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EVIDENCE-BASED CASE STUDY

Treating the Untreatable: A Single Case Study of a Psychopathic Inpatient Treated With Schema Therapy

Farid Chakhssi
Maastricht University

Truus Kersten
Forensic Psychiatric Centre de Rooyse Wissel, Venray, The Netherlands

Corine de Ruiter and David P. Bernstein
Maastricht University

From its first conceptualization in modern psychiatry, psychopathy has been considered difficult if not impossible to treat. Schema Therapy (ST) is a psychotherapeutic approach that has shown efficacy in patients with borderline personality disorder. ST has recently been adapted for personality disordered forensic patients, including patients with high levels of psychopathy. The present case study examined the process of individual ST, combined with movement therapy and milieu therapy by the nursing staff, with a forensic inpatient with psychopathic features (Psychopathy Checklist-Revised total score = 28.4). The patient had been sentenced to a mandatory treatment order in relation to a sexual assault. We assessed change using independent assessments of psychopathic traits, cognitive schemas, and risk-related behaviors over the 4-year treatment period and a 3-year follow-up. We also assessed the quality of the working alliance. Reliable change analyses showed significant improvements in psychopathic traits, cognitive schemas, and risk-related outcomes. At 3 years posttreatment, the patient was living independently outside of the forensic institution without judicial supervision and he had not reoffended. While many questions remain about the effectiveness of psychotherapeutic treatment for psychopathic patients, our study challenges the view that they are untreatable.

Keywords: schema therapy, psychopathy, sex offender, case study, forensic treatment

Psychopathy is viewed as a severe form of antisocial personality disorder (ASPD) with greater risk of violence than ASPD (e.g., Coid & Ullrich, 2010), characterized by a lack of empathy and remorse, self-aggrandizement, superficial charm, and poor behavioral controls. The Psychopathy Checklist-Revised (PCL-R; Hare, 2003) is a reliable and valid assessment tool for measuring psychopathy (Neumann, Hare, & Newman, 2007), and provides a description of psychopathy that involves two factors: Factor 1 comprises the interpersonal and affective traits of emotional detachment and a manipulative interpersonal style, and Factor 2 comprises the behaviors of an impulsive and antisocial lifestyle (Hare, 2003). The emotional detachment in psychopathy is thought to be related to innate neurobiological deficits in emotion processing (i.e., callous–unemotional traits; Blair, 2003; Viding, Blair, Moffitt, & Plomin, 2005), whereas impulsivity, hostility, and antisocial behavior may be best understood as an emotional adaptation to adverse experiences in childhood (e.g., Caspi et al., 2002; Huizinga et al., 2006; Weiler & Widom, 1996).

Psychopathy, affecting 13% to 47% of the population in forensic settings (Patrick, 2006), has been surrounded by therapeutic pessimism. Many experts believe that psychopathic characteristics are difficult, if not impossible, to ameliorate (Harris & Rice, 2006), and the findings of some studies suggest that treatment increases recidivism rates for psychopathic patients (Hare, Clark, Grann, & Thornton, 2000; Rice, Harris, & Cormier, 1992; Seto & Barbaree, 1999). However, more recent studies have revealed that some psychopathic patients, including sexual offenders, may benefit from (inpatient) cognitive–behavioral treatment programs (Chakhssi, de Ruiter, & Bernstein, 2010a; Hildebrand & de Ruiter, 2012; Olver & Wong, 2009; Skeem, Monahan, & Mulvey, 2002). However, the effectiveness of these approaches is difficult to evaluate owing to the

Farid Chakhssi, Department of Clinical Psychological Science, Maastricht University; Truus Kersten, Forensic Psychiatric Centre de Rooyse Wissel, Venray, The Netherlands; Corine de Ruiter and David P. Bernstein, Department of Clinical Psychological Science, Maastricht University.

Farid Chakhssi is now at the Bureau Apeneus, Enschede, The Netherlands.

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Correspondence concerning this article should be addressed to Farid Chakhssi, Department of Clinical Psychological Science, Maastricht University, PO Box 616, 6200 MD Maastricht, The Netherlands. E-mail: fchakhssi@gmail.com

methodological limitations, such as a lack of randomized controlled trials (see Salekin, Worley, & Grimes, 2010).

Schema Therapy (ST; Rafaeli, Bernstein, & Young, 2011; Young, Klosko, & Weishaar, 2003) is an integrative therapy for personality disorders that combines elements of cognitive, behavioral, psychodynamic, and humanistic/experiential forms of psychotherapy. ST targets chronic emotional and cognitive maladaptive patterns, called "early maladaptive schemas" (EMS), which originate in adverse childhood experiences and early temperament. EMS are repeating themes about oneself and one's relationships that affect emotional processing, influence interpersonal style, and guide behavior. The primary objective of ST is ameliorating EMS, replacing maladaptive coping responses with adaptive ones, and the modification of transient, state-related manifestations of EMS, termed "schema modes" (Young et al., 2003). The latter are activated when specific EMS are triggered by specific situations, leading to overwhelming emotions and maladaptive coping responses that account for rapid changes in mood and behavior often observed in personality disordered patients (e.g., Kellogg & Young, 2006; Lobbestael & Arntz, 2010). ST has shown effectiveness in three clinical trials of nonforensic outpatients with borderline personality disorder (BPD), including two randomized controlled trials (Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006) and one open trial (Nadort et al., 2009). A substantial proportion of the patients in these studies were judged to be in remission from their BPD and to show clinically significant improvement.

Bernstein and colleagues (Bernstein, Arntz, & de Vos, 2007) adapted ST for forensic patients. They hypothesized that antisocial and psychopathic patients make prominent use of five schema modes that involve overcompensatory coping styles: attempts to con and manipulate ("conning and manipulative mode"), self-aggrandizement and devaluation of others ("self-aggrandizer mode"), attempts to bully and intimidate ("bully and attack mode"), focusing of attention to detect a hidden threat or enemy ("paranoid overcontroller mode"), and cold calculated aggression aimed at eliminating a threat or rival ("predator mode"). Furthermore, schema modes were conceptualized as the psychological risk factors for patients' offending behavior (Bernstein et al., 2007). Recent research supports the schema mode model in patients with antisocial personality disorder and psychopathy (Chakhssi, Bernstein, & de Ruiter, 2012; Lobbestael, Arntz, Cima, & Chakhssi, 2009), including the hypothesized link between schema modes and offending (Keulen-de Vos et al., 2012).

Given its goal of forming a genuine emotional connection with the patient, and altering the patient's core personality traits, ST represents a departure from other cognitive–behavioral treatments for psychopathy (e.g., Wong & Hare, 2005) that assume that changing psychopathic personality features is impossible owing to these patients' serious emotional deficits (Blair & Mitchell, 2009). In contrast, ST views psychopathic patients on a continuum in their capacity for emotional relatedness. This notion is consistent with findings from recent studies showing considerable heterogeneity within psychopathic populations (e.g., Brinkley, Newman, Widiger, & Lynam, 2004; Hildebrand & de Ruiter, 2004), and suggests that some psychopathic features may be linked to insecure attachment styles (e.g., Frodi, Dernevik, Sepa, Philipson, & Bragesjø, 2001; van IJzendoorn et al., 1997) and early trauma (e.g., Farrington, 2006; Lang, af Klinteberg, & Alm, 2002; Marshall & Cooke, 1999; Poythress, Skeem, & Lilienfeld, 2006; Weiler & Widom, 1996), and not solely to innate neurobiological factors.

Empirical studies that have examined psychopaths' treatment responsiveness are scarce, and to our knowledge, studies using a psychotherapeutic approach to further our understanding of psychopathy are absent from the literature. The aim of this study is to contribute to the current literature by exploring the use of ST, more specifically Bernstein and colleagues' (2007) forensic adaptation of ST, in the understanding and treatment of a patient with psychopathic traits. We describe the 4-year ST treatment and 3-year follow-up of a 25-year-old male with psychopathic features (pretreatment PCL-R total score = 28.4) who was admitted to a Dutch forensic psychiatric hospital. First, we will describe the treatment process. Second, we present scores of the working alliance and the progress of the patient as repeatedly measured during treatment by the PCL-R, a self-report measure of EMS, and measures of risk-related behaviors.

