Antisocial Personality Disorder and Psychopathy

(2 CE Hours)

After concluding this course learners should be able to:

- Define antisocial personality disorder and psychopathy
- Identify various treatment modalities used to attempt to treat antisocial personality disorder and psychopathy
- Describe why, according to the DSM-V, psychopathy is a variant of antisocial personality disorder
- List identified risk factors for antisocial personality disorder and psychopathy
- Describe how DSM-V and ICD define personality disorders
- Define personality characteristics of antisocial personality disorder
- Discuss various settings where the disorder has been treated
- Describe how the disorder has been treated
- Discuss the concept of socialized psychopathy

Introduction

Antisocial personality disorder has intrigued and challenged licensed mental health professionals as they have struggled for years to address the causal factors and aberrant behaviors found within individuals with the disorder. Answers, while more honed in the last century, remain elusive even into the twenty-first century.

Normal images of antisocial personality disorder and psychopathy normally center on infamous crime figures, such as Jessie James or Al Capone. For example, the following article synopsis focuses on a more recently convicted mobster by the name of James “Whitey” Bulger, (Michelle McPhee, August 6, 2013, retrieved Aug. 7, 2013).

The jury in the James "Whitey" Bulger trial began deliberating the notorious accused mob boss' fate following almost two months of testimony from crooked FBI against and killers. Bulger, age 83, was charged with racketeering that includes 19 murders, including the strangling of two young women. During the trial he traded “expletives” with his former co-criminals who testified against him.

Jurors heard testimony from 63 government witnesses including underworld figures who arrived at court in wheelchairs and in oxygen masks to describe being victimized by Bulger. One drug dealer told the court he was forced to play Russian roulette with Bulger and his crew during a shake down. A bookie described being forced to stand on a plastic tarp and told "that's to make the mess easier to clean up" as the father of five was extorted for $100,000.
There was testimony from hitmen like John Martorano, who confessed to killing 20 people, some accidentally. There was Stephen "the Rifleman" Flemmi, who was convicted of murdering 10 people and has since confessed to slaying another 10, including his own girlfriend and stepdaughter. Another killer, Kevin Weeks, threatened to "step outside" with Bulger's lawyer from the witness stand.

Mr. Bulger and his companion Catherine Greig were fugitives until June 2011 when they were captured at a rent-controlled Santa Monica apartment where they lived as Charlie and Carol Gasko. He had hidden $822,000 in cash behind the walls and 30 high-powered weapons, many of them loaded, around the apartment.

In closing arguments a federal prosecutor told jurors that Bulger was "one of the most vicious, violent and calculating criminals ever to walk the streets of Boston."

Bulger's defense attorneys leveled back at the government by saying that the testimony against their client "was bought and paid for" from despicable killers who are now "walking among us" on the streets of Boston.

The Bulger case inspired the Oscar-winning movie "The Departed" and many television shows. Until his capture, Bulger was the FBI's Most Wanted fugitive, second only to Osama bin Laden.

While the above example reflects the more aberrant aspects of the anti-social disorder variant, psychopathy, some mental health professionals also report something called socialized psychopath behavior that uses shallow charm, lack of guilt, and lies to manipulate their victims, in lieu of knives or guns.

Within the U.S. usual discussion of antisocial personality disorder and psychopathy falls under the category of Personality Disorders section within the DSM-V, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association in 2013. The diagnosis of Antisocial Personality Disorder incorporates Psychopathy, with variant characteristics. The diagnosis is also outlined in the ICD or International Classification of disorders.

Some societal costs of antisocial personality disorder, like the suffering endured by victims of the crimes committed by people with this disorder, are obvious. However, when people with antisocial personality disorder, (ASPD) are the charismatic leaders of religious cults, the devastation they can create is often not known until a catastrophe occurs. The mass suicide that occurred at the command of the Reverend Jim Jones in Guyana in 1978 is just one example.
Individuals who suffer from antisocial personality disorder have a higher risk of abusing alcohol and other drugs and repeatedly committing crimes. Imprisonment is a potential consequence. People with antisocial personality disorder are also vulnerable to mood problems, such as major depression, anxiety, and bipolar disorder; having other personality disorders, especially borderline (BPD) and narcissistic personality disorders; self-mutilation and other forms of self-harm, as well as dying from homicide, suicide, or accident.

Antisocial personality disorder tends to make the prognosis of other conditions more problematic. Having antisocial personality disorder makes the treatment for substance-abuse problems even more difficult. People who have both antisocial personality disorder and schizophrenia are less likely to comply with treatment programs and are more likely to remain in institutions like prison or a hospital. These risks become magnified if antisocial personality disorder is not treated. Statistics indicate that many people with antisocial personality disorder experience a remission of symptoms by the time they reach 50 years of age.

This course focuses on antisocial personality disorder and psychopathy. It will provide an overview of personality disorders, defined in the DSM-V and ICD-10, and then drill down to DMS-V criteria for anti-social personality disorder, in addition to discussion of topic research, causes, risk factors, and treatment for the disorder, with additional insight into what some mental health professionals identify as “socialized psychopathy”.

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<th>The Difference between Psychopathology and Psychopathy</th>
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<td><strong>Psychopathology</strong></td>
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<td>Psychopathology is a term which refers to either the study of mental illness or mental distress, or the manifestation of behaviors and experiences which may be indicative of mental illness or psychological impairment. Many different professions may be involved in studying mental illness or distress. And, many different specialties may be involved in the study of psychopathology. For example, a neuroscientist may focus on brain changes related to mental illness. Therefore, someone who is referred to as a psychopathologist, can be one of any number of professions specializing in studying this area. Psychiatrists in particular are interested in descriptive psychopathology, which has the aim of describing the symptoms and syndromes of mental illness. This is both for the diagnosis of individual patients (to see whether the patient's experience fits any pre-existing classification), or for the creation of diagnostic systems (such as the Diagnostic and Statistical Manual of Mental Disorders) which define which signs and symptoms should make up a diagnosis, and how experiences and behaviors should be grouped in particular diagnoses.</td>
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| **Psychopathy**                                       |
| Psychopathy is *not the same as psychopathy*, which has to do with antisocial personality disorders and criminality. Psychopathology is defined as the study of any significant behavioral or psychological syndrome that impairs an individual's daily functioning in society. |
Personality Disorders

DSM-V

According to the DSM-V the “current” approach describes personality disorder as an “enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.” The newer DSM-V as opposed to the DSM-IV reflects the decision of the APA Board of Trustees to preserve continuity with current clinical practice, while introducing a new approach that aims to address numerous shortcomings of the current approach to personality disorders. “For example, the typical patient meeting criteria for a specific personality disorder frequently also meets criteria for other personality disorders. Similarly, other specified or unspecified personality disorder is often the correct (but mostly uninformative) diagnosis, in the sense that patients do not tend to present with patterns of symptoms that correspond with one and only one personality disorder.”

DSM-V general criteria for personality disorders include:

A. Moderate or greater impairment in personality (self/interpersonal) functioning
B. One or more pathological personality traits
C. The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations
D. The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood
E. The impairments in personality functioning and the individual’s personality trait expression are not better explained by another mental disorder
F. The impairments in personality functioning and the individual’s personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g. severe head trauma)
G. The impairments in personality functioning and the individual’s personality trait expression are not better understood as normal for an individual’s developmental stage or sociocultural environment.

