev, M. T., Mattivi, J. T., Jørgensen, M. S., et al. (2020). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews, 5*, CD012955.

Tanzilli, A., Colli, A., Del Corno, F., & Lingiardi, V. (2016). Factor structure, reliability, and validity of the therapist response questionnaire. *Personality Disorders: Theory, Research, and Treatment, 7*, 147–158.

Tanzilli, A., Gualco, I., Baiocco, R., & Lingiardi, V. (2020). Clinician reactions when working with adolescent patients: The therapist response questionnaire for adolescents. *Journal of Personality Assessment, 102*, 616–627.

Tanzilli, A., Lingiardi, V., & Hilsenroth, M. (2018). Patient SWAP-200 personality dimensions and FFM traits: Do they predict therapist responses? *Personality Disorders: Theory, Research, and Treatment, 9*, 250–262.

Taubner, S., Hauschild, S., Kasper, L., Kaess, M., Sobanski, E., Gablonski, T.-C., et al. (2021). Mentalization-based treatment for adolescents with conduct disorder (MBT-CD): Protocol of a feasibility and pilot study. *Pilot and Feasibility Studies, 7*, 1–10.

Taubner, S., White, L. O., Zimmermann, J., Fonagy, P., & Nolte, T. (2013). Attachment-related mentalization moderates the relationship between psychopathic traits and proactive aggression in adolescence. *Journal of Abnormal Child Psychology, 41*, 929–938.

Thomas, N., & Jenkins, H. (2019). The journey from epistemic vigilance to epistemic trust: Service-users experiences of a community mentalization-based treatment programme for anti-social personality disorder. *The Journal of Forensic Psychiatry & Psychology, 30*, 909–938.

Thylstrup, B., & Hesse, M. (2016). Impulsive lifestyle counseling to prevent dropout from treatment for substance use disorders in people with antisocial personality disorder: A randomized study. *Addictive Behaviors, 57*, 48–54.

Thylstrup, B., Schroder, S., & Hesse, M. (2015). Psycho-education for substance use and antisocial personality disorder: A randomized trial. *BMC Psychiatry, 15*, 283.

Thylstrup, B., et al. (2017). Did you get any help? A post-hoc secondary analysis of a randomized controlled trial of psychoeducation for patients with antisocial personality disorder in outpatient substance abuse treatment programs. *BMC Psychiatry, 17*, 7.

Tyrer, P., Mitchard, S., Methuen, C., & Ranger, M. (2003). Treatment rejecting and treatment seeking personality disorders: Type R and Type S. *Journal of Personality Disorders, 17*, 263–268.

van Dam, A., Rijckmans, M., & Bosch, L. (2022). Explaining the willingness of clinicians to work with patients with antisocial personality disorder using the theory of planned behaviour and emotional reactions. *Clinical Psychology & Psychotherapy, 29*, 676–686.

Van den Bosch, L., Rijckmans, M., Decoene, S., & Chapman, A. (2018). Treatment of antisocial personality disorder: Development of a practice focused framework. *International Journal of Law and Psychiatry, 58*, 72–78.

Verheul, R. (2001). Co-morbidity of personality disorders in individuals with substance use disorders. *European Psychiatry, 16*, 274–282.

Verheul, R., & van den Brink, W. (2005). Causal pathways between substance use disorders and personality pathology. *Australian Psychologist, 40*, 127–136.

Vogt, K. S., & Norman, P. (2019). Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. *Psychology and Psychotherapy: Theory, Research and Practice, 92*, 441–464.

Wall, T. D., Wygant, D. B., & Sellbom, M. (2015). Boldness explains a key difference between psychopathy and antisocial personality disorder. *Psychiatry, Psychology and Law, 22*, 94–105.

Ware, A., Wilson, C., Tapp, J., & Moore, E. (2016). Mentalisation-based therapy (MBT) in a high-secure hospital setting: Expert by experience feedback on participation. *The Journal of Forensic Psychiatry & Psychology, 27*, 722–744.

Warner, A., & Keenan, J. (2022). Exploring clinician wellbeing within a mentalization-based treatment service for adult offending males with antisocial personality disorder in the community. *International Journal of Forensic Mental Health, 21*, 287–297.

Werner, K. B., Few, L. R., & Bucholz, K. K. (2015). Epidemiology, comorbidity, and behavioral genetics of antisocial personality disorder and psychopathy. *Psychiatric Annals, 45*, 195–199.

Widiger, T. A. (2006). Psychopathy and DSM-IV psychopathology. In C. J. Patrick (Ed.), *Handbook of psychopathy*. Guilford Press.

Yakeley, J. (2014). Mentalization-based group treatment for antisocial personality disorder. In A. Williams & J. Woods (Eds.), *Forensic group psychotherapy: The Portman clinic approach*. Karnac Books.

Yakeley, J., & Williams, A. (2014). Antisocial personality disorder: New directions. *Advances in Psychiatric Treatment, 20*, 132–143.