Method

Setting

The case study took place at the forensic psychiatric hospital "de Rooyse Wissel" (dRW) in the Netherlands. dRW is a maximum-security hospital for the treatment of mentally disordered offenders sentenced to involuntary treatment under the Dutch "maatregel van TerBeschikkingStelling" (TBS-order). The TBS-order is a mandatory treatment order imposed on offenders who suffer from a mental or developmental disorder, and who have committed a serious offense, carrying a sentence of at least 4 years imprisonment (de Ruiter & Hildebrand, 2003). The TBS-order is imposed for at least 2 years and prolonged annually or biannually as long as the court deems the patient a danger to society.

Patient

Andy (not his real name) is a white Dutch man who was 25 years old on admission to dRW. For committing a sexually violent offense, he was sentenced to 3 years imprisonment and, on completion of his term, to an involuntarily admission to a forensic psychiatric hospital under the TBS-order (de Ruiter & Hildebrand, 2003).

Andy grew up as the only child from a marriage of young parents. Andy recalled being beaten by his authoritarian father on a daily basis, usually for some misbehavior. His mother, on the other hand, was a quiet and compliant woman who tried to protect him from his father's abusiveness. Andy and his mother were both regularly physically abused. By the age of 8, Andy's behavior became problematic. He was caught regularly committing thefts (e.g., shoplifting, taking money from his family). Later, he got involved with antisocial peers resulting in criminal behaviors such as vandalism, theft (e.g., car radio), and assault (e.g., toward other youth). At age 11, juvenile court placed Andy in a correctional care center for youth because of problematic behavior at home and at school. At the age of 14, Andy returned to his family but quickly resumed his defiant and oppositional behavior. The frequent physical assaults by his father continued. By the age of 16, Andy reported increasing difficulty controlling his aggressive impulses.

He started to experiment with drugs and failed to complete secondary education. He took several unskilled jobs, but had difficulty maintaining them. He often did not show up for work or came to work intoxicated. His first conviction occurred at age 17 for aggravated assault. More convictions ensued: for vandalism, theft, drug possession, and aggravated assault that left the victim in a coma. His parents divorced when he was 18. Andy lived alternately with his father and his mother, but he did not get along with either of them. He stayed with friends until he managed to acquire his own apartment.

At the age of 19, Andy committed a sexual offense. Together with a fellow perpetrator, Andy being the dominant perpetrator, he kidnapped a female stranger, used physical violence to restrain her, and both men raped her successively (i.e., forced genital intercourse). After his arrest, he did not admit committing the sexual offense and tried to lay the blame on the victim ("it was consensual sex," "she was a prostitute") and on the fellow perpetrator ("I was forced by my friend to rape the girl").

Andy was assessed with the Structured Interview for *DSM–IV* Personality Disorders (SIDP–IV; Pfohl, Blum, & Zimmerman, 1997). Classification for Axis-I disorders was performed by a hospital psychiatrist. Andy's full scale IQ on the Wechsler Adult Intelligence Scale (WAIS–III; Wechsler, 2001) was 85 (verbal IQ = 83, performance IQ = 91). Andy fulfilled *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM–IV–TR)* criteria (American Psychiatric Association, 2000) for alcohol abuse, cocaine abuse, amphetamine abuse (all in remission), and for antisocial personality disorder with borderline and narcissistic traits.

Psychotherapist

Dr. T.K., a certified cognitive–behavioral and ST psychotherapist with extensive forensic experience, conducted the psychotherapy. Although ST is usually given twice per week for patients with severe personality disorders (Young et al., 2003), it was given once a week because the patient was chosen as a "training case" to give the psychotherapist the opportunity to learn to practice ST. Some therapy sessions were videotaped and viewed during supervision with a certified ST supervisor (Dr. D.P.B.) and peer therapists providing feedback.

Measures

The measures used in the study are displayed in Table 1. We used the formally translated Dutch versions of the PCL-R (Vertommen,

Table 1
List of Measures Used in the Case Study, When Administered, and by Whom

Topic	Measures	Description	Time in treatment	Rated by
Psychopathy	Psychopathy Checklist-Revised (PCL-R; Hare, 2003)	The PCL-R consists of 20 items, divided over four facets: Interpersonal, Affective, Impulsive Lifestyle and Antisocial.	Pre- and posttreatment	Certified psychologists/Dr. C.d.R.
Early maladaptive schemas	Young Schema Questionnaire (YSQ; Young & Brown, 1994)	The YSQ is a self-report assessment instrument of 205 items, to assess the 16 early maladaptive schemas.	Pre-, mid-, and posttreatment	Self-report administered by Dr. T.K.
Risk-related behaviors	Behavioural Status-Index (BEST-Index; Reed, Woods, & Robinson, 2000)	The BEST-Index is a structured observational measure that contains 63 items, divided over four scales: Insight, Social Skills, Interpersonal Hostility and Physical Violence.	Pre-, mid-, and posttreatment	Psychiatric nurses
Risk of future violence	Historical-Clinical-Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997)	The HCR-20 is designed for assessing the risk of future violence among persons with mental disorders resulting in a final risk judgment of low, moderate, or high.	Pre- and posttreatment	Treatment coordinator (psychologist)
Working alliance	The Working Alliance Inventory—Observer, Short version (WAI-O-S; Tichenor & Hill, 1989; Tracey & Kokotovic, 1989)	The WAI-O-S is a 12-item observer-rated measure, consisting of three subscales: Bond, Tasks, and Goals.	Four videotaped sessions during the first year, second year, third year, and last year of psychotherapy.	Master-level research assistants (posttreatment ratings)
Therapy adherence	Schema Therapy Rating Scale (STRS; Young & Fosse, 2005)	The STRS measures the psychotherapist competency in using Schema Therapy.	Two videotaped sessions during the first and second year of psychotherapy.	An independent rater, a certified ST psychotherapist

Note. Pretreatment = at the start of ST treatment; Midtreatment = beginning of third year of ST treatment; posttreatment = end of 4 years ST treatment, except for the PCL-R, which was completed 6 months after ending ST treatment.

Verheul, de Ruiter, & Hildebrand, 2002), the Young Schema Questionnaire (YSQ; Sterk & Rijkeboer, 1997), the Behavioural Status-Index (BEST-Index; van Erven, 1999), and the Historical-Clinical-Risk Management-20 (HCR-20; Philipse, de Ruiter, Hildebrand, & Bouman, 2000). The Dutch versions have been validated in Dutch forensic or clinical samples (e.g., Chakhssi, de Ruiter, & Bernstein, 2010b; Hildebrand, de Ruiter, de Vogel, & van der Wolf, 2002; Rijkeboer, van den Bergh, & van den Bout, 2005; de Vogel & de Ruiter, 2006). For the therapy adherence ratings, we used the English version of the Schema Therapy Rating Scale (STRS; Young & Fosse, 2005).

Process measure ratings. To measure therapeutic alliance, we used the English version of the Working Alliance Inventory—Observer, Short version (WAI-O-S; Tichenor & Hill, 1989; Tracey & Kokotovic, 1989). Previous studies showed that the WAI-O-S can be rated reliably (Myers & Hayes, 2006), and that the observer-rated alliance is a stronger predictor of therapy outcome than the therapist-rated alliance (Horvath & Symonds, 1991).

Procedure

Informed consent. Andy participated in the case study after giving written informed consent. He understood and agreed that we could examine his hospital files, including his criminal records, and make use of the psychotherapist's notes, psychotherapy process, PCL-R, YSQ, HCR-20, and BEST-Index for the purpose of the single case study. Additional informed consent was obtained for readministrating the PCL-R and for scoring the videotaped therapy sessions.

Psychotherapy process. The ST treatment process was documented on the basis of the psychotherapist's case notes and extensive discussions with her. Several drafts of the manuscript were sent to the psychotherapist for review. She had many comments and suggestions that helped us to describe the psychotherapy process in detail. Please note that the patient's narrative was translated into English, which may have led to seemingly increased sophistication of his language.

Process measure ratings. The WAI-O-S was coded by three Masters-level students (two female, one male, and their ages ranged from 23 to 25 years) who watched the beginning, the middle, and the end of four randomly selected (out of 10 available) videotaped sessions. The students were provided with the manual, were briefly instructed how to score the WAI-O-S, and scored one "training session" before they rated the videotaped sessions. The coders had no knowledge of the study, the therapist, or the patient. The segments (i.e., beginning, middle, and end) were randomly presented to the three coders. Coders based their ratings on viewing each segment. Interrater agreement was assessed using the $r_{wg(j)}$ (James, Demaree, & Wolf, 1984) to compare the observed variance in multiple raters' rating of a single subject. Interrater agreement for the WAI-O-S total score was high at .98.