Personality disorders include: schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, personality change due to another medical condition, and other specified
personality disorder and unspecified personality disorder. These disorders are clustered into A, B or C descriptive similarities. (DSM-V, 2013)

Cluster A personality disorders are those that include symptoms of social isolation, and/or odd, eccentric behavior. These disorders include
- paranoid personality disorder,
- schizotypal personality disorder,
- schizoid personality disorder.
Cluster B personality disorders are those that include symptoms of dramatic or erratic behaviors (counter-social behaviors). These personality disorders include
- antisocial personality disorder,
- borderline personality disorder,
- histrionic personality disorder,
- narcissistic personality disorder.
Cluster C personality disorders are dominated by difficulties with anxiety and inhibited behavior. These disorders are referred to as and include
- avoidant personality disorder,
- dependent personality disorder,
- obsessive compulsive personality disorder (OCD).
An adults-only diagnosis, antisocial personality disorder describes individuals who tend to disregard and violate the rights of others around them. Antisocial personality disorder is best understood within the context of the broader category of personality disorders.

ICD-10 Revision

The International Classification of Diseases (ICD) is one of the most long-standing diagnostic classifications of mental and physical disorders. It is a categorical classification, organized into 17 major sections, which divide conditions into types depending upon their defining features. The ICD-10 Classification of Mental and Behavioral Disorders (1992) is part of a series of clinical descriptions and guidelines that make up the tenth revision of the International Classification of Diseases and Related Health Problems (1992). Disorders of personality are listed in the ICD-10 under subsection F60 to F69. In its notes on selected categories, the ICD suggests that this was not an easy category to write guidelines for, with concerns about the difference between observation and interpretation made by clinicians, as well as the number of criteria that must be filled before diagnosis can be confirmed, still unresolved by the ICD working committee. It also states that the personality disorders described are not mutually exclusive and can overlap in some of their characteristics.
Personality disorders are defined as deeply ingrained and enduring attitude and behavior patterns that deviate markedly from the culturally expected range. They are not secondary to other mental illnesses, or attributable to gross brain damage or disease, although they may precede and coexist with other disorders. Disorders of personality are regarded as developmental conditions which tend to appear in late childhood or adolescence and continue to manifest into adulthood.

Diagnosis of a personality disorder, therefore, would not usually be appropriate before the age of sixteen years, although the presence of conduct disorder during childhood or adolescence can indicate a predisposition towards the syndrome.

Dissocial personality disorder (F60.2) is grouped under the heading ‘Specific personality disorders’ along with syndromes such as Paranoid, Schizoid and Histrionic disorder. These conditions are defined as a ‘severe disturbance in the characterological constitution and behavioral tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal and social disruption’ (Section F60, World Health Organization, WHO, 1992)

The classification of Dissocial personality disorder is intended to include previous diagnostic categories of sociopathic, amoral, asocial, psychopathic and sociopathic personality disorders, but excludes conduct disorder and emotionally unstable personalities. The condition is described as usually coming to attention because of a gross disparity between behavior and the prevailing norms and is characterized by the WHO (1992) by the following signs and symptoms:

- Callous unconcern for the feelings of others
- Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations
- Incapacity to maintain enduring relationships, though having no difficulty in establishing them
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence
- Incapacity to experience guilt and to profit from experience, particularly punishment
- Marked proneness to blame others, or to offer plausible rationalizations, for the behavior that has brought the patient into conflict with society
- Persistent irritability may also be an associated feature

Clear evidence is usually required of at least three of the above traits before a confident diagnosis of Dissocial personality disorder can be made.

The ICD-10 made an attempt to assemble the core personality traits of the psychopathic personality and have produced criteria which overlap with other classifications of the syndrome.
Although the ICD suggests an emphasis on personality characteristics rather than types of behavior, many of the features of dissocial personality may have to be inferred from a patient’s behavior patterns rather than a true understanding of their underlying personality abnormalities. It has also been suggested that criterion (g), persistent irritability, demonstrates a potential for overlap with two criteria for ICD’s ‘emotionally labile personality disorder’ and does not easily distinguish an implied personality trait from an affective disturbance (Coid, 1993).

**Antisocial disorder (ASPD or APD) and its cousin - psychopathy**

According to the “current” approach, described in the DSM-V, antisocial personality disorder, is specifically a pervasive pattern of disregarding and violating the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit and manipulation are central features of antisocial personality disorder and it is helpful to integrate information acquired from systematic clinical assessment with information collected from collateral source.

In the newer version, the DSM-V outlines typical features of antisocial personality disorder as “a failure to conform to lawful and ethical behavior, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, along with maladaptive traits in the domains of Antagonism and Disinhibition.”

Diagnostic criteria for this disorder include:

- **A.** Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
  1. **Identity – Egocentrism:** self-esteem derived from personal gain, power or pleasure
  2. **Self-direction-** Goal setting based on personal gratification; absence of pro-social internal standards, associated with failure to conform to lawful or culturally normative ethical behavior.
  3. **Empathy –** Lack of concern for feelings, needs, or suffering of others: lack of remorse after hurting or mistreating another
  4. **Intimacy –** Incapacity for mutually intimate relationships, as exploitation is primary means of relating to others, including by deceit and coercion; use of dominance or intimidation to control others.

- **B.** Six or more of the following seven pathological personality traits:
  1. **Manipulativeness (an aspect of Antagonism):** Frequent use of subterfuge to influence or control others: use of seduction, charm, glibness, or ingratiation to achieve one’s ends
2. Callousness (an aspect of Antagonism): Lack of concern for feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one’s actions on others; aggression; sadism
3. Deceitfulness (an aspect of antagonism): Dishonesty and fraudulence; misrepresentation of self; embellishment of fabrication when relating events
4. Hostility (an aspect of Antagonism): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior
5. Risk-taking (an aspect of Disinhibition): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard for consequences; boredom proneness and thoughtless initiation of activities to counter boredom; lack of concern for one’s limitations and denial of the reality of personal danger
6. Impulsivity (an aspect of Disinhibition): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of the outcomes; difficulty establishing and following plans
7. Irresponsibility (an aspect of Disinhibition): Disregard for and failure to honor financial and other obligations or commitments; lack of respect for and lack of follow through on agreements and promises (DSMV- 2013)

The individual is at least 18 years of age. The affected person must have shown symptoms of this diagnosis at least since 15 years of age. It cannot be diagnosed if the person only shows symptoms of antisocial personality disorder at the same time they are suffering from schizophrenia or when having a manic episode. This disorder tends to occur in about 1% of women and 3% of men in the United States, with much higher percentages among the prison population.

Antisocial personality symptoms in women tend to include self-harm and more of the other symptoms of borderline personality disorder (BPD) than in men. (Melissa Conrad Stöppler, MD, on 10/9/2012, retrieved 8/7/2013)

According to the DSM-V, twelve-month prevalence rates of antisocial personality disorder, using criteria from previous DSMs are between 0.2% and 3.3%. The highest prevalence of antisocial personality disorder (greater than 70%) is among most severe samples of males with alcohol use disorder and from substance abuse clinics, prisons, or other forensic settings. Prevalence is higher in samples affected by poverty of sociocultural factors.
And, antisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. The DSM-V states that “only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.

Psychopathy, although not a mental health disorder formally recognized by the American Psychiatric Association, is considered to be a more severe form of antisocial personality disorder. Specifically, in order to be considered a psychopath, also called a sociopath, an individual must experience a lack of remorse of guilt about their actions in addition to demonstrating antisocial behaviors. While statistics indicate that 50%-80% of incarcerated individuals have been found to have antisocial personality disorder, only 15% of those convicted criminals have been shown to have the more severe antisocial personality disorder type of psychopathy.

Psychopaths tend to be highly suspicious or paranoid, even in comparison to individuals with antisocial personality disorder. The implications of this suspicious stance can be extreme, in that paranoid ideations tend to lead the psychopathic person to interpret all aggressive behaviors toward them, even those that are justified, as being arbitrary and unfair. A televised case study of a psychopath provided a vivid illustration of the resulting psychopathic anger. Specifically, the criminal featured in the story apparently abducted a girl and sexually abused her over the course of a number of days in an attempt to prove to investigating authorities that his stepdaughter's allegations that he sexually abused her were false. (Stöppler, on 10/9/2012, retrieved 8/7/2013)

The legal category of ‘psychopathic disorder’ has been heavily criticized by a number of psychiatrists, for being too elastic and ill-defined and for making no contact with any validated psychiatric category of the condition. Arguably there has been little legal explanation of the meaning of the term ‘psychopathic disorder’ or the concepts of ‘abnormally aggressive’ or ‘seriously irresponsible conduct’.

