Psychotherapeutic Processes and Outcomes in Outpatient Treatment of Antisocial Behavior: An Integrative Psychotherapy Approach

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Presents a descriptive 1-group prepost design study on psychotherapeutic processes and outcomes in outpatient treatment of antisocial, violent behavior. Five psychotherapists were involved in a long-term therapeutic use study applying integrative psychotherapy (cognitive–behavioral, relaxation, and psychodynamic methods) to an unselected sample of 28 male adults with dominant symptoms of acting out and violence against intimates. Clinical interviews according to DSM–IV resulted in primary diagnoses of 17 antisocial personality disorders, 6 specific adjustment disorders with disturbances of conduct, and 5 impulse control disorders. Treatment duration ranged between 7 and 19 months. Long-term outcomes were evaluated with reference to external criteria, including 5-year follow-ups (criminal and police records, occupational adjustment, and social integration). Results on psychotherapeutic processes point at the significance of adaptively planned changes in the frequency of therapeutic sessions and in alternations of therapists. Long-term outcomes are positive for symptomatology, criminal offense relapses, being on the job at least for 2 years, and integration in nondeviant social networks. Conclusions refer to suggestions for the planning and implementation of integrative psychotherapy in outpatients with dominant symptoms of violent, antisocial behavior.

Keywords: antisocial personality disorder, integrative psychotherapy, psychotherapeutic processes, psychotherapeutic outcomes, antisocial behavior

Although bibliometric results show that publications on the clinical psychology of antisocial, violent, aggressive behavior have significantly increased in the past 2 decades (Schui & Krampen, 2007), empirical evidence for

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treatment outcomes is rather weak. Whereas there is evidence for small to moderate effect sizes of treatment and prevention programs for antisocial behaviors in children and adolescents (e.g., Bennett & Gibbons, 2000; Fraser et al., 2005; Lösel & Beelmann, 2003), meta-analyses on psychotherapeutic outcomes in antisocial, violent adults reveal effects due to treatment in the small range (Babcock, Green, & Robie, 2004; Salekin, 2002).

However, Salekin (2002) concluded from his review of 42 treatment studies on psychopathy that there is little scientific basis for the widely held belief that psychopathy is an untreatable disorder. In addition, Salekin demands long-term follow-up studies to establish a modern view of the treatment possibilities for antisocial, violent behaviors. The conclusions of the meta-analytic review of 22 controlled quasi-experimental and experimental studies evaluating treatment efficacy for domestically violent males from Babcock et al. (2004) are similar: Effect sizes are in the small range, meaning that the interventions (i.e., cognitive–behavioral therapy, education groups for batterers, and some other types of treatment on subsequent recidivism of violence) have a minimal impact on reducing recidivism beyond the effect of being arrested; there were no differences in effect sizes in comparing different interventions, and study design tended to have a small influence on effect size.

The bibliometrically observed increase in publications on the clinical psychology of antisocial, violent, aggressive behaviors over the last two decades (Schui & Krampen, 2007) surrounds primarily its etiology, diagnosis, comorbidities, psychopathology, and symptomatology. Similar to research on aggressiveness and aggressive behavior (see, e.g., Anderson & Bushman, 2002; Granic & Patterson, 2006; Loeber & Hay, 1997), this clinical research resulted in multivariate, biopsychosocial diathesis stress models for the etiology and maintenance of conduct disorders, antisocial personality disorders, and impulse control disorders (see, e.g., Hare & Hart, 1993; Lykken, 1995; Roth, 1987; Salekin, 2002), calling for multidimensional treatment methods for patients with dominant symptoms of acting out and violence against intimates and others, for example, patients with antisocial personality disorders, impulse control disorders, and specific adjustment disorders with disturbances of conduct.

Given biological diatheses (i.e., genetics; weak autonomic nervous system reactivity for aversive and shock stimuli, but high heart rate in stress anticipations inhibiting cortical arousal; hypothesis of deficits in prefrontal cortex, septal nuclei, and hippocampus; high physiological arousal in reticular formation), social stress by deficient family and peer socialization (i.e., modeling by antisocial parents and peers; inconsistent or missing child discipline, and missing responsibility education; parent–child conflicts; missing educational warmth and parental rejection) precipitates and facilitates antisocial behavior and conduct disorders in childhood and adolescence. Behavior symptoms (e.g., repeated disobedience, truancy, lying, theft, robbery, vandalism; violence

against objects, animals, and humans; criminal behaviors) increase in interaction with deviant but high status peers and continue in early adulthood on the basis of psychological factors. These psychological factors refer to high physiological arousal and impulsivity; deficient and biased information processing ignoring context information; delinquency and violence without morality and feelings of guilt as well as remorse; deficient empathy, and detachment; low anxiety level and high risk taking; and social–cognitive biases in misinterpretations of ambiguous social actions as signs of hostility increasing anger and aggressive, violent behavior. Figure 1 illustrates the heuristics of such a biopsychosocial diathesis stress model for the etiology and maintenance of conduct disorders, antisocial personality disorders, and impulse control disorders in adulthood, which constitutes the basis for integrative psychotherapy of patients with dominant symptoms of acting out and violence against intimates and others.