Results

Patient's Pretreatment Scores on the Measures

Andy obtained a pretreatment PCL-R total score of 28.4. Andy received scores of 4 out of 8 on the Interpersonal facet, 7 out of 8 on the Affective facet, 6 out of 10 on the Impulsive Lifestyle facet, and 8 out of 10 on the Antisocial facet of the PCL-R. According to these scores, Andy showed a high level of a manipulative and arrogant interpersonal style and had a history of frequent and diverse antisocial behaviors. Also, he showed some features of deficient affective experience, such as lack of remorse and failure to accept responsibility for his actions, and he had also shown impulsive and irresponsible behavior. Table 2 provides the pretreatment scores for the YSQ, BEST-Index total and scales scores, and the PCL-R total and facet scores.

Table 2
Scores on the YSQ Schema Domains, BEST-Index and PCL-R Scores, Reliable Change Indices, and Effect Sizes for Pretreatment to Posttreatment

Scales	Pretreatment	Midtreatment	Posttreatment	RCI	ES
Schema domains					
Disconnection/rejection	2.91	1.55	1.65	6.59*	1.62
Impaired autonomy/performance	1.90	1.15	1.30	3.11*	0.98
Impaired limits	3.58	1.41	1.97	5.06*	2.15
Other-directedness	1.63	1.28	1.26	1.08	0.53
Over-vigilance/inhibition	3.44	1.59	1.47	5.44*	2.43
BEST-Index total	266	275.5	306.5	4.76*	1.17
Social skills	101.5	105	114.5	2.80*	0.79
Insight	82.5	87	101	3.74*	1.18
Interpersonal hostility	50	48.5	56	1.49	0.79
Physical violence	32	35	35	1.43	1.03
PCL-R Total	28	NA	14	3.28*	2.19
Facet 1: Interpersonal	4	NA	1	1.78	1.34
Facet 2: Affective	7	NA	1	4.74*	3.30
Facet 3: Impulsive lifestyle	6	NA	3	1.63	1.40
Facet 4: Antisocial	8	NA	8	0	0

Note. RCI scores for the schema domains and PCL-R have been reversed to correspond with positive treatment progress; higher scores on the PCL-R means more psychopathic features, and higher scores on schema domains means more maladaptive schemas. RCI = Reliable Change Index; ES = Effect size; BEST-Index = Behavioural Status Index; PCL-R = Psychopathy Checklist revised; NA = not applicable.
* $p < .05$.

Psychotherapy Process

Andy began ST 6 months after admission to the forensic psychiatric hospital, continued psychotherapy for 4 years, and was discharged from the hospital by court on conditional release approximately 1 year after completing ST. His TBS-order was terminated unconditionally after court review about 3 years after the end of ST.

Initial Phase of Psychotherapy (First Year Approximately)

Initial impressions, aggression, and impulse control training. Dr. T.K.'s initial contact with Andy was for aggression-management treatment. Andy suffered from stress and frustration on the ward, which resulted in frequent outbursts of verbal aggression. In the first psychotherapy sessions, Andy presented himself as "macho": a tough, charming, and dominant young man. He was not emotionally detached but rather angry and overcontrolling. If not interrupted, he could speak nonstop throughout entire sessions, without room for the psychotherapist. Getting him to stop and experience his emotions was extremely difficult. He was reluctant to discuss his abuse history and refused to talk about the details of his offense. He was often angry about events that had happened on the ward, or between him and his treatment coordinator (i.e., the head of the treatment unit where he resided). After Dr. T.K. felt that she had gained some trust, she used empathic confrontation and limit setting when the patient's anger or aggression threatened to escalate. An example of how the psychotherapist used limit setting during these first sessions (i.e., 10th session) is illustrated by the following:

Andy: I can't trust anyone on my ward, patients nor nurses. They don't keep their agreements, they are not straight with me, they lie to me about a lot of things, I can't rely on them anymore. Therefore I have to be in charge, take control of everything because I won't let them abuse me . . . [his demeanor felt threatening and intimidating].

Dr. T.K.: Andy, please stop! (makes a "stop" sign with her hand). *I now see a side of you that takes over control, not only on the ward, but also in this therapy session. I have seen this side in previous sessions also and I know it has an important survival and protective function for you, but it's so dominating now that it obstructs the therapy. This side makes it impossible for me to have a conversation with you. So please listen to me for a moment.*

Andy: Why do I have to stop talking? I'm frustrated about this! I am . . .

Dr. T.K.: Stop, Andy, listen to me! I know you're frustrated and I really understand that and want to hear more about your frustrations. But first, I want to stop that side of you that's controlling this therapy session . . . I can't make a genuine connection with you and with your feelings, your vulnerable side, that lies behind this controlling protector side . . . Can you recognize this controlling side?

Andy (irritated and embarrassed): *Well, this is not a side, it's normal that I take control when other people lie to me!*

Dr. T.K.: I can understand that you take control if you can't trust others but I think this is a way of coping you learned when you were very young, because you never could trust an adult.

Dr. T.K. had to interrupt Andy several times before he stopped. She did not find it easy to use limit setting because she felt that the patient could become aggressive if he experienced the limit setting as an attack. Andy slowly began to recognize his controlling intimidating side. After Dr. T.K. used limit setting, there were glimpses of a more vulnerable anxious side, which seemed easily threatened. Andy described a violent childhood and he appeared to have strong needs for fairness, autonomy, consistency, and predictability. Andy stated that he was startled when the therapist interrupted him firmly but later during the same session, he could acknowledge his controlling side and its protective function for him.

After the use of limit setting in these first sessions, which led to further insights into the origins of Andy's strong need for control, combined with behavioral interventions aimed at aggression regulation, Andy gained greater control over his anger and impulsivity. For example, Dr. T.K. taught Andy to recognize triggers (mostly perceived authoritarian behavior) and how to cope with these triggers by using stop signs, avoiding or escaping from triggering situations. Now that he attained his immediate goals, he saw no reason to continue treatment. Notable in Andy's case and with psychopathic patients in general, is that clear treatment goals, measurable in behavioral terms, have to be formulated. Andy's treatment coordinator, therefore, suggested that the next goal should be to develop a schema-focused case conceptualization and offense scenario analysis, a description of the factors involved in his index offense (i.e., the sexual offense that led to the TBS-order) using schemas and schema modes as the conceptual framework.

In the Netherlands, an offense scenario analysis, based on Laws' relapse prevention model for sexual offenders (1999), is a core component of forensic psychiatric treatment to help offenders recognize risk factors for their offenses and take responsibility for them (Buschman & Van Beek, 2003). In offense scenario analysis, the patient and psychotherapist systematically examine the events leading up to, and culminating in, the patient's offense, using a cognitive–behavioral framework (i.e., antecedents, cognitions, emotions, behaviors, and consequences) to understand them (Buschman & Van Beek, 2003; Dowden, Antonowicz, & Andrews, 2003; Laws, 1999). For Andy, the offense scenario analysis was incorporated into the initial phase of ST, to create an integrated approach. Also, substance use treatment was integrated into the ST using schema mode concepts.

Schema therapy assessment and case conceptualization, including offense scenario analysis. The initial phase of ST involves uncovering the patient's EMS, maladaptive coping responses, and schema modes, their childhood origins, and their relationship to the patient's problem behaviors. This process ends with a case conceptualization, which the psychotherapist shares with the patient. In ST, the assessment process is collaborative, where the psychotherapist teaches the patient the "language" of EMS and modes, and they work together to develop a shared understanding of the patient's problems using these concepts. Because in Andy's case, the offense scenario analysis was incorporated into ST, and there were many sessions where the focus was on the therapeutic alliance and working with the patient's schema modes (see below), the assessment and case conceptualization phase took much longer than is normally the case, occupying the first year.

The assessment began by exploring Andy's childhood experiences, first examining the origins of his EMS, and subsequently, of his modes. Dr. T.K. used the concepts of EMS and modes to

explain his problems, such as drug abuse, relationship conflicts, and criminal and violent behavior. It is best to first approach the patient's childhood history, and only later his offenses. Once the patient comes to understand the effects of his childhood experiences, it is easier for him to understand his offenses. An example of how the EMS and modes are explored is illustrated by the following:

Andy: My father was Hannibal Lector, a real psychopath. When I came home, one minute late, he would hit me and lock me up in my room for the rest of the day. So when I grew up, I decided to take the upper hand, I became a member of a street gang and I learned to attack before anyone could attack me. On the street I felt safer than at home.

