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The efficacy of a Compassion Focused Therapy-based intervention in reducing psychopathic traits and disruptive behavior: A clinical case study with a juvenile detainee

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The efficacy of a Compassion Focused Therapy-based intervention in reducing psychopathic traits and disruptive behavior: A clinical case study with a juvenile detainee

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Conflict of interests

The authors declared no potential conflicts of interests

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The efficacy of a Compassion Focused Therapy-based intervention in reducing psychopathic traits and disruptive behavior: A clinical case study with a juvenile detainee

Abstract

Conduct Disorder (CD) is the most diagnosed psychopathological disorder in juvenile detainees. The presence of a CD diagnosis, especially when associated with psychopathic traits, contributes to a poor prognosis, high recidivism rates and low responsivity to treatment in these youth. Although group intervention programs have proven to be effective in decreasing antisocial behavior, studies testing their efficacy in reducing psychopathic traits are scarce and limited. Moreover, there is a lack of research focused on the efficacy of individual treatment approaches specifically designed to reduce psychopathic traits and disruptive behavior in juvenile detainees. Compassion Focused Therapy (CFT) shows promising results in the treatment of several psychopathological disorders. Besides, there is some theoretical support to consider CFT a suitable approach to treating juvenile detainees. However, there are no treatment programs based on CFT that are designed to target psychopathic traits and disruptive behavior in these youth. Consequently, treatment outcome research in this area is absent. This clinical case study presents the treatment of a juvenile detainee with CD, a high psychopathic profile, and a very high risk for criminal recidivism using the PSYCHOPATHY.COMP program (a 20-session individual CFT program), which was specially designed to reduce psychopathic traits and disruptive behavior. The treatment outcome data revealed a significant reduction in psychopathic traits and disruptive behavior. The treatment gains were maintained and/or increased over time (3 months after program completion). This clinical case study demonstrates the feasibility and efficacy of the PSYCHOPATHY.COMP program in reducing psychopathic traits and disruptive behavior in this juvenile detainee.

Keywords: Compassion Focused Therapy; Conduct Disorder; Disruptive Behavior; Juvenile Detainees; Psychopathic Traits.

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1. Theoretical and Research Basis for Treatment

The high prevalence of the Conduct Disorder (CD) diagnosis among juvenile detainees is well established in the literature (Abram et al., 2015; Rijo et al., 2016). In addition, psychopathic traits (i.e., Grandiose-Manipulative/GM, Callous-Unemotional/CU; and Impulsive-Irresponsible/II traits) are more prevalent in detained youth than in normative youth (Andershed, Kerr, Stattin, Levander, 2002; Ribeiro da Silva, Salekin, & Rijo, 2019a). Several studies have noted that the combination of a CD diagnosis with high levels of psychopathic traits is linked to a more persistent and severe pattern of antisocial behavior, higher recidivism rates and less engagement and responsivity to treatment than when CD is not associated with high levels of psychopathic traits (Herpers, Rommelse, Bons, Buitelaar, & Scheepers, 2012; Leistico, Salekin, DeCoster, & Rogers, 2008). In the early 40s, Cleckley (1941/1988) wrote that "We do not at present have any kind of psychotherapy that can be relied upon to change the psychopath fundamentally" (p. 478). After almost 80 years, there is still a lack of studies testing the efficacy of intervention programs specifically tailored for juvenile detainees with CD in reducing psychopathic traits and disruptive behavior.

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Treatment efforts

Behavioral and cognitive-behavioral interventions are among the most effective in the treatment of antisocial behavior problems, in both adult and youth criminal samples (Andrews & Bonta, 2010; Koehler, Lösel, Akoensi, & Humphreys, 2013; Lipsey, 2009; MacKenzie & Farrington, 2015). However, regarding psychopathic traits, there is a long debate about whether they are or are not treatable (see Ribeiro da Silva, Rijo, & Salekin, 2013; Frick, Ray, Thornton, & Kahn, 2014; Wilkinson, Waller, & Viding, 2015 for a review). Some authors (Harris & Rice, 2006) argued that psychopathy is a non-treatable condition and that therapeutic efforts may even worsen psychopathic traits, antisocial behavior and recidivism risk, making individuals avoid legal detention in more successful ways. Other authors contended that psychopathic traits and disruptive behaviors seem to be changeable, especially, but not exclusively, if individuals are identified early

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2 in life (during childhood or adolescence) and treated properly (Hecht, Latzman, & Lilienfeld, 2018;
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4 Salekin, 2002; Salekin, Worley, & Grimes, 2010; Wilkinson et al., 2015). In this respect, behavioral
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7 interventions, cognitive-behavioral interventions, and parent/family-based interventions seem to be
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9 the most effective in reducing psychopathic traits and disruptive behaviors (e.g., Caldwell,
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11 McCormick, Wolfe, & Umstead, 2012; Datyner, Kimonis, Hunt, & Armstrong, 2016; Fleming,
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13 Kimonis, Datyner, & Comer, 2017; Hecht et al., 2018; Kimonis & Armstrong, 2012; McDonald,
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16 Dodson, Rosenfield, & Jouriles, 2011; Mills, Babinski, & Waschbusch, 2018; Polaschek & Skeem,
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18 2018; Salekin, 2002). Another promising avenue to treat these youth is interventions based on
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20 positive and/or prosocial/affiliative emotions (Dadds, Cauchi, Wimalaweera, Hawes, & Brennan,
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23 2012; Salekin, Tippey, & Allen, 2012).
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25 Nevertheless, the scientific literature on the treatment of psychopathic traits is scarce, the
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27 rigor of treatment designs is limited, and the assessment of treatment efficacy presents several
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30 methodological problems (Hecht et al., 2018; Polaschek & Skeem, 2018; Ribeiro da Silva et al.,
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32 2013; Wilkinson et al., 2015). In addition to being scarce, the majority of studies on this field were
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34 conducted prior to the 1980s, few used methodological rigorous designs, and even fewer were
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37 conducted in forensic settings, namely, with young offenders (Hecht et al., 2018; Polaschek &
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39 Skeem, 2018; Salekin, 2002). Only three studies, meeting ethical requirements and basic
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41 methodological standards (a relatively large sample size and a control group), examined whether
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44 treatment reduces criminal behavior and/or psychopathic traits in young offenders (Butler, Baruch,
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46 Hickey, & Fonagy, 2011; Caldwell, Skeem, Salekin, & Van Rybroek, 2006; Manders, Deković,
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48 Asscher, van der Laan, & Prins, 2013). Overall, the results of these studies showed that
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51 psychopathic traits and/or criminal behavior can be reduced after the delivery of an intensive
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53 treatment approach using cognitive-behavioral techniques (Caldwell et al., 2006) or an intensive
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55 multimodal family intervention (Butler et al., 2011; Manders et al., 2013).
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57 Several promising pathways to the treatment of young offenders with psychopathic traits
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60 have been identified (see Hecht et al., 2018 for a review). First, the past few decades have seen

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significant gains regarding the scientific understanding about the etiology and assessment of CD and psychopathic traits (Ribeiro da Silva, Rijo, & Salekin, 2012, 2015; Hecht et al., 2018), which is fundamental to the development and delivery of intervention programs targeting theoretically sound mechanisms of change (Hecht et al., 2018; Salekin, 2002). Second, new forms of cognitive-behavioral therapies (CBT) have been developed in recent years, showing growing empirical support (Kahl, Winter, & Schweiger, 2012). Unlike traditional CBT, these new therapeutic approaches mainly focus on changing the function of psychological events (e.g., cognitions, motives, and emotions) rather than on changing their particular content or frequency (Kahl et al., 2012). However, no research has been published testing the efficacy of these new CBT approaches in treating juvenile detainees.

