ANTISOCIAL PERSONALITY, MENTALIZING AND DISTRUST - AVOIDING THE NOISE AND FACILITATING RELATIONAL AND SOCIAL CHANGE IN VIOLENT OFFENDERS

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Swedish Personality Psychiatric Congress May 2026

THREE PILLARS OF MBT-ASPD

Personality

Aggression

Social adaptation

ANTISOCIAL PERSONALITY/DISSOCIAL

- **Antisocial**
  - **Nonconformity:** Repeatedly breaking laws or social norms.
  - **Deceitful:** Lying, conning, or alias for profit/pleasure.
  - **Impulsive:** Failing to plan ahead/disregard consequences
  - **Aggressive:** Frequent fights or assaults.
  - **Reckless:** Disregard for safety of self/others.
  - **Irresponsible:** Inconsistent work or financial behavior.
  - **Lack Remorse:** Indifference to or rationalizing harm to others.

- **Narcissism**
  - **Disregard** for the feelings and rights of others - self-centeredness and lack of empathy
  - **Entitlement,** expecting others to admire them. Having rights that are not respected
  - **Centre** of other people's attention.
  - **Rage**: If others do not respond as they wish they may dramatically express their dissatisfaction
  - **Disregard** of the importance of others
  - **Focus** in social interaction on their own needs, desires and comfort.

REJECTED BY HEALTH

ENTER CRIMINAL JUSTICE SYSTEM

PERSONALITY AS A DEVELOPMENTAL PHENOMENA

CRITERION A

Long term disturbances in **self** and **interpersonal** functioning

Self

Identity

- The experience of oneself as **unique**
- Stability of **self-esteem**
- Emotion **regulation**

Self-direction

- Pursuing meaningful **goals**
- Maintaining **prosocial** standards of behaviour
- Ability to **self-reflect** productively

Interpersonal

Empathy

- Comprehending and appreciating **others' experiences** and motivations
- Tolerating **differing perspectives**
- Understanding the effects of one's own behaviour on others- **impact awareness**

Intimacy

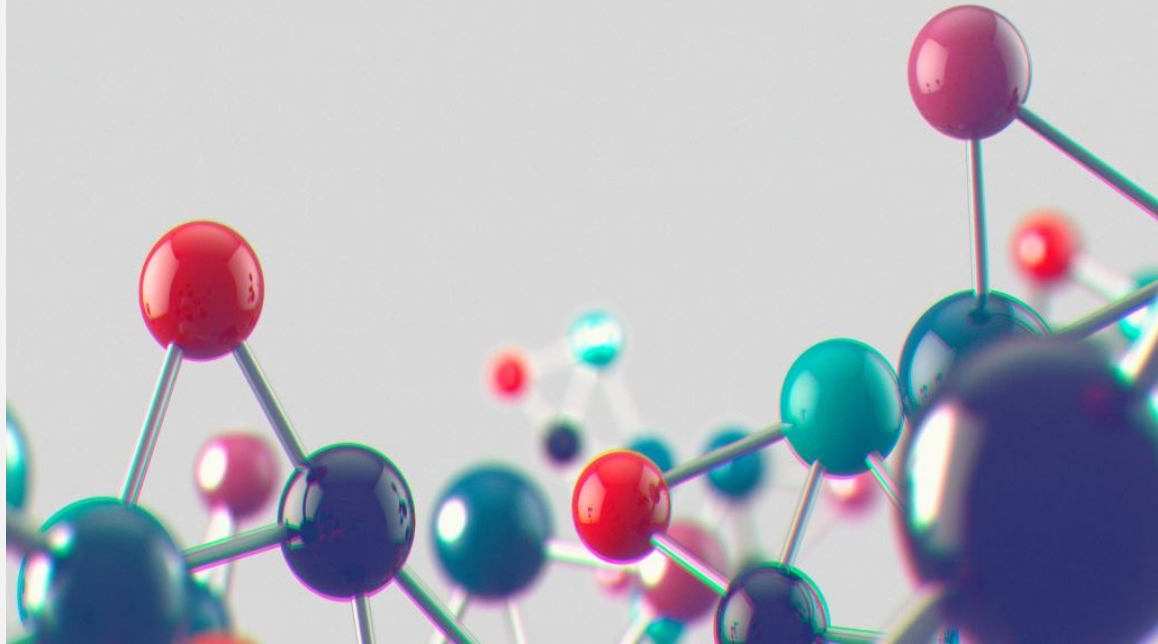
- Depth and duration of **connection** with others
- Desire and capacity for **closeness**
- **Mutuality** of regard reflected in interpersonal behaviour.

Mentalizing as the core dimension

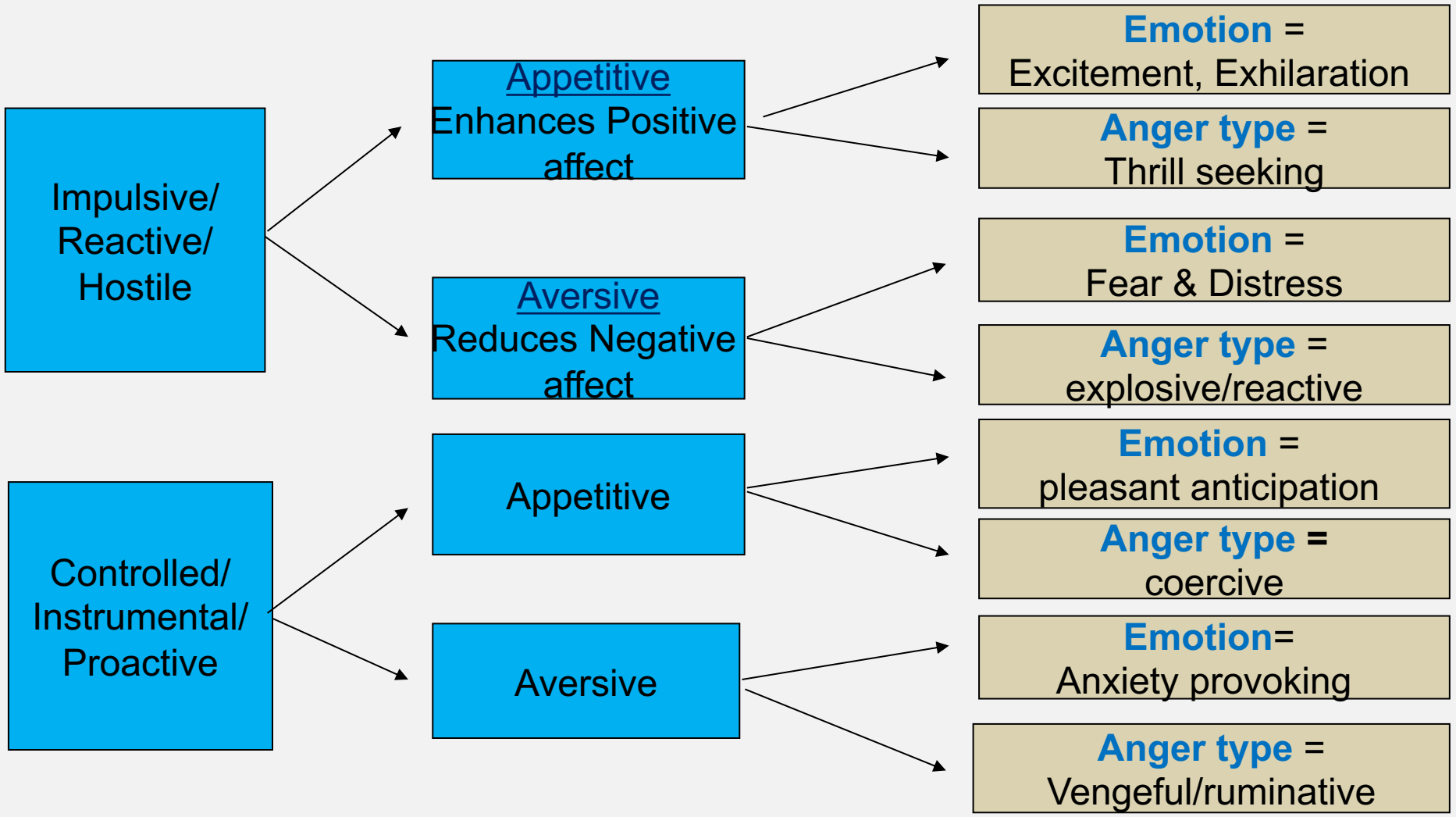
APA, (2013) DSM-5

AN EVOLUTIONARY FRAMEWORK

- Interpersonal **aggression** is an important evolutionary **adaptation**.
  - In certain human environments it is likely to **contribute** materially **to the survival** of the individual's genes.
  - In other contexts it is seriously **maladaptive**
    - it **undermines** the possibility of safe **collaboration:** the optimization of human capacities for **meaning generation**, communication and creativity.



A TYPOLOGY OF VIOLENCE (AFTER HOWARD, 2012).



Personality + Situation → Cognitive/Affective/Arousal → Appraisal → Action – Social/Interpersonal

Mentalizing Compromised

SOCIAL DISCONNECTION

- Failure to generate prosocial connection
  - Protective social learning systems decrease aggression perhaps by interacting with affective and cognitive developmental systems
- No reward from prosocial relationships
- Social connection becomes Subversive/Hostile/Distrustful/Coercive

SOCIAL RECONNECTION

Risk taking/Physical Excitement/Gangs

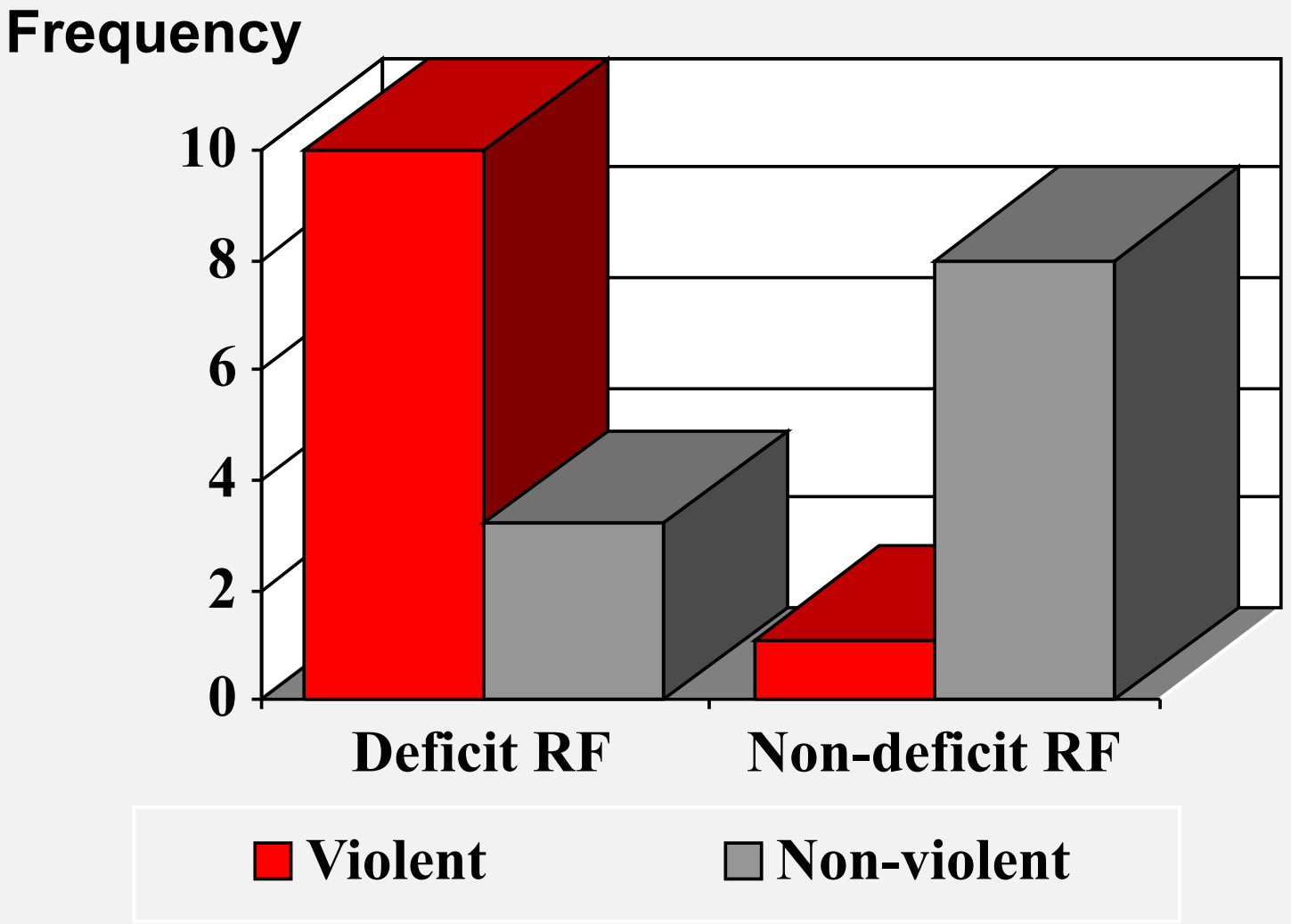
WHAT IS MENTALIZING?