Dr. T.K.: So your father hit and abused you a lot, you have already given me other examples. You developed schemas and modes as a consequence. You learned at a young age that you couldn't trust your father and that your mother couldn't stand up for you, so you felt very unsafe. This is the schema mistrust/abuse: you learned to mistrust people first-off. And later on you tried to cope with your mistrust by taking the upper hand and become an aggressive chap. You developed what we call the "bully and attack mode" to survive.

During this initial phase, the psychotherapist is highly structured, making systematic inquiries about his childhood temperament, experiences with parents, and other aspects of the childhood environment. Dr. T.K. consistently but gently pushed him to examine his emotions. When she did so, there was more vulnerability evident in his voice and his appearance changed.

At first, Andy was barely able to talk about his index offense; he could not say the word "rape" out loud. He admitted he had tried to lay blame on his accomplice. Now, he admitted to being the main perpetrator. He appeared to feel shame, confusion, and regret about having raped a woman and having used force and intimidation. With tears in his eyes, he asked, "How can I have done this to a woman?" He had experienced a complete loss of control during his offense, and felt guilty that he had not stopped himself when at a certain moment he had realized that what he was doing was wrong. He said he deserved to pay the rest of his life for what he had done to his victim.

After nearly a year, the case conceptualization was complete. The psychotherapist shared a simplified version of the case conceptualization (see Figure 1) with the patient, using only schema modes. The left of Figure 1 represents overcompensatory modes present in Andy's case; the rectangle shape represent "protector" modes, protecting the child modes behind a defensive wall. Most forensic patients find this concept easier to understand than EMS. As a result, we focus on schema modes, much more than EMS, in working with forensic patients (Bernstein et al., 2007).

Having finished the offense scenario analysis and case conceptualization, Andy was able to make a formal presentation about his offense scenario, with Dr. T.K.'s support, at a meeting with his treatment team and significant family members. This is a common procedure in Dutch forensic hospitals, an important step toward taking responsibility for the offense. In his own words, Andy described the schema modes that played a central role in his offenses, including his aggressive behavior toward girlfriends, and the "random violence" he had displayed as part of a gang. He provided a detailed analysis of his index offense in terms of an unfolding sequence of schema modes, each mode described in terms of associated feelings, thoughts, behaviors, intentions, and consequences (see Table 3). For example, after his girlfriend left, Andy's feelings of abandonment were triggered (abandonment schema). He felt anxious and powerless (vulnerable child mode). To cope with these feelings, Andy got high on drugs (detached self-soother mode). However, as a consequence of the drug use his anger toward his girlfriend became uncontrollable (angry child mode) and he set out to seek revenge (predator mode). Although he was tense beforehand, Andy's presentation went well. He answered critical questions from the treatment team without becoming defensive. While it had been quite an emotional experience, the presentation provided Andy with a sense of closure regarding this difficult phase of treatment. Based on his presentation, Andy developed a relapse prevention plan together with his psychotherapist.

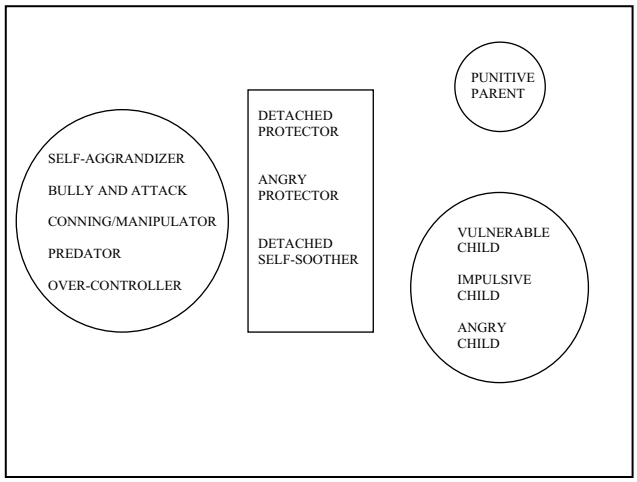

Figure 1. Schema Mode Model used in Andy's therapy. Schema modes = state-related manifestations of early maladaptive schemas and represent the current emotional, cognitive, and behavioral state that a patient is in once they are active.

Andy also gave a presentation to the team of psychiatric nurses on his ward. Subsequently, the treatment goals for the psychiatric nurses were formulated in schema mode language. The nurses received basic training in ST, and learned to recognize and respond to the patient's behaviors on the ward—for example, angry, impulsive, aggressive, avoidant, or dominant behavior—in terms of schema modes.

Limited reparenting, empathic confrontation, and limit setting. Limited reparenting, a focus on the patient's unmet emotional needs, was of central importance throughout Andy's psychotherapy, but especially in the initial phase, when the psychotherapist strives to establish an emotional bond with the patient. The most important basic needs for Andy were safety and stability, trustworthiness (e.g., keeping agreements), fairness and justice, consistency and clarity, transparency (e.g., admitting mistakes), and giving emotional support and attention. These basic needs of childhood are often not met in psychopathic patients (Chakhssi et al., 2012). Dr. T.K. adapted her limited reparenting stance to fit these basic needs. Being transparent, genuine, straightforward, and self-disclosing within appropriate limits, were key aspects of her approach. An example of limited reparenting, after Andy has

Table 3
Andy's Crime Scenario Analysis in Terms of a Sequence of Schema Modes

Events leading up to the crime	
Event	Girlfriend breaks up the relationship and has left me (abandonment schema).
Self-aggrandizer	
Feelings	Glad, powerful (entitlement schema).
Thoughts	Well, if it is a sure thing that you are going to leave me, I am going to have a nice evening, I am going to use again (XTC and coke), I am going to party.
Behavior	1. Substance abuse. 2. Call a friend to go out.
Intention	Feeling more powerful/better, freeing myself from my girlfriend (who keeps telling me what to do), decide for myself what I want to do.
Consequences	In a daze, intoxicated from substances. I revert back to feelings of powerlessness.
Self-soother	
Feelings	Powerless, afraid to be alone (abandonment schema).
Thoughts	I cannot stand to be alone at home, I have nobody left, usually I swap my former girlfriend for a new one and now I don't have a new one, I want to hide my powerlessness.
Behavior	1. More substance abuse. 2. Going out and party.
Intention	Forget about the abandonment, not feeling anxious/powerless.
Consequences	More intoxicated, sweating, tingling.
Angry child/predator	
Feelings	Angry, furious (insufficient self-control schema)
Thoughts	You cannot leave me, I am going to get you back or I will kill you.
Behavior	Demand friend to drive me to my girlfriend's place.
Intention	Take revenge, get power over my girlfriend back.
Consequences	Stress: the closer I get to her place, the more tense I get because she gives as good as she gets, I am figuring out scenario's how I can regain control over the situation.
Bully and attack/predator	
Event	Friend says that we are lost and I do not believe him.
Feelings	Angry, powerful (entitlement schema).
Thoughts	You obstruct my plans and you are lying.
Behavior	Threaten, intimidate, I said: I will kill you.
Intention	Take my anger out on my friend.
Consequences	Feeling frustrated, because my friend does not know the directions and it does not help if I threaten, intimidate him.
Event	A girl is walking down the street, I ask her for directions and she tells me that she does not know.
Feelings	Disappointed.
Thoughts	This sucks. She did not know the directions either. She probably doesn't live in the neighborhood.
Behavior	I thanked her for her effort in helping me to find the directions.
Intention	Find the directions to my girlfriend's house.
Consequences	Continuing to threaten my friend, getting angrier.
Predator/self-aggrandizer	
Event	Doubts about the intentions of the girl (she is still walking around, so she must know her way around in this neighborhood), feelings of being fooled (mistrust/abuse schema).
Feelings	Angry
Thoughts	You fooled me, although I asked it nicely.
Behavior	Threatening by saying: You do know the neighborhood, you live here! She replies that she does not know the directions.
Intention	I want to know the directions from her.
Consequences	Frustrated, became really angry, I wanted to make it very clear to her: do not try to fool me.
Feelings	Very angry (entitlement schema).
Thoughts	If you fool me, I will retaliate.
Behavior	Pull her into the van.
Intention	I wanted to say that I had enough trouble on my mind.
Consequences	I was sitting on the backseat with her.
Event	She is sitting next to me.
Feelings	Not angry anymore, maybe I felt good.
Thoughts	Maybe I can get something from her, like a kiss, or something more
Behavior	I asked her several times for a kiss
Intention	I wanted her to pay for making a fool out of me (that is what I thought).
Consequences	She said no and kept saying no, meanwhile my friend was driving towards the inner city, and when I became aware of this, I told him to drive away from the city, I don't know why, but apparently, because it was quiet, finally we ended in a dark place.
Event	She is struggling and saying no.
Feelings	Angry, callous, detached (predator mode).
Thoughts	You do not reject me.
Behavior	I forced myself on the girl.
Intention	I wanted her to pay for rejecting me.
Consequences	I sexually abused her.

brought in a situation in which he had experienced unfairness that triggered his mistrust and abandonment schemas, is provided:

Andy: Last week, I had a quarrel with a nurse who treated me unfairly. He allowed another patient to stay in his room when he was feeling sick, but when I was feeling sick, I had to come to the dinner table that same evening! So I became angry and said: "This is not fair! Why do I have to come to the dinner table when I am feeling sick, and he doesn't?" Then I walked away and didn't talk to this nurse any more. He again confirmed that I can't trust him.