**How are anti-social disorder and psychopathy related?**

The term ‘psychopath’ means “psychologically damaged”. It has long been used in Britain and America to refer to a socially damaged person who engages in impulsive and irresponsible behavior, of an antisocial or deviant kind (Hare, 1985; World Health Organization, 1992; American Psychiatric Association, 1994). A narrower meaning of the term ‘psychopathic’ first appeared in the work of Koch (1891) who under the heading ‘Psychopathic Inferiorities’, grouped abnormal behavioral states, which he believed resulted from psychological weaknesses in the brain. Koch's work was succeeded by the writings of Schneider (1923) who in Psychopathic Personalities established psychopathy as a subclass of abnormal personality and
suggested ten different forms of the psychopathic syndrome. Henderson’s Psychopathic States (1939), set the pattern that was to later characterize Anglo-American psychiatric delineations of the disorder, by confining attention only to the grossest forms of psychopathic abnormality and emphasizing the antisocial nature of the condition. Henderson's contribution to the concept was his threefold subdivision of psychopaths into aggressive, inadequate, and creative forms.

Later, Cleckley (1964) and McCord and McCord (1964) went even further by narrowing the category to aggressive psychopaths and establishing core criteria for the disorder centered around antisocial behaviors. Cleckley’s publication of “The Mask of Sanity” (Fourth ed., 1964) has proved to be one of the most influential sources of the view that the psychopathic personality is a distinct clinical entity.

Higgins (1995) argues that the term psychopath has acquired a pejorative connotation within the mental health and social services. The implications are that the patient is untreatable, has no proper place in a hospital and is disliked by clinical staff. Indeed, the term is often employed in order to reject patients for treatment and for this purpose may be deliberately applied to patients with other psychiatric disorders such as schizophrenia or hypomania (Coid, 1988).

Today psychiatrists and psychologists are still debating the nature and etiology of the psychopathic condition. Since Henderson’s publication of Psychopathic States, numerous reclassifications of psychopathy have been put forward in the form of ‘sociopathy’ (American Psychiatric Association, 1952); ‘primary’ and ‘secondary psychopathy’ (Blackburn, 1975) and the more recent notions of ‘dissocial’ and ‘antisocial personality’, recommended in the current editions of the International Classification of Diseases and Related Health Problems (World Health Organization, 1992) and the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994; since revised to DSM-V). The last two categories, however, together with Hare's Psychopathy Checklist (1985) have been able to establish some validity as core diagnostic entities for psychopathy and as a result are now the most widely used classifications of the disorder (Coid, 1993).

The DSM-V states that psychopathy is a distinct variant of anti-social personality disorder that is “marked by a lack of anxiety or fear and by a bold interpersonal style that may mask maladaptive behaviors such as fraudulence. The variant is characterized by low levels of anxiousness and withdrawal and high levels of attention seeking. High attention seeking and low withdrawal essential component of psychopathy and the low anxiousness captures the stress immunity component”.

The symptoms of antisocial personality disorder can vary in severity. The more harmful or dangerous behavior patterns are referred to as sociopathic or psychopathic. There has been debate as to the distinction between these descriptions. Sociopathy is chiefly characterized as a something severely wrong with one's conscience; psychopathy is characterized as a complete
lack of conscience regarding others. Some professionals describe people with this constellation of symptoms as "stone cold" to the rights of others. Complications of this disorder include imprisonment, drug abuse, and alcoholism. And:

- Disregard for society's laws
- Violation of the physical or emotional rights of others
- Lack of stability in job and home life
- Lack of remorse
- Superficial wit and charm
- Recklessness, impulsivity
- A childhood diagnosis (or symptoms consistent with) conduct disorder

Antisocial personality is confirmed by a psychological evaluation. Other disorders should be ruled out first, because this is a serious diagnosis.

People with antisocial personality disorder often use alcohol and other drugs, which can exacerbate symptoms of the disorder. The coexistence of substance abuse and antisocial personality disorder complicates treatment for both. (Psychology Today online- retrieved 8/7/2013)

While the exact causes of this disorder are unknown, environmental and genetic factors have been implicated. Genetic factors are suspected since the incidence of antisocial behavior is higher in people with an antisocial biological parent. Environmental factors are believed to contribute to the development of antisocial personality disorder since a person whose role model had antisocial tendencies is more likely to develop the disorder.

Antisocial personality disorder is one of the most difficult personality disorders to treat. Individuals rarely seek treatment on their own and may only initiate therapy when mandated by a court. There is no known effective treatment for this disorder.

People with this illness may seem charming, but they are likely to be irritable and aggressive as well as irresponsible. They may have numerous somatic complaints and perhaps attempt suicide. Due to their manipulative tendencies, it is difficult to separate what they say about themselves that is true from what is not.

Antisocial personality disorder is characterized by a long-standing pattern of a disregard for other people’s rights, often crossing the line and violating those rights. It usually begins in childhood or as a teen and continues into their adult lives. Antisocial personality disorder is also often referred to as psychopathy or sociopathy in popular culture.
Individuals with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy and may be particularly distinguishing of antisocial personality disorder in prison or forensic settings where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships.

Again, antisocial personality disorder is diagnosed when a person’s pattern of antisocial behavior has occurred since age 15 (although only adults 18 years or older can be diagnosed with this disorder) and consists of the majority of these symptoms more specifically outlined in the DSM-V criteria discussed earlier in this course:

- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults
- Reckless disregard for safety of self or others
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

There should also be evidence of conduct disorder in the individual as a child, whether or not it was ever formally diagnosed by a professional. Early onset of antisocial behavior, including that of conduct disorder, and engaging in activities that are grounds for arrest are central items in most classifications of the disorder. A number of researchers have paid particular attention to this feature and produced a considerable amount of evidence to demonstrate the degree of aggression and intolerance characteristic of the psychopathic condition.

Williamson, Hare and Wong (1987), in an examination of the violent offences of psychopathic prisoners compared to non-psychopathic groups, found that the victims of psychopaths tended to be male and unknown, and that their violence tended to have revenge or retribution as the motive. In general psychopathic violence was callous and cold-blooded or part of an aggressive or macho display, but without the affective coloring that accompanied the violence of the non-
psychopathic group (Williamson et al, 1987). In a longitudinal study of male psychopaths and their criminal careers, Hare, McPherson and Forth (1988) also found that psychopaths, as measured on the PCL-R, engage in an inordinate amount of violence and aggressive behavior compared with other non-psychopathic criminals.

Like most personality disorders, antisocial personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

**Risk Factors**

Although the precise cause of antisocial personality disorder isn't known, certain factors seem to increase the risk of developing or triggering it, including:

- Diagnosis of childhood conduct disorder
- Family history of antisocial personality disorder or other personality disorders or mental illness
- Being subjected to verbal, physical or sexual abuse during childhood
- Unstable or chaotic family life during childhood
- Loss of parents through traumatic divorce during childhood
- History of substance abuse in parents or other family members

Other conditions, thought to be risk factors for antisocial personality disorder, include substance abuse, attention deficit hyperactivity disorder (ADHD), reading disorder, or conduct disorder, which is diagnosed in children. People who experience a temporary or permanent brain dysfunction, also called organic brain damage, are at risk for developing violent or otherwise criminal behaviors. Theories regarding the life experiences that increase the risk for developing antisocial symptoms in teenagers and adults provide important clues for its prevention. Examples of such life experiences include a history of prenatal drug exposure or malnutrition, childhood physical, sexual, or emotional abuse; neglect; deprivation or abandonment; associating with peers who engage in antisocial behavior; or a parent who is either antisocial or alcoholic. (Dryden-Edwards MD, 10/9/2012, retrieved on 8/7/2013).