Integrative psychotherapy approaches are predestined to be used for the treatment of patients with dominant symptoms of acting out and violence against intimates and others because treatment planning as well as the adjustment of therapeutic strategies and techniques within the treatment process itself can systematically refer to the etiology and maintenance factors of the multidimensional diathesis stress models. In addition, the integrative, multidimensional treatment approach can aim especially at the multidimensional treatment objectives which are postulated—and at least partly empirically supported—as being significant in treatment and prevention programs for antisocial, violent behavior (see, e.g., Dodge & Frame, 1982; Gacono, Meloy, & Bridges, 2000; Morrison, Robertson, Laurie, & Kelly, 2002; Sanderlin, 2001; von Held, 1987). These are treatment objectives like:

(1) the enhancement of social-emotional skills, empathy, and morality, for example, by modeling, operant and respondent techniques, role playing, therapeutic homework, moral dilemma techniques, mirroring, free association, and guided imagery;
(2) the reduction of psychophysiological arousal in favor of impulse control and mastery, for example, by relaxation therapy, self-control techniques, distraction techniques, thought stop, and delayed negative feedback techniques;
(3) the development of adaptive self-statements, for example, by cognitive restructuring of self-defeating thought patterns and social–cognitive biases misinterpreting others' ambiguous social behavior, and anger control training;
(4) the reconstruction of attachment abilities, trust, and social relationships, for example, by resource activation, focusing, behavior and problem analyses, biographical analyses, development of life projects, role playing, and therapeutic homework;

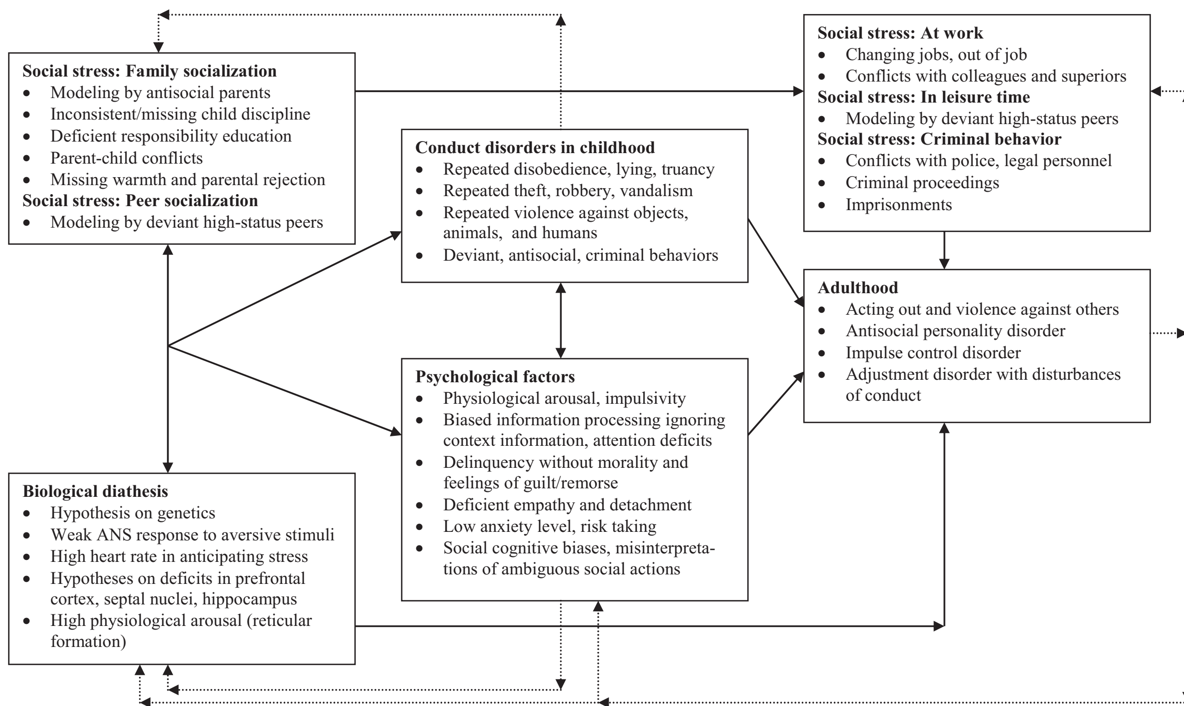

Figure 1. Heuristics of a biopsychosocial diathesis stress model for the etiology and maintenance of conduct disorders, antisocial personality disorders, and impulse control disorders in adulthood. ANS = autonomic nervous system.

(5) and the reduction of deviant peer influences in favor of nondeviant peer relations including social support and supervision by peers, for example, by therapeutic involvement of nondeviant peers, and modeling.

Treatment objectives should be aimed at by the adaptive application of a broader scope of psychotherapeutic methods and techniques such as those listed above. Therapeutic offers must be structured and refer to plain, unambiguous objectives that are realistic and relevant to the present day. The therapeutic relationship must be actively and clearly defined, including professional distancing of the therapist as well as alternation of therapist. Especially for patients with dominant symptoms of acting out and violence against intimates, this requires an adequate professional therapist's distance while being aware of the dangers of countertransference responses (like fear of assault or harm, helplessness and guilt, loss of professional identity, denial of danger, rejection of the patient; see, e.g., Strasburger, 2001). This includes—if necessary in cases of countertransference and/or therapeutic stagnation or backward steps—changes of the treatment context, that is, changes in the frequency of sessions and alternations of therapists (Murphy & Baxter, 1997).

These treatment objectives as well as the requirements of multidimensional treatment methods can be implemented by an integrative, common (i.e., nonschool-oriented) form of psychotherapy with a consistent theoretical basis (see, e.g., Goldfried & Norcross, 2005; Grawe, 2004; Norcross, 2005). With reference to an expectancy-value perspective, Grawe (2004) presented a psychological theory of psychotherapy that maintains a systems view of human experience and behavior as well as to taxonomies of general (common) therapeutic factors shared by all psychotherapies. This is used here in designing differential and adaptive psychotherapeutic interventions for the treatment of antisocial, violent behavior. The basic idea is that common therapeutic factors—that is, (a) resource activating interventions, (b) mastery-oriented intervention, and (c) consciousness-creating interventions in a three-component model of the change mechanism of psychotherapy—are involved in the psychotherapeutic process with differing levels of importance, recombining continuously, and altogether are responsible for treatment outcomes.

Thus, differential therapeutics are postulated to apply principles derived from research and clinical experience in matching the individual patient to the most efficacious treatment under the circumstances specific to that individual. Differential therapeutics are opposed to randomization or planning from group means in treatment studies that ignore the individual (Clarkin, 2005); this, however, at costs of methodological difficulties inherent in conducting this research (see, e.g., Schottenbauer, Glass, &

Arnkoff, 2005). It is hypothesized that these therapeutic factors are significant not only in treatment planning and initial differential indication but also in the adjustment of therapeutic strategies and techniques within the treatment process itself as well. Resource activating and relationship oriented interventions close the important clinical issue of the "missing link" (Castonguay & Hill, 2007) between insight (i.e., consciousness-creating interventions) and action (i.e., mastery-oriented interventions).

When applied to the treatment of patients with dominant symptoms of antisocial, violent behavior with the treatment objectives named above, the three-component model of the change mechanism of psychotherapy (Grawe, 2004) results in a general psychotherapeutic approach of differential, adaptive, and repeated changes. These changes focus on:

(1) resource activating interventions: that is, involvement of nondeviant peer, problem actualization, and focusing, active definition of therapeutic relationship including professional distancing of therapist as well as alternation of therapist;
(2) mastery-oriented intervention: that is, social skill training by operant, respondent, and modeling techniques, relaxation therapy, anger control training, self-control techniques, delayed feedback techniques, mirroring, therapeutic homework, and role playing as well as high versus low frequency of therapeutic sessions;
(3) consciousness-creating interventions: that is, cognitive restructuring, behavior and problem analyses, biographical analyses, development of life projects, guided imagery, free associations, therapeutic use of transference, and moral dilemma techniques.

Differential and adaptive indications of these interventions are reflected in regular therapists' supervision sessions. Special attention is given to transference and countertransference processes as well as to the results of postsession questionnaires measuring patients' and therapists' perceptions of psychotherapeutic processes with reference to progress, stagnation, and backward steps in resource activation (resource perspective), problem solving (problem perspective; i.e., mastery), and consciousness (motivational perspective; i.e., insight and future outlook) of the patient (Grawe, 2004; Krampen, 2002).

Systematic and close reference to these common therapeutic factors in the adaptive indication of psychotherapeutic techniques—aiming at the multiple treatment objectives deduced and described above—is the crucial characteristic of the integrative treatment model in contrast to traditional methods that are used with patients with dominant symptoms of acting out and violence (for overviews see, e.g., Babcock et al., 2004; Gacono, Nieberding, Owen, Rubel, & Bodholdt, 2001; Salekin, 2002). Traditional treat-

ment approaches focus either at single factors or a broad range of primarily social issues in community-oriented or group treatment. More or less single factor approaches aim at, for example, the improvement of patients' self-control by the treatment of the superego and ego-building (Draughon, 1977), irrational cognitions (Ellis, 1961; Templeman & Wollersheim, 1979), or impulsivity (e.g., Newman, Patterson, Howland, & Nichols, 1990; Patterson & Newman, 1993). Group psychotherapies focus at opportunities for antisocial patients to experience relationships with others (Maas, 1966), at the restructuring of early social relations and deviant attachment patterns (Beacher, 1962; Borriello, 1990), or at social skills training (Hamberer & Hastings, 1988; Pence & Paymar, 1993). The improvement of social relations as well as attachment and affiliation issues are as well the main elements of community-oriented programs and therapeutic communities for adolescent and adult patients with dominant symptoms of acting out (see, e.g., Holland, Moretti, Verlaan, & Peterson, 1993; Kiger, 1967).

In the present therapeutic use study, the effectiveness of the integrative psychotherapeutic approach described above is analyzed with reference to an unselected sample of male outpatients with dominant symptoms of acting out and violence against intimates and others focusing especially on characteristics of psychotherapeutic processes, that is, the mechanisms of change in a real-world setting. Research questions focus on whether the adaptive therapeutic process features of treatment duration and session frequency, alternations of session frequency, alternations of therapists, involvement of peers, and relaxation exercises are significant for treatment outcomes in psychopathology and social integration. Long-term therapeutic outcomes under study are clinical symptomatology, being on the job, social integration, treatment readmission, and—most significantly (see, e.g., Babcock et al., 2004)–recidivism of violence. In accordance with demands on research (see, e.g., Scott, 2001), outcome assessments are multiple, that is, they refer not only to patient data but to peers' and psychotherapists' data as well; moreover, an examination of objective criteria (i.e., criminal and police records) is used to complete the assessments.

METHOD

Participants

Participants were an unselected sample of 28 adult male Germans who consulted five psychotherapists in independent practice for outpatient psychotherapy because of their antisocial, violent criminal behaviors. Thus,

sampling refers to consecutive admissions of all patients (within 2 years) with dominant symptoms of acting out and violence against intimates and others (eligibility criteria). Participants were referred as usual to the five treatment settings by physicians (n = 12), other psychotherapists (n = 8), or legal personnel (n = 8) in the Southwestern region of Germany. Age ranges from 25 to 56 years (M = 34.3, SD = 6.6). Approximately half of the sample was unemployed (n = 16); the others had constantly changing jobs, having been given their notice very often. In terms of level of education and (former) occupational status, the participants were lower and lower-middle class.

All participants had repeated experiences with police and criminal justice because of multiple acting out and violence against intimates (current or former spouses, children, boyfriends, girlfriends, colleagues at work); the treatment of eight of them was court mandated, and they were supervised by probation officers. All other participants had criminal records as well because of violence against intimates (n = 20) and—in part additionally— because of damage to property (n = 4) or theft (n = 3), but legal proceedings were not instituted or stopped because witness statements were withdrawn.

After being thoroughly informed about the treatment in personal interviews, individual consent of all patients to psychotherapy, to diagnostic and evaluation procedures, as well as to involvement of their peer were gathered by signing informed-consent forms with their full names. Information refers as well to the fact that the patient's records are recorded anonymously and that later rescinding consent will have no effect on the therapy. There were neither treatment refusals nor treatment dropouts; the latter may be an effect of the social pressure participants were experiencing (court-mandated treatment: n = 8; threat of job loss: n = 12; threat of renewed witness' statement: n = 10) and of the high frequency of therapy sessions at the start of treatment.

Initial stage clinical interviews according to *DSM–IV* (SCID-I and SCID-II; First, Gibbon, Spitzer, & Williams, 1996; First, Spitzer, Gibbon, & Williams, 1996) were conducted by the therapists with all patients. Clinical diagnoses referred to the data of criminal and police records as well. Primary diagnoses were antisocial personality disorders (*DSM–IV*: 301.7, n = 17), adjustment disorders with disturbances of conduct (*DSM–IV*: 309.3 and 309.4, n = 6), and impulse control disorders (*DSM–IV*: 312.3, n = 5), all with dominant symptoms of acting out and violence against intimates and others. All patients had at least one comorbidity diagnosis: Most frequent were substance abuse (n = 16), stress and adjustment disorders (n = 12), attention deficit/hyperactivity disorders (n = 13), and/or affective disorders (n = 8).

Psychotherapists

Outpatient psychotherapies were conducted by five experienced psychotherapists in independent practice (job experience: 12–27 years), that is, in five different outpatient treatment settings. All therapies were charged regularly to health insurances as long-term psychotherapies after two to four approvals of requests for outpatient psychotherapy evaluated by external psychotherapeutic experts in accordance with the German public health care delivery system. All therapists were licensed professionals and had full certifications in cognitive–behavioral psychotherapy ($n = 4$), psychodynamic therapy ($n = 3$), client-centered psychotherapy ($n = 3$), and/or relaxation therapy ($n = 5$). Their basic therapeutic orientation refers to the general psychological therapy approach (Grawe, 2004); they were trained and had opportunities to reflect on their professional experiences in regular group supervision sessions (at least once every 2 weeks).

Participants of these group supervision sessions were the five therapists involved in the study and one professional supervisor (job experience: 25 years) with professional licensure and full certification in cognitive–behavioral psychotherapy, psychodynamic therapy, client-centered psychotherapy, and relaxation therapy, as well as scientific and applied experience with integrative psychotherapy. Blinding to outcomes was not possible in this therapeutic use study. Professional supervision regulated psychotherapeutic processes (e.g., by focusing on one of the three psychotherapeutic factors, frequency of sessions, alternation of therapist) by analyses of transferences and countertransferences as well as of stagnation, backward steps, and progress in resource perspective, problem perspective (mastery), and motivational perspective measured by postsession questionnaires (Grawe, 2004; Krampen, 2002).

Procedure

A descriptive one-group prepost design observational study on psychotherapeutic processes and outcomes in real-world outpatient treatment of antisocial, violent behavior was employed. The study was planned in response to an increasing demand for psychotherapy of antisocial, criminal behaviors with acting out and violence against intimates, which has been observed with increasing frequency in outpatient psychotherapy practices in the region under study.

In a scientist-practitioner model, the professional supervisor and the five psychotherapists in independent practice jointed together informally with the objective to optimize psychotherapeutic care for this demand. The

supervisor and planner of the study (having professional licensure and full certification in cognitive–behavioral psychotherapy, psychodynamic therapy, client-centered psychotherapy, and relaxation therapy, as well as scientific and applied experience with integrative psychotherapy) moderated training in psychotherapy integration from the perspective of common factors (similar to the conceptions of Castonguay, 2000, 2005; Norcross & Halgin, 2005).

Training in psychotherapy integration started—first—with reference to the "school oriented, pure form" psychotherapy training (cognitive–behavioral psychotherapy, psychodynamic therapy, client-centered psychotherapy, and/or relaxation therapy) and psychotherapy experience the five psychotherapists had. Second, integration of their rather major eclectic psychotherapeutic practice was fostered from the perspective of common factors and the theoretical foundations developed by Grawe (2004). Intensive literature study and discussions were followed—third—by the practical application of this concept of psychotherapy integration to recent psychotherapies of patients with different mental disorders by the five practicing therapists. This was extended—fourth with careful supervision—to current psychotherapeutic processes. The final, fifth step of the training in psychotherapy integration focused on the treatment of mental disorders with dominant symptoms of acting out and violence against intimates and others, which was continuously supervised as well. Training duration—up to the treatment of the first patient under study here—was 6 months, with one session (2–3 hr) weekly.

Sampling refers to the consecutive admissions of all patients (within two years) with dominant symptoms of acting out and violence against intimates and others (eligibility criteria). All patients were referred as usual to the five treatment settings by physicians ($n = 12$), other psychotherapists ($n = 8$), or legal personnel ($n = 8$) in the Southwestern region of Germany. Pretests including clinical interviews according to *DSM–IV* and participant information including informed consent were carried out in the initial two or three preliminary sessions. Blinding to diagnosis was not possible in this therapeutic use study.

For each patient, the therapists submitted individual approvals of requests for long-term outpatient psychotherapy. These requests were evaluated and granted by external psychotherapeutic experts in accordance with the German public health care delivery system and—if necessary—repeated after every 25–45 sessions. All therapy sessions were thus covered by the patients' health insurance. Continuous professional supervision regulated the psychotherapeutic processes (e.g., focusing one of the three psychotherapeutic factors, frequency of sessions, alternation of therapist) by analyses of transference and countertransference as well as of stagnation, backward steps and progress in resource perspective, problem per-

spective (mastery), and motivational perspective measured by postsession questionnaires (Grawe, 2004; Krampen, 2002). Frequency of group supervision sessions with the five psychotherapists and their supervisor was at least once every 2 weeks.

Measures

Initial stage and final stage clinical interviews according to *DSM–IV* were conducted by the therapists with SCID-I and SCID-II (First, Gibbon, et al., 1996; First, Spitzer, et al., 1996). Patients' and therapists' perceptions of psychotherapeutic processes with reference to progress, stagnation, and backward steps in resource activation, problem solving (mastery), and consciousness (motivational perspective) of the patients were measured with postsession questionnaires for patients and therapists (STEP; Krampen, 2002). These postsession questionnaires were constructed and validated by large samples of psychotherapy out- and inpatients ($N > 500$; Krampen & von Eye, 2006). The subscales refer to (a) patient's perception of resource and relationship activation in the therapy session (three items, item example: "In today's Session I the patient > was very much emotionally engaged"; $r_{tt} > .77$ in the present sample); (b) patient's perception of having gotten active help in problem solving in the session (four items, e.g., "Today I have < the patient has > learned new behavior options"; $r_{tt} >$ .82); and (c) patient's perception of having gotten insight in own psychodynamics and future outlook in the session (five items, e.g., "In today's Session I have < the patient has > gotten more insight into my person and my problems"; $r_{tt} > .89$). Scaling of answers ranges between 1 (*total disagreement*) and 7 (*total agreement*).

Posttreatment measures and 5-year follow-ups included data of (a) criminal and police records (relapse), (b) occupational adjustment (i.e., data collected from both the patients and their peers about being on the job at least for two years), (c) social integration (data collected from both the patients and their peers), and (d) frequency of relaxation exercises in everyday life (patients' data only). Further on, at follow-up, data on treatment readmission were gathered from the former patients and their peers.

At the planning of the study, the following psychometric instruments were included with the goal of assessing (1) psychopathy (revised Psychopathy Checklist; Hare, Harpur, Hakstaian, Forth, & Hart, 1990), (2) state-trait anger expression (State-Trait Anger Expression Inventory, STAXI; Schwenkmezger, Hodapp, & Spielberger, 1992; $r_{tt} > .82$ in the present sample), (3) aggressiveness (German Questionnaire on reactive and spon-

taneous aggression as well as inhibition of aggression and self-aggression, FAF; Hampel & Selg, 1975; $r_{tt} > .84$), and (4) general symptomatology (Symptom Checklist 90-revised; Derogatis, 1983; $r_{tt} > .68$). However, these psychometric instruments could not be interpreted meaningfully because of response biases (i.e., social desirability, faking); in this sample, there were high scores at pretest (a) in the anger control scale of the STAXI ($n = 21$); (b) in the inhibition of aggression scale of the FAF ($n = 20$); and (c) in the Marlowe-Crowne Desirability Scale (Crowne & Marlowe, 1964; $r_{tt} = .86$).

RESULTS

Mean single psychotherapy duration was approximately 1 year (M = 12.2 months, $SD = 7.27$, Range: 7–19 months) with sessions ranging from 32 up to 115 ($M = 66$, $SD = 11.21$). Adaptive changes of session frequency were indicated in most therapies by data of postsession questionnaires on stagnation and/or backward steps in resource perspective, problem perspective (mastery), and motivational perspective (see Table 1). Frequent

Table 1. Characteristics of Psychotherapeutic Processes in Psychological Therapy of 28 Male Outpatients With Dominant Symptoms of Acting Out and Violence

Characteristics of psychotherapeutic process	Psychotherapeutic stage *(f)*: Initial stage (week 1–10)		Major stage (week 11–12/95)		Final stage (last 4–12 weeks)	
Frequency of sessions						
4 sessions weekly	4		0		0	
3 sessions weekly	12		6		0	
2 sessions weekly	11		21		0	
1 session weekly	1		1		21	
1 session weekly to monthly	0		0		5	
1 session monthly	0		0		2	
Alternation of therapist						
None ($n = 1$)	0		0		0	
One ($n = 23$)	4		19		0	
Two ($n = 4$)	0		4		0	
	f	%	*f*	%	*f*	%
Peers						
Involvement in therapy	24	86	28	100	28	100
Alternation of peer	0	0	11	39	1	4
	Introduced		Exercises applied		Exercises applied	
Relaxation therapy						
Progressive relaxation	13	46	10	77	8	62
Autogeneous training	15	54	15	100	15	100

sessions, that is, two or three sessions weekly, are characteristic for the initial stage as well as for the major stage of most therapies; treatment termination was extended with one session weekly or less controlling for relapses and recidivisms.

Adaptive alternations of therapists were indicated in the treatment of most patients by the data of postsession questionnaires and problems in countertransference identified in supervision as well (see Table 1); there was no therapist alternation for one patient (4%) only. Most therapist alternations were indicated in the major stage (82%), a few in the initial treatment stage (14%) caused by countertransference phenomenon detected in supervision ($n = 8$; 29%), by therapeutic stagnation (repeatedly indicated by postsession questionnaire results; $n = 12$; 43%), or by backward steps (indicated by clinical judgments or postsession questionnaires; $n = 6$; 21%).

In accordance with Murphy and Baxter (1997), changes of treatment context (i.e., alternations of therapist) were substantiated toward patients by the necessity for positive treatment outcomes. Ten of the 27 patients affected by therapist alternations (37%) accepted alternation spontaneously and adjusted quickly. However, most patients ($n = 17$; 63%) responded at first negatively (ranging from astonishment to anger, partly verbal aggressive behavior); within 3 to 10 sessions, all of them adjusted, resulting in a more positive treatment involvement and compliance as indicated by the STEP scale scores of the postsession questionnaires.

Active therapeutic involvement of a peer was possible with patient's consent in most treatments, for most already during the initial stage (86%), and for some (14%) later on (see Table 1). However, changes of the peer involved in the therapy—caused by death of parent, marital separation/relationship termination, or interpersonal problems—occurred in 12 patients (43%). Peers involved were family members ($n = 17$), spouses/girlfriends ($n = 12$), probation officers ($n = 6$), and attorneys ($n = 5$).

With reference to a four-stage model of differential patient-treatment matching (see Krampen & von Eye, 2006), 13 patients were introduced to progressive relaxation (PR) and 15 patients were introduced to autogeneous training (AT) in the initial treatment stage. Relaxation therapy succeeded in 10 patients for PR and 15 patients for AT with regular exercises outside the treatment setting (see Table 1). All of the patients having learned AT continued AT exercises (100%) in the final stage; for PR there are only eight patients (62%).

Posttreatment clinical interviews according to *DSM–IV* show, for all patients, positive outcomes in symptom reduction (see Table 2). Only four of the patients had residuals (14%), that is, some symptoms of antisocial personality disorder continued, which are—however—not sufficient for a clinical diagnosis. Difference to pretreatment diagnoses is significant as well (binominal test: $p < .01$) as for the 5-year follow-up data on no

Table 2. Pretest Data and Treatment Outcomes of Psychological Therapy in 28 Male Outpatients With Dominant Symptoms of Acting Out and Violence

	Differential diagnosis according to DSM-IV							
	Antisocial personality disorder		Specific adjustment disorder		Impulse control disorder			
Variable	*n*	%	*n*	%	*n*	%	*N*	%
Pretest								
SCID: diagnosis	17	61	6	21	5	18	28	100
Posttreatment								
No SCID-diagnosis	13	46	6	21	5	18	24	86
Residual SCID-diagnosis	4	14	0	0	0	0	4	14
Pretest								
Court-mandated therapy	4	14	2	7	2	7	8	29
Five-year follow-up								
Criminal relapse[a]	1	4	0	0	1	4	2	7
Pretest								
In criminal/police records	11	39	4	14	3	14	20	71
Five-year follow-up								
Criminal relapse[a]	1	4	0	0	1	4	2	7
Pretest								
On the job	7	25	3	11	2	7	12	43
Five-year follow-up								
Occupational adjustment[b]	12	43	6	21	5	18	23	82
Five-year follow-up								
Social integration[c]	13	46	6	21	4	14	23	82
Treatment readmission[d]	0	0	0	0	0	0	0	0
PR exercises[e]	1	4	4	14	0	0	5	18
AT exercises[e]	10	36	0	0	4	14	14	50

Note. PR = progressive relaxation; AT = autogeneous training.
[a] Criminal and police records. [b] On the job at least for 2 years. [c] Peers' data about nondeviant social network. [d] Peers' and patients' data. [e] Patients' data on relaxation exercise once a week or more often.

criminal relapse (n = 24; 86%), occupational adjustment (n = 23; 82%), and social integration (n = 23; 82%; Table 2).

These outcomes are in agreement with follow-up data on treatment readmission: Follow-up data show that former patients and their peers are in complete agreement (100%) that there was not any treatment readmission because of acting out and violence against others in the context of a mental or behavioral disorder. Furthermore, patients' subjective follow-up data are in complete agreement (100%) with objective data on criminal relapse (criminal and police records), occupational adjustment (peers' data on patients' being on the job continuously for at least 2 years), and social integration (peers' data about patient's nondeviant social network including at least two persons). Follow-up data gathered from the former patients

on the frequency of their relaxation exercises in everyday life show that 14 (see Table 2) of the 15 patients (see Table 1) who learned the AT technique are regularly applying AT 5 years later (93%). Long-term outcome for PR is lower: Only 5 of 13 patients who learned the PR technique are applying PR 5 years later (38%).

DISCUSSION AND CONCLUSION

First, it should be noted that the results presented suggest rather good long-term outcomes of long-term integrative psychotherapy oriented at the general psychological therapeutic approach (Grawe, 2004) in male outpatients with dominant symptoms of acting out and violence against intimates and others. Significant symptom reductions, only a few relapses as well as positive outcomes in occupational and social adjustment were observed in most patients in long-term follow-ups (e.g., Salekin, 2002, is demanding). Outcome assessments are multiple—referring to subjective patient data, peers' data, and objective criteria, that is, criminal and police records as well as semistructured clinical interviews (Scott, 2001)–and are in total agreement.

However, there are no psychometric data on treatment outcomes because of strong response biases in participants at pretest. In addition, the results must be replicated in controlled studies because of internal validity deficiencies of the descriptive one-group prepost observational design applied. Some of the methodological problems may be moderate because there were no dropouts, sampling was unselected, and spontaneous remissions are seldom in antisocial personality disorders and impulse control disorders. However, there are major internal validity restrictions, for example, because blinding to outcomes was not possible in the therapeutic use study. These are the costs, that is, the difficulties inherent in conducting research on differential therapeutics with reference to integrative psychotherapy up to now (Schottenbauer et al., 2005).

At any rate, the results have some heuristic value for an integrative psychotherapy approach in designing interventions for patients with dominant symptoms of acting out and violence against intimates. The basic idea refers to an adaptive, flexible indication of psychotherapeutic methods and techniques in accordance with significant treatment objectives. This was regulated by postsession questionnaires' measurements of patients' as well as therapists' perceptions of psychotherapeutic processes with reference to progress, stagnation, and backward steps in resource activation (resource perspective), problem solving (problem perspective, i.e., mastery), and consciousness (motivational perspective, i.e., insight and future outlook) of

the patient (Grawe, 2004; Krampen, 2002), which were reflected in regular supervision sessions. Together with the supervisory control of transference and countertransference, this leads to adaptively planned changes in the frequency of therapy sessions and of alternations of therapists (i.e., changes in the treatment context; Murphy & Baxter, 1997) as well as changes of involvement of patients' peer. These characteristics of the psychotherapeutic process may be main determinants and mechanisms of change for the success of the treatment of patients with dominant symptoms of antisocial, violent, criminal behavior. The results of this long-term follow-up study point at the special significance of a high frequency of sessions in the initial and major stage of therapy, of systematic alternations of therapists, of the therapeutic involvement of a peer, and—for most patients—of relaxation therapy (in favor of autogeneous training) in the integrative psychotherapy of patients with dominant symptoms of acting out and violence against intimates and others.

Taken together, these findings advance theory and practice on the field of psychotherapy integration twice: First, integration of psychotherapeutic techniques is deduced from a multivariate, integrative biopsychosocial model for the etiology and maintenance of conduct disorders, antisocial personality disorders, and impulse control disorders (see Figure 1). Second, multiple treatment objectives are deduced from this integrative model and are closely related to the psychotherapeutic techniques applied adaptively in the therapeutic process. This leads to differential therapeutics using the integrative common therapeutic factors approach focusing at resource activating, mastery-oriented and consciousness-creating interventions. Thus, the common factors approach bridges the gaps between multivariate, biopsychosocial models for the etiology and maintenance of antisocial disorders, the necessarily multiple treatment objectives, and the integrative psychotherapeutic treatments, respectively, that are prerequisites for favorable treatment outcomes in patients with dominant symptoms of acting out and violence against intimates and others.

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