Dr. T.K.: I can imagine that you felt angry and mistreated, because you had to come to the dinner table and the other patient didn't while you were both not feeling well. I think this must feel the same for you as you felt in your childhood when you were constantly treated unfairly by your father. Children need their parents to be fair and consistent, because then they can grow up trusting other people. That's what you missed in your childhood.

Andy: Yes, you're right, he's just like my father. He treats me the same.

Dr. T.K.: I understand that this is painful for you. But on the other hand, Andy, I also want to be straight with you. You told me that you went to play soccer in the afternoon, so could it be possible that the nurse thought that you were feeling better and concluded that you could attend dinner at the table?

Andy: But then he should have asked me first! He didn't ask me at all if I was feeling better, he was only very authoritarian to me and you know: no one can be authoritarian to me!

Dr. T.K.: So you missed his interest in you and in how you felt. You actually needed his attention and sympathy.

Andy: Yes, that's what I felt, that no one cares about me as a human being, and they only see me as someone who doesn't comply with the rules on the ward.

Dr. T.K.: I understand, and I want to let you know that I care about you and that I really want to help you to handle these difficult situations and feelings. I will be there for you, at your side.

Dr. T.K. stated that she was affected by his vulnerability and the easily triggered feelings of being treated unfairly. It felt as if he was reliving an emotionally distressing experience belonging to a complex trauma. She indicated that he needed the reparenting because he never had someone who was there for him. Instead of dominating the therapy session and expressing his anger, Andy became silent, less tense, and listened to the therapist when she said she wanted to help him and to be there for him. Dr. T.K. also showed her caring toward Andy by occasionally acting on his behalf outside of sessions, for example, making phone calls when necessary, and meeting with the treatment coordinator and nurses of his ward to discuss issues concerning his treatment.

In the beginning, Andy tested if Dr. T.K. would keep her agreements. He had always been strongly triggered if someone arrived late for an appointment, viewing this as evidence of untrustworthiness. On occasions when Dr. T.K. arrived late, he became very angry. After she let him ventilate his rage, they made a functional analysis of the situation. It became clear that the patient's sensitivity originated from the verbal and physical abuse he had suffered as a child, when his father arrived home late and exploded unpredictably in rage.

The psychotherapist made frequent use of empathic confrontation with regards to the effect of the modes on her, including self-disclosure (e.g., "I know that this is your protective side, but I feel threatened if you say . . . ."). When she confronted the patient in this way, he was usually stunned, was able to stop his verbally aggressive behavior, and apologized. Through the ups and downs of psychotherapy, Dr. T.K. continued to offer reliability, openness, and honesty.

ST makes extensive use of experiential techniques, such as chair work and guided imagery (Young et al., 2003), to reprocess the patient's emotional distress stemming from painful childhood experiences. At first, Andy refused the psychotherapist's suggestion to try experiential techniques. He found these exercises "artificial" and was afraid of losing control of his emotions. Dr. T.K. decided to wait until later in the psychotherapy to reintroduce these techniques.

Over time, Andy started to trust Dr. T.K. more, and a strong bond developed between them. He said he now noticed that his psychotherapist was a "human being" and not just a distant professional. Trust was central for Andy. Because he used to lie often, he was never trusted by others; now, he needed to feel that someone trusted and believed him. Obviously, Dr. T.K. realized that he might not be always telling the truth, but she decided to come from the position of trust rather than mistrust. Sometimes, Andy would take advantage of this trust, for example, by trying to use the material Dr. T.K. wrote in his treatment plan to his advantage. Dr. T.K. was careful not to write anything in her reports about the veracity of his accounts that she couldn't prove. If she felt that he was misusing her trust, she took more distance, and became business-like (e.g., "I said this, but not that"). Essentially, the Dr. T.K.'s stance was: "I'll give you the benefit of the doubt, unless I'm proven otherwise. And if you do lie, then I want to understand why." In doing so, Dr. T.K. supported the healthy side of the patient, the side that wanted to be honest and forthcoming, and that was beginning to show genuine vulnerability. While in the first year his angry and impulsive sides were more prominent, during the second year, the vulnerable, abused child side became more visible.

Middle Phase of Psychotherapy (Second Year, Approximately)

Role of ancillary therapies (Milieu Therapy, Psychomotor Therapy) in treatment. Over time, there was increasingly closer collaboration between Andy's ST psychotherapist and the psychiatric nurses on Andy's ward, as well as the other disciplines that were involved in his treatment. Dr. T.K. met regularly with the nurses, providing coaching about the mode approach that they were implementing on the ward (i.e., milieu therapy based on the schema mode model). Andy also began working with a movement therapist, who had received training in ST. The movement therapy focused on aggression and addiction issues, using experiential movement exercises to trigger schema modes, such as the bully and attack mode, so that the patient could learn to recognize and manage them. Through these exercises, Andy learned to recognize the signals in his body that tension was building up and how to intervene in a timely way, before he reached a point of no return. An example of a movement therapy technique was that Andy had to "protect his territory" in the room. The goal for Andy was to recognize bodily tension in the bully and attack mode. The therapist's task was to enter his territory, to start a duel with the patient. During the first step, the therapist stopped when he observed Andy's arousal level became too high. During the second step, the therapist stopped after 1.5 minutes (indicated by the sound of a

timer). During the third step, Andy had to stop himself when he felt his arousal became too high. Afterward, Andy and the therapist watched the videotaped exercise so he could observe his body signals. He also recognized the overcompensatory nature of his aggression: because he had been physically abused, he had learned "to turn passive into active," becoming an aggressor himself.

Motivation and engagement in psychotherapy, and therapeutic alliance. Following his offense scenario presentation to the treatment team, Andy wanted to close the door on his past. Instead, Dr. T.K. pushed him gently but persistently to continue to examine difficult topics such as the abuse he suffered and to get in touch with his feelings. Over time, he realized that his need to keep his past at a distance was due to his mistrust and fear of losing control, and underneath it, painful feelings of vulnerability that he wanted to avoid. He continued to refuse to do experiential exercises, but agreed that further exploration of his modes could take place via role playing if he stayed in one chair, rather than use multiple chairs. Thus, the psychotherapist compromised, when necessary, to get the patient to try experiential work.

At about one and a half years into the treatment, Dr. T.K. noted that Andy's trust in her increased. He began to show real shame, became upset, and felt pain, when discussing his abuse history and his offense. Sometimes psychopathic patients find it easy to discuss their offenses, but not so with Andy, because his offense did not fit his self-image. He felt shame for having violated a woman. In one session, he acknowledged that he was very anxious in sexual relationships, and had had trouble with sexual performance. He recalled his first sexual encounter when he was 12 years old with a girlfriend who was 14, when he was afraid to initiate sex. While he acted tough and macho with his antisocial friends, Andy felt quite anxious underneath. He also felt anxiety about intimacy when he later developed a relationship with a woman: "I had raped a woman. How would I feel when trying to initiate sex?"

Patient's behavior in the hospital. During his second year of treatment, Andy showed increasingly more vulnerability and healthy adult behavior outside of ST. However, triggers continued to appear that left him feeling agitated, and made it difficult not to relapse into verbally aggressive behavior. A key moment occurred when his leave application was denied. This event triggered feelings of guilt and shame, and a self-punitive side became activated ("I am nothing, a monster, Hannibal Lecter"). He had suicidal thoughts, experienced considerable distress, and did not want to continue psychotherapy. Despite this setback, he was able to recover his equilibrium and move forward with his treatment, indicating growing resilience.

Andy started a new relationship with a young woman, an acquaintance of his mother. She often accompanied Andy's mother during her visits to the hospital. This led to discussions of his fears: "What is friendship? What is love? Is this a healthy relationship, when she has her freedom and I don't?" It also led to discussing previous relationships and what went wrong in them. Andy wanted to build this new relationship in a healthy adult way, without violence. The relationship lasted 6 months before he learned that his girlfriend was cheating on him. He broke off the relationship, recognizing that it was not a healthy one for him.

Final Phase of Psychotherapy (Last Two Years, Approximately)

Experiential techniques: Imaginary rescripting and letter writing. Andy continued to refuse to do imagery exercises, which Dr. T.K. felt were essential to alleviating the emotional triggers that were at the root of his offenses. Eventually, after 2 years and 4 months of treatment, Dr. T.K. and his treatment coordinator decided to make his participation in these exercises a precondition for approval of his leave application. This limit setting succeeded: Andy finally agreed to do experiential exercises, although still with great reluctance. Andy and Dr. T.K. negotiated the conditions under which the imagery exercises would be conducted, which helped him to retain a measure of control. They agreed to try the exercises two or three times, and then evaluate how they were going before proceeding. Dr. T.K. also taught him to use the "time out" signal, so that he could end the exercise at any time. She began each exercise with a "safe place" image, where she asked Andy to close his eyes and imagine himself in a tranquil safe environment.

In total, Andy and Dr. T.K. did five imagery exercises, all of which involved vivid recollections of physical and emotional abuse by his father. For example, in one exercise Andy clearly recalled a very hot day when he was 8 or 9 years old and his father locked him in a car for the whole day without food or water. In each of these exercises, the psychotherapist used imagery rescripting—that is, reworking the traumatic scene to give it a more satisfactory outcome—to counteract the destructive effects of these experiences. She asked Andy's permission to enter the image to protect the child and provide for his emotional needs. In the image, she confronted the father forcefully, standing up for the child and insisting that the father had no right to abuse him. She and Andy devised ways to protect the child, for example, having the police come to take the father to jail and lock him up. In a final imagery exercise, Andy recalled a later experience, when he was 16 years old, and was finally a physical match for his father. His father was beating him savagely while Andy feigned a posture of passive surrender. At a certain moment, Andy caught his father off-guard, suddenly attacking him and beating him into submission. This was the last occasion on which his father had attempted to beat him. The image of turning the tables on his father made the overcompensatory nature of Andy's aggression understandable to him: by becoming a violent predator, he had learned how to avoid being a victim. After each of these exercises, Andy reported considerable relief, and feeling less easily triggered to anger and aggression in his interactions with others.

Later that year, Andy's supervised leave application was finally approved; under strict supervision of two guards and one psychiatric nurse, he was allowed to leave the hospital for periods of a few hours. Then, again, a stalemate occurred: he was no longer motivated to continue his treatment. He was eager to return to society and to put his past behind him. This reluctance to continue with treatment is a common reaction when patients begin the resocialization process and have a first "taste" of freedom. Eventually, his treatment coordinator had to set another limit: either Andy continued to work through his traumas and his offense or he would not write a new leave request. Andy agreed to continue his psychotherapy.

Dr. T.K. recommended that he write a letter to his father. At first, Andy refused, stating that he "wasn't a writer," and wanted to "stop delving into the past." However, Dr. T.K. and his treatment coordinator persisted and Andy eventually agreed, after 3.5 years of ST, to write the letter. A few quotes from the letter to his father read as follows:

> "It pains me to write this. I was raised with a lot of violence in my home and I lived for 18 years in a completely unsafe environment. I have a lot of questions toward you: why so many beatings? So much violence? So much sadness? So many unsafe situations? So little love? So little warmth? So little family feeling?
>
> A little child doesn't know right from wrong, you have to learn everything from your parents. I missed this at home, but I saw that it was more quiet and kind-hearted at my friends' home. I always thought about this and said to myself: this is the way I want to do it, when I have my own family.
>
> I've always been angry toward you and I even made plans to kill you. I am really disappointed in you and I will never forget what you did to me, but I can learn from this and NEVER do this to my own family, but to guarantee them warmth, safety and the love they deserve. This will be the best revenge on you."

After the imagination exercises and writing the letter to his father, Andy reported feeling less pain about his past. He said that if he were to meet his father, he would be able to speak to him in a calm fashion. He would like to ask him: "Why have you beaten me so much? Why have you given me such a childhood?"

During this same period, Andy's relationship with his mother was discussed extensively. While warmer and less emotionally charged than his relationship with his father, Andy came to realize that he and his mother had an enmeshed relationship. In a sense, they were too close, which served his mother's emotional needs, but prevented him from becoming independent. Andy worked on breaking free from this enmeshment and began to develop more independence and sense of his own identity.

Reprocessing the offense. Dr. T.K. wanted him to come to terms with his offense, taking responsibility for what he had done, processing feelings of shame and guilt, and then reaching a resolution in order to move on with his life. However, Andy was adamantly opposed to letting go of the pain and guilt that he experienced: he said that it reminded him of what he had done, and therefore served as a deterrent for the future. Eventually, Andy proposed a way to reprocess his offense. He decided to visit the scene of the offense.

In the meantime, he developed a new relationship with a young woman who visited him in the hospital. His new girlfriend had been sexually abused as a child, an issue that was very upsetting for Andy because of his own role as the perpetrator of a sexual offense. He discussed the sexual abuse and his own offense with his new girlfriend. His girlfriend said that she could forgive him for having raped a woman, which helped Andy forgive himself.

Resocialization phase of treatment. The resocialization phase, in which Andy was allowed more frequent supervised leaves, and eventually, unsupervised leaves, was successful. As he earned more frequent leaves, he felt liberated and wanted to focus more on his life outside. The main triggers during this period were frustrations over the uncertainty and slowness of the resocialization process, and the continuation of the TBS-order. On the ward, Andy trusted the psychiatric nurses more, and was able to have more constructive discussions with them about his concerns. Thus, a generalization of learning was taking place. At first, only his psychotherapist and movement therapist could be trusted but by the end of treatment, he could discuss personal topics with some of the nurses, too.

Changes over the entire course of psychotherapy. A comprehensive evaluation of Andy's schema modes by Dr. T.K. showed that Andy had made significant progress. The antisocial modes, such as the predator, bully and attack, and self-aggrandizer modes, were clearly less prevalent than at the beginning. They were still present but less strong. Moreover, there was more room for healthy adult considerations and vulnerable emotions. His main vulnerability remained the mistrust/abuse schema (i.e., the expectation of being abused, mistreated, or cheated by others). The triggers for mistrust remained inconsistent behavior or application of rules by authority figures, lack of clarity over rules, and unclear and inconsistent situations and communications in general. When Andy's mistrust was triggered, he continued to react either with avoidance ("I do not need them anymore") or with aggression. A positive change was that Andy could identify a trigger or conflict more quickly, and address it more constructively. For example, when he became mistrustful toward a male psychiatric nurse who had been recently assigned as his mentor ("He is not straightforward; he speaks with two tongues"), he addressed this immediately by arranging an appointment with the nurse to discuss his concerns. Also, in his new romantic relationship, he was noticeably less suspicious than previously. Andy acknowledged that abandonment fears in the relationship with his new girlfriend remained an important risk factor. At the same time, he recognized that even if the relationship were to end, he had learned a great deal from it and that it had helped him in his personal growth. Previously, Andy had always stated, "I engage in therapy for my mother, not for myself." At the end of this period, Andy said for the first time, "I engage in this process for myself, not for my girlfriend, and not for my mother."

Termination of Psychotherapy

After deliberation with Andy, Dr. T.K. and his treatment team decided to begin terminating ST. Over a period of about 6 months, the sessions were reduced to once every 2 or 3 weeks. Thereafter, sessions were even less frequent. Andy's relationship with his girlfriend continued to be monitored, as well as other aspects of his continuing reintegration into society. He took a position as a construction worker. The final 6 months of psychotherapy were focused on consolidating therapeutic gains and expanding his social and work network. Before his final session, Andy and Dr. T.K. watched a video recording of the initial phase of ST. Andy found it confronting to see himself as he previously was—how angry and aggressive he had been—which deepened his awareness of how much he had changed. Dr. T.K. gave Andy a card with a personal goodbye message. As requested by Dr. T.K., Andy wrote the following evaluation in response to three questions:

> How were you before the psychotherapy?

"I behaved aggressively, trusted no one (was very suspicious), responded quickly and aggressively, let no one tell me what to do

(especially not someone who was older than me) and was very rebellious and attributed everything to others."

What developments have you been through?

"I have learned to think differently. I am less worried about things that may happen to me or are happening. I have started to talk about my feelings and what's on my mind. That is my most important change."

How is it with your different sides (modes) at the moment?

"Some of the modes are gone (predator behavior and addiction) and some are still present, but to a lesser extent (trust/mistrust, powerful/powerless, impulsivity). They used to be problematic, but not anymore."

After he completed ST, Andy occasionally asked for follow-up sessions, especially when he became frustrated by the lack of progress in termination of his TBS-order. About 1 year after the end of ST, he was transferred to a resocialization ward and granted unsupervised leaves. Approximately 1 year later, after ending his second relationship during his TBS-order stay, he met another woman with whom he began a romantic relationship. At this time, he was living outside of the hospital. She soon became pregnant. When she gave birth, with Andy in attendance, the first person whom he thought of was his psychotherapist. She was the first person to whom he sent a birth announcement.

Follow-up Interviews

About 2 years after ending ST, Dr. T.K. invited Andy for a follow-up interview. Andy immediately agreed because he felt grateful and he "wanted to pay the psychotherapist back" for her efforts. During this interview, he told about his difficulties outside of the hospital, in getting a decent job, in the collaboration with his probation officer, and about the stigma of being a psychopath. He experienced life outside as much more difficult and there were more triggers than inside the hospital. He did not relapse into drug abuse or criminal behavior, although there were some situations that still triggered him (e.g., conflicts with his mother), though not to the same extent as before. An evaluation of the schema modes and triggers showed that the psychopathic modes were not present. When Dr. T.K. asked Andy about the meaning of ST and the therapeutic bond, he said he saw her as a real person who sometimes was touched by his pain, a mother figure, and that she had become a very important person in his life. Dr. T.K. was touched and surprised, especially as Andy had never before revealed such warm personal feelings about her.

About three years after ending ST, Dr. T.K. again invited Andy for a follow-up interview. This time, Andy seemed more adjusted to living in the community. He had a full-time job and provided for his girlfriend and their child. During the 3-year follow-up period, he had not relapsed into drug abuse nor any criminal behavior, as confirmed by records obtained from the Department of Criminal Justice.

Quantitative Assessment of Psychotherapy Outcome

To examine Andy's change from pre- to posttreatment, we used the reliable change index[1] (RCI: Jacobson & Truax, 1991). The RCI provides a *z*-score, where higher scores correspond with improvement and the threshold for significant improvement (at $p < .05$) lies at a *z*-score ≥ 1.96. For the YSQ and the PCL-R, we used the reliability coefficients and standard deviations obtained in a comparable sample of personality disordered offenders to calculate the RCI (Chakhssi et al., 2012). For the BEST-Index, we used reliability coefficients and standard deviations from a BEST-Index validation study (Chakhssi et al., 2010b). Effect sizes (Cohen's *d*) were calculated as the difference between pretreatment and posttreatment means divided by the standard deviations for the YSQ, PCL-R, and BEST-Index from normative samples (mentioned above). Table 2 provides the mid- and/or posttreatment scores on the YSQ schema domains, BEST-Index total and scale scores, PCL-R total and facet scores, the reliable change indices, and effect sizes.

Early maladaptive schemas (YSQ). The scores on the YSQ decreased significantly from pre- to posttreatment for four of the five EMS domains: Disconnection/Rejection, Impaired Autonomy/Performance, Impaired Limits, and Overvigilance/Inhibition. The observed change on Other-directedness from pre- to posttreatment was not significant (see Table 2). This indicates that the majority of Andy's EMS improved from pre- to posttreatment.

Risk-related behaviors (BEST-Index). Andy's risk-related behaviors as measured with the BEST-Index showed a significant improvement from pre- to posttreatment on the total score, on Social Skills and Insight. The BEST-Index scale, Social Skills, measures adaptive social behavior, social skills, and the maintenance of interpersonal relationships. Based on the BEST-Index Social Skills scores, Andy developed better social skills and was better at maintaining relationships. The Insight scale measures insight into the nature of the one's problems and attribution of responsibility. The scale also measures how patients cope with

[1] The RCI is calculated as: $(X2–X1)/\sqrt{2(SD\sqrt{1-\alpha})^2}$ where $\times 1$ is a subject's pretreatment score and $\times 2$ the posttreatment score (or reversed if lower scores on the measure mean better functioning). The *SD* is the standard deviation for the measure or a subscale of a sample at pretreatment. The internal consistency (Cronbach's alpha) is used as a reliability coefficient for the measure or subscale. The specific RCI computations for the measures are as follows: Disconnection/Rejection schema domain, the RCI is calculated as: $(2.91–1.65)/\sqrt{2(.78\sqrt{1-.97})^2} = 6.59$; Impaired Autonomy/Performance domain: RCI $= (1.90–1.30)/\sqrt{2(.61\sqrt{1-.95})^2} = 3.11$; Impaired Limits domain: RCI $= (3.58–1.97)/\sqrt{2(.75\sqrt{1-.91})^2} = 5.06$; Other-Directedness domain: RCI $= (1.63–1.26)/\sqrt{2(.70\sqrt{1-.88})^2} = 1.08$; Over-Vigilance/Inhibition domain: RCI $= (3.44–1.47)/\sqrt{2(.81\sqrt{1-.90})^2} = 5.44$; BEST-Index Total score: RCI $= (306.5–266)/\sqrt{2(34.74\sqrt{1-.97})^2} = 4.76$; BEST-Index Social Skills: RCI $= (114.5–101.5)/\sqrt{2(16.39\sqrt{1-.96})^2} = 2.80$; BEST-Index Insight: RCI $= (101–82.5)/\sqrt{2(15.63\sqrt{1-.95})^2} = 3.74$; BEST-Index Interpersonal Hostility: RCI $= (56–50)/\sqrt{2(7.59\sqrt{1-.86})^2} = 1.49$; BEST-Index Physical Violence: RCI $= (35–32)/\sqrt{2(1.43\sqrt{1-.74})^2} = 1.43$; PCL-R Total: RCI $= (28.40–14.00)/\sqrt{2(6.61\sqrt{1-.78})^2} = 3.28$; PCL-R Interpersonal facet: RCI $= (4.00–1.00)/\sqrt{2(2.08\sqrt{1-.67})^2} = 1.78$; PCL-R Affective facet: RCI $= (7.00–1.00)/\sqrt{2(1.91\sqrt{1-.78})^2} = 4.74$; PCL-R Impulsive Lifestyle facet: RCI $= (6.00–3.00)/\sqrt{2(2.34\sqrt{1-.69})^2} = 1.63$; PCL-R Antisocial facet: RCI $= (8.00–8.00)/\sqrt{2(2.64\sqrt{1-.64})^2} = 0$.

stress. Based on the BEST-Index Insight scores, Andy developed more insight into his disorder and was able to more adequately cope with stressful events. According to the BEST-Index, Andy did not show significant improvement on Interpersonal Hostility and Physical Violence scores (see Table 2).

Psychopathy (PCL-R). During the posttreatment PCL-R interview, Andy presented as a thoughtful person who had largely come to terms with his childhood experiences and the ensuing psychological pain. He also owned up to the offense that led to his conviction to the TBS-order. He was sincere, cooperative, and willing to show his "weaker" sides. Andy obtained a PCL-R total score of 14, which is clearly in the nonpsychopathic range. On the PCL-R Interpersonal facet, Andy obtained a score of 1 for his lies in the past and during the first phase of treatment. On the PCL-R Affective facet, Andy also scored 1: although he did show empathy toward the victim of the rape, he was less compassionate with the victim who went into a coma after getting into a fight with him. On the PCL-R Impulsive Lifestyle facet, he obtained a score of 3. Throughout his treatment in the forensic hospital, Andy showed behaviors that belonged to this facet. He still acted somewhat impulsively (mainly verbally) if he did not get his way. He showed responsible behavior during his hospital stay in terms of showing up for work engagement and therapeutic activities, and paying off a financial compensation for the victim. However, in the past, his irresponsible behaviors were extreme and he still had to show how he maintained his responsibility in the community. Finally on the PCL-R Antisocial facet, he scored 8 points. Although his behavioral controls improved substantially, he sometimes still acted out when he was frustrated. Most of the items belonging to the PCL-R Antisocial facet are historical and rated on the basis of previous (pretreatment) criminal behavior. As displayed in Table 2, the PCL-R total score showed significant improvement from pre- to posttreatment.

Risk of future violence (HCR-20). Andy's risk of future violence according to the HCR-20 decreased from "high" pretreatment to "medium" posttreatment. According to the professional judgment of the assessor based on the HCR-20, Andy showed increased insight, fewer negative attitudes, less impulsivity, and better treatment compliance. Also, Andy was judged to have become less susceptible to destabilizing events and more compliant with professional supervision.

Process Measures Ratings

The working alliance (WAI-O-S). The scores on the WAI-O-S ranged between 4 and 5, indicating that the coders observed positive indicators of the working alliance. The average total alliance score was 4.62 (SD = .88), 4.95 (SD = .89) for the Bond subscale, 4.25 (SD = 1.03) for the Task subscale, and 4.65 (SD = .97) for the Goal subscale. The average total alliance scores and subscales during the course of the psychotherapy are displayed in Table 4.

Scores on working alliance for patients with psychopathic traits have not been reported in the literature, although some scholars suggest that psychopathic patients are unable to form a therapeutic bond (Skeem et al., 2002). However, the average alliance ratings for this patient were indicative of a positive working alliance and comparable with average alliance ratings of therapists and patients in a sample of borderline outpatients who completed treatment (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007), higher than therapist alliance ratings of borderline outpatients who dropped out of treatment (Spinhoven et al., 2007), and also higher than the average alliance ratings with the WAI-O (long version) in a sample of substance abusers (Fenton, Cecero, Nich, Frankforter, & Carroll, 2001).

Table 4
Working Alliance Total and Subscales Mean Scores (and SD) During the Course of Psychotherapy

	Time during psychotherapy			
WAI-O-S scores	First year	Second year	Third year	Fourth year
Total	4.11 (.06)	4.83 (.38)	4.79 (.40)	4.72 (.53)
Bond	4.50 (.42)	5.29 (.13)	4.96 (.38)	5.04 (.63)
Task	3.67 (.08)	4.50 (.05)	4.54 (.45)	4.29 (.46)
Goal	4.17 (.17)	4.71 (.54)	4.88 (.38)	4.83 (.50)

Note. WAI-O-S = Working Alliance Inventory—Observer, Short version.

Discussion

This single case study is the first to describe the apparently effective treatment of a psychopathic patient. The treatment included individual ST, combined with movement therapy and milieu therapy by the nursing staff. After the 4-year treatment and 3-year follow-up, the patient no longer displayed prominent psychopathic features, displaying more empathy, shame, and guilt, and significantly more insight and better communication skills compared to his pretreatment scores. Although he remained somewhat mistrustful, he was able to develop meaningful interpersonal and intimate relationships: he became a father, took adequate care of his family, and maintained a job. He reprocessed painful feelings from childhood experiences with his father and developed more autonomy in his relationship with his mother. Although the treatment posed many challenges, this case study refutes the widely held view that patients with psychopathic features are untreatable, or that treatment makes them worse (Rice et al., 1992; Seto & Barbaree, 1999). In contrast to clinical lore, the patient was able to engage in treatment (e.g., Hobson, Shine, & Roberts, 2000; Ogloff, Wong, & Greenwood, 1990), form a bond with his therapist (e.g., Lösel, 1995; Mealey, 1995), and show a positive treatment response. Moreover, the treatment did not appear to make the patient more dangerous (e.g., Rice et al., 1992; Seto & Barbaree, 1999). These findings concur with those of recent studies indicating that some psychopathic patients may benefit from treatment (Chakhssi et al., 2010a; Hildebrand & de Ruiter, 2012; Olver & Wong, 2009; Skeem et al., 2002). They are also consistent with preliminary, but not statistically significant, results from a randomized clinical trial in the Netherlands suggesting that ST reduces risk and speeds reentry into the community in forensic patients with Cluster B personality disorders, including psychopathic ones (Bernstein et al., 2012).

In contrast to standard cognitive–behavioral therapy, ST places more emphasis on the childhood origins of maladaptive behaviors, and uses the therapeutic relationship (e.g., limited reparenting, empathic confrontation) and experiential, emotion-focused tech-

niques to reach the patient's vulnerable side (Rafaeli et al., 2011; Young et al., 2003). This may also explain the prolonged time, nearly a year, it took to develop an integrated case conceptualization in Andy's case, including an offense scenario analysis. Although this was the psychotherapist's first case using ST with a patient with psychopathic traits, and future case conceptualizations may require less time, we believe that developing an integrated case conceptualization while focusing on the therapeutic alliance is essential in the treatment of patients with psychopathic traits and may require more time than usual (five to eight sessions). This case study showed that it was possible to break through the emotional detachment of a psychopathic patient to heal his underlying emotional pain, reflected in significantly improved scores in four of the five EMS domains. This is consistent with a recent pilot study showing that ST was about twice as effective treatment-as-usual in reaching forensic patients' vulnerable emotions (Van den Broek, Keulen-de Vos, & Bernstein, 2011).

One of the premises of ST is that individuals are capable of experiencing at least a minimum of empathy, emotions, and feelings of connectedness. This case study showed that a patient's potential for empathy and attachment may not be evident at the beginning of treatment. At the start, Andy was described by some of those who worked with him as a "classic psychopath." Furthermore, in our clinical experience, there are patients who appear to possess callous–unemotional traits and a history of childhood trauma, and the callousness may serve as a protection against experiencing vulnerable emotions. However, until there are sufficient empirical data on which patients are likely to benefit from ST, and which are not, it is premature to exclude patients from ST because certain psychopathic features, such as callous–unemotional traits, are present.

By the end of his treatment and follow-up, Andy's scores on PCL-R items for prominent psychopathic features, such as lack of empathy, impulsivity, and failure to take responsibility, were reduced from high to moderate, indicating improvement on these characteristics, but a certain degree of risk of future violence still remained. Andy's scores on the HCR-20 risk assessment instrument were also reduced from high to medium. Thus, while our best estimate is that Andy's risk for future violence has diminished, we cannot say with certainty that he will not recidivate. ST makes no claims to completely eliminate risk in psychopathic or other personality disordered patients (Bernstein et al., 2007, 2012). Follow-up in the future will determine whether the gains made will hold up while living in the community. Certainly, his ability to exert self-control over his behavior during his final treatment phase offers reason to be hopeful about the future.

The findings of our study have several limitations. First, Andy's pretreatment PCL-R score of 28.4 was slightly lower than the conventional cutoff score of 30 used in North American samples (i.e., PCL-R total score $\geq$30), but was higher than the cutoff score of 25 used in European samples (Cooke, Michie, Hart, & Clark, 2005; Hare, 2003). Also, it was higher than the cutoff score (PCL-R $\geq$ 25) used in studies that demonstrate that psychopathy is a more severe form of ASPD than ASPD alone (e.g., Coid & Ullrich, 2010). However, it may be difficult to generalize these results to patients with much higher PCL-R scores, such as those with scores above 30. Furthermore, the length of treatment in Andy's case was 4 years, which was longer than the 3 years applied in the recent clinical trials of ST in BPD patients (Farrell et al., 2009; Giesen-Bloo et al., 2006), but shorter than the average time until conditional discharge (M = 9.8 years) in Dutch TBS-patients (Nagtegaal, van der Horst, & Schönberger, 2011).

Finally, psychopathic patients are well-versed in impression management (e.g., Lilienfeld, 1994). We cannot verify with certainty the patient's reports of the motives for his offense, nor his accounts of his life after leaving the institution. Thus, we cannot be absolutely sure that the patient's treatment progress was genuine and not a manipulative attempt to shorten his forensic psychiatric treatment. On the other hand, there is also evidence of the patient's apparently sincere efforts to come to terms with his offenses and refrain from further antisocial behavior. The improvements on the standardized assessment instruments also support this positive view. Note that three out of the four instruments were observer-rated tools, rated during the course of treatment by several different and independent raters, indicating that positive progress was not confined to the therapy sessions. This positive view is also supported by the absence of recidivism according to official arrest records. Recidivism rates for psychopaths are high: about three to four times higher than for other offenders at 1 to 3 years after discharge from secure institutions (Hemphill, Hare, & Wong, 1998). In this light, Andy's lack of reoffending over a period of 3 years post release is reassuring. Thus, while some ambiguities remain, our overall impression is of a patient whose progress is genuine.

Future Directions

We conclude that some or perhaps even many patients with psychopathic traits may prove amenable to psychotherapeutic treatment, if they are given an evidence-supported therapy that is specifically targeted to the nature of their problems. More research is needed into a variety of treatment methods to further investigate which patients with psychopathic traits are able to benefit from which treatment method, or a combination thereof. A randomized controlled trial to test the hypothesis that ST is an effective treatment for personality disordered offenders, including psychopathic ones, is currently in progress (Bernstein et al., 2012).

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