**How is Antisocial Personality Disorder diagnosed?**

Personality disorders such as antisocial personality disorder are diagnosed by a trained and licensed mental health professional, such as a psychologist or psychiatrist. There is no specific definitive test, such as a blood test, that can accurately assess whether a person has antisocial personality disorder. Practitioners conduct a mental-health interview that gathers information to look for the presence of the symptoms previously described.
Due to the use of a mental-health interview in making the diagnosis and the fact that this disorder can be quite resistant to treatment, it is important that the mental-health professional know to assess the symptoms in the context of the individual's culture so the person is not assessed as having antisocial personality disorder when he or she does not. Research shows that many practitioners lack the knowledge, experience, and sometimes the willingness to factor cultural context into their assessments.

When doctors believe someone has antisocial personality disorder, they typically run a series of medical and psychological tests and exams to help determine a diagnosis. These evaluations generally include:

- **Physical exam.** This is done to help rule out other problems that could be causing symptoms and to check for any related complications.

- **Lab tests.** These may include, for example, a complete blood count (CBC), a thyroid function check, and screening for alcohol and drugs to determine if there are other causes for symptoms.

- **Psychological evaluation.** A doctor or mental health provider explores thoughts, feelings, relationships, behavior patterns and family history, which may include psychological tests about personality. He or she asks about symptoms, including when they started, how severe they are, how they affect daily life and whether similar episodes have occurred in the past. The doctor also asks about thoughts of suicide, self-injury or harming others.

A person with antisocial personality disorder is unlikely to provide an accurate account of his or her signs and symptoms. Family and friends may be able to provide helpful information. It's sometimes difficult to determine if symptoms point to antisocial personality disorder or another personality disorder because some symptoms overlap more than one disorder. A key factor in diagnosis is how the affected person relates to others. Someone with antisocial personality disorder is likely to have an accurate, sometimes superior understanding of others' thinking with little awareness or regard for their feelings. This leads the person to act out and make other people miserable with no feeling of remorse.

**Hare’s Psychopathy Check-list**

The Hare Psychopathy Checklist-Revised (PCL-R) is a diagnostic tool used to rate a person's psychopathic or antisocial tendencies. People who are psychopathic prey ruthlessly on others using charm, deceit, violence or other methods that allow them to get with they want. The symptoms of psychopathy include: lack of a conscience or sense of guilt, lack of empathy, egocentricity, pathological lying, repeated violations of social norms, disregard for the law, shallow emotions, and a history of victimizing others.
Originally designed to assess people accused of or convicted of crimes, the PCL-R consists of a 20-item symptom rating scale that allows qualified examiners to compare a subject's degree of psychopathy with that of a prototypical psychopath. It is accepted by many in the field as the best method for determining the presence and extent of psychopathy in a person.

The Hare checklist is still used to diagnose members of the original population for which it was developed, adult males in prisons, criminal psychiatric hospitals, and awaiting psychiatric evaluations or trial in other correctional and detention facilities. Recent experience suggests that the PCL-R may also be used effectively to diagnose sex offenders as well as female and adolescent offenders.

The PCL-R is used for diagnosing psychopathy in individuals for clinical, legal or research purposes. Developed in the early 1990s, the test was originally designed to identify the degree of a person's psychopathic tendencies. Because psychopaths, however, are often repeat offenders who commit sexual assaults or other violent crimes again and again, the PCL-R is now finding use in the courtroom and in institutions as an indicator of the potential risk posed by subjects or prisoners. The results of the examination have been used in forensic settings as a factor in deciding the length and type of prison sentences and the treatment subjects should or should not receive.

Diagnosing someone as a psychopath is very serious. It has important implications for a person and for his or her associates in family, clinical and forensic settings. Therefore, the test must be administered by professionals who have been specifically trained in its use and who have a wide-ranging and up-to-date familiarity with studies of psychopathy.

Professionals who administer the diagnostic examination should have advanced degrees (M.D., Ph.D., or D.Ed.) in a medical, behavioral or social science field; and registered with a reputable organization that oversees psychiatric or psychological testing and diagnostic procedures. Other recommendations include experience working with convicted or accused criminals or several years of some other related on-the-job training. Because the results are used so often in legal cases, those who administer it should be qualified to serve as expert witnesses in the courtroom. It is also a good idea, if possible, for two experts to test a subject independently with the PCL-R. The final rating would then be determined by averaging their scores.

Many studies conducted in North America and Europe attest to the value of the PCL-R for evaluating a person's degree of psychopathic traits and, in many cases, for predicting the likelihood of future violent behavior. Some critics, however, are more skeptical about its value.

The Hare PCL-R contains two parts, a semi-structured interview and a review of the subject's file records and history. During the evaluation, the clinician scores 20 items that measure central elements of the psychopathic character. The items cover the nature of the subject's interpersonal
relationships; his or her affective or emotional involvement; responses to other people and to situations; evidence of social deviance; and lifestyle. The material thus covers two key aspects that help define the psychopath: selfish and unfeeling victimization of other people, and an unstable and antisocial lifestyle.

The twenty traits assessed by the PCL-R score are:

- glib and superficial charm
- grandiose (exaggeratedly high) estimation of self
- need for stimulation
- pathological lying
- cunning and manipulativeness
- lack of remorse or guilt
- shallow affect (superficial emotional responsiveness)
- callousness and lack of empathy
- parasitic lifestyle
- poor behavioral controls
- sexual promiscuity
- early behavior problems
- lack of realistic long-term goals
- impulsivity
- irresponsibility
- failure to accept responsibility for own actions
- many short-term marital relationships
- juvenile delinquency
- revocation of conditional release
- criminal versatility

The interview portion of the evaluation covers the subject's background, including such items as work and educational history; marital and family status; and criminal background. Because psychopaths lie frequently and easily, the information they provide must be confirmed by a review of the documents in the subject's case history.

When properly completed by a qualified professional, the PCL-R provides a total score that indicates how closely the test subject matches the "perfect" score that a classic or prototypical psychopath would rate. Each of the twenty items is given a score of 0, 1, or 2 based on how well it applies to the subject being tested. A prototypical psychopath would receive a maximum score of 40, while someone with absolutely no psychopathic traits or tendencies would receive a score of zero. A score of 30 or above qualifies a person for a diagnosis of psychopathy. People with no criminal backgrounds normally score around 5. Many non-psychopathic criminal offenders score around 22.
Hare’s idea of psychopathy is based upon the clinical concept of the psychopath provided by Cleckley in the five editions of his work, *The Mask of Sanity* (Fourth ed., 1964). Cleckley believed that psychopaths suffered from a central and deep-seated semantic disorder in which meaning related, associative and elaborative processes are missing. He suggested that these deficits are well masked by a well-functioning, expressive and receptive process, whereby the psychopath can express himself vividly and eloquently, often conning others with his superficial charm.

Hare added to this theory the notion that psychopaths differ from normal persons in the temporal integration of rewards and punishments. He argues that psychopathy is characterized by a relatively steep temporal gradient of fear arousal and response inhibition. This means that as the temporal remoteness of punishment increases, the amount of fear elicited by cues associated with the punishment decreases. To the extent that anticipatory fear mediates response inhibition, the psychopath is unlikely to inhibit a response for which the reward is immediate and the anticipated punishment is remote in time (Hare and Quinn, 1971).