Compassion Focused Therapy

Compassion Focused Therapy (CFT) emerged from developments within this CBT movement but stands out because of its evolutionary underpinning and its focus on the promotion of a compassionate motivation in individuals (Gilbert, 2014). Compassion can be conceptualized as a motivation to be sensitive to the suffering of the self and others, allied with the wisdom, strength, and commitment to prevent and/or alleviate that same suffering (Gilbert, 2010). Therapists serve as models, guiding and helping individuals overcome their fears, blocks, and resistances to compassion and bringing forth the different flows of compassion: having compassion towards the self, giving compassion to others, and receiving compassion from others (Gilbert, 2017, 2019).

Case formulation in CFT is similar to standard formulation processes, encompassing a series of interconnected stages (Gilbert, 2016): background and historical influences (i.e., early attachment experiences and life events, which light up emotional memories of feeling (un)safe and (un)cared for and/or easily threatened); key threats (i.e., external and internal key threats around archetypal and innate themes of abandonment, rejection, shame, and abuse/harm; external threats relate to what the world or others might do, while internal threats are associated with what emerges inside the self); safety strategies (i.e., ways of coping with external and/or internal threats; these can be either

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internalizing or externalizing); and unintended consequences (i.e., efforts of individuals to deal with their key threats often lead to unintended consequences, which usually worse those same threats).

In a CFT-based intervention, therapists compassionately guide patients to discover the universal and evolutionary role of human functioning (in a mind/body duality) and the adaptive role of the individual's own functioning, taking into account his/her background and current life context (Carter, Bartel, & Porges, 2017; Cowan, Callaghan, Kan, & Richardson, 2016; Gilbert, 2014; Shirtcliff et al., 2009). As humans, we all have universal, automatic, and instinctive reactions to threats (linked to our reptilian brain, part of the "old" brain area), which are crucial to surviving and thriving (MacLean, 1985). Most problems arise when the reptilian brain conflicts with affiliative motivations (linked to the mammalian brain, also part of our "old" brain) and with the unique cognitive skills of the human cerebral cortex (linked to the "new" brain) (MacLean, 1985). To regulate emotional states, which always combine a multiplicity of emotional patterns (i.e., our multiple selves: angry self, sad self, anxious self…), humans may resort to three emotion regulation systems: the threat system (shared by all species; its function is to protect individuals from threats); the drive system (its function is to allow individuals to experience positive feelings that guide, motivate, and encourage them to seek out resources to survive and prosper); and the soothing system (its function is to allow individuals to experience peacefulness and safeness) (Gilbert, 2015). Psychopathological symptoms and disorders arise when there is an unbalance of these three emotion regulation systems, particularly when the threat activation commands the individual's functioning. In this respect, shame (encompassing unbearable and persistent feelings of being inferior, inadequate, and worthless) and shame regulation play a major role in CFT. Thus, as we all share the need to create positive feelings about ourselves in the mind of others, when individuals feel devalued, neglected, and/or abused since early ages, they tend to become vulnerable to shame, which, in turn, over-stimulates the threat system and its archaic responses (freeze, flight, fight; Gilbert, 2015, 2017). In fact, research has found evidence for the key role of shame and shame regulation problems in several psychopathological disorders (Ribeiro da Silva et al., 2015). When

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individuals tend to internalize the shame experience (e.g., "I am inferior and worthless"), they usually develop internalizing psychopathology. In turn, when individuals tend to externalize the shame experience (e.g., "Others are trying to put me down"), they are more prone to develop externalizing psychopathology (Elison, Pulos, & Lennon, 2006; Nathanson, 1992; Vagos, Ribeiro da Silva, Brazão, Rijo, & Elison, 2018b).

In sum, in a CFT-based intervention, therapists compassionately guide patients to discover that our functioning is actually not our fault, as we are just one version of ourselves, which was shaped by evolutionary, genetic, epigenetic, and environmental influences that we did not choose (Cowan et al., 2016; Gilbert, 2019). However, it is also our responsibility, once we can know ourselves better, learn and practice new regulation strategies, and guide our automatic responses instead of being guided by them (Gilbert, 2017, 2019). To encourage this responsibility, CFT provides training on specific practices that are designed to address the triggering of the threat system, balance the emotion regulation systems and cultivate compassion in individuals. This is called Compassionate Mind Training (CMT), a cross-cutting ingredient throughout a CFT intervention (Gilbert, 2016, 2019).

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From a CFT perspective, antisocial behavior patterns and psychopathic traits are conceptualized as evolutionary rooted responses to deal with harsh rearing scenarios (Ribeiro da Siva et al., 2015). In detail, if the human brain is evolutionarily designed to survive and thrive in adverse environments, when individuals are raised in hostile psychosocial backgrounds, as are the majority of juvenile detainees, their brains also become calibrated for such environments (Abram et al., 2015; Vagos, Ribeiro da Silva, Brazão, & Rijo, 2018a; Vagos, Ribeiro da Silva, Brazão, Rijo, & Gilbert, 2016, 2017). Thus, these youth tend to present an overdeveloped threat system, which functions mostly according to survival principles (e.g., "better safe than sorry"), as well as central emotional dysfunctions (e.g., Garofalo, Neumann, & Velotti, 2018; Kosson, Vitacco, Swogger, Steuerwald, & Gacono, 2016). These emotional dysfunctions comprise, among others, high levels of shame and shame regulation problems; i.e., shame seem to be massively externalized by

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compensation (GM traits), avoidance (CU traits) and/or attack mechanisms (II traits) (Del Giudice & Ellis, 2015; Nyström & Mikkelsen, 2012; Ribeiro da Silva, Vagos, & Rijo, 2019b; Shirtcliff et al., 2009). In sum, although early conceptualizations emphasized the appearance of sanity and the lack of emotional experience as core features of psychopathy (Cleckley, 1941/1988), a growing body of research is finding evidence that psychopathic traits probably act as a mask of invulnerability that hides deep suffering and a shameful nucleus (Nathanson, 1992; Ribeiro da Silva et al., 2015, 2019b).

CFT is applied in the treatment of several mental health problems in adulthood, some of them previously considered difficult to treat (Braehler et al., 2013, Kirby, Tellegen, & Steindl, 2017; Sommers-Spijkerman, Trompetter, Schreurs, & Bohlmeijer, 2018). Moreover, CFT has been indicated as a suitable treatment approach for children and youth (Carona, Rijo, Salvador, Castilho, & Gilbert, 2017). Finally, there is some theoretical support to consider CFT as an appropriate approach to treat juvenile detainees (Ribeiro da Silva et al., 2015). However, until now, no study has tested this hypothesis.

Psychopathy.comp

The growing empirical support of CFT (see Leaviss & Uttley, 2015 for a review), the reliability of conceptual models explaining psychopathic traits under the lens of a CFT approach (Ribeiro da Silva et al., 2019b), and the compelling theoretical support of CFT as an adequate treatment for youth with disruptive behavior and psychopathic traits (Ribeiro da Silva et al., 2013, 2015) lead Ribeiro da Silva and colleagues (2017) to develop the PSYCHOPATHY.COMP program: an individual compassion-based psychotherapeutic intervention for juvenile detainees with CD and psychopathic traits. The main goal of this program is to reduce psychopathic traits and disruptive behavior through the development of a compassionate motivation in these youth, towards both the self and others.

The PSYCHOPATHY.COMP program was developed by a research team that included experts in CFT and/or CBT (including Paul Gilbert, the founder of CFT), most of them with clinical

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experience in the assessment and treatment of antisocial individuals. In the first stage, the research team had intensive training on CFT and discussed the program´s structure and methodologies. From this effort, a draft of the PSYCHOPATHY.COMP program was developed, manualized, and tested individually with a small group of young offenders. Based on the qualitative feedback data from this feasibility study and on supervision sessions with Paul Gilbert, content-related changes were identified and conducted to develop the final version of the PSYCHOPATHY.COMP program. The PSYCHOPATHY.COMP program has many similarities with other CFT programs (e.g., strategy of change, CMT; Gilbert, 2010) but stands out by being highly experiential and tailored for the specific difficulties and life experiences of juvenile detainees. Moreover, as individuals with psychopathic traits tend to present poor treatment engagement (Hecht et al., 2018; Herpers et al., 2012; Leistico et al., 2008), the PSYCHOPATHY.COMP program was designed taking into account motivational interviewing strategies aligned with a CFT framework (Steindl, Kirby, & Tellegan, 2018).

PSYCHOPATHY.COMP is a manualized program of 20 60-min sessions, which runs on a weekly basis. Sessions must be delivered by therapists skilful in CFT. The program's structure follows a progressive strategy of change, which occurs in four sequential modules (see Table 1): (1) The basics of our mind; (2) Our mind according to CFT; (3) Compassionate Mind Training; and (4) Recovery, relapse prevention, and finalization. As a common feature of all therapeutic sessions, therapists are focused on developing a secure therapeutic relationship, assessing the motivational stage of the youth (acting accordingly by using motivational interviewing strategies aligned with a CFT framework; Steindl et al., 2018), and stimulating the CMT.

[Insert Table 1]

The main goal of module 1 is to offer youth insights about the evolutionary roots of humans' basic motives, needs, and emotions, including the automatic and universal responses to social and physical threats. Adopting a non-pathological and de-shaming perspective, youth are dynamically encouraged to understand that even if we cannot change events, emotions, and thoughts themselves,

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we can change the way we interact with them and act on them, and accordingly, we can change our behavioral response. CMT is introduced in module 1 as a fundamental platform to begin the process of building participants' compassionate mind and awareness.

Module 2 brings awareness to youth about the functioning of the human mind according to a CFT formulation and continues the CMT. Therapists compassionately enable youth to discover that although we are "just one version of ourselves" (i.e., we probably would be different if genetic or contextual factors in our lives have been different), our evolutionary, genetic, epigenetic, and contextual inheritance does not lead to determinism, as we all could make conscious actions as we increase our knowledge about our own functioning. To encourage such conscious actions, beyond the importance of CMT, youth are experientially guided to understand the concepts of emotion regulation systems, which may help us regulate our emotional states, shame, and shame regulation strategies.

Although CMT started in module 1 and continued during module 2, module 3 is explicitly focused on CMT. Using experiential exercises, youth are gradually exposed to the triggering of the threat system (mostly anger/shame exposure) to allow them to understand its outputs (in the mind and body), differentiate and integrate their multiple selves, seek out and test compassionate strategies to tolerate and cope in healthy ways with their own distress.

Finally, module 4 is aimed at revisiting the motivations for recovery and preventing relapse, always under the lens of compassion. Youth are encouraged to deeply understand that although suffering will always be part of our lives, this therapeutic journey offered them several compassionate emotion regulation strategies to deal with suffering. However, therapists always emphasize youth's control and personal choices, as well as their responsibility for change.

Sessions present a predefined structure, starting with the therapist making a grounding exercise before the session, which is aimed to bring the compassionate self of the therapists into the session. The sessions themselves are then divided into three parts. Part 1 starts with a grounding exercise (i.e., Soothing Rhythm Breathing; Gilbert, 2010), which is aimed at helping youth to be

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compassionate before starting the session itself, followed by an overview of the last session and, lastly, by a moment to explore any insights and/or events that occurred during the week. Part 2 starts with an exercise, which is followed by the development of the session theme, where youth are guided to a deeper level of understanding. Finally, part 3 starts with a session summary, and afterwards, youth are invited to do a CMT practice. At the end, a “Magic Card” is given to youth, which works like a keyword that mirrors and summarizes the session’s theme.

Despite PSYCHOPATHY.COMP’s compelling theoretical support for changing psychopathic traits and disruptive behavior in juvenile detainees, this is the first study to report on the application of this program.

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2. Case Introduction

Peter (pseudonym) is a 16-year-old male who was detained in a Portuguese maximum security juvenile detention facility for the first time. Peter was convicted to 26 months after being charged with 35 counts of offenses against people (e.g., armed robberies, physical aggression). Before detention and since the age of 14, Peter lived in a foster care facility; he was registered in the seventh grade but had dropped out of school, having been previously held back three years. Peter was invited to voluntarily participate in this study. All ethical requirements were guaranteed, including institutional authorizations, his parents’ written consent, his own oral consent, confidentiality, and anonymity.

According to the Portuguese legal system, detention in a maximum-security unit is the most severe consequence a court can apply to youth who have committed an offense between the ages of 12 and 16. Under this sentence, youth are monitored and controlled 24/7 in the detention facility using a token economy system. However, regardless of their behavior, youth leave the facility only when they are released; i.e., school, medical appointments, visits, etc. all occur inside the facility. Exceptions are made if clearly justified (e.g., medical urgency, court assignments) or if there is a very clear and consistent behavioral improvement (e.g., youth can spend Christmas at home).

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The therapist was a psychologist with 14 years of clinical experience. She had had training in CFT for the last 7 years and had clinical experience in delivering CFT-based interventions with young offenders. During this case study, the therapist had weekly supervised sessions with a CFT expert.

3. Presenting Complaints

Peter presented with significant antisocial symptoms consistent with Oppositional Defiant Disorder (ODD) and CD (childhood-onset type, severe). He also reported alcohol and substance abuse before detention. Peter showed poor insight about the impact of his behavior on others, blamed others for the detention, was very resistant to change, and reported difficulties in the adjustment to the juvenile detention facility rules: "There was no need for this (detention). Yes, I committed some robberies, but I was ok when the judge convicted me. I did not change anything since I come in here and I am never going to change, never!"

According to Peter's juvenile justice record file, before the detention, he was highly impulsive, self-centered, oppositional, defiant, violent; presented low empathy, poor frustration tolerance, antisocial cognitions and behavior, tended to minimize his conduct; had little insight about the impact of his behavior on others and was associated with delinquent peer groups.

According to Peter's results on the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge, Andrews, & Leschied, 2002), he presented a "very high" risk for criminal recidivism (on a scale from "low" to "very high"). In detail, Peter showed high scores in all the domains of the YLS/CMI: Prior and Current Offenses/Disposition (4 out of 5 points); Family Circumstances/Parenting (4 out of 5 points); Education/Employment (6 out of 7 points); Peer Relations (4 out of 4 points); Substance Abuse (4 out of 5 points); Leisure/Recreation (3 out of 3 points); Personality/Behavior (6 out of 7 points); and Attitudes/Orientation (4 out of 5 points); Total score = 35 points. This assessment was completed by a probation officer before Peter´s detention.

4. History

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A personal history was obtained via interviews with Peter, his family (mother, father, and grandparents), and by consulting his juvenile justice record file. Peter's mother became pregnant at 18 years old. He was born to term, and no complications were reported. Peter reached developmental milestones on time and had no significant medical concerns. He is an only child of both his parents, though he now has one younger brother from his father and a younger sister from his mother. Peter grew up in a large city in Portugal and lived with both parents until he was 8 years old. However, the relationship between his parents was marked by domestic violence, and they ended up getting divorced at that time. His father was described as absent, impulsive and violent and was said to engage frequently in thrill-seeking behaviors; he also had two guns at home. Peter's father used to beat him, including with objects (e.g., once he threw a chair at him). Peter also witnessed several fights between his father and other adults. For instance, he remembers a fight between his father and two other men, during which his father shot at their house windows. After the divorce, his parents continued to have a conflict-ridden relationship, especially concerning issues related to child-rearing practices, which affected Peter's relationship with both parents. Against this background with his parents, Peter always had a very positive and consistent bond with his maternal grandparents.

Peter was described as a temperamentally difficult child since he was at least 1 year old, with little tolerance for frustration and poor self-control. He started to display oppositional defiant behaviors and insensitivity to punishment at the age of 3. At the age of 5, Peter was sent to therapy for the first time (for about a year and a half), but he was not able to establish a good therapeutic relationship with the psychologist ("I did not like her"), and his behavior did not improve. After the divorce of his parents (at the age of 8), Peter's behavior became even more problematic, both at school and at home. Less than a year after the divorce, his parents went to live with other partners, who are now his stepmother/stepfather. Peter had difficulties accepting both of them, becoming even more defiant to his parents, to his stepmother/stepfather and to his teachers and peers. Consequently, at the age of 9, Peter was sent again to therapy (for about a year), but his behavior

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did not improve, and he was not able to establish a good therapeutic relationship with this psychologist, either ("I did not like her, either"). Although Peter was living with his mother/stepfather, he often ran away to his father's house (for the first time when he was 10 years old), but when the relationship with his father/stepmother became more problematic, he would eventually return to his mother's house. At the age of 11, Peter began to engage in physical fights with peers, became a member of delinquent groups, missed school, smoked weed and hashish, and ran away from home again. When his stepfather found him, he brutally spanked Peter (he broke his nose and caused him several contusions and wounds on his face and body – this was the only time Peter´s stepfather was physically abusive to him). Peter felt that his mother did not protect him since she continued to live with his stepfather and said to him, "You need to learn not to run away from home and to behave properly". She also forbade him to leave the house until he had no wounds; it was his grandparents who took care of his injuries. When Peter talked to his father again (more than 2 weeks later), he contacted the police, but with no physical evidence and with his mother saying that he was lying, his stepfather was not charged. Finally, his mother said to Peter, "You are dead to me". Peter lived for a year with his father, although he regularly visited his grandparents, but his antisocial behavior worsened. At the age of 13, he went to live with his grandparents, but there was no improvement in his behavior. Peter said, "I was living with my grandparents, but the rules were my mother's rules". With the worsening of his antisocial behavior pattern (Peter completely missed school, often ran away from home and frequently engaged in physical fights, etc.), the judge determined that he should be placed in a foster care facility. Peter entered the foster care facility at the age of 14, and he started therapy with the psychologist of the institution, with whom he was able to establish a good therapeutic relationship ("I did like her, she was nice to me"). However, his behavior rapidly worsened. He began to shoplift, carry out robbery, and then hold armed robberies. He did not respect any of the foster care facility rules (e.g., he ran away, missed school, lied, was disrespectful and physically aggressive towards adults/peers), and he tried to set the institution on fire. Some of the victims of the armed robberies and physical

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aggression episodes pressed charges against Peter, which led him to a juvenile justice court and then to the juvenile detention facility.

5. Assessment

Semi-Structured Clinical Interview

At baseline, Peter was assessed with the Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-KID; Sheehan et al., 2010; Portuguese Authorized Version by Rijo et al., 2016). This baseline assessment took place 4 months after Peter's placement in the detention facility. The MINI-KID is a structured clinical diagnostic interview that assesses DSM (Diagnostic and Statistical Manual of Mental Disorders, DSM-5; American Psychiatric Association, 2013) Axis I disorders in children and adolescents in a way that is both comprehensive and concise. The MINI-KID is organized into diagnostic sections, each starting with 2 to 4 screening questions for each specific disorder. Additional symptom questions within each disorder section are asked only if the screen questions are positively answered. All questions are in a binary "yes/no" format. The MINI-KID takes into account not only DSM criteria A but also the impairment and duration of the symptoms and is considered a short and accurate instrument to diagnose Axis I disorders, namely, mood disorders, anxiety disorders, substance-related disorders, tic disorders, disruptive disorders and attention-deficit hyperactivity disorder, psychotic disorders, eating disorders, and adjustment disorders. Moreover, items are included to address ruling out medical, organic, and/or drug causes for disorders. Diagnostic criteria are summarized and documented within each disorder section and on a summary sheet. The MINI-KID takes between 30 and 90 minutes to administer. Inter-rater reliability was found to be excellent for all mental health disorders assessed with the MINI-KID (Sheehan et al., 2010). Peter met the criteria for CD (childhood-onset type, severe) as the main diagnosis, but he also met the criteria for ODD and substance use disorders (alcohol and cannabis). Peter was diagnosed with no other mental health disorders, either in the past or in the present.

Psychopathic Traits

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Psychopathic traits were assessed using the Youth Psychopathic Traits Inventory-Short (YPI-S; Van Baardewijk et al. 2010; Portuguese version by Pechorro, Andershed, Ray, Maroco, & Gonçalves, 2015) at three time points: at baseline (4 months after Peter's placement in the detention facility), at the end of the PSYCHOPATHY.COMP program (post-treatment assessment) and at a three-month follow-up (follow-up assessment, which was completed while Peter was still detained). The YPI-S is an 18-item self-report version of the original Youth Psychopathic Traits Inventory (YPI; Andershed et al., 2002), which assesses psychopathic traits in youth via ratings within three different factors: Grandiose-Manipulative (GM; e.g., "It's easy for me to manipulate people"), Callous-Unemotional (CU; e.g., "I think that crying is a sign of weakness, even if no one sees you"), and Impulsive-Irresponsible (II; e.g., "I like to do exciting and dangerous things, even if it is forbidden or illegal"). Each factor is estimated by a set of six items; each item is rated on a four-point scale (1 = "Does not apply at all" to 4 = "Applies very well"). Both the total YPI-S and the YPI-S factor scores range from zero to 4, with higher scores indicating higher levels of psychopathic traits (Van Baardewijk et al. 2010). The YPI-S has shown strong convergence with the original YPI and good psychometric proprieties (Van Baardewijk et al. 2010). In a study with a Portuguese sample of young male offenders, the YPI showed a three-factor structure, acceptable internal consistency based on alpha (alphas for the GM, CU, and II factors were .79 .69, and.73, respectively), and high correlations between the YPI-S factors and the total YPI-S (ranging from .74 to .79) (Ribeiro da Silva et al., 2019a).

Taking into account the psychopathic severity profiles found in the study by Ribeiro da Siva and colleagues (2019a) (ranging from a low psychopathic profile to a high psychopathic profile), Peter´s baseline scores were consistent with a high psychopathic profile. Peter's baseline, post-treatment, and 3-month follow-up scores on the YPI-S are reported in Table 2.

Disruptive Behaviors

A grid was developed by researchers to collect the following behavioral data from Peter's record file (these data were reported by staff members of the juvenile detention facility): the total

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number of disciplinary infractions he committed (e.g., school absence, defiant/oppositional behavior, aggressive and violent behavior, destruction of detention facility property), as well as the total number of days in punishment (as a consequence of these disciplinary infractions). Behavioral data were collected for four time intervals: during the 3 months before the beginning of the PSYCHOPATHY.COMP program (the first month of detention was not considered because it corresponds to an adaptation period), during the first 3 months of the program, during the last 3 months of the program, and during the 3 months after the completion of PSYCHOPATHY.COMP (which was completed while Peter was still detained). Peter´s behavioral data across time were computed for each time interval and taken as disruptive behavior indicators (see Table 2).

[Insert Table 2]

6. Conceptualization

In conceptualizing Peter's difficulties according to a CFT framework, different aspects of his own functioning must be integrated into a comprehensive case formulation. In addition to the evolutionary predisposition that makes humans react quickly and instinctively to threats (Del Giudice & Ellis, 2015; Ferguson, 2010), Peter seemed to present some genetic predispositions that lead him to be a temperamentally difficult child (Lykken, 2006), and he was raised in a harsh environment (Cowan et al., 2016; Shirtcliff et al., 2009). In detail, Peter was described as a temperamentally difficult child (with little tolerance for frustration and poor self-control since he was at least 1 year old), who started to show oppositional defiant behaviors and insensitivity to punishment early in life (at the age of 3). In addition, in the first 8 years of his life, Peter witnessed several episodes of domestic violence between his parents, and he was frequently physically punished for presenting misbehaviors. After his parents divorced, things became worse, as his parents continued to have a conflict-ridden relationship and to be emotionally, verbally, and physically abusive towards Peter. Peter´s parents also had difficulties in setting boundaries for him and in applying effective parental discipline strategies; moreover, they were frequently in conflict regarding those boundaries. Additionally, Peter felt that he was not truly loved by his parents,

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especially after they went to live with other partners (which occurred less than a year after the divorce). Finally, Peter witnessed several unpredictable and violent fights between his father and other adults.

With the combination of these evolutionary, genetic, epigenetic, and environmental influences, Peter developed a hypersensitive, vigilant, and reactive threat system. His threat system was easily triggered by his key threats, both external (abuse, abandonment, rejection) and internal (e.g., feelings of being worthless, unlovable, inferior, and lonely). To address these key threats, Peter started to externalize the experience of shame and other unpleasant emotions very soon in life, either through avoidance (e.g., "I remember that I did not care about my parents beating me, it did not hurt!") or through oppositional behaviors (e.g., "If they said to me that I could not go for a walk, I would find a way to go anyway"). According to a CFT case formulation, although dysfunctional, these oppositional behaviors can be seen as heroic efforts in trying to find independence from a harsh authority (building the courage to choose for himself, rather than being frightened and adopting submissive/compliant behaviors).

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Over time, Peter's avoidance strategies worsened; he started to drink and to smoke weed and hashish and stated that "I did not care about the ones I hurt, I did not care about anything"; i.e., he was apparently unemotional towards others' distress (including the distress he caused) and to his own distress (i.e., CU traits). He also started to display GM traits (e.g., "I was the boss. I could make people to do whatever I want"), as well as II traits and antisocial behaviors (e.g., lie, run away from home, miss school, blame other for his behavior, attack others). These safety strategies lead Peter to be placed in a foster care facility (separated from his family; unintended consequences). As his antisocial behavior quickly escalated to severe offenses against people (e.g., physical aggressions, armed robberies), he was then placed in a juvenile detention facility. In sum, Peter was caught in a vicious cycle, unwittingly reinforcing his own external and internal key threats of abandonment and rejection and of being worthless, inferior, and lonely.

7. Course of Treatment and Assessment of Progress

Peter's treatment progressed through the four PSYCHOPATHY.COMP modules.

Module 1

During the first module, Peter was very resistant to the detention process and to changing his behavior. For instance, he stated, "They took my freedom away"; "I cannot be with my family, I cannot go outside to take some fresh air, this place is driving me crazy"; "I am losing my time"; "I am losing the best years of my life"; "I am losing my mind", "No one is helping me, everyone is just punishing me"; "I just want to destroy this place, to run away, and go home"; "I am not going to change, ever! No one is going to change me. I don´t need to change, I don't want to change". Despite this initial resistance, he quickly managed to establish a good relationship with the therapist. Peter also easily understood the evolutionary value of humans' automatic and universal responses to threats, as well as the possibility we all have to change the way we cope with these threats across life. In addition, by using motivational interviewing strategies aligned with the CFT framework (Steindl et al., 2018), in session 2, Peter started to move into the contemplation stage by stating: "I want to find a way to be helped"; I want to find a way to calm myself down"; "I want to find new ways of thinking". No resistances to CMT were detected. In contrast, Peter found CMT useful and practiced it between sessions (namely, at night in his bedroom).

Module 2

During the initial sessions of this module, Peter showed even more ambivalence towards change. On the one hand, he started to understand the benefits of change, but he also maintained some resistance: "You know, it is not easy, I just want to leave this place, but time drags on"; "On one side it was good to have been caught. Here, I can change, I can learn to calm myself down, but not because of others, I just don´t like to be incarcerated". However, his rage was out of control, especially with some peers and staff members: "I am so angry, everything about this place pisses me off"; "People want to shut me up, to make me behave this way, or that way. But no one buys me; I do what I want, when I want"; i.e., Peter was using the same externalizing safety strategies

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that led him to the juvenile detention facility. Most likely, for these reasons, his behavior was not improving, which was observable from his record file.

After session 6, Peter became more conscious about his own functioning; he realized that he was constantly trying to regulate his emotional states by using the threat regulation system. By doing so, he could only use the automatic responses of the threat system (especially the fight response), which led him to be caught by anger and to display disruptive behaviors. For instance, every time he started to think that it was best for him to behave properly, his mind automatically stated that he would not be able to do that ("I want to behave properly, but I can't, I just can´t"). Therefore, he started to get angry, to feel tension in his jaw and hands, to feel threatened, to be overwhelmed by angry thoughts ("I just want to hit people, to destroy all of this") and to act accordingly. These insights, along with the knowledge and practice of other emotion regulation tools (resort to drive and soothing systems to balance the functioning of the three emotion regulation systems; test different and non-destructive ways to express his rebellion and courage) and CMT, probably contributed to a clear improvement in his behavior from the middle of this module.

Module 3

During this module, which is mainly focused on CMT, Peter continued to improve his behavior at the juvenile detention facility. This improvement was probably due to the effect of compassion and the nature of the session's exercises; i.e., these are very experiential, allowing for anger and shame exposure (and exposure of all the negative emotions that may arise when the threat system is triggered), but always offer the opportunity to reframe the experience in a compassionate way. Additionally, Peter clearly moved from the stage of denying his antisocial conduct, shame, and externalizing shame regulation strategies to acknowledging the shame experience, tolerating it and starting to feel guilty about the harm he caused others and himself.

One event was probably crucial for this change. In session 13, Peter was very anxious, and for the first time, he was not able to perform the CMT practice at the beginning of the session.

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Validating his emotional state and genuinely showing concern for him, the therapist asked him what was going on. After several attempts, Peter was able to tell, in tears, that he and his peers had been breaking a rule of the juvenile detention facility for two weeks (they were secretly using a cell phone). He was clearly disturbed by this, feeling shame, remorse and guilt: “I do not deserve all you people do for me, you trusted me and I broke that trust”; “You know, it is a stupid cell phone, but when I saw it I could not resist. Yes, I made a few phone calls to my family and friends, and I knew that it was against the rules. All you people were thinking that I was getting better, and I just disappointed you”. Compassionately guiding and holding his distress, the therapist said to Peter that this confession was an act of courage and kindly asked him if he had ever felt this way before: “No, I never felt this way before. Even when I robbed people, when I knockout people, I never felt like this. I can’t sleep, I can´t eat. I don´t know what is wrong with me.” The therapist maintained a compassionate attitude and led Peter to acknowledge that he was starting to develop consciousness about the impact his behaviors may have on others, and consequently, he was starting to feel guilt. When Peter became calmer, the therapist suggested alternative actions he may take after this episode: keep it a secret, talk to the head of the facility, or talk to the head of the facility in the presence of the therapist. First, Peter thought that confessing would be “stupid” because he could never be caught. The therapist kindly stated that that was true, but there was one person who knew the truth. Peter acknowledged that that person was himself and that he was unable to deal with it. Therefore, he decided to confess to the head of the facility in the presence of the therapist. While confessing, Peter was again very disturbed, crying and sweating, but at the end, he stated that he felt relieved. The therapist normalized his behavior, as we all make mistakes, validated his courage, and told him that what he had done was an act of compassion, as he was able to acknowledge his own distress and the suffering he might have caused others and actually did something to prevent/alleviate that suffering. The next day, Peter moved forward, convincing his peers to confess to the head of the facility that they were also using the cell phone.

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The remaining sessions of module 3 flowed naturally, with Peter increasing and expanding his compassionate motivation to other areas: he was more attentive to the suffering of others (peers, staff, family members) and made efforts to alleviate that suffering (e.g., after a session he saw a peer, and acknowledging that he was distressed, approached him, placed his hand on his shoulder, and kindly asked him what was going on); he was also more willing to receive compassion from others (e.g., when facing difficult moments, he asked for help from the therapist but also from his social worker, some members of the staff, and peers); and he started to act compassionately towards himself. In this respect, he wrote letters to his family members (mother, father, grandfather, grandmother) and expressed gratitude for the good things they had done for him. In the letters to his mother and father, he also compassionately specified that some of their attitudes towards him had made him suffer and feel bad about himself. Moreover, role playing an armed robbery, Peter was able to display guilt and compassion towards his victims. Acknowledging that he never looked into his victims eyes, he stated, "No, I never looked at their faces. Although I was very aggressive, I think that I could not bear that distress. I would acknowledge that they were someone else's son, someone else's grandson… and they were indeed".

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Module 4

During the last module, Peter continued to show improvements, but concerns about the end of the therapeutic process emerged, which probably spurred his fears of abandonment. This issue was addressed according to a compassionate framework. Moreover, Peter felt reassured by understanding that the therapist would be available for booster sessions any time he needed. At the end of therapy, Peter was compassionately challenged to describe himself before and after treatment: "Do you remember saying that you would never change? You are in the same environment, in the same difficult context, but your behavior has clearly improved. Can you tell me what changed?" and Peter quickly answered "It was me, I changed, and I am grateful for being detained and for being in here with you every week. If I was not caught at that time, I would end up hurting people severely, or even killing someone."

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8. Complicating Factors

The major complicating factors were related to the juvenile justice system services and policies. First, it took almost a year after Peter's detention to determine the exact time of his detention period, which hindered Peter´s emotional, cognitive and behavioral regulation ("I am always thinking about this. My mind doesn't stop. I have no idea when I am leaving this place"). After this period, the court decided to shorten the detention period from 26 to 18 months; however, Peter considered that his improvements were not fully taken into account: "They put me in here so I could get better. Now I am better, and they are just punishing me, so what was the point of this". Second, the nature of the maximum-security juvenile detention facility is very restrictive. In detail, although the token economy system is crucial to control youth's disruptive behaviors, even if youth do not present any disruptive behavior for a considerable amount of time, they still have few privileges; i.e., they may have access to an mp3 player, keep their own clothes and make phone calls every day, but they are not allowed to receive extra visits (e.g., on their birthday) or to leave the detention facility until release. However, because Peter´s behavior was clearly and consistently improving, the court made an exception and allowed him to spend Christmas at home.

9. Access and Barriers to Care

There were no apparent access issues or barriers to care considerations because of the inherent characteristics of the juvenile detention facility; this allowed Peter to be available for the entire treatment process and follow-up period. Moreover, the juvenile detention facility administration and staff provided the logistics for all treatment sessions (e.g., schedules, setting). Although PSYCHOPATHY.COMP is not a family intervention program; the regular and consistent presence of Peter's family during the weekly visit and their encouraging attitude towards him were also crucial. In detail, after detention, Peter's family called him regularly, wrote him encouraging letters, and always visited him during the allowed weekly visit, being supportive and kind. Additionally, the communication between his parents exponentially improved: "Now they talk without screaming or attacking each other, I think that they finally understood that they were driving me nuts!"

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10. Follow-Up

To examine the changeability of psychopathic traits in Peter's case, from pretreatment to post-treatment and from pretreatment to 3-month follow-up, we used the Reliable Change Index (RCI; Jacobson & Truax, 1991). The RCI is an index considered to have high reliability for testing the efficacy of a particular therapy or program and can show whether an individual improves or deteriorates in comparison to baseline; the threshold for significant improvement at p <.05 lies at a z-score ≤ - 1.96 (z-scores lower than -0.84 or -1.28 indicate, with a confidence interval of 80% or 90%, respectively, that real, reliable, and significant change has also been verified; Wise, 2004). To determine whether the observed change is in fact reliable, the RCI also takes into account normative data and the measurement error of the instrument (Jacobson & Truax, 1991). Thus, the RCI is computed using the formula: $RCI = \frac{(\mathrm{x2} - \mathrm{x1})}{\sqrt{2(\mathrm{SD0}\sqrt{1-\alpha})^2}}$ where x2 represents the results of the individual in the post-treatment/follow-up, x1 represents the results of the individual in the pretreatment, SD0 represents the standard deviation of the variable in a normative sample, and α represents the internal consistency of the scale in that same sample. To compute the RCI, we relied on the data of the normative/community sample used in the study by Ribeiro da Silva and colleagues (2019a) (i.e., YPI-S-GM: α = .79, SD0 = 3.20; YPI-S-CU r: α = .69, SD0 = 2.85; and YPI-S-II: α = .73; SD0 = 2.62).

To examine the indicators for disruptive behavior, as there were no normative data for computing the RCI, we were able to focus on only the differences across time, considering the number of disciplinary infractions and the number of days in punishment.

Table 2 reports Peter´s improvements in psychopathic traits and disruptive behaviors. His YPI-S total score and YPI-S factor scores decreased significantly from pre-treatment to post-treatment (the threshold for significant improvement at p <.05 was not reached only for the GM factor; RCI = -1.86) and continued to decrease at the follow-up (the threshold for significant improvement at p <.05 was reached both for the YPI-S total score and for all the YPI-S factor scores). Peter´s

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behavior also clearly improved since the beginning of the program (when he committed the last disciplinary infraction), but especially after the middle of the program.

11. Treatment Implications of the Case

This is the first study to examine the efficacy of the PSYCHOPATHY.COMP program in reducing psychopathic traits and disruptive behaviors in juvenile detainees with CD. Although group intervention programs have proven to be effective in decreasing antisocial behavior (Andrews & Bonta, 2010; Koehler et al., 2013; Lipsey, 2009; MacKenzie & Farrington, 2015), the literature testing the efficacy of interventions in reducing psychopathic traits is scarce and limited (see Hecht et al., 2018 for a review). To the best of our knowledge, this is the first psychotherapeutic program specifically tailored for reducing psychopathic traits and disruptive behaviors in juvenile detainees and the first study to use a CFT-based intervention to treat these youth. As an individual intervention, the PSYCHOPATHY.COMP program can be easily adjusted for each youth (maintaining its core aims and design), offering an in-depth treatment alternative to surpass the limitations of group programs.

This case study demonstrated that the PSYCHOPATHY.COMP was effective in reducing psychopathic traits and disruptive behaviors in a 16-year-old male detained in a maximum security juvenile detention facility, who presented a very high risk for criminal recidivism, CD (childhood-onset type, severe; and comorbidity with ODD and substance use disorders), and a high psychopathic profile. In detail, Peter's YPI-S scores improved from a high psychopathic profile (pretreatment) to normative scores in the post-treatment, but mostly at the follow-up (Ribeiro da Silva et al., 2019a). Peter´s behavior also improved over time and after the beginning of the program (see table 2); these improvements were evident enough to lead the court to make an exception to the rules and allow him to spend Christmas at home.

The PSYCHOPATHY.COMP program seemed to be suitable for treating Peter, as it followed a compassionate approach that gradually and respectfully helped him to understand his own difficulties, first related to resistance to the detention process and change and then to his own fears

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of compassion, which were disguised by his psychopathic traits, among others (Ribeiro da Silva et al., 2019b). The therapeutic relationship and the compassionate bridging between Peter and the therapist probably helped him to gradually feel safe and to start to find compassionate ways to balance the functioning of his emotion regulation systems.

Despite these findings, it is possible that CFT in general and the PSYCHOPATHY.COMP program in particular may raise some concerns when applied to juvenile detainees with psychopathic traits. Namely, some clinicians and researchers may argue that this approach may help to cover-up or worsen psychopathic traits more efficiently than other treatment approaches, allowing youth to more successfully achieve their antisocial goals. However, if we take into account recent research conceptualizing psychopathic traits as an adaptive response that masks central emotional dysfunctions and a shameful nucleus (e.g., Garofalo et al., 2018; Kosson et al., 2016; Ribeiro da Silva et al., 2015; 2019b), PSYCHOPATHY.COMP might be an effective alternative to address and reduce psychopathic traits and disruptive behaviors. In detail, and as verified in this case study, psychopathic traits may be conceptualized as a mask of invulnerability that externalizes unpleasant emotions by compensation (GM traits), avoidance (CU traits) and/or attack mechanisms (II traits) (Ribeiro da Silva et al., 2019b). In this sense, although psychopathic traits seem to be the opposite of compassion (Shirtcliff et al., 2009), building a compassionate motivation in these individuals is not only what they need, but it is also an effective alternative to change those same traits. Thus, PSYCHOPATHY.COMP may offer these youth a safe environment that allows them to (a) process their own unpleasant memories and emotions compassionately; (b) build the wisdom, strength, and courage to start to become more self-aware, in control, and responsible for their emotional states, gradually dropping out their mask of invulnerability; and (c) find and test compassionate alternative strategies to bear and cope in healthy ways with their own distress and/or the distress of others.

Nevertheless, the findings from this case study must be considered within the context of some limitations. As a clinical case study, it is difficult to clearly ascertain whether Peter´s improvements

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were due to the PSYCHOPATHY.COMP program or other external variables, namely, the juvenile detention facility interventions, which include a token economy system. Thus, future empirical research may help to disentangle whether improvements are due to the program, to the juvenile detention facility interventions, or both. However, it is important to highlight that Peter began the program 4 months after detention and, during that period, no improvements were noticed. Another important limitation is that all assessments were made while Peter was still detained. Thus, we cannot assure whether Peter´s improvements will be maintained after release and/or whether these improvements will have an impact on his risk of criminal recidivism/recidivism rate. Future studies should therefore test the effects of the PSYCHOPATHY.COMP program over time (i.e., after release), including the risk of criminal recidivism and criminal recidivism rates as outcome measures.

Given that youth with CD and high levels of psychopathic traits usually have poorer treatment outcomes than youth with lower levels of psychopathic traits (see Hecht et al., 2018 and Polaschek & Skeem for a review), there is a critical need to test novel interventions targeting theoretically sound mechanisms of change in these youth. The encouraging research findings from this case study suggest that CFT in general and PSYCHOPATHY.COMP in particular may fit the intervention needs of this population. However, additional research on the efficacy of this therapeutic program in treating juvenile detainees is needed.

12. Recommendations to Clinicians and Students

This case study demonstrates meaningful clinical improvements in Peter's levels of psychopathic traits and disruptive behaviors after completion of a 20-session individual program based on CFT. These gains were maintained/increased after a 3-month follow-up period, which indicates that this was an effective treatment approach for this youth. The findings from this case study provide initial support for the efficacy of the PSYCHOPATHY.COMP program in reducing psychopathic traits and disruptive behaviors in juvenile detainees. However, future research is needed to extend these findings, testing its efficacy in a clinical trial design, as findings from case

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studies are not always replicated in rigorous trials (CONSORT; Moher et al., 2010). Finally, it will be important to track the progress of youth after release, as there is a large risk for juvenile detainees to relapse into crime and to face prison sentences in the future (Herpers et al., 2012).

Efforts to design and test the efficacy of intervention programs specifically tailored for changing psychopathic traits in juvenile detainees may help to ameliorate the significant negative impact that antisocial behavior and psychopathic traits have on society and on the individuals themselves. These preliminary findings also support the need for future clinical research with juvenile detainees, holding promise for reducing psychopathic traits and disruptive behavior over time.

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Table 1. *Brief Overview of the PSYCHOPATHY.COMP Program*

Module	Session	Theme	Key messages of the session
1. The basics of our mind	1	Presentations	We have a lot of things in common with each other. Most of the things in our lives are not our choice.
	2	Our basic ingredients	We all have the same instinctive reactions to threats.
2. Our mind according to CFT	3	Old brain/New brain = tricky brain	Humans have a tricky mind
	4	Multiple versions	We are just one version of ourselves
	5	Responsibility and freedom	We are not prisoners of our evolutionary, genetic, and environmental past experiences.
	6	Emotion regulation systems	It is important to be aware that we all have three emotion regulation systems
	7	Emotion regulation systems (cont.)	A good way to achieve stability is to balance the functioning of our emotion regulation systems
	8	Outputs of the threat system	We are all sensitive to shame
	9	Coping strategies	What is the best strategy to deal with shame
	10	Motivations and recovery	Knowing our motivations help us to follow a path of recovery
3. Compassionate Mind Training	11	Compassion: What is and what is not	No matter what, we can always choose compassion
	12	Multiple selves	We all encompass a multiplicity of selves, differentiate and integrate that multiplicity is key
	13	Fears of compassion	We all have fears, blocks, and resistances of compassion that we should face and overcome
	14	Flows of compassion	All the flows of compassion are important, though they may encounter roadblocks.
	15	Self-compassion	Self-compassion is key and the only tool we have available 24/7
	16	Flows of compassion revised	Compassion always give us an outlet
	17	Safe place	We can go to our safe place and reach our compassionate self whenever we need it
	18	Compassionate letter	Compassion is powerful and can impact in our lives.
4. Recovery, relapse prevention	19	Revisiting motivation and recovery: The role of compassion	We now have the tools to be responsible for our choices.
	20	What has changed? An overview	Life is always going to be bittersweet, learn to bear and face difficult moments compassionately is key

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Table 2.

Peter's Scores on the YPI-S, Disruptive Behavior Indicators, and Reliable Change Indices for Pre-treatment to Post-treatment and 3-month follow-up

Measures	T0	T1	T2	T3	RCI-1	RCI-2
YPI-S-T	-	3.11	1.89	1.67	-3.29	-3.89
YPI-S-GM	-	2.83	2	1.83	-1.86	-2.23
YPI-S-CU	-	2.67	1.5	1.17	-2.25	-2.89
YPI-S-II	-	3.83	2.17	2	-3.24	-3.57
Disruptive behavior						
Disciplinary infractions	4	1	0	0	-	-
Days in punishment	7	2	0	0	-	-

Note: YPI-S = Youth Psychopathic Traits Inventory-Short (YPI-S-T = Total score; YPI-S-GM = Grandiose-Manipulative; YPI-S-CU = Callous-Unemotional; YPI-S-II = Impulsive-Irresponsible).

Psychopathic traits outcome measure was collected in three time-points: pre-treatment (T1), post-treatment (T2), and 3 moth follow-up (T3). Disruptive behavior outcome measures were collected for four time-intervals: during the 3 months before the beginning of the program (T0), during the PSYCHOPATHY.COMP's first 3 months (T1); during the PSYCHOPATHY.COMP's last 3 month s (T2) and during the 3 months after PSYCHOPATHY.COMP completion (T3). RCI = Reliable Change Index (RCI-1 = from pre-treatment to post-treatment; RCI-2 = from pre-treatment to 3-month follow-up).

For Peer Review