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RESEARCH ARTICLE

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Establishing an optimal working relationship with patients with an antisocial personality disorder. Aspects and processes in the therapeutic alliance

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Abstract

Objective: Developing good interpersonal relationships is one of the main impediments for people with an antisocial personality disorder (ASPD). However, in treatment of psychiatric disorders, establishing a strong therapeutic alliance (TA) is important for effective treatment. Nevertheless, there is little knowledge on how to establish this TA with this challenging patient group. This study investigates which factors are important in TA development.

Method: For this study, a qualitative research methodology is applied. In-depth interviews with therapists experienced in treating ASPD were conducted and analysed through thematic analysis.

Results: The analysis revealed six themes important in alliance formation: the patient's needs, regulating interpersonal dynamics, connective attitude, connective skills, treatment process and treatment goals. Each theme is defined including aspects of the recommended therapeutic attitude and required skills for therapists working with patients with ASPD.

Conclusions: This study determined that, for therapists working with patients with ASPD, several key factors are essential in establishing a strong TA. These factors include the ability to be firm, authentic, non-judgmental and genuinely involved. An attentive presence is crucial, in which the therapist takes initiative in establishing contact and makes the patient feel that he is truly seen as an autonomous and equal person. In doing so, the therapist needs to provide clarity and structure while remaining perceptive to boundary violations. The therapist must be able to set limits using

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a clear yet kind tone of voice. Furthermore, it was notable that an intensive appeal is made to the therapist's reflective capacity in these treatments.

KEYWORDS

antisocial personality disorder, psychological treatment, thematic analysis, therapeutic alliance, therapist's attitude

Practitioner's points

- Creating a therapeutic climate in which patients with antisocial personality disorder can improve in lowering their resistance, distrust, and subversive behaviour and developing sensitivity in therapy pose a significant challenge for therapists.
- Building and maintaining an effective therapeutic alliance requires therapists to be firm, but also flexible and adaptable to the patient's needs and difficulties. Additionally, authenticity and an open, non-judgmental attitude are core values.
- Specific therapeutic skills can enhance the therapeutic alliance. Therapists need to be attentive, provide clear guidance, and establish boundaries in a way that maintains the connection with the patient.

INTRODUCTION

In psychotherapeutic treatment, therapeutic alliance (TA) is one of the most important factors contributing to treatment effect (Beutler et al., 2004; Lambert & Barley, 2002; Norcross & Wampold, 2011). The term 'therapeutic alliance' or 'therapeutic relationship' refers to interpersonal processes in the treatment context (Wampold & Imel, 2015). TA is a construct that is studied extensively in psychotherapy. A widely used description of the construct is Bordin's (1979), who defined TA as the professional collaboration between patient and therapist and their agreement on therapeutic tasks and goals, in a context of a personal bond. Creating a therapeutic bond, trust, and working together on therapy tasks and goals are in the essence of a TA setting, as is the appropriate management of alliance ruptures (Flückiger et al., 2018; Safran et al., 2011). The TA is a robust factor positively related to treatment outcomes, which has been demonstrated in different treatment approaches and patient populations (Flückiger et al., 2018). When considering the establishment of a strong TA in psychotherapeutic contact, regardless of diagnoses, several factors come into play, such as therapeutic warmth, sincerity, empathy, and respect (Frank & Frank, 1991; Patterson, 1984). In addition to the therapist's deployment of specific interpersonal skills, the formation of the TA is explicitly a collaborative process between the patient and the therapist, as described by Bordin (1979) and supported in subsequent research (e.g., Horvath et al., 2011). Furthermore, the approach should be tailored to the patient's characteristics (Hatcher, 2015; Norcross & Wampold, 2018).

How can a strong TA be established when those very factors like collaboration and forming a personal bond are the patient's core problems? Developing and maintaining a good TA, establishing an affective patient–therapist bond, and reaching agreement on therapeutic goals can be particular challenging when working with patients diagnosed with an antisocial personality disorder (ASPD). This difficulty arises due to various factors, including problems with trust and authority, a tendency to manipulate, limited insights into own issues, and resistance to therapy. These obstacles can significantly impede the progress of the therapeutic process (Bender, 2005; Davis & Beck, 2015; Sprey, 2015). Thus,

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establishing and continuing a constructive reciprocal relationship, as reflected by the description of psychopathology, is difficult for these patients.

According to the Diagnostic and Statistical Manual of Mental Disorders 5 TR (DSM-5-TR), ASPD can be defined as 'a pervasive pattern of disregard for the rights of other people that often manifests as hostility and/or aggression'. Often, these patients 'lack empathy, are generally cold, cynical, and full of contempt towards the feelings, rights or suffering of others' (American Psychiatric Association, 2022, p. 868). It seems inevitable that these characteristics will affect the TA. In addition, many of these patients are treated in a forensic psychiatric setting, which presents further obstacles. Risk assessments and reports for legal authorities must be delivered; information about the patient and his offending behaviour can affect the therapist's attitude towards the patient; and motivational problems may also complicate the development of a constructive TA, both in a voluntary and involuntary treatment context (Ferrito & Moore, 2017; McGauley et al., 2011; Ross et al., 2008; Shaw & Edelmann, 2017).

Many therapists also appear to be reluctant to work with patients with ASPD (Chartonas et al., 2017; Djadoenath & Decoene, 2015; Van Dam et al., 2022). They experience negative attitudes towards patients with ASPD and have indicated feeling insufficiently competent to treat these patients (Van Dam et al., 2022). The lack of evidence-based guidelines for building an effective TA with these patients is believed to be one of the reasons for the therapists' reluctance. The availability of more knowledge on how to build and maintain a good TA can contribute significantly to a better sense of therapist competence and treatment quality (Van Dam et al., 2022). Providing high quality treatment for these patients is important, given that ASPD can cause significant emotional burden and costs for society, the social environment, and the patients themselves (Rijckmans et al., 2020; Van den Bosch et al., 2018).

Also for patients with ASPD, a strong TA is an important precondition for providing high-quality treatment (Flückiger et al., 2018). Several studies showed that a positive TA is positively associated with the outcome in treatment of patients with ASPD (Fahlgren et al., 2020; Kennealy et al., 2012; Polaschek & Ross, 2010). While some principles for treating individuals with ASPD have been described in the psychotherapy literature, a specific and comprehensive approach for working with these patients is currently lacking. Treatment protocols for mentalization-based treatment (Bateman, 2021; McGauley et al., 2011) and schema focused therapy (Bernstein et al., 2021; Chakhssi et al., 2014) have been adapted for individuals with ASPD by targeting the elements underlying ASPD, such as impaired mentalizing ability, attachment disorders, and trauma, implying a more personal, psychotherapeutic contact between patient and therapist. Therefore, analysis of TA is essential in the treatment and management of ASPD. However, in these treatment protocols, insufficient attention is paid to TA development in relation to ASPD.

In the forensic setting, the Risk Need Responsivity (RNR) model, developed by Andrews et al. (2006), serves as a valuable foundation for the treatment and risk management of patients with ASPD, emphasizing three essential principles for effective treatment within this population and other offender groups. In addition to the Risk and Need principles, the Responsivity principle states that evidence-based treatment methods should be used (general responsivity) and tailored to patients' characteristics and capabilities (specific responsivity). The TA can be seen as a crucial part of specific responsivity but has received little attention in the specific elaboration of the RNR model (Sturm et al., 2021). Some studies focusing on TA in offender counselling provide additional insights. For example, a study involving offenders exhibiting antisocial behaviour, though not necessarily diagnosed with ASPD, highlighted the importance of developing trust between probation workers and offenders in establishing a TA (Sturm et al., 2021). In a qualitative study by Ferrito and Moore (2017), therapists offering cognitive behavioural therapy to mentally disturbed offenders emphasized the importance of responsivity and creating a safe treatment environment. Therapists were recommended to be sensitive to patients' cues, demonstrate trustworthiness, and use language that resonates with the patient. Attention to change readiness as an intermediary in the TA and maintaining therapeutic optimism are also recommended (Fiedler, 2018; Pasyk et al., 2022). Ross et al. (2008) proposed a framework integrating research developments and knowledge with Bordin's model, demonstrating that the therapeutic relationship in the treatment of offenders occurs within

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a specific context, involving treatment setting, therapist and patient characteristics, interpersonal processes referring to the interaction between the therapist and the patient, concerning both overt and more covertly present cognitions, perceptions, emotions and behaviours, all of which interact with each other. They showed the multi-faceted nature of the therapeutic relationship. However, research that specifically focusses on patients with ASPD is scarce. Recently, Morken et al. (2022) employed an autoethnographic qualitative study of mentalization-based group treatment for patients with ASPD. Based on their own experience, they concluded that a direct approach with clarity about boundaries and structure was essential, alongside an open-minded, non-judgmental attitude that respects the patient's autonomy.

To date, there is a lack of in-depth exploration and available guidelines on the optimal approach for developing TA in psychotherapy for patients with ASPD. Therefore, the purpose of this study is to investigate the factors crucial for the establishment of a TA with patients with ASPD. By gaining these insights, practitioners can enhance their therapeutic practices with this complex group, better meet individual patient needs, and increase the likelihood of effective treatment. This study aims to obtain detailed insights into the therapeutic aspects and processes that are important in the TA when treating patients with ASPD, including treatment goals, treatment tasks and therapeutic bond as was directed by Bordin (1979). Additionally, the study also seeks to clarify which interpersonal processes and challenges arise in the treatment of patients with ASPD. A qualitative research design is employed to gather knowledge about the experiences, processes and perspectives of the therapists who have extensive experience working with patients diagnosed with ASPD (Hammarberg et al., 2016). The main research question guiding this study is: 'What do therapists perceive as essential in therapy regarding the interpersonal processes, treatment processes, and treatment for patients with ASPD?'

METHODS

Design

Since little is known about TA with patients with ASPD, an exploratory research design was used and qualitative research methods were employed to investigate experiences, perspectives, and experiential knowledge (Hammarberg et al., 2016). Therefore, semi-structured interviews were conducted. The use of semi-structured interviews is a robust technique for generating a description and understanding of people's opinions, beliefs, and overt experience (Ritchie et al., 2014). Therapists with experience working with patients with ASPD were interviewed to gain a comprehensive view on the themes (therapeutic goals, tasks, and bond) important to the development of a TA. To maximize transparency and in line with standards for qualitative research, the consolidated criteria for reporting qualitative research (COREQ) guideline[1] was used (Tong et al., 2007). According to this checklist, qualitative research should cover all 32 items that address sampling methods, methods of data collection and data recording, respondent validation of findings, description of themes derivation, and inclusion of supporting citations (Tong et al., 2007). Ethical approval was obtained from the Ethics Review Board for the Social and Behavioural Sciences of Tilburg University (EC-2019.26).

Participants

Participants were recruited from participating mental healthcare institutions and forensic mental healthcare institutions in the Netherlands through oral and written information. Therapists with at least seven and a half years of practical experience, of which 5 years with patients with ASPD and trained as mental

[1] http://intqhc.oxfordjournals.org/content/19/6/349.long.

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health psychologists, psychotherapists, clinical psychologists, or psychiatrists were invited to participate in the study. Psychologists in the Dutch mental health system can be trained in different specializations. Mental health psychologists complete a 2-year training after their Master's degree. Psychotherapists and clinical psychologists respectively complete a 3- and 4-year postdoctoral training after their training as mental health psychologists. Fifteen therapists participated in the study, 11 women and four men. They were between 35 and 63 years old ($M = 45.6$, $SD = 10.4$), had between 10 and 33 years of experience in mental health care ($M = 19.3$, $SD = 7.6$), and worked in different settings; outpatient (voluntary and involuntary), inpatient (involuntary) and mixed settings.

Procedure

In-depth interviews were conducted by the first author of this manuscript following the method described by Ritchie et al. (2014). A semi-structured interview guide and a topic list were used that combined structure and flexibility with an interactive style aimed at real understanding and generating knowledge (Table 1). The interview guide was designed with the intention of initiating an open-minded conversation so that the participants could adopt an exploratory and curious attitude and talk freely about their experiences, needs and expectations. The interview started with open-ended questions to help the participants focus on the topic investigated. Then, the experiences in building and maintaining a strong TA with patients with ASPD were discussed. Based on the topic list, more in-depth questions were asked. If it appeared at the end of the interview that a topic from the topic list had not been covered, this was still discussed. Interviews were conducted between September 2019 and January 2021 at the participants' workplaces. Due to the COVID-19 pandemic, six interviews were conducted via video calling. Interviews were audio-recorded and transcribed verbatim. The duration of the interviews was between 50 and 70 min.

Data analysis and validation

Thematic analysis was used to identify themes, using an inductive view and analysing the data without a pre-existing code frame (Braun & Clarke, 2006). This procedure contains the following steps.

1. Familiarization with the data; each interview was transcribed in a uniform format. The texts were studied in detail for the researcher to become familiar with the content and gain ideas about patterns and possible themes in the data.
2. Encoding the text with Atlas.ti program version 9 (Scientific Software Development GmbH, 2018). Codes were created based on actual phrases or concepts in the text and were not prepared in advance. The first and fourth author coded two interviews separately. The coded material was compared and discussed by both coders and combined into one set. Using theses codes, three other interviews were coded by the first coder and checked by the second coder. After discussing and rechecking the codes, the code set was determined, and the remaining interviews were coded by the first coder. At the end of this process, the interview transcriptions were divided into 779 quotations, and 269 codes were assigned to the quotations.
3. Identification and definition of themes and subthemes. The process of defining themes involved repeated steps. Codes were sorted by potential (sub)themes, overlapping subthemes were combined into overarching themes, and some codes were discarded. During coding and thematization, the focus was on the therapeutic relationship and related factors. First, a comprehensive overview was used to prevent relevant information from being lost. Second, after theming, the key factors related to the TA were selected. These themes and subthemes were assessed by rereading each code and quotations and subsequently defined. The themes were also reviewed by reading them next to the data set to see if they reflected the content of the data. Finally, 221 codes were identified and divided into six themes

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TABLE 1 Questions included in the interview guide.

Introduction
The aim of this study is to obtain well-described, detailed knowledge about therapeutic aspects and processes that are important in developing a positive TA in treatment of patients diagnosed with ASPD. With this information, we aim to provide a comprehensive guideline outlining the essential elements for establishing a strong therapeutic relationship during therapy with patients diagnosed with ASPD
I would like to ask you a series of questions about your expertise and knowledge in building an effective TA in the treatment of patients with ASPD
Questions
Introductory questions
• What do you think of an antisocial personality disorder?
• What do you think of working with this target group (both positive and negative)?
• What do you expect to encounter in a treatment process with a patient with ASPD?
• What do you hope happens in a treatment of these clients?
• How would this target group view therapy?
Treating and contact
• How can a therapeutic relationship be established with these patients?
• What do you think are the needs of patients with ASPD?
Treatment process
• How do you think you should establish a treatment process?
• What are potential pitfalls?
• What should you avoid during the treatment of these patients?
Therapist's interest
• What are your needs as a practitioner of this target group?
• What do you need to give patients with ASPD proper treatment?
Completion
• Is there anything else important in the therapeutic relationship that we have not discussed yet?
Topic list
• How to shape the therapeutic contact (starting and during therapy)
• Positive and negative/difficult experiences
• Obstacles experienced in contact with the patient
• How to cope with these obstacles
• Dealing with alliance ruptures (examples)
• Dos and don'ts in a TA approach
• Patient's experience from the therapist's point of view
• Therapist characteristics and qualities

and 25 subthemes. The themes were named and defined in a way that captured the essence of the themes.

4. Several checks were performed to increase reliability and validity.
   (i) To test the overall level of agreement on themes and subthemes between two raters (the first and second author), an inter-rater reliability check was performed on 25 randomly selected interview sections. The interview sections were divided into 56 quotations, independently rated and compared. The level of agreement was calculated on the initial themes and codebook by using Cohen's Kappa. For both themes ($K=0.76$) and subthemes ($K=0.77$), the level of agreement was sufficient (McHugh, 2012).
   (ii) The themes and subthemes were checked for clarity and agreement with the text by five independent research fellows familiar with qualitative research methods. Also, a member check was performed in which four participants provided feedback on the recognizability, clarity, and comprehensiveness of the analysis and results.

   Based on the information from both validity checks, the authors revisited, discussed, and adjusted the classification of the (sub)themes.

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Reflexivity

Because little is known regarding the requirements of the therapeutic relationship with patients diagnosed with ASPD, an inductive method of analysis was employed. A comprehensive range of data was collected and analysed with an open-minded approach to identify specific factors influencing the TA with this particular patient group. The first author works as a clinical psychologist/psychotherapist and scientific practitioner in general mental healthcare. She conducted the interviews, performed the analyses, and contributed to the development of the (sub)themes. Given that she does not have extensive experience in working with patients with ASPD, she maintained an open attitude towards the information provided. The remaining three authors are senior researchers in the field of developmental psychopathology, forensic psychology, aggression, and antisocial behaviour. They have extensive experience as (clinical) psychologists/psychotherapists working with offenders and patients with ASPD. The data analyses were conducted by researchers with this specific background and theoretical knowledge (Braun & Clarke, 2006).

RESULTS

The analysis of the interviews revealed six themes, which encompass important aspects and processes of the TA in the treatment of patients diagnosed with ASPD (Table 2). There was a broad consensus among the interviewed therapists. The differences observed were mainly related to variations in emphasis and focus. Notable, there were no discernible differences in the described TA approaches among therapists from different therapy settings, including outpatient (voluntary and involuntary) and inpatient forensic health care. The first two themes highlight the specific characteristics of the TA with patients diagnosed with ASPD. The subsequent themes describe different components of the TA and offer strategies for addressing the unique aspects of the TA within this target group. The following section provides a detailed description of each theme, supplemented with relevant quotations. These quotations have been translated and edited to enhance their relevance and readability.

Patients' needs

Participants emphasize that patients diagnosed with ASPD decidedly value gaining *respect* and being recognized as individuals with qualities and talents when engaging with others. Furthermore, *autonomy* is regarded as highly significant for these patients as they need to feel independent from others. Therapists should acknowledge this and support this need for autonomy. According to participants, *trust* was identified as a crucial element. Patients require a safe and non-judgmental environment where they can feel seen and trusted by others. It takes time for patients with ASPD to transition from a primarily independent state to genuinely connecting with another person. As one participant expressed, 'They have been neglected so often that being heard, being taken seriously, the recognition of what they think and feel, that they matter to others, the autonomy and the safety, are very important aspects.' (Interview O)

Regulating interpersonal dynamics

Several factors that specified interpersonal difficulties in the TA with patient with ASPD emerged from the interviews. According to the participants, these facets in the interpersonal dynamics in the TA require specific attention of the therapists. Attention to sensitivity, appropriate intimacy and leeway

TABLE 2 Overview superordinate and subordinate themes.

Superordinate themes	Subordinate themes
Patients' needs	Autonomy
	Respect
	Trust
Regulating interpersonal dynamics	Balancing between personal closeness and distance
	Balancing between being restrictive and giving space
	Dealing with resistance and distrust
	Dealing with subversive or hostile behaviour
	Dealing with sensitivity
Connective attitude	Authenticity
	Open attitude, without judgement
	Genuine involvement
	Firmness
Connective skills	Connecting and phasing
	Seeing the person (understanding behaviour)
	Providing clarity and structure
	Limit setting
	Being perceptive
	Reflective ability
Treatment process	Developing trust
	Recognizing one's own responsibility
	Exploring problematic patterns
Treatment goals	Reducing burden
	Improving interpersonal relationships
	Reducing risk
	Changing as a person

are needed to build and sustain the TA as is dealing with dismissive behaviour. The following five sub-themes can be distinguished:

Balancing between personal closeness and distance. Participants described considerations that are recurrent in therapy. One of the core tasks during psychotherapy with these patients is finding a suitable balance between personal closeness and professional distance in the therapeutic bond. 'There must be a balance in the level of activation of the attachment system. If you turn the thermostat too high, you will lose them, but too low, you will lose them as well'. (Interview D)

Balancing between being restrictive and giving space. Striking a good balance between providing space and setting appropriate boundaries is also important but complex. Participants describe difficult situations where they aimed to maintain a good relationship with the patient while also being aware and decisive regarding boundary violations. 'The moment you are very restrictive toward manipulative behaviour, you lose them, and if you give them too much space, you also lose them. So, it is a balancing act between being restrictive and giving space, just to be able to feel that autonomy'. (Interview D)

Dealing with resistance and distrust. Participants appointed different attitude issues commonly observed in patients with ASPD, such as motivational problems, resistance to therapy and change, and fragile or inconsistent progress. Recognizing and understanding these behaviours as part of psychopathology can help in effectively managing them.

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Dealing with subversive or hostile behaviour. This subtheme refers to negative behaviours displayed by patients that disrupt therapy, including manipulation, disqualification, and threatening and coercive behaviours. These behaviours stem from the underlying psychopathology and are also targeted within therapy.

Dealing with sensitivity. Participants noted the importance of addressing the patient's emotionality and sensitivity. Patients diagnosed with ASPD are sensitive to rejection and can quickly perceive a lack of engagement from therapists. To gain a better understanding, therapists can benefit from actively seeking the patient's perspective as their perception of the world with different standards and values. 'The trust in others is often lacking, and to get trust, it is a long process. If a little trust is developed, it is often very fragile, you only have to say something wrong once or interpret it differently for the trust to be broken again, so that, yes, that makes it very complicated' behaviour'. (Interview C)

Connective attitude

All the relevant aspects with regard to attitude in contact with patients diagnosed with ASPD are aggregated in this theme. This theme refers to the (emotional) bond therapists hope to develop with a patient. Participants indicate that therapists need to make genuine contact, offer positive dynamics, be authentic, be firm, and attune their tone to the patient. Four subthemes can be distinguished:

Authenticity – just be natural. Most participants argued that it is important for patients to perceive their therapists as authentic individuals. One participant stated the importance of 'just being natural', not assume a role but showing yourself as you are. This includes being honest, engaging in therapy related self-disclosure, and being open to feedback. Therapists should avoid adopting an authoritarian attitude as patients with ASPD are sensitive to such behaviour, which can lead to resistance.

Open attitude, without judgment. Participants indicate that TA is based on cooperation, a positive rapport and treating the patient as equal, distinguishing between their behaviour and their underlying self. Ideally, therapists should adopt an open and non-judgmental attitude, accepting the patient while setting boundaries for transgressive behaviour. Participants emphasise that learning alternative, more desirable behaviour can be difficult and not always pleasant for the patient. Therapists should be aware that transitioning to an adjusted life without delinquency may be difficult. 'The question is 'do you have to focus on that [offence],' or do you take a closer look to create a bond of trust? Who are you and what have you been through? The latter is what I try to do. To make contact with them and create a bond of trust, and then to see what is possible in treatment.' (Interview H)

Genuine involvement. Participants indicate that it is crucial to make authentic connections and genuinely attend to the patient. Therapists can display this through curiosity, understanding, transparency and trustworthiness. It is essential for therapists to be fully 'present' during sessions, showing the patient that they are aware of their background and really try to understand, support, motivate, and, if necessary, engage in additional conversation.

Firmness. Participants indicate that therapists need to be able to stand firm, take responsibility, and exhibit firmness and persistence. The capacity to assert oneself is described as necessary to gain the patient's trust and respect. 'It should not be too soft, also in setting limits. That can be quite firm. You don't have to be too gentle with them. That is actually what they are asking for.' (Interview A)

Connective skills

This theme contains specific skills that participants describe as relevant in building and maintaining a strong TA. These skills are deemed essential for overcoming the specific challenges involved in engaging with the target group. The following six subthemes can be distinguished:

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Connecting and phasing. The participants stress the importance of therapists actively engaging with their patients and striving to establish a connection with (the perception of) their patients, phasing their interventions and being patient. Therapists should tune into what is needed during the session (e.g., give room for emotions if the patient has been through something difficult even if you had planned something else). In addition, participants also mentioned the significance of timing interventions appropriately and adjusting attitudes based on the phase of therapy. According to participants, therapists tend to be more compliant in the early stages of therapy and may become more directive in later stages if necessary. 'So, I think you really have to keep checking to see if I'm not going too fast and keep checking to see if I still have a connection with my patient, or if he is just sitting here biding his time'. (Interview J)

Seeing the person (understanding behaviour). Participants emphasize both the importance of equality between the patient and the therapist and the ability to make the patient feel accepted as an individual. This helps reduce resistance, aloofness, and distrust. It is useful to explicitly distinguish the patient's behaviour from the underlying self and convey this to the patient.

Providing clarity and structure. In order to facilitate a successful therapy process, it is important to establish clarity. This involves creating an unambiguous treatment plan, providing sufficient explanations about diagnoses and treatment options, and discussing the limitations of interventions. Therapists should strive for consistency, maintain a structured approach, avoid getting side-tracked by unrelated discussions, and ensure that the focus remains on treatment goals.

Limit setting. Participants indicate the importance of establishing preconditions and boundaries within the treatment. Therapists and patients need to reach agreements, for example, on dealing with aggression. A therapist should be capable of setting boundaries without losing sight of the patient's individuality. 'You have to identify problem behaviour, set limits and make clear what you expect without rejecting the person'. (Interview B)

Being perceptive. In treatment, it is also important for therapists to remain perceptive of the patients' actions, as well as their own emotions, thoughts, and behaviour. Vigilance is necessary to closely monitor the underlying motives of the patients, in order to intervene when necessary while still maintaining a connection with the patient. 'Yes, you have to remain very aware of what is and what is not acceptable and what you want to achieve, and they are, of course, the smooth talkers, then you have to think, right, what's going on here'. (Interview M)

Reflective ability. According to participants, reflective ability is an essential capability for therapists. Therapists must be able to observe the situation and themselves with emotional distance, share these thoughts and doubts with colleagues, and be honest about their competences.

Treatment process

Participants highlighted several processes that are specifically present in the treatment of patients with ASPD. Three subthemes have been identified: *Developing trust* is a prominent part of the treatment process as patients with ASPD often struggle with distress. Establishing trust is necessary to shape the treatment process and foster collaborating between the therapist and the patient. *Recognizing one's own responsibility* is seen as one of the first steps towards change. Patients with ASPD tend to externalize their problems and blame others. By examining and acknowledging their own responsibility, they can initiate behavioural change. Also, *exploring problematic patterns* and developing trust are ongoing tasks that both the therapist and patient work on during therapy, with the ultimate aim of changing these patterns. This involves behavioural patterns and cognitions that lead to problems in relationships with others, work problems, mental health complaints and rule-breaking behaviour. 'That they recognize that the behaviour they are exhibiting does not actually suit them, that it is not what they had hoped. That they realise: 'hey, wait a minute, I internalised that as a survival mechanism, a coping mechanism'. (Interview K)

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Treatment goals

The treatment goals mentioned by participants can be divided into four subthemes: Consistent with treatments of other types of patients, *reducing burden* is a vital goal. The participants indicate that *improving interpersonal relationships* is an issue for nearly all patients as they experience considerable problems in this area. Also, *reducing risks* receives significant attention, especially in the forensic setting. Finally, some patients also want a substantial transformation of their personality: *changing as a person*. Participants indicated that they strive to set collaborative goals and negotiate the goals with patients when necessary. The goals should be personally tailored and consistent with risk factors and the patient's needs. 'There needs to be a clear (treatment) plan, and we need time to make this a collaborative plan. There must be a framework to start with, so that you can address each other's responsibilities' (Interview E).

DISCUSSION

The purpose of this study was to gain insights into therapeutic aspects and processes in the TA when treating patients with ASPD. Based on the collected expert knowledge of therapists, six themes were identified and described: first, two themes reflecting the specific features and dynamics encountered in TA with patient with ASPD; second, two themes highlighted the attitude and skills required to establish a strong TA and effectively address the challenges. A connective attitude, characterized by authenticity, non-judgmental openness, genuine involvement, and firmness, was identified as essential for developing personal bonds with the patients and for meeting their needs for autonomy, respect, and trust. The described connective skills can be deployed to properly regulate interpersonal dynamics apparent in TA with patients with ASPD. Third, these skills and attitudes are considered to be contributing to a valuable treatment process and treatment goals, as described in the last two themes.

The last four themes were revealed to be closely related to the three components described by Bordin (1979). *Connective attitude* and *connective skills* are related to the bond aspect and describe the desired therapeutic attitude and specific skills that therapists can adopt to establish and maintain a strong TA. Bordin's treatment tasks and goals are reflected in the described *treatment processes* and *treatment goals* in which the participants emphasize the collaborative aspect, aligning with Bordin (1979) concept of TA. Moreover, this study also found support for the revised model for TA described by Ross et al. (2008). They describe several additional factors that can be seen as part of TA, such as characteristics, behaviours, and perceptions of the patient and therapist. Those factors are also reflected in the themes *patient needs, regulating interpersonal dynamics, connective attitude* and *connective skills*.

These findings are consistent with previous research that emphasized factors such as trust, sensitivity and using the patient's language (Ferrito & Moore, 2017; Sturm et al., 2021). Some of these factors are generic and important for establishing a good TA with patients in general, such as showing interest, respect, and genuineness (Blasko et al., 2018; Hatcher, 2010; Nienhuis et al., 2018; Wampold et al., 2017). These factors have been found to be important in studies involving patients with anxiety disorders, depression with comorbid alcohol use problems, and personality disorders (Bender, 2005; Knock et al., 2021; Luong et al., 2020). On the other hand, other factors, such as clarity, transparency and trustworthiness, appear to be more specific to personality disorders in the dramatic or erratic cluster and of particular importance for patients with ASPD (Bender, 2005; Morken et al., 2022). These aspects were described in the subtheme *genuine involvement*, emphasizing the value of establishing genuine contact through curiosity, understanding, transparency and trustworthiness. The relevance of these aspects for the TA can be explained by psychopathological characteristics, including need for respect, distrust, and antagonism. Patients with such characteristics are unlikely to connect with therapists easily and may not readily trust the good intentions of others. Building trust takes time, as does demonstrating sincerity, transparency, and an open, non-judgmental attitude. A direct approach is also important, including setting clear boundaries while still maintaining respect and honouring the patient's autonomy. The significance of firmness in setting boundaries was also highlighted in recent studies by Morken et al. (2022)

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and Seaward et al. (2021). Van den Bosch et al. (2018) similarly recommended a 'firm but kind' attitude. The importance of firmness seems to be specific to the treatment of ASPD and does not arise in other research on therapists' traits positively affecting TA (Ackerman & Hilsenroth, 2003). These outcomes demonstrate the dual challenge in working with this patient group. On the one hand, the therapist must be sensitive to the need for respect and autonomy and the fragility of trust; on the other hand, the patient needs a therapist who can provide structure and set boundaries. This approach demands flexibility from the therapist, who must adopt a collaborative attitude and focus on the patient's needs while also standing firm when boundaries are tested or violated (Morken et al., 2022; Van den Bosch et al., 2018).

Overall, the results of this study can be seen as the concrete implementation of the principle of specific responsivity within the RNR model (Bonta & Andrews, 2007). Being responsive to the patient entails establishing a connection, as described in *connective attitude*. Additionally, *connective skills* are necessary to work effectively within the therapeutic relationship. One important aspect highlighted in these findings is the presence of the therapist. Therapist's presence, a concept described by Hayes and Vinca (2017), entails therapists being attentive, focusing their attention on both the patient and their own experience, and being able to respond from these dual perspectives. The described *connective attitude* requires an outward and insistent attention to the patient while therapists must rely on their *connective skills* to *regulating interpersonal dynamics* that reflect internal processes necessary to therapeutic interventions (e.g., *connecting and phasing, being perceptive and reflective ability*). Therapists play an active role in connecting with their patients with ASPD due to their limited interaction orientation and insecure (and often dismissive) attachment style (Frodi et al., 2001; Van IJzendoorn et al., 1997). These patients are often more focused on objects or activities rather than on others, making it challenging to establish contact. Therefore, therapists need to exhibit outward attention and invest effort in making connections. On the other hand, therapists also require a highly developed reflective capacity, including a strong sense of self and awareness of personal boundaries, which has been consistently identified as crucial for working with patients with ASPD (Morken et al., 2022; Van den Bosch et al., 2018). This reflective capacity helps therapists navigate the complexities of the therapeutic relationship.

Interestingly, empathy was not explicitly mentioned by the participants in our study, although it is generally regarded as an important component in TA building (Bohart et al., 2002; Elliott et al., 2018; Kim, 2018). Empathy involves understanding and emotionally responding to other's experiences, and its absence may be attributed to the avoidant attachment style common among patients with ASPD, making it difficult to disclose their feelings (Watson et al., 2020). Moreover, therapists may be hesitant to express empathy for patients seen primarily as perpetrators due to societal norms, stigma, and negative expectations about treatability (Chartonas et al., 2017; Van Dam et al., 2022). Although empathy was not explicitly mentioned, elements of empathy were implicitly present in our study. Participants described feelings of compassion, sympathy, and a sense of connection with their patients.

Limitations and future research

This study has several limitations. First, the interviewed therapists had experience in different settings, including voluntary, involuntary, outpatient, inpatient, and mixed settings. Although the responses of the therapists did not differ across these settings, it is possible that there are variations in TA formation in different settings.

Second, this study primarily focussed on the therapist's perspective, which is a one-sided perspective. To gain broader understanding of TA, the perspective of patients with ASPD must also be considered (Horvath et al., 2011). Therefore, further research is needed that engages the perspective of patients with ASPD.

Although this study has taken a first and important step in understanding TA with ASPD, more research is needed to determine whether the elements of TA described by our participants are recognized by larger groups of therapists. In addition, the knowledge derived from this study may be used to adapt and refine existing therapy modalities and followed by testing their effectiveness.

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Considering the different aspects of TA, as described by Bordin (1979), the agreement between the patient and therapist on goals and tasks is a vital component of the TA. The therapist's perspective is integrated into the themes *treatment goals* and *process* in which they emphasize the collaborative aspect. To obtain knowledge about the extent of rapport between the patient and therapist, further research is encouraged, focusing on the patient's perspective and the patient–therapist agreement.

CONCLUSIONS

This study identified six crucial aspects for establishing and strengthening the therapeutic alliance (TA) with patients with ASPD. The findings emphasize the need for therapists to adjust their approach to the specific needs and challenges of this patient group. Patients' desire for autonomy and respect and their difficulties with trust require therapists to adopt an authentic, non-judgmental attitude and demonstrate genuine involvement while maintaining a firm stance. An attentive presence, initiated by the therapist, is crucial in establishing and maintaining the therapeutic alliance. Therapists must actively engage with patients, phase the therapy process, and make patients feel seen and understood. At the same time, therapists need to provide clarity and structure and be perceptive to boundary violations by setting limits with a clear but compassionate tone. These skills are essential for overcoming the challenges encountered in building a connection with patients with ASPD, who struggle with establishing healthy relationships. This way, therapists can ensure that patients remain engaged in the therapy and continue working towards their treatment goals. Therapists' reflective capacity plays a significant role in these treatments, requiring ongoing introspection and self-awareness. The insights gained from this study have important implications for the therapeutic alliance in the treatment of ASPD patients and may contribute to the refinement and adaptation of existing treatment approaches.

AUTHOR CONTRIBUTIONS

J. E. M. Aerts: Conceptualization; data curation; methodology; investigation; formal analysis; writing – original draft; writing – review and editing. **M. J. N. Rijckmans:** Conceptualization; methodology; supervision; formal analysis; writing – review and editing; validation. **S. Bogaerts:** Conceptualization; methodology; validation; writing – review and editing; formal analysis; supervision. **A. van Dam:** Conceptualization; methodology; validation; formal analysis; supervision.

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CONFLICT OF INTEREST STATEMENT

The authors declare no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon request.

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