Initially Hare took the list of 16 characteristics considered to be typical of the psychopath and applied them to a series of prisoners. After further studies, Hare expanded the preliminary PCL to a 22-item version. Two items were subsequently dropped from the list.

Some authors have criticized the PCL-R, however, for including too many criteria involving criminal behavior and excluding other personality traits that have been found relevant to psychopathy behavior. Hare’s emphasis on obtaining information from case files, in addition to that obtained at interview also gives his classification a marked advantage over the other two scales in terms of reliability. Because psychopaths can deceive and manipulate others in prison and hospital settings as frequently as they do outside, it is unwise to use self-report studies as a means of assessing the psychopath. Indeed, Hare himself observed large discrepancies between the verbal reports obtained from psychopaths in interviews and questionnaires and their documented behavior (Hare, 1990). Hare and his colleagues were able to demonstrate high inter-rater and test-retest reliability using both the PCL and PCL-R on prisoners and forensic psychiatric hospital in-patients, when the checklist is used by properly trained researchers (Hare, 1980).

The ICD-10, DSM-IV and Hare’s Psychopathy Checklist have been able to establish some validity as core diagnostic entities for the psychopathy syndrome. On re-examination all three of these clinical classifications appear consistent with several traditional views of the personality traits and types of behavior defining the construct of psychopathy. A series of earlier authors, for instance, have described psychopaths as selfish, lacking in shame and empathy, and having a callous disregard for other individuals, with an incapacity to maintain enduring relationships. They have also described them as unable to control their impulses or to delay gratification and as
demonstrating a high propensity for lying, thrill seeking and poor judgment (McCord and McCord, 1956; Cleckley, 1964; Craft, 1966; Blackburn, 1986). Clinical practice measured by surveys with British forensic psychiatrists and prison medical officers have also confirmed very similar or overlapping features. (Davies and Feldman, 1981). Perhaps the most distinguishable feature of the psychopath, however, appears to be their high propensity for violence and their disregard for law enforcement, which explains why a high number of those suffering with the disorder come in contact with the legal system.

A diagnosis for antisocial personality disorder is made by mental health professionals comparing symptoms and life history with the diagnosis criteria. They make a determination whether symptoms meet the criteria necessary for a personality disorder diagnosis.

**Causes of Antisocial Personality Disorder**

There are many theories about what causes personality disorder. However, researchers are not positively sure about the possible causes of antisocial personality disorder. Like all personality disorders, and most mental disorders, antisocial personality disorder tends to be the result of a combination of biologic/genetic and environmental factors.

Personality is the combination of thoughts, emotions and behaviors that makes everyone unique. It's the way people view, understand and relate to the outside world, as well as how they see themselves. Personality forms during childhood, shaped through an interaction of these factors:

- **Genetics.** Inherited tendencies are aspects of a person's personality passed on by parents, such as shyness or having a positive outlook. This is sometimes called temperament.

- **Environment.** The surroundings a person grows up in, events that occurred, and relationships with family members and others. It includes such life situations as the type of parenting a person experienced, whether loving or abusive.

Personality disorders are thought to be caused by a combination of these genetic and environmental influences. Some people may have genes that make them vulnerable to developing antisocial personality disorder, and life situations may trigger its development.

There may be a link between an early lack of empathy, understanding the perspectives and problems of others, including other children, and later onset of antisocial personality disorder. Identifying these personality problems early may help improve long-term outcomes.

Most professionals subscribe to a bio-psychosocial model of causation, meaning the causes of are likely due to biological and genetic factors, social factors such as how a person interacts in their early development with their family and friends and other children, and psychological
factors or the individual’s personality and temperament, shaped by their environment and learned coping skills to deal with stress.

One of the most frequently asked questions about antisocial personality disorder by both professionals and laypeople is whether or not it is genetic. Many wonder if it is hereditary, but if this were the case, children of antisocial people would be highly expected to become antisocial themselves, whether or not they live with the antisocial parent.

Although there are no clear biological causes for this disorder, research on the possible biologic risk factors for developing antisocial personality disorder indicates that, in those with antisocial personality disorder, the part of the brain that is primarily responsible for learning from one's mistakes and for responding to sad and fearful facial expressions (the amygdala) tends to be smaller and respond less robustly to the happy, sad, or fearful facial expressions of others. That lack of response may have something to do with the lack of empathy that antisocial individuals tend to have with the feelings, rights, and suffering of others.

While some individuals may be more vulnerable to developing antisocial personality disorder as a result of their particular genetic background, it is thought to be a factor only when the person is also exposed to life events such as abuse or neglect that tend to put the person at risk for development of the disorder. And while there are some theories about the role of premenstrual syndrome (PMS) and other hormonal fluctuations in the development of antisocial personality disorder, the disorder can, so far, not be explained as the direct result of conditions.

All of this suggests that no single factor is responsible. It is the complex and likely intertwined factors that impact a person.

**Research**

There is a considerable amount of controversy surrounding the treatment of psychopathic and antisocial personality disorders. Different methods of treatment have been tried, but the lack of controlled follow-up research in this area has made it difficult to evaluate their effectiveness. What has emerged, however, is that the core elements of psychopathy (as the variant of antisocial personality disorder) make it one of the most difficult to treat. This has not been helped by the fact that there is still considerable debate surrounding the etiology of the syndrome and that it is defined by incompatible legal and clinical systems. As a consequence, the ‘treatability’ of psychopathic disorder has been questioned by a number of psychiatrists and psychologists and alternative methods of managing the disorder have been put forward. (Lee, Phil, “Personality Disorders: A Review”, retrieved 8/9/2013)

Two research samples below represent different facets of looking at antisocial disorder.
“Reconstructing Psychopathy: Clarifying the Significance of Antisocial and Socially Deviant Behavior in the Diagnosis of Psychopathic Personality Disorder”

A survey of clinical views suggests that the significance of antisocial and socially deviant behavior in the diagnosis of antisocial personality disorder is unclear. To investigate this issue, researchers evaluated Psychopathy Checklist-Revised ratings (PCL-R; Hare, 1991) using structural equation modeling. One model, referred to as the measurement model, included PCL-R ratings related to antisocial behavior as primary symptoms of psychopathy; a second, referred to as the causal model, included the same PCL-R ratings as secondary symptoms or consequences. Compared to the measurement models, the causal model included more PCL-R items, was more parsimonious, and had equal or superior fit indices. These findings suggest that antisocial behavior is best viewed as a secondary symptom or consequence of psychopathy. In addition, the findings have important implications for future research and clinical-forensic practice, especially concerning the assessment of risk for criminality and violence.

David J. Cooke, PhD, FRSE, Christine Michie, BSc, Stephen D. Hart, PhD, Daniel A. Clark, BSc, MSc, Reconstructing Psychopathy: Clarifying the Significance of Antisocial and Socially Deviant Behavior in the Diagnosis of Psychopathic Personality Disorder, Douglas Inch Centre (D.J.C.), Glasgow Caledonian University (D.J.C., C.M.), Simon Fraser University (S.D.H.), and the National Probation Directorate (D.A.C.).

“Differentiating Psychopathy and Antisocial Personality Disorder Using Psychophysiology”

Psychopathy and Antisocial Personality Disorder (APD) are both characterized by impulsive, externalizing behaviors. Though often used interchangeably, researchers contend that psychopathy is distinguished from APD by interpersonal-affective features that reflect an underlying deficit in defensive (or fear) reactivity. To this end, research has demonstrated that psychopathic subjects, relative to non-psychopaths, exhibit reduced startle potentiation while viewing aversive stimuli (e.g., Patrick et al., 1993). However, no studies have examined defensive reactivity deficits in APD. Here, using a sample of incarcerated offenders (N = 108), we examined blink reflex reactivity and ERP responses to auditory startle probes presented during affective pictures. Psychopathy was determined using the Psychopathy Checklist – Revised (PCL-R; Hare, 2003), while APD was diagnosed using DSM-IV criteria. Psychopathic subjects showed (1) a lack of defensive startle blink reflex reactivity to unpleasant pictures, and (2) a general diminution of the P3 component of the ERP response to startle probes, suggesting reduced orienting to unpleasant stimuli. Both of these effects were specific to the interpersonal-affective component of the disorder, rather than the antisocial, externalizing features. Further, neither of these effects was evident in subjects with APD. The specificity of these results suggests a dissociation between fear and externalizing at the neurobiological level.