Mentalizing is the process whereby the BRAIN becomes a MIND.

A form of ***imaginative*** mental activity about <u>others</u> or <u>oneself</u>, namely, perceiving and interpreting <u>human</u> behaviour in terms of ***intentional*** mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).

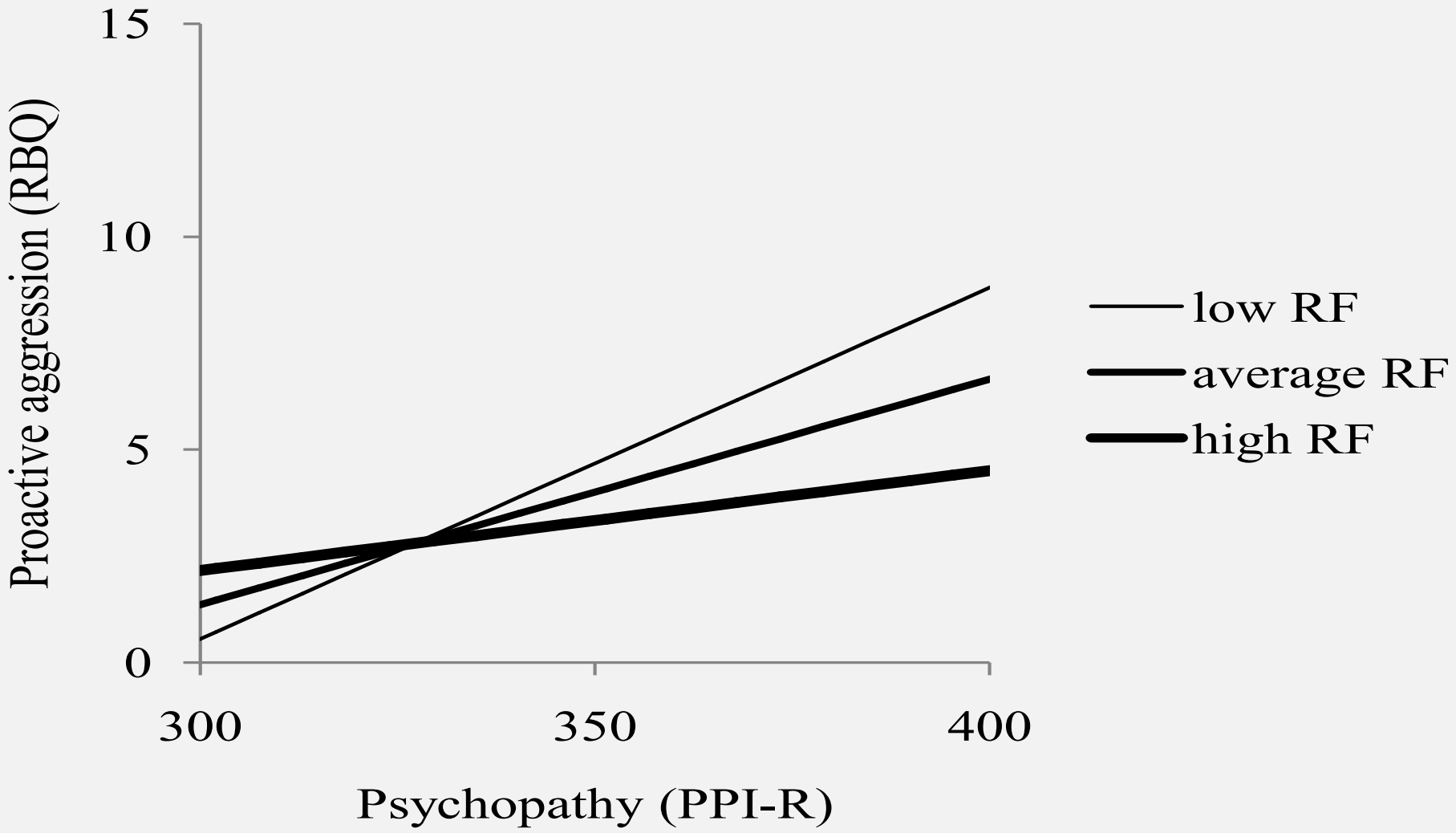
DEFICIT OF REFLECTIVE FUNCTION IN VIOLENT AND NON-VIOLENT PRISONERS WITH PD

LEVINSON AND FONAGY (2004)



RF MODERATES THE RELATIONSHIP BETWEEN PSYCHOPATHY AND PROACTIVE AGGRESSIVE BEHAVIOUR

TAUBNER, WHITE, ZIMMERMANN, FONAGY & NOLTE, 2013, JACP)



MENTALIZING, PERSONALITY, AGGRESSION

Tab. 8. Correlations between mentalizing functions, pathological personality, and aggression (n=118)

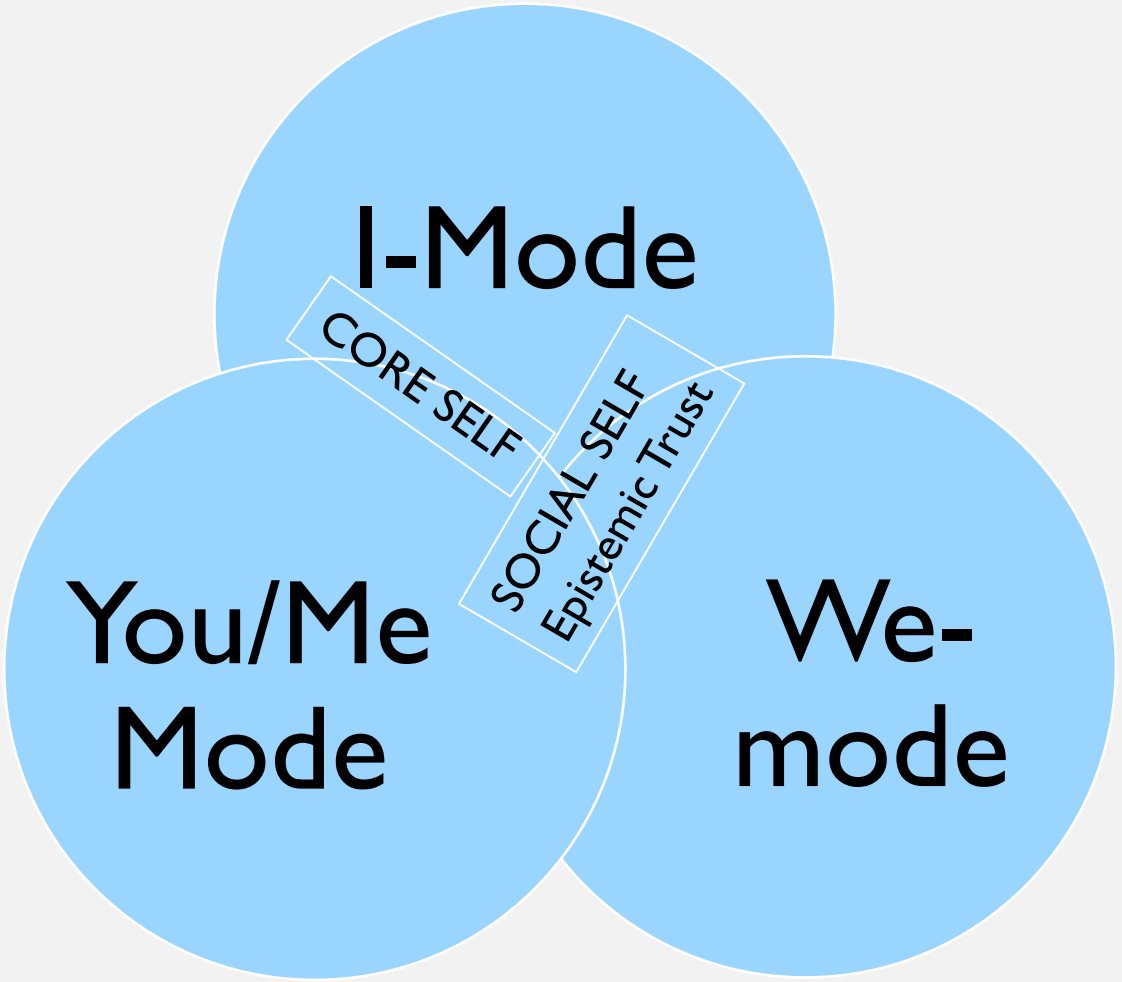
		RFQ				PID-5				AQ
		Gen	Cer	Unc	Psy	Ant	Dis	Det	Neg	Total
RFQ	General	–								
	Cer	.91**	–							
	Unc	.88**	–.52**	–						
	Psy	-.53**	–.58**	.40**	–					
PID-5	Ant	-.38**	–.46**	.19*	.59**	–				
	Dis	-.39**	–.46**	.35**	.70**	.53**	–			
	Det	-.48**	–.38**	.33**	.65**	.53**	.85**	–		
	Neg	-.49**	–.47**	.39**	.71**	.66**	.64**	.64**	–	
AQ	Total	-.58**	–.58**	.42**	.43**	.49**	.53**	.41**	.47**	–

Note: RFQ: Reflective Functioning Questionnaire; PID-5: Personality Inventory for DSM-5; AQ: Aggression Questionnaire; Cer: Certainty; Unc: Uncertainty; Psy: Psychoticism; Ant: Antagonism; Dis: Disinhibition; Det: Detachment; Neg: Negative Affect; *$p < .05$; **$p < .001$.

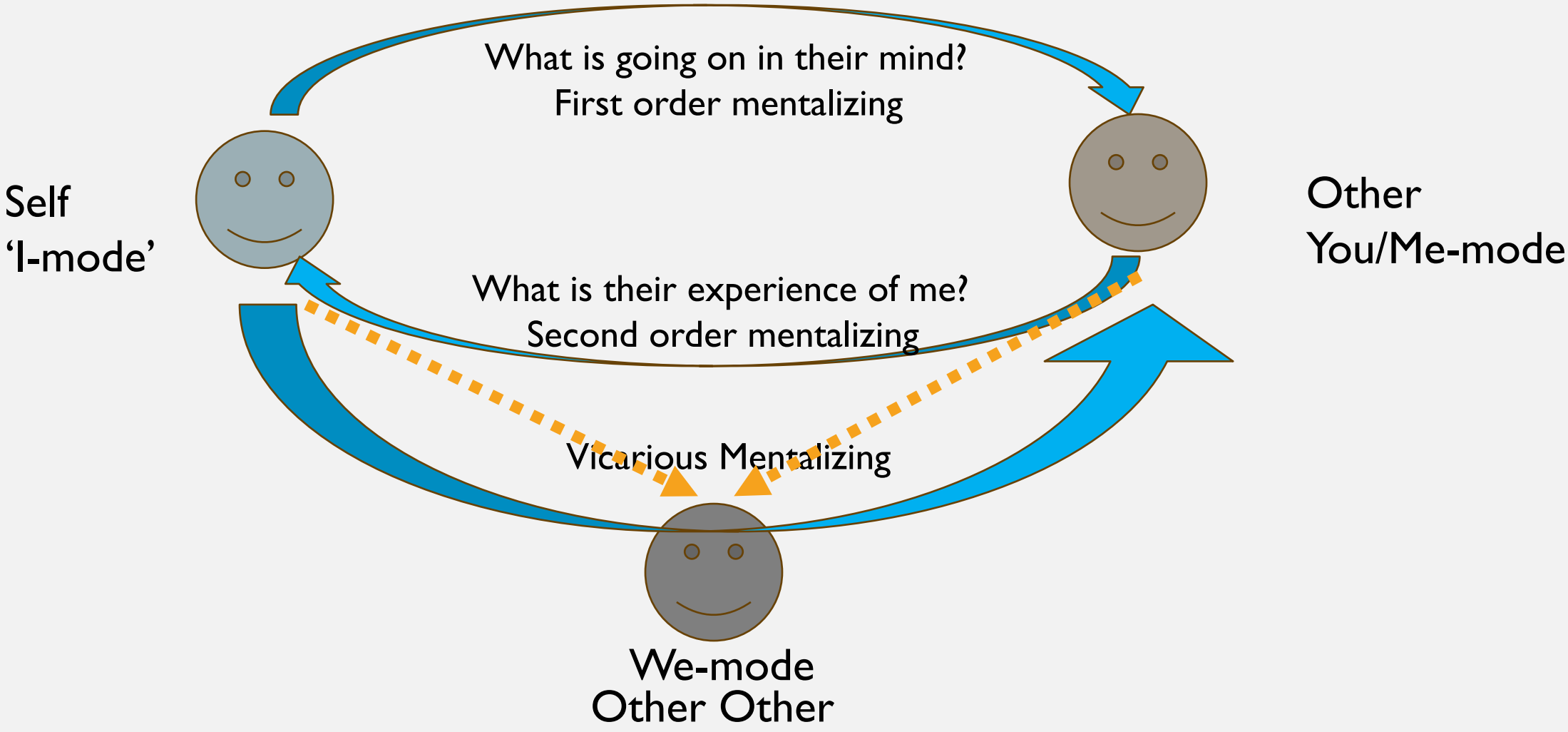
Velotti, P., Rogier, G., Ciavolino, E., Pasca, P., Beyer, S., & Fonagy, P. (2021). Mentalizing Impairments, Pathological Personality and Aggression in Violent Offenders. *Psychology Hub*, *38*(1), 51–60. https://doi.org/10.13133/2724-2943/17437

SOCIAL MENTALIZING

DEVELOPMENTAL MODES OF SOCIAL MENTALIZING



MENTALIZING AS A MODE OF SOCIAL INTERACTION



JOINT ATTENTION

- Significance of ‘joint attention’ in human social cognition
  - Joint attention refers to the ability to focus with another on both external objects, and on mental content – of particular significance is the ability to understand how and why mental states might differ
  - Infant who benefits from being effectively mentalized is rich in experiences of joint attention to mental states. As well as feeling intensely rewarding for an infant, such moments of “we-ness” confer the powerful benefit of stimulating epistemic trust and creating an openness to collaborative social learning

WE-MODE

- Coordination of perspectives
- Appreciate the distinction between the subjective (one's own view) and the objective (actual physical reality "out there")
- Coordinate knowledge (content) of another individual's mental state: quite a complex triangulation
- Cooperation is immeasurably advanced by being able to compare and coordinate different perspectives on the same situation
- Experience of being part of a set of thoughts and feelings that are beyond their own.
- In treatment
  - **Shared picture of reality that clinician and patients can examine together.**

THE *WE* MODE
THE FIRST PERSON PLURAL PERSPECTIVE

- May be organized around **cognitive and neural structures**
  - **intrinsic** to our individual make-up
  - product of a **distinct developmental** and **evolutionary** history

The "I" becomes part of a **unit** → **"we"**

The unit is the object of experience evaluated principally from the perspective of the likely **success** of **collaborative** activities

Not a '**contrast**' between the **individual** and the **social**

but the **embedding of social cognition in the social environment** makes it inseparably linked to its function and dysfunctions

Relational Mentalizing

Shared **thinking and feeling within a social system**, a dyad, a family or other social group.

Associated with **intentional states** that are **assumed** by individuals in the system **to be** joint or **shared** by everyone

Higgins, 2020; Gallotti & Frith, 2013; Schilbach, 2016; Schilbach et al., 2013; Asen & Fonagy, 2012, 2017; Bateman & Fonagy, 2016

Socialisation: a necessity for desistence.

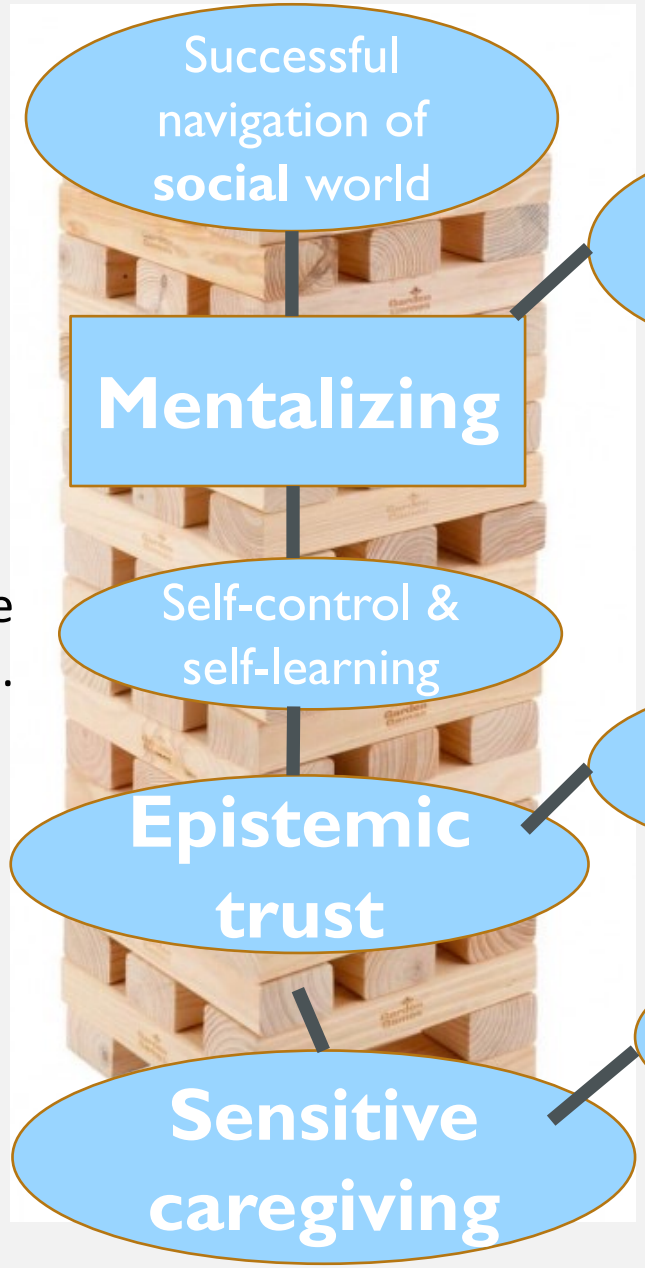
How does socialisation come about?

Caregiver's **mentalizing of the infant** acts as the prototypical **ostensive cue**

Learning channel opens (selectively)

This lays the foundations for…

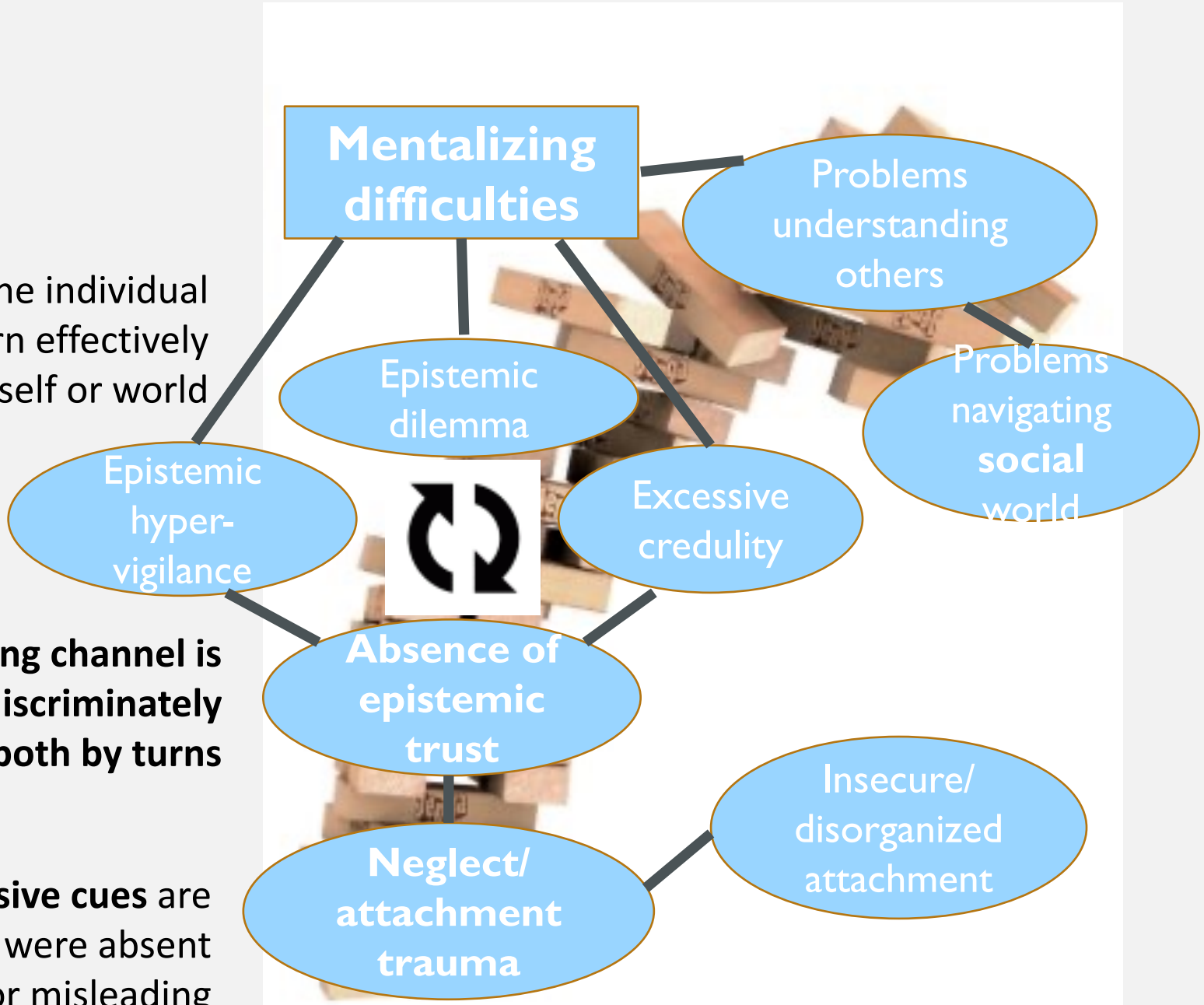
Which enables…



In all 3 cases, the individual struggles to learn effectively about either self or world

Learning channel is closed, indiscriminately open or both by turns

Ostensive cues are **not processed**, were absent or misleading



The nature of trauma is isolation from ones social group

MENTALIZATION BASED DEFINITION OF TRAUMA

- Adversity becomes traumatic when it is compounded by a sense that **one's mind is alone**
- Normally an accessible **other mind** provides the **social referencing** that enables us to frame a frightening and otherwise overwhelming experience.

Allen & Fonagy (2010)

REASONS BEHIND NOT EXPERIENCING TRUST

- Deprivation and trauma → **chronic mistrust**
  - **Fear of mentalizing** → avoidance of mental state and
  - **Inadequate mentalizing → misrepresent** how others represent the person → feel **persistently misunderstood** and experience intense and consistent **epistemic injustice** (never being accurately represented)
  - **Inaccurate view of self → perception of personal narrative in others** is **not** experienced as a **match**

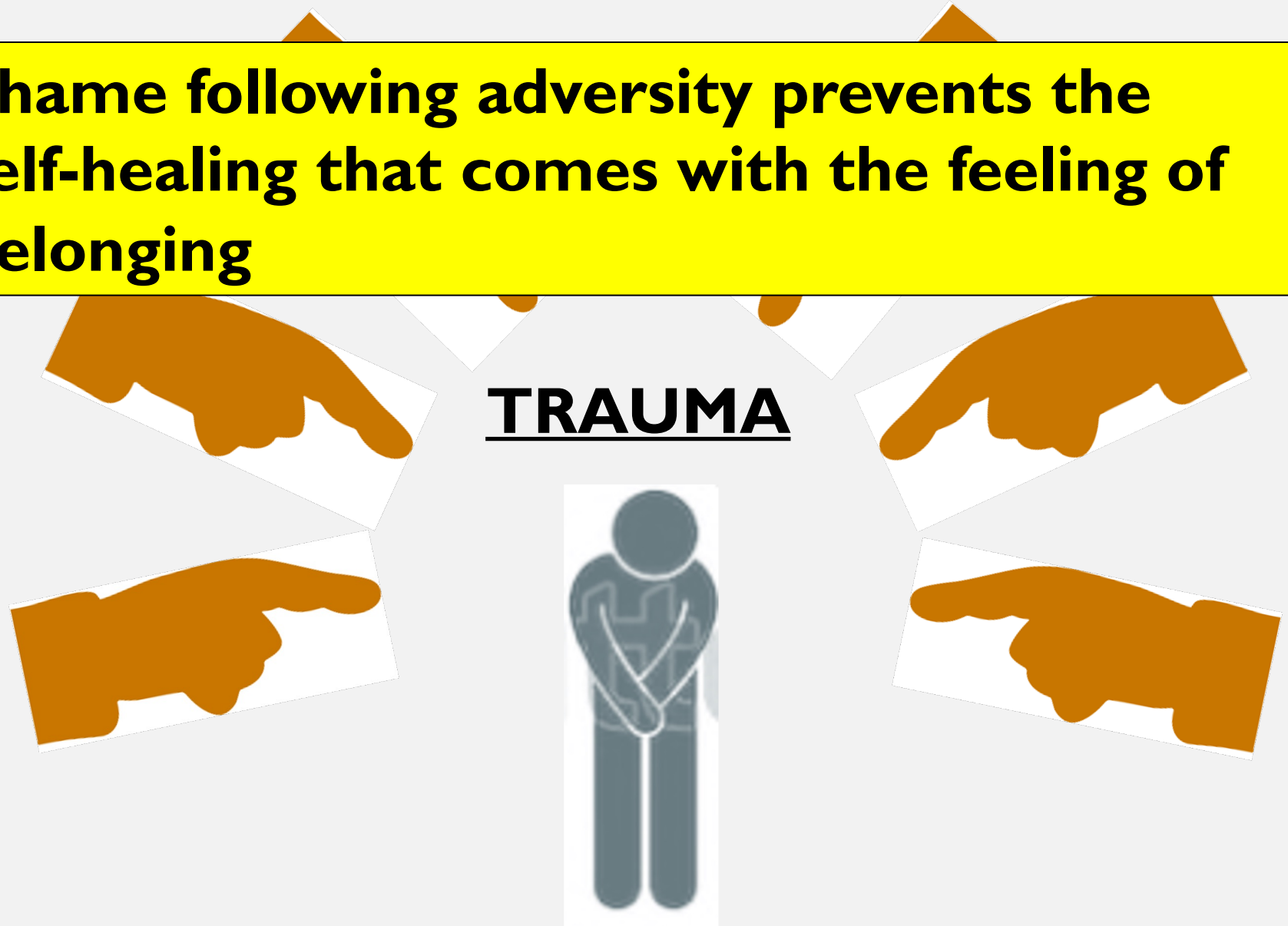
BUILDING A SOCIAL NETWORK IN CHILDHOOD AND ADOLESCENCE AND ADULTHOOD

WHEN THE CAPACITY TO FORM BONDS OF TRUST IS SHAKY AND TENDS TO BREAK DOWN…

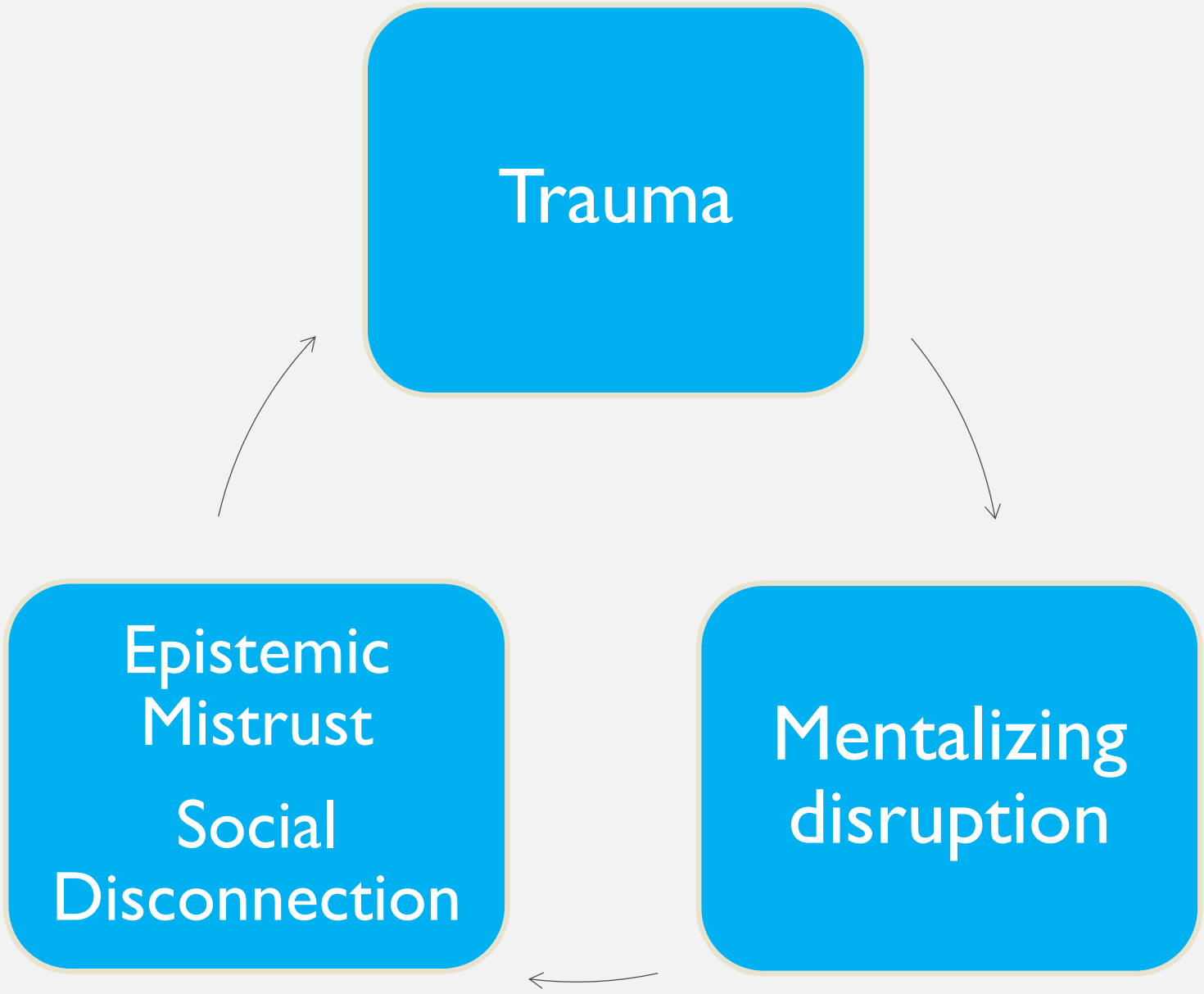
…WE **LOSE** OUR **MENTALIZING NETWORK** AND ADVERSITY IS PROCESSED IN ISOLATION➔TRAUMA

NOT THE EVENT; THE EXPERIENCE OF THE EVENT

Shame following adversity prevents the self-healing that comes with the feeling of belonging



OVERALL SUMMARY

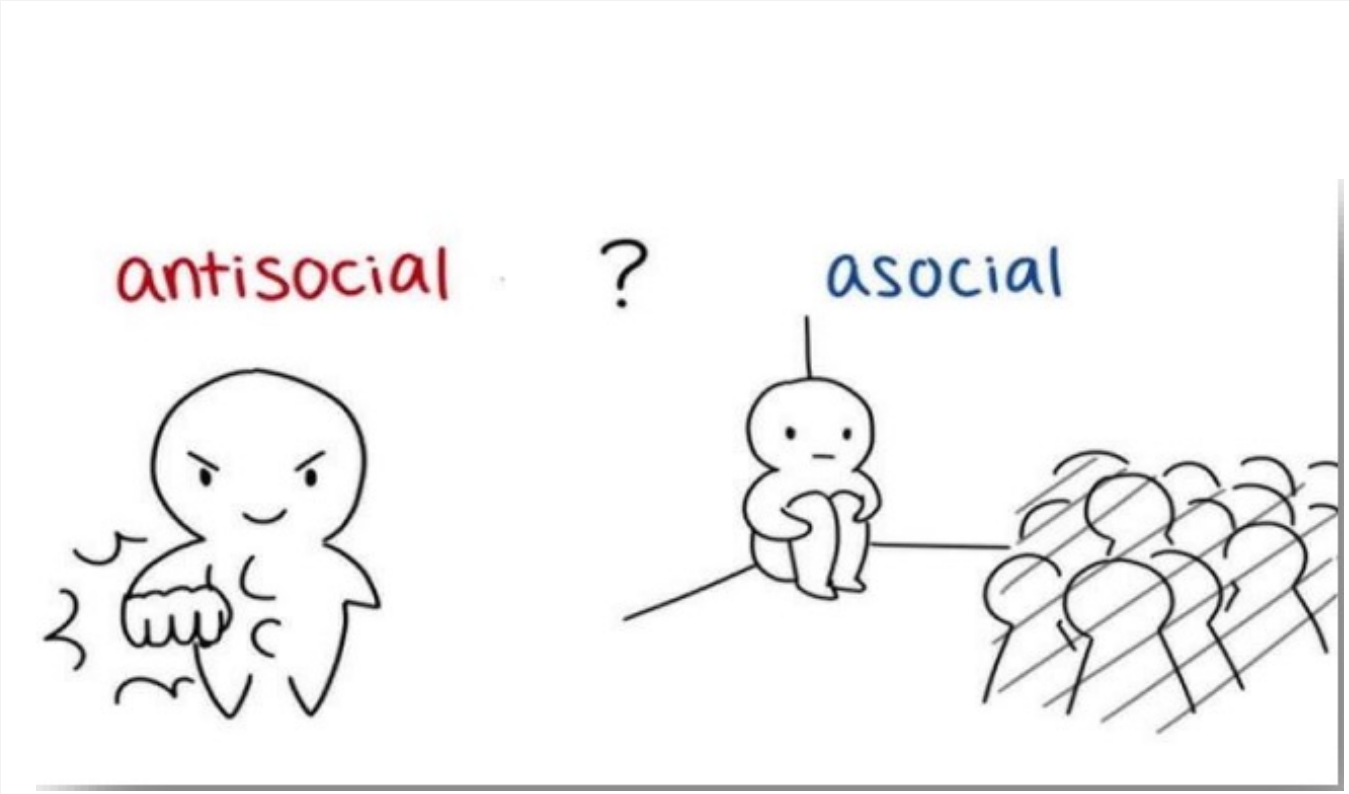


Aim of treatment:

Optimise conditions for Social Learning

Via

Social Reconnection



INITIAL MEETINGS

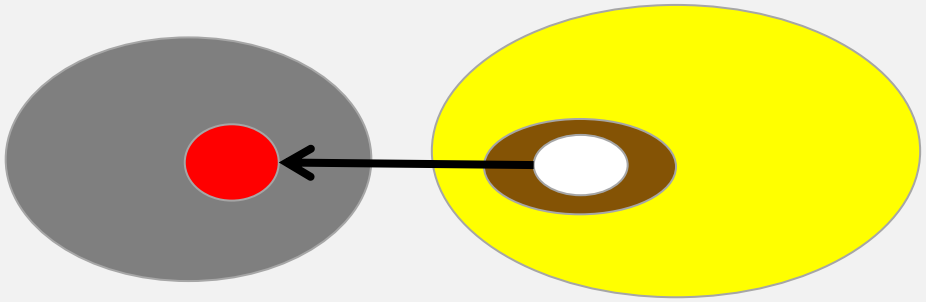
Involvement

Engagement

Seeing the Prosocial Self

Agency

THE THERAPEUTIC CHALLENGE



The stabilisation of mental processes on ASPD/Narcissism depends on **rigid** externalization of the *alien self*

Threats to this externalisation cause arousal of the attachment system and **experience of problematic emotions (shame**) and Epistemic Distrust

Inability to control internal states leads to increase externalization

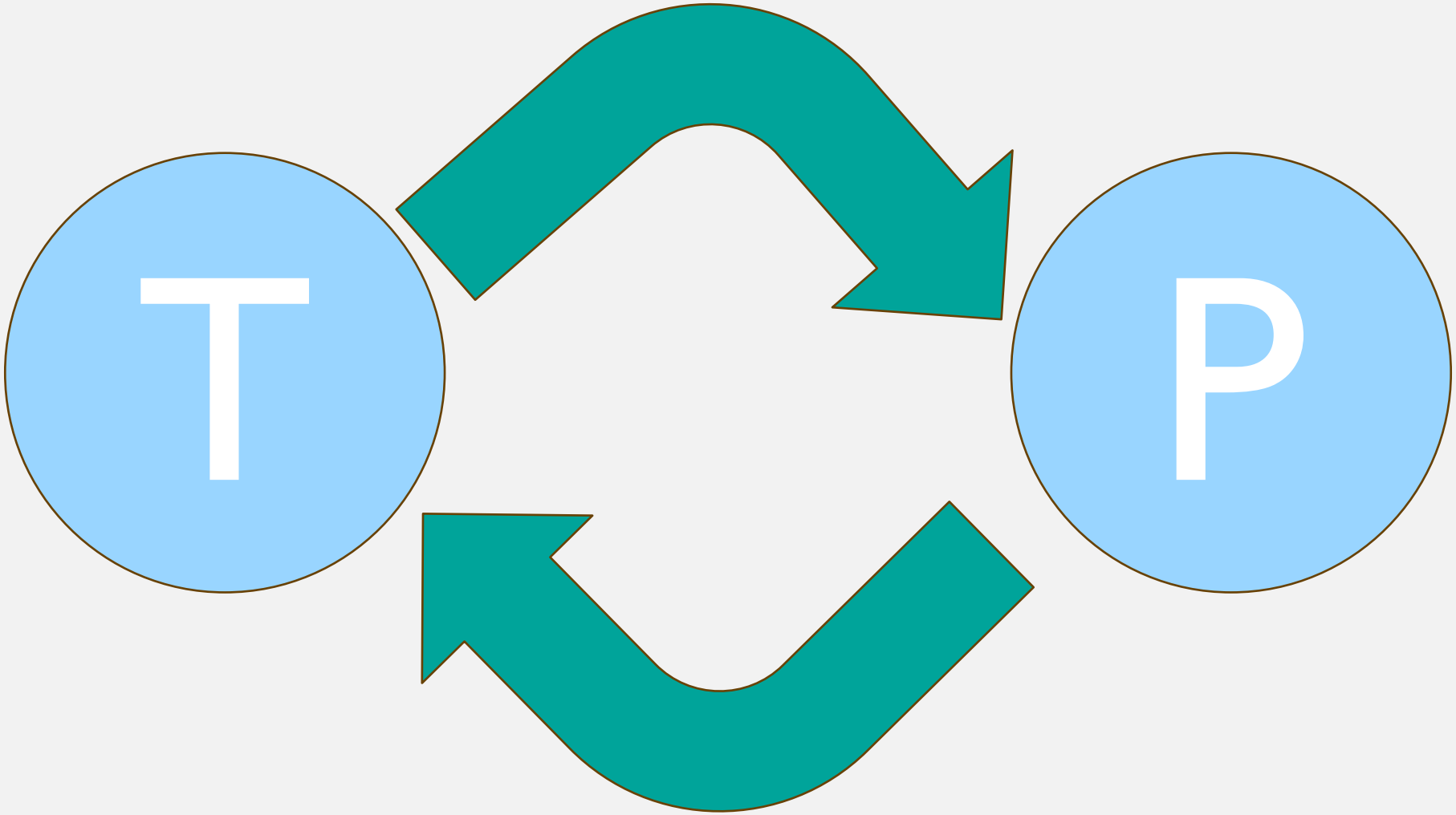
Mentalization failure
Shame, Anger, Fear

Violent control of the perceived source of threat

What if Alien self is fractured Antisocial-Narcissistic/Prosocial-Altruistic orientated identity?

MBT Fundamentals

Find the client's mind



Help the client find your mind

Tell them who you are?

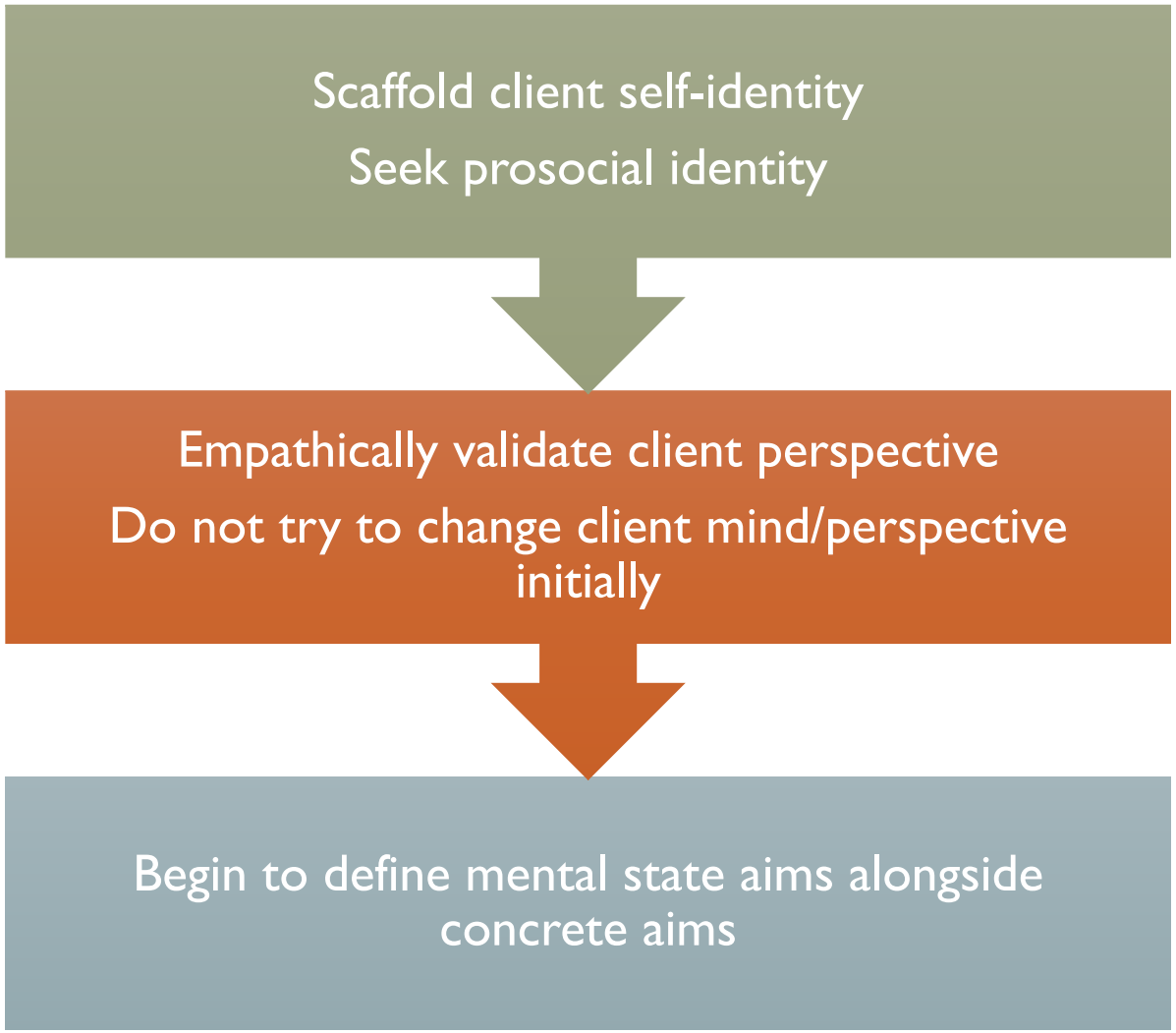
Find out who they are?

Generate discussion about their relationships to systems/society/family/friends

Identify relationship(s) that are important to them

ENGAGEMENT

ENGAGEMENT


Scaffold client self-identity
Seek prosocial identity
Empathically validate client perspective
Do not try to change client mind/perspective initially
Begin to define mental state aims alongside concrete aims

GENERIC MENTALIZING PROCESS

Self-narrative matched by other mind – therapist/group member

Create joint attention with focus on narrative

Generalize to broader social environment

OVERVIEW OF CLINICAL TRAJECTORY

Individual		Group		
2-4 sessions		6-8 sessions	40 sessions	
Assessment	**Formulation →**	**MBT-I →**	**Exploratory Phase →**	**Ending → F/U**
General Psychiatric	Introduction to model	Psychoeducation	Go-around/Synthesis/Focus/Closure	Review Group
Forensic History/Risk History	Treatment Focus Relational Passport	Agreements	Exercises to promote MZ	Review initial formulation and explore time-line of change
Mentalizing profile	Contact agreement e.g. text/phone	Confidentiality	Agreed measures	Plan follow-up
	Confidentiality	Values	Initiate new patient entry when necessary	
	Risk and Crisis Plan		Review client formulations 3 monthly	
	Meet EbE		Review Group values and formulation 3 monthly	

CHANGE PROCESS

- Recognise others as similar and so relevant to them
- Review own life trajectory less dominated by cognitive rigidity and distortion
- Extend to others outside
- Change in identity in I-mode through You/Me-mode and We-mode of group
  - What was important reduces in value and what was not important increases in value
  - Representation of a different future self
  - Finding prosocial 'hooks' in environment
- Openness to social communication rather than new attachments in current context

Facilitating the development of epistemic trust (1)

Clinician Attitude and Personal characteristics:

- Honesty, transparency, humour, relatable (**ordinary**)
- Searching for synchrony (**elasticity**) rather than rigidity
- Egalitarian stance (**not knowing stance**) and **minimise power differential**
- **Professional deference**
  - **disarming** interpersonal **boundaries (self-disclosure)** e.g. about no similar personal experience

Increasing bi-directionality – learning from client

- **Enable** client to **feel** that their perspective is **being understood**
  - recognition of the **client as the knower** of their story
  - client's perspective is valued and believed
  - Client giving information relevant to clinician so they feel moments of being 'in charge'
- **Joint exploration** not just delivering truths and information
  - offer opportunity for **active shaping of narrative** (give **tools to solv**e problems rather than solving problems for the patient)
- Also **addresses** power **differential**
  - openness to achieving **we-mode function** (searching for common ground of shared intent)

Facilitating the development of epistemic trust (2)

Engage in a **process** towards epistemic trust (not destination)

- **Walk along** with the mind of client and validate rather than aim to fix- see it through their eyes
- **Positive feedback loop** – to and fro - cycle of **exchanges** between client and therapist **generating** more **progress**

Enabling self-control, decision making and agency

- **Holding** but not taking over the **process of decision making –** interest in **how** rather than what
- Encouraging other activities that give **agency outside** of **therapy**
- **Recognising** patient has priorities **beyond therapy** and deferring to them
- Giving advice in a collaborative way, letting client **come to conclusion**, not dictatorial

Trust in the model being used

- Based on **evidence** and experience of success – engagement through peers and experts by experience
- Has a **structure** that tells you where you are but can use with elasticity
- Provides **content** that **optimizes** making use of **self-change**, change in **circumstances** (a job), family and social **support** and **fortuitous events**, **faith**, **persistence**, **community** involvement
- Creating optimal conditions for social learning, not just from therapists but also from peers and other socializing agents (Group)

Research

OUTCOMES

Primary Outcome	Reduction in the frequency of aggressive acts
Secondary Outcomes:	Criminal: other (re)offending behaviour
	Mental Health : anxiety and depression, drug and alcohol use, self-harm and suicidal behaviour, impulsivity, and beliefs
	Health: quality of life, health and functioning
	Service use: services including A & E and use of social services during the treatment and follow-up period.
	Cost-benefit analysis to determine the actual cost of service delivery in both treatment conditions and whether MBT-ASPD leads to reduction in costs compared to PAU.

INCLUSION/EXCLUSION CRITERIA

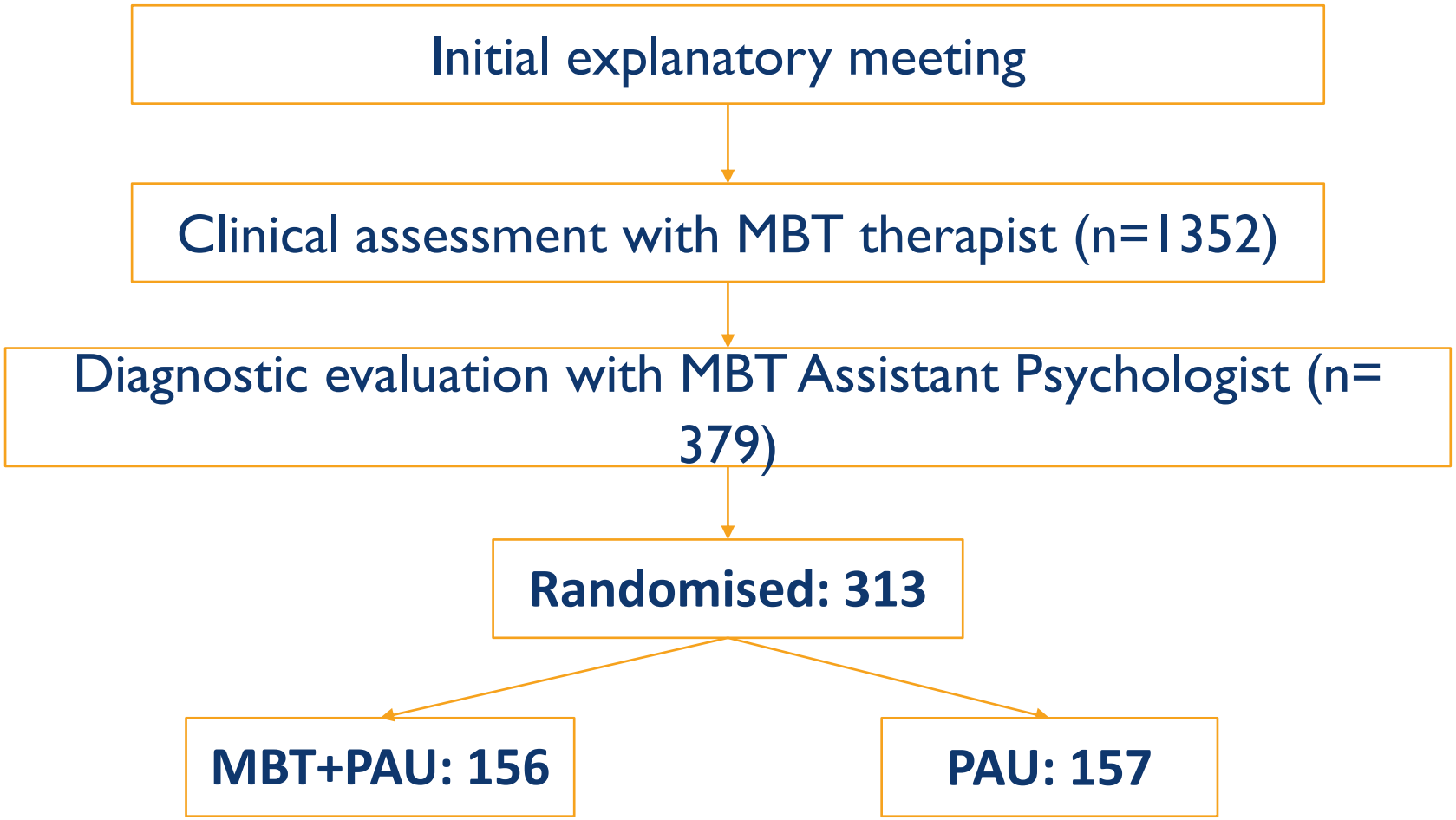
Inclusion

- Male
- Aged 21 years and over
- DSM-IV-R diagnosis of ASPD (using SCID-II)
- Evidence of aggressive acts in the 6 months prior to assessment
- Subject to statutory provision by the National Probation Service with at least 6 months remaining of their license or community sentence

Exclusion

- Current diagnosis for schizophrenia or bipolar disorder
- Severe substance or alcohol addiction
- Convictions for child sexual offences (including child pornography)
- Neurodevelopmental disorder or significant cognitive impairment.
- Inadequate English or cognitive capacities to provide informed consent and participate in group therapy

Research design



Followed up every 3 months for 24 months assessing offending behaviour, mental and physical health, alcohol and drug use among other variables

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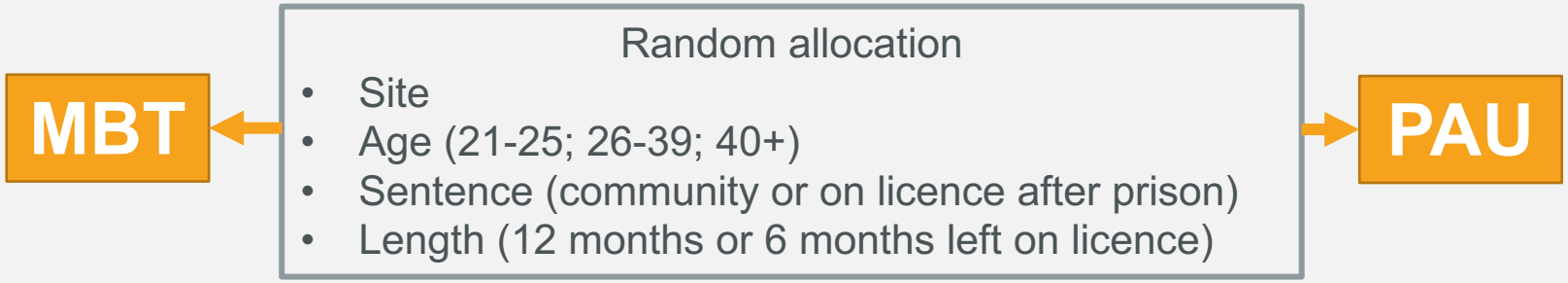
RESEARCH DESIGN

- Multi-site randomized control trial in a real life NHS/Probation setting.
- Recruitment target 302 participants across 13 sites
- Participants randomly allocated to MBT or Probation as Usual (PAU)
- **User Voice Peer Researchers** collected data alongside traditional Research Assistants
- Participants followed up every 3 months for 24 months post randomisation.

-Primary outcome measures and offending records obtained every 3 months post randomisation

-Secondary outcomes collected every 6 months



PEER RESEARCHERS (PR)

Advantages

- Break down barriers to engagement and
- Research 'with' and 'by' public rather than 'to', 'on' or 'about'
- Reduced power differential
- Improved data collection – quality, depth, validity

Potential problems

- PR needs support and training e.g.
  - may enter probation and prison settings where they themselves were
- Seen as being part of the system
- Identified as the 'enemy'
- May have different offending behaviour
- Suspicion from other professionals

Mentalisation-based treatment for antisocial personality disorder in males convicted of an offence on community probation in England and Wales (Mentalization for Offending Adult Males, MOAM): a multicentre, assessor-blinded, randomised controlled trial

Peter Fonagy, Elizabeth Simes, Karen Yirmiya, James Wason, Barbara Barrett, Alison Frater, Angus Cameron, Stephen Butler, Zoe Hoare, Mary McMurran, Paul Moran, Mike Crawford, Stephen Pilling, Elizabeth Allison, Jessica Yakeley, Anthony Bateman

Lancet Psychiatry 2025; 12: 208–19

See Comment page 166

Research Department of Clinical, Educational and Health Psychology, University College London, London, UK

Summary

Background Antisocial personality disorder is a major health and social problem, but scepticism about its treatability has restricted development of the evidence base for psychological treatments. Mentalisation-based treatment (MBT) tailored for antisocial personality disorder (MBT-ASPD) can address problematic behaviours by improving the ability to understand and regulate the negative effects of thoughts and feelings. This study aimed to evaluate the clinical and cost-effectiveness of MBT-ASPD compared with probation as usual in reducing aggressive behaviours from baseline to 12 months of follow-up.

Primary outcome

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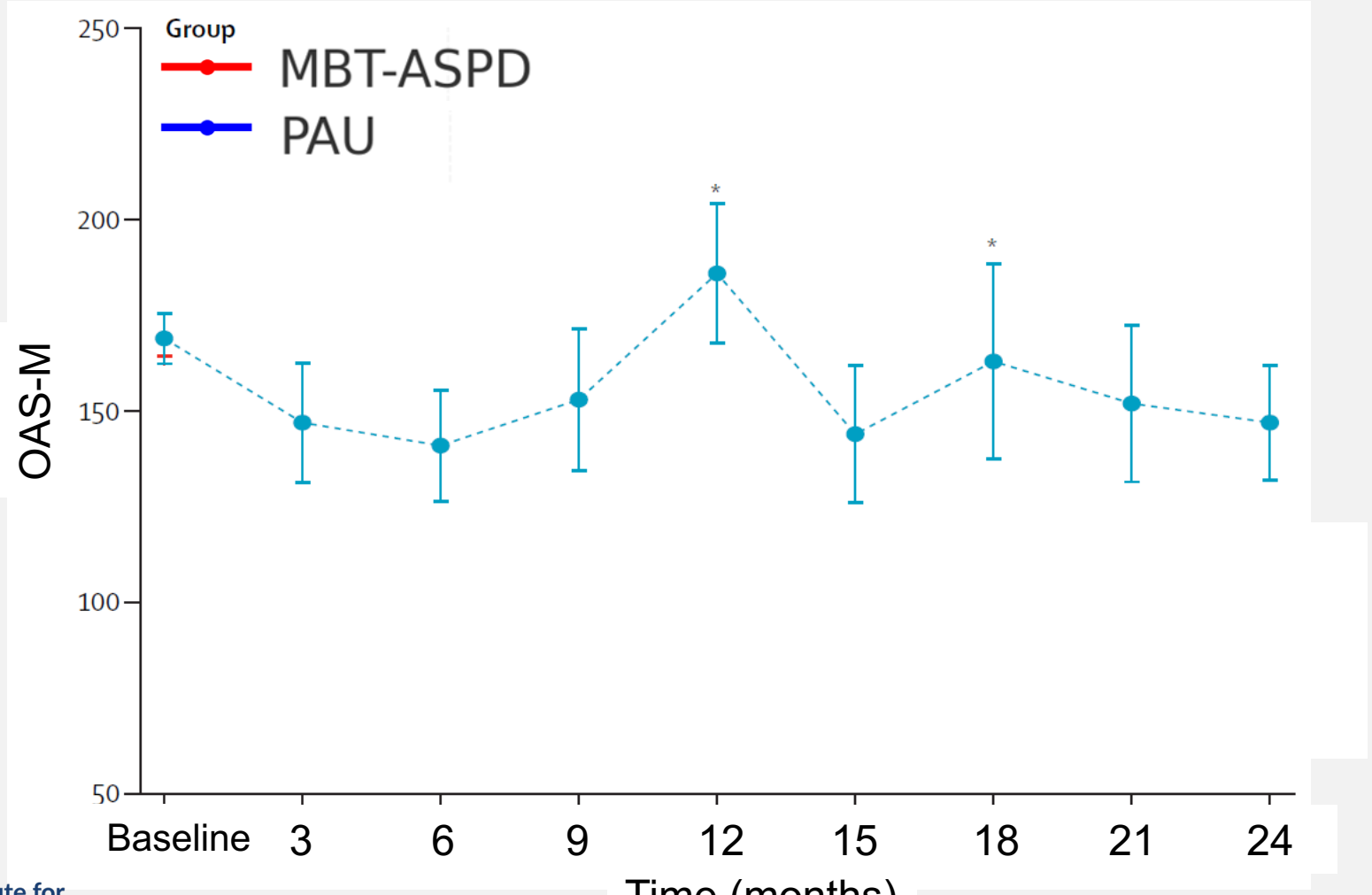
MBT SIGNIFICANTLY REDUCED OVERALL AGGRESSION (OVERT AGGRESSION SCALE MODIFIED; OAS-M)

Overall Adjusted Mean: -38.6 (95% CI: -62 to -15.3), p = 0.0015, Effect Size = -0.39



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Fonagy et al., The Lancet Psychiatry, 2025

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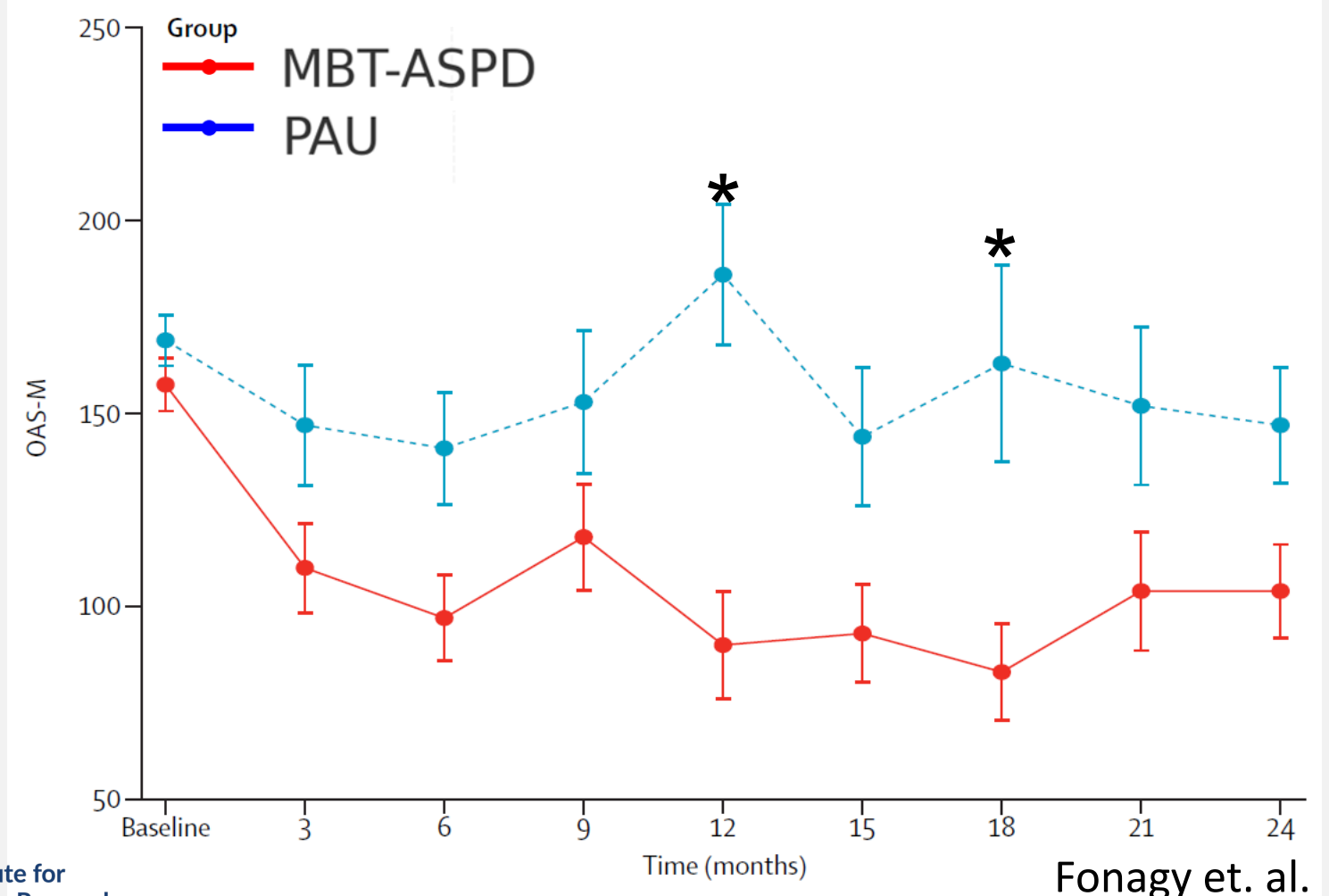

Fonagy et. al. (2025, *The Lancet Psychiatry*)

FUNDED BY
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Secondary outcomes

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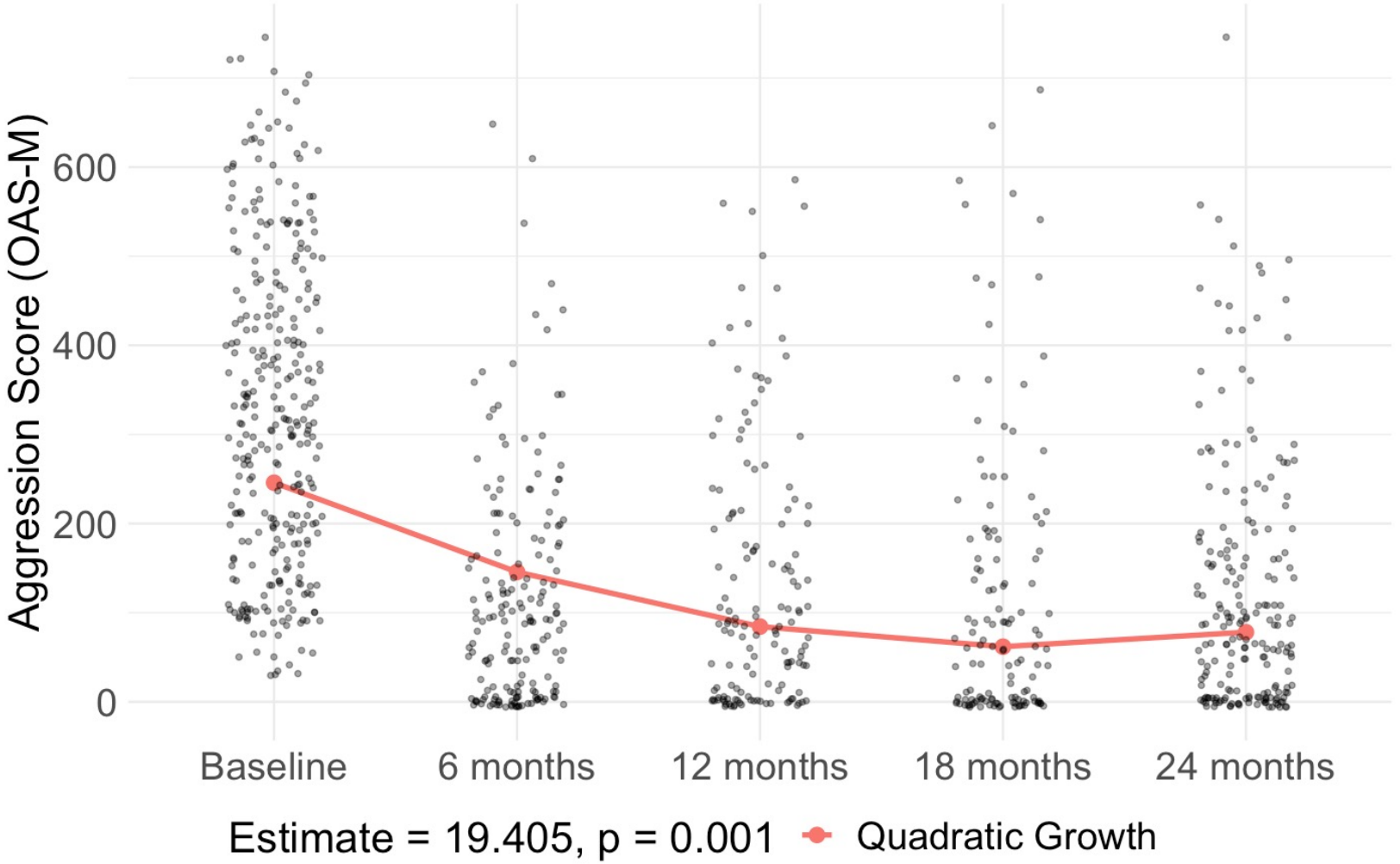
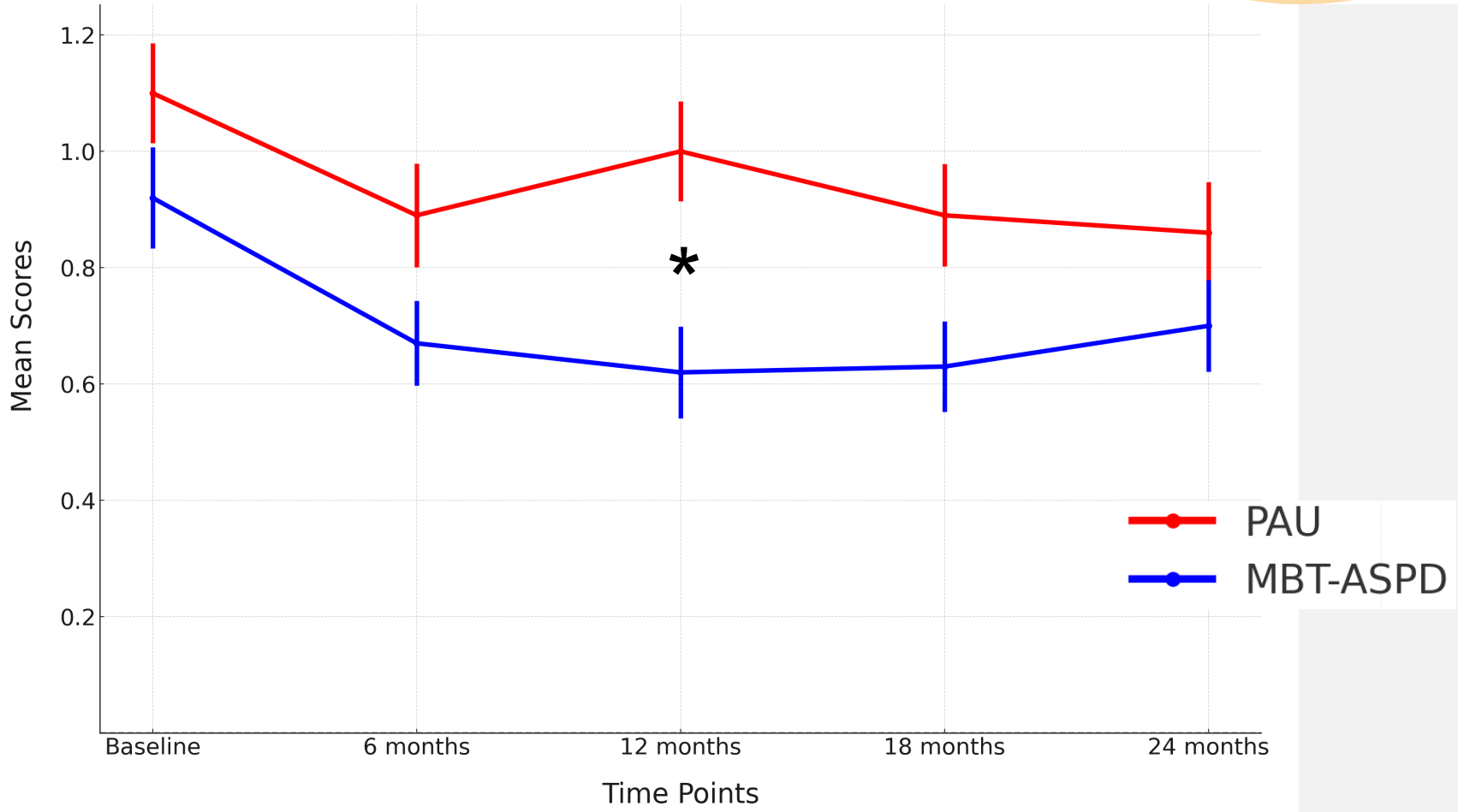
LONGITUDINAL RESULTS SUPPORT THE ROLE OF REFLECTIVE FUNCTIONING IN PREDICTING AGGRESSION FOR THE ENTIRE MOAM POPULATION



*Reflective Functioning as a covariate influencing aggression levels over time

MBT SIGNIFICANTLY REDUCED OVERALL UNCERTAINTY IN REFLECTIVE FUNCTIONING (REFLECTIVE FUNCTIONING QUESTIONNAIRE; BRFQ)

Overall Adjusted Mean: -0.15 (95% CI: -0.3 to -0.0061), p = 0.04



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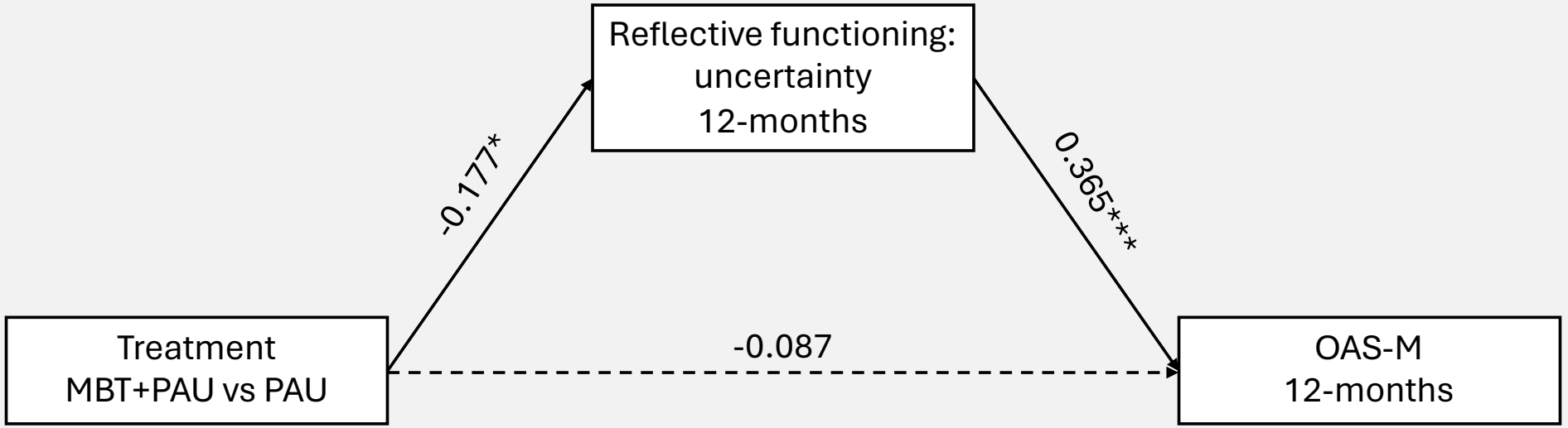
Fonagy et. al. (2025, *The Lancet Psychiatry*)

PRE-DESIGNATED POTENTIAL MEDIATORS BETWEEN TREATMENT EFFECT AND AGGRESSION

- Alcohol use (AUDIT)
- Drug use (DUDIT)
- Mood, assessed via the anxiety and depression subscales of the Symptom Checklist-90-Revised (SCL-90-R)
- **Mentalizing competence**, measured by the Reflective Functioning score (RFQ)



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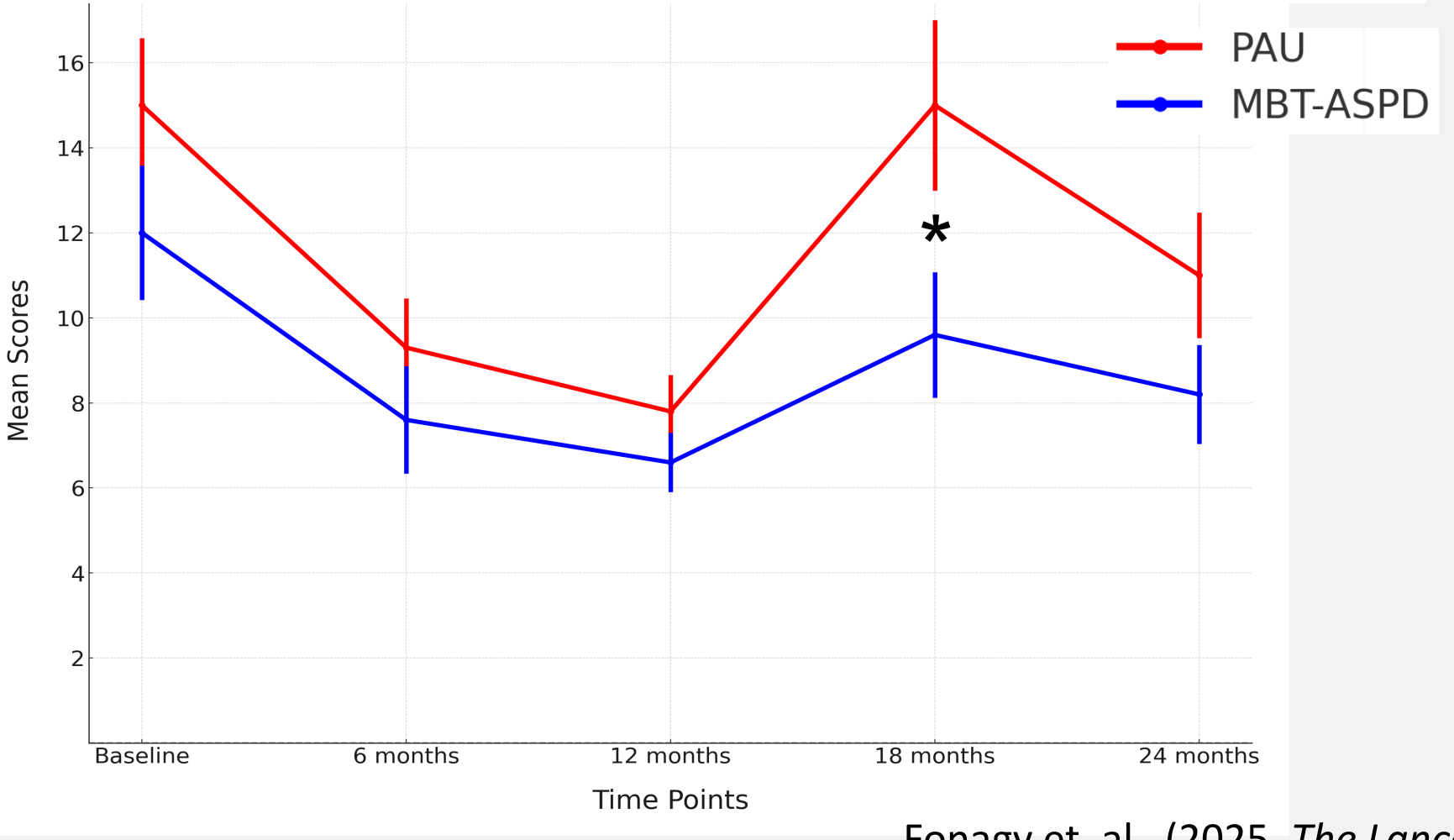
Fonagy et. al. (2025, *The Lancet Psychiatry*)

MBT SIGNIFICANTLY REDUCED CONFLICT LEVELS AT 18-MONTHS (NEGOTIATION COGNITIVE SUBSCALE IN CONFLICT TACTICS SCALES; CTS2S)

Overall Adjusted Mean: -1.9 (95% CI: -4.5 to 0.84), p = 0.19, Effect Size = -0.16



FUNDED BY
NIHR | National Institute for Health and Care Research

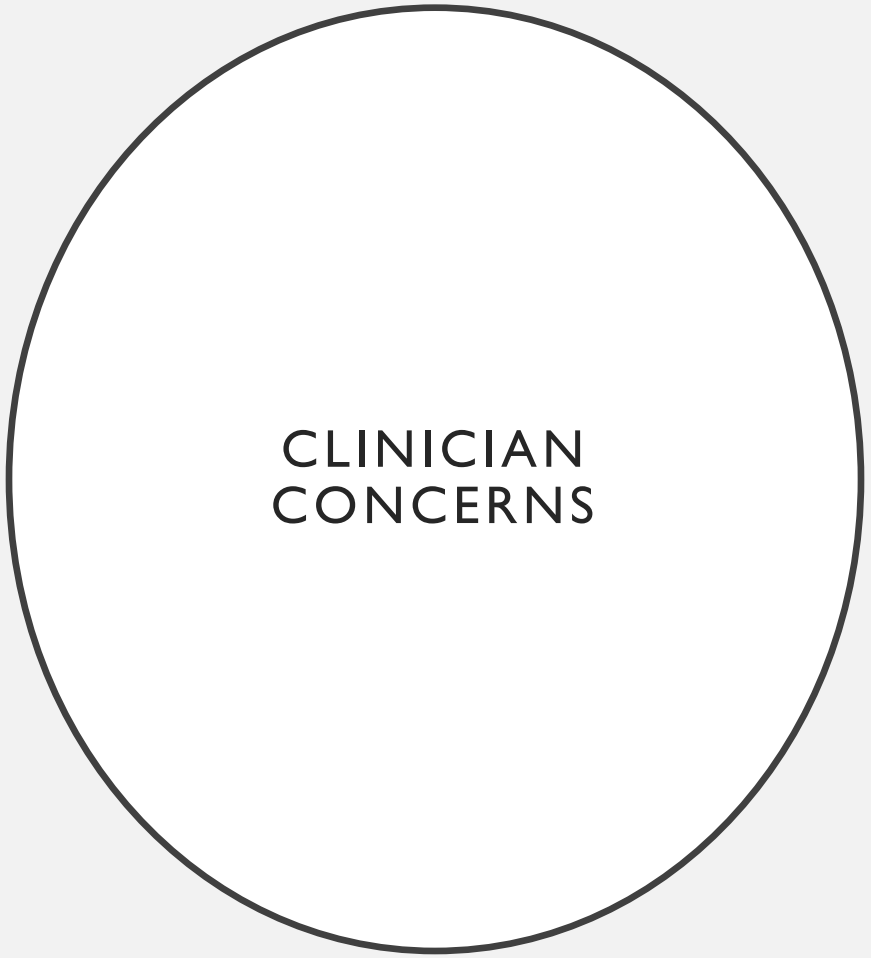
Fonagy et. al. (2025, *The Lancet Psychiatry*)

Finally:

Clinician Experience

with last word to

Client Experience



- Adequate emotional support for impact of work
- Attrition rates and group formation/Attachment issues
- Systemic issues of interface between Health and Criminal Justice. Re-organization of probation
- Treatment intervention. Recall by Probation
- Research design and Randomisation

CLINICIAN THEMES

Katharina T.E. Morken, Morten Ovrebø, Charlotte Klippenberg, Therese Morvik, Elisabeth Lied Gikling Antisocial personality disorder in group therapy, kindling pro-sociality and mentalizing. *doi: 10.4081/ripppo.2022.649*

Gaining safety by getting to know them better – watch out for your assumptions/stigma

Establish cooperation through clear boundaries and a non-judgmental stance – social/MZ/values talk v rules and requirements

Shifting inner boundaries – clients do not follow social norms in terms of content. Watch out for intrusive/personal questioning

Timing interventions in a high-speed culture – jokes/humour about serious issues/rapid fire talk/banter

KEEP UP and SLOW DOWN

CLIENT THEMES

"What you see is what you get", indicating a reliance on observable behaviours as indicators of personal characteristics

"You are on your own", reflecting a pervasive sense of isolation and self-reliance

" Fear of losing control", suggesting that feelings and particularly aggression is perceived as uncontrollable and that participants fear their own emotions' effect on their behaviour

"The system screws us"

CLIENT CHANGE

Ulrik Hagen Hamre, Per Einar Binder, Elisabeth Lied Gikling, Bjarne Olsen, Morten Øvrebø & Katharina T. E. Morken (07 Mar 2026): "I Could Be Wrong": Men's Passage Through Uncertainty And Change In Mentalization-based Treatment For Personality Disorder And Substance Use, Psychotherapy Research, DOI: 10.1080/10503307.2026.2638260

I could be wrong—developing cognitive flexibility and self-reflection

I know what it takes—acquiring emotion regulation skills and confidence

It doesn't have to be anything more—reduced interpersonal hypersensitivity

I understand what others need—enhanced interpersonal awareness

Something's happened, and I don't know what—varied and sometimes ambiguous transformation

THANK YOU FOR MENTALIZING PEOPLE WITH ANTISOCIAL PERSONALITY

I will leave the final words to them