Uma Vaidyanathan, Florida State University, Jason Hall, University of South Florida,
National and International Organizations Studying Personality Disorders

**APPA** The American Psychopathological Association (APPA), founded in 1910, is one of the oldest research organizations in North America. The APPA is devoted to the scientific investigation of disordered human behavior, and its biological and psychosocial substrates. Its primary function is to sponsor an annual conference on a specific topic relevant to research in psychopathology. Leading investigators from the U.S. and abroad are invited to give original papers on the topic, which have been collected and published in the past by American Psychiatric Publishing, Inc. (APPI). Future conference proceedings will be published by Oxford University Press.

**The International Society for the Study of Personality Disorders, ISSPD**, stimulates and supports scholarship, clinical experience, international collaboration and communication of research on all aspects of personality disorders including both diagnosis, course and treatment. Through its Regional and National organizations ISSPD encourages the initiative of education and research on personality disorders as well as collaborative efforts across countries and regions. ISSPD is open to professionals who are actively involved or interested in the study, assessment and treatment of personality disorders.

**The North American Society for the Study of Personality Disorders (NASSPD)** is an organization devoted to research concerning personality disorders. During the past decade, the view of personality disorders has changed dramatically. Rather than being seen as chronic conditions, it has been found that they have a particularly good symptomatic outcome. We are committed to further research on these disorders. We are also committed to informing clinicians, patients, and their family members about the latest information concerning this set of disorders. Finally, we are committed to aggressively advocating for the funding that these common but disabling disorders deserve. As we move forward, we look to established leaders in the field for guidance. We also hope to cultivate a new generation of researchers who will advance the field and by doing so, will lessen the suffering of these challenging patients.

What occurs with anti-social and/or psychopathy when it exists within people who are NOT involved in criminal behavior?
The DSM-V states that antisocial personality disorder “must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. The DSM-V states that “only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.” Even outside of prison, individuals with this diagnosis and its variant continue to live and injure those who they come into contact. Take the example of David and his wife Kelly, for example.

David was handsome, charming, seemingly well-connected, and had the most beautiful brown eyes Kelly had ever seen. They met at a charity affair where he was the dealer at the black jack table for the event. They struck up a conversation, Kelly won at the game, and David asked her out the same evening.

During their courtship David wasn’t terribly aggressive, and she liked the way he took an interest in her life. Their growing relationship felt different to her as David “wined and dined” her. He was clear that he wanted her in his life and soon into their dating began talking about getting married.

Kelly, wasn’t too sure about marrying within three months of their meeting, but she felt that if she didn’t give the relationship a shot he would leave. Having divorced shortly after birthing two children a year apart twenty years before she was struggling and being on her own had been lonely. She felt very special when she was with David and, after briefly discussing his proposal with her children and closest friends, and in spite of their strong reservations, she decided to take the big step. Kelly and David were married.

The honeymoon lasted as long as, well, the honeymoon. David got drunk on the first night of their cruise, following their morning wedding, and then disappeared. She found him at the gambling tables with a couple of new acquaintances, and he promised he’d return to their cabin soon. Kelly didn’t see him until morning when David wandered back to the room as though nothing out of the ordinary happened. He discarded her feelings of worry and anger. At different ports of call in the next week, he often forgot his wallet, and Kelly ended up paying for most of their purchases and excursions while he adopted something of a macho attitude and forgot to share appreciation for her generosity.

Things went from bad to worse after their honeymoon. They had opted to live in Kelly’s house, because David had run into some “hard times” and didn’t want to disrupt her way of living. But, while promising to look for full time work, he left for the race track in the early afternoons. A few months into their marriage Kelly
discovered that the credit card she loaned him had been maxed out at the same
time she learned her mother’s silver was missing. Any inquiries were met with
David’s hostility and verbal insults. She discovered he more or less talked at her
and not to her.

Then they were visited by someone serving legal papers regarding unpaid child
support. This was when Kelly also learned David had married six other times to
women living in other states. When she also discovered his affair she filed for
divorce. But the experience left her in debt, distrustful, and traumatized.

Nothing had prepared Kelly for someone like David. And in the beginning of their marriage she
had first blamed herself for David’s behavior. At her friends’ prompting she entered
psychotherapy and soon discovered he had a personality disorder that appeared to be
pathologically narcissistic and anti-social, and reflected a kind of socialized borderline form of
psychopathy.

Psychiatrists may understandably struggle with the term “socialized psychopathy”. The focus of
the problem lies in the lack of anxiety and remorse as well as victims being the object of personal
gratification. However, these individuals appear to live their lives without participating in blatant
acts of criminality. Mathews (retrieved 8/6/2013) developed a brief questionnaire that may
indicate borderline psychopathy that focuses in on the following questions:

1. Do they have trouble sustaining stable relationships, both personally and in
   business?
2. Do they frequently manipulate others to achieve self-goals, with no considerations
   of the effects on those manipulated?
3. Are they cavalier about the truth, and capable of telling lies to your face?
4. Do they have an air of self-importance, regardless of their true standing in
   society?
5. Have they no apparent sense of remorse, guilt or shame?
6. Is their charm superficial, and capable of being switched on to suit immediate
   ends?
7. Are they easily bored, and seem to demand constant stimulation?
8. Are their displays of human emotion shallow and unconvincing?
9. Do they enjoy taking risks, and acting on reckless impulse?
10. Are they quick to blame others for their mistakes?
11. As teenagers, did they resent authority, play truant and or steal?
12. Do they have no qualms about parasitically sponging off others?
13. Are they quick to lose their temper?
14. Are they sexually promiscuous?
15. Do they come across as belligerent?
16. Are they unrealistic about their long-term aims?
17. Do they lack any ability to empathize with others or to see themselves in the same situation?
18. Would you regard them as essentially rash and irresponsible?

People with this condition do horrible damage to those they come into contact, in addition to causing debt, and participating in reckless behavior that ruins businesses and other institutions. They represent the spectrum of economics, society and gender. For example, senior managers at schools and non-profit institutions have dominated and bullied subordinates and colleagues with their aggression, deceit and recklessness. These individuals can be charming and highly successful while cold and egocentric in their closer relationships. In the business world they can be making large amounts of money and yet they can have massive debt. They devise schemes to manipulate people out of their money. And it is not unusual to get into legal battles with these folks that are often child custody disputes.

When given free rein in “aggressive” companies they can unleash unprovoked mental abuse, leaving behind other employees who believe somehow they are to blame for the treatment. These “go-getters” in any profit or nonprofit institution may be undiagnosed anti-social personalities or borderline psychopaths. With their attitudes and love of risk, they can emerge as highly successful and well-regarded by their bosses, and yet are viewed as bullies by co-workers. These individuals have a very destructive effect on others.

Treatment

Can antisocial personality disorder be cured? While it can be extremely resistant to change, research shows there are some effective treatments for this disorder. For example, teenagers who receive therapy that helps them change the thinking that leads to their maladaptive behavior (cognitive behavioral therapy) have been found to experience a significant decrease the incidence of engaging in repeat antisocial behaviors.

Many people with antisocial personality disorder don’t seek treatment. People with personality disorders, in general, do not often seek out treatment until the disorder starts to significantly interfere or otherwise impact one’s life. This most often happens when a person’s coping resources are stretched too thin to deal with stress or other life events.

The treatment of ‘psychopathic disorder’ has been a controversial issue among psychiatrists ever since the concept was first introduced to psychiatric branch of medicine. Much of this controversy stems from a lack of consensus among clinical psychiatrists and psychologists on three critical issues. The first issue concerns the nature of the psychopathic condition and the
specific class of persons to whom it applies. The second issue relates to the most appropriate goals and targets for the clinical management of the disorder, the form treatment should take, and to how successful treatment outcome should be evaluated by the clinicians involved. The third issue concerns the extent to which ‘psychopathic’ behaviors are treatable and to whether evidence of psychological change during treatment implies reduced risk of re-engaging in such behavior once treatment has culminated. To assess treatability it is essential to first specify the nature of the disorder to be treated and, therefore, the targets of therapeutic change.

According to Chiswick (1992), there is a lack of understanding among psychiatrists about the nature and etiology of the disorder and there has been little in the way of legal explanation for what exactly is meant by the term. Tests with those who have been legally defined as psychopathic have also found that the disorder has a high comorbidity with other clinical syndromes, which has an important bearing on its treatment. (Blackburn, 1990; Dolan and Coid, 1993). The controversy surrounding the classification of psychopathy may have distracted from efforts to treat the syndrome. Although numerous methods of therapy have been tried with psychopathic patients, including pharmacological treatments, physical treatments, cognitive and behavioral approaches, therapeutic community approaches and individual and group psychotherapy, few have been able to bring about any great improvement in the patients concerned.

What research is available, however, does indicate that although the core antisocial behaviors of the psychopath are difficult to manage, some of the associated behaviors displayed by the condition, and more commonly linked with other clinical syndromes, may be responsive to clinical intervention. This presents psychiatrists with an unusual treatment dilemma and begs the question of whether it is better to target the untreatable aspects of psychopathy on the grounds that they are what led to the hospital admission in the first place, or the alternative symptoms of the condition, which are known to be more responsive to intervention.

Programs that have tried to use a purely reflective (insight-oriented) approach to treating depression or eating disorders in people with antisocial personality disorder often worsen rather than improve outcomes in those individuals. In those cases, a combination of firm but fair programming that emphasizes teaching individuals with antisocial personality disorder the skills that can be used to live independently and productively within the rules and limits of society has been the more effective treatment for this condition. (However, treatment approaches will be discussed further in this course.)

While medications do not directly treat the behaviors that characterize antisocial personality disorder, they can be useful in addressing conditions that co-occur with this condition. Specifically, depressed or anxious individuals who also have antisocial personality disorder may
benefit from antidepressants, and those who exhibit impulsive anger may improve when given mood stabilizers. (Dryden-Edwards MD, 10/9/2012, retrieved 7/8/2013)

Patients with psychopathic disorder have higher recidivism rates than the mentally ill and that a history of prior criminal convictions is the factor most strongly associated with re-conviction after release (Black, 1982; Tennent and Way, 1984; Murray, 1989). On the basis of this evidence, that some clinicians believe that even if psychological change can be brought about during therapy, it is unlikely that this will be maintained beyond release.

Treatment of antisocial personality disorder typically involves long-term psychotherapy with a therapist that has experience in treating this kind of personality disorder. Medications may also be prescribed to help with specific troubling and debilitating symptoms. (PsychCentral online, retrieved 8/7/2013)

Methods of Treatment

Treatment Settings
The treatment of patients with psychopathic disorder can take place in a variety of in-patient settings, including special hospitals, secure units, intensive psychiatric care units and in conventional psychiatric hospitals.

A psychiatrist may care for such patients at the initial stage of their presentation to the psychiatric services, while they are in hospital, after being arrested and charged, or while being detained under a hospital or interim hospital order (which is designed to test a patient’s co-operation with and response to treatment).

- Special hospitals
The overwhelming majority of those under the legal category of psychopathic disorder are admitted to special hospitals and most of this group is detained under hospital orders with restrictions

Assessing the needs of the patient
It is widely recommended that, on arrival at a new hospital, a careful clinical evaluation of psychopathic patients should be carried out before any strategy of treatment is developed. Liebowitz, Stone and Turkat (1986) recommend that an initial out-patient assessment or in-patient evaluation should be scheduled to last at least 90 minutes. During this consultation the mental health professional, should take an active role in obtaining the history of the present disorder. This will include an evaluation of psychiatric history, medical history, family history, and personal history as well as the patients cognitive and affective10 levels of functioning.
Particular attention should also be paid to the patient’s criminal history and to evidence of previous behavioral disorder, including attention deficit disorder (ADD) in childhood.

An assessment will rely upon a combination of interviews, psychometric measures (including the MMPI scales, repertory grids and Hare’s Psychopathy Checklist) and file information, in which records of social, psychiatric and criminal history can usually be found. Information from independent sources, including family members, court records and victims should also be sought. It is important that the psychiatrist gains some impression of the extent to which the patient feels able to exert control over behavioral dysfunction, as well as general attitudes toward antisocial conduct. This will involve an investigation of the lifestyle factors conducive to deviant behavior, including attitudes to self and others, interpersonal style and substance abuse. The motivation of each patient together with personal capabilities will have an important bearing on the individual’s treatment plan. Because the goals of therapy will vary according to each patient’s particular needs, it is also important to agree upon treatment targets with each individual before treatment starts. Higgins (1995) also recommends being realistic with the patient about what can be expected from therapy.

- **Out-patient care**
  It is possible for patients with antisocial personality disorder to receive treatment in an out-patient clinic. Some mental health treatment centers offer psychoanalytical out-patient treatment for adults, adolescents and children who have engaged in criminality or sexual deviation. A large proportion of these patients who attend out-patient clinics will have had previous contact with the psychiatric services and will be receiving out-patient care as a follow-up to a period of in-patient treatment. A high standard of after care for psychopathic patients is essential if dangerous behavior is to be prevented in the future. Out-patient clinics, which are provided as part of forensic psychiatry services, can also provide care.

- **Treatment in prisons**
  Although each prison is responsible for seeing that there is proper health care for the inmates in their establishment, not all are willing or have the means to engage in long-term therapy with those who have mental illness. This means that some patients may have to remain untreated until they can be granted a transfer to a mental hospital.

**Pharmacological treatments**

There are no medications specifically approved by the Food and Drug Administration to treat antisocial personality disorder. However, several types of psychiatric medications may help with certain conditions sometimes associated with antisocial personality disorder or with symptoms such as aggression. These medications may include antipsychotic, antidepressant or mood-
stabilizing medications. They must be prescribed cautiously because some have the potential for misuse.

The most common forms of medication used with personality disordered patients are neuroleptics, antidepressants, lithium, benzodiazepines, psycho-stimulants and anticonvulsants. Many treatments may take time to become effective and a substantial measure of active patient co-operation with them is necessary. The danger of violence may be immediate, so although there is no specific anti-aggression drug, reduction of arousal using the more sedative neuroleptics is often helpful and necessary during a crisis (Faulk, 1994). It has to be emphasized, however, that medication is only one aspect of patient management and is complimentary to psychological treatments.

- **Neuroleptics**
  Neuroleptics can have both a tranquillizing effect on disturbed behavior, most notably persistent tension, anger and hostility and a specific antipsychotic effect (Blackburn, 1993). Clinicians may have had personal experience of administering neuroleptics to a range of disturbed and aggressive patients in hospital settings to control crises. Early observations by American psychoanalysts suggest that low dose neuroleptic therapy (i.e. doses lower than would normally be prescribed for schizophrenics or depressed patients) can be helpful in the reduction of anger, hostility and occasionally, behavioral disturbances, such as suicidal gestures or aggression (Dolan and Coid, 1993).

- **Antidepressants**
  Antidepressants, such as serotonergic reuptake inhibitors, tricyclics and monoamine oxidase inhibitors (MAOIs) have been used with patients who display persistent dysphoric mood and major or atypical depression, such as panic attacks, mood swings and dysthymia (Gunn and Taylor, 1993). Imipramine, one of the tricyclic antidepressants, is the most studied and is probably most effective with psychotic depression, but has also been used successfully with obsessives and patients with unusual states of pain. (Gross, 1992). In subjects with personality disorder, MAOIs, have been used to produce a reduction in certain core features including anger control, impulsivity and interpersonal sensitivity. In view of the potential serious side effects, however, a trial of MAOIs may only be appropriate, after lithium has failed.

- **Lithium**
  Lithium is often used in the treatment of psychopathy patients because it can bring about a reduction in impulsive, explosive and emotionally unstable behaviors. (Stein, 1993). In many parts of the world lithium has been described as a mood stabilizing agent because of its primary action in preventing mood swings in patients with bipolar disorder (Katzung, 1982). Sheard (1971), who has conducted a number of experiments with lithium, suggests that it is perhaps the closest to being a specific agent for the control of anger and aggressive outbursts in personality
disordered patients. Sedation is a side effect of lithium and that high levels of the drug are associated with tremor and un-coordination. It is also possible that the optimum serum level will vary among individuals and will have to be determined for each patient. It is important that any patient taking lithium is carefully supervised (Stein, 1993).

- **Benzodiazepines**
  Benzodiazepines are known among clinicians to be highly effective in their control of anxiety states and insomnia. Although the available literature on the effect of benzodiazepines on psychopathy is not of a high quality, a single administration of benzodiazepine for a disturbed and aggressive patient may be helpful during episodes of severe disturbance or when for instance, recommends the use of diazepam for patients who have a history of aggression and behavioral problems.

- **Psycho-stimulants**
  Psycho-stimulants are known to reduce feelings of tension and dysphoria in patients with disturbed behavior. It has been suggested that stimulants are useful when the behavior exhibited by a patient can be understood as an adult development of childhood hyperactivity with attention deficit (Faulk, 1994). According to Dolan and Coid (1993), even if there is not a direct relationship between attention deficit disorder and antisocial personality disorder, it is likely that the two conditions share at least some overlapping genetic components.

- **Anticonvulsants**
  It is recognized among psychiatrists that anticonvulsant compounds have an important spectrum of clinical activity in both neuropsychiatric syndromes and behavioral disorder, as well as their effect on epileptic disorders (Gunn and Taylor, 1993). Carbamazepine (CBZ), for instance, which has been in use as an anticonvulsant since the 1960’s, is valuable in the treatment of dyscontrol episodes, such as angry outbursts, violence and self-mutilation, as well as the psychological problems experienced by epileptics. It has been suggested that anticonvulsants may be helpful in the treatment of psychopathy because of evidence that the behavioral dyscontrol exhibited by psychopaths could be linked to a disorder of the limbic system and that the condition is similar to the postulated syndrome of ‘episodic dyscontrol’ (Lishman, 1978). Further encouragement to use anticonvulsants has also emerged from electroencephalography (EEG) studies of psychopaths. The incidence of EEG abnormality, for instance, is thought to be highest in patients with personality disorder and behavioral abnormalities, and particularly aggressive psychopaths, who together with those who have a history of habitual aggression and explosive rage, show the highest incidence of all. (Williams 1969).

**Physical treatments**
Physical treatments of antisocial personality disorder are based upon the principle that abnormalities of brain function are a central factor in antisocial conduct. It is frequently
suggested, for instance, that for some specific subgroups of patients, a neurological impairment interacts with other psychosocial factors to place patients at risk of certain forms of antisocial behavior. White (1964) has argued that the psychopathic personality is produced by generalized brain injury, which weakens an individual’s capacity for inhibition and control and Gorenstein (1982) has implicated frontal lobe and limbic system damage in some psychopathic conduct. Views of this kind have supported the use of physical treatments of psychopathy, such as electroconvulsive therapy (ECT) and psychosurgery.

ECT treatment involves placing electrodes on the patient’s temples and giving them shock lasting a fraction of a second, to produce a generalized convulsion. In cases of severe depression, bilateral ECT is preferable, because it acts relatively quickly and fewer treatments are needed. In unilateral ECT, an electrode is applied to the non-dominant side of the hemisphere, with the intention of reducing the potential side effects of memory disruption. It is not entirely clear whether electroconvulsive therapy is useful in the treatment of psychopaths, although according to Gunn and Taylor (1993) it may be helpful in circumstances where a patient has developed a severe depressive illness.

Psychosurgery represents the most dramatic form of physical intervention and is by far the most controversial of the medical approaches (Gross, 1992). Although the use of lobotomies (the partial separation of other parts of the brain from prefrontal lobes) enjoyed brief popularity in the 1940’s, modern psychosurgery has become much more sophisticated, with very small amounts of brain tissue being destroyed in very precise locations (fractional operations). It has been suggested that for patients who are abnormally aggressive, the neural circuit connecting the amygdala and the hypothalamus should be removed, in the hope that this will reduce the subjects’ aggressive and assaultive behavior. However, surgery of this kind would not usually be considered until all other forms of treatment had failed, or when the patient was suffering from an obvious brain abnormality.

Behavior therapy

Behavior therapy, or the use of behavior modification techniques, is an attempt to apply the results of learning theory and experimental psychology to the problems of maladaptive behavior (Lantz and Ingram, 1984). Within such a model the patient is regarded as an individual whose antisocial behavior has been acquired by learning or improper conditioning. Behavior is seen, not as the product of spiritual or mental processes, but as the inevitable result of an interaction between environmental history and current environmental situations. As a consequence, behavior therapists usually approach assessment through a functional framework, which places emphasis upon current behavior environment relations and which seeks to determine the personal and environmental factors of which the antisocial behavior is considered a function. All behaviors, with the exception of organic syndromes are considered to be the outcome of these complex
interactions and potentially amenable to the scientific process of prediction and control (Crawford, 1984).

One of the most well-known cognitive behavioral techniques is therapeutic modeling, which is a direct application of the theory of observational learning developed by Bandura (1971). Modeling has been used to reduce anxiety, but also to teach social skills and anger management, by using the powerful effects of social imitation. Treatment usually involves arranging for a patient to observe a competent, coping human model of behavior, in the hope that this will be reflected in the patient’s future conduct.

One of the most widely used anger management programs is based upon procedures developed by Novaco (1975), who believed that subjects could gain control over their behavior through a combination of cognitive restructuring and relaxation training. This approach identifies and modulates cognitive, behavioral and physiological responses to provocation, through various treatment techniques, including physiological monitoring, assertiveness training, reappraisal, cognitive self-control, relaxation training and self-instruction. The treatment goal is to regulate each individual’s anger, through the understanding of personal anger patterns, but also the acquisition of skills involving more adaptive alternatives to provocation. It can be used on an individual or group basis.

Psychodynamic psychotherapy has its origins in the work of Sigmund Freud and the principles of psychoanalysis. Whereas behavioral therapy focused upon externally observable behavior and on manipulating deviant conduct towards an agreed norm, dynamic psychotherapy is more concerned with approaching the patient empathetically and with helping him or her to identify and understand what is happening in their inner world, with regard to background, upbringing and personal development. Freud regarded the psychotherapeutic process as one in which those in distress could share and explore the underlying nature of their troubles and possibly change some of the determinants of these, through the experience of unrecognized forces in themselves (Brown and Pedder, 1979).

Psychodynamic app...
that is governed by the reality principle) in the early course of development. According to Freud, damage of this type impairs the ego’s strength and therefore its capacity to contain and manage primitive anxieties and impulses. A crucial part of psychotherapy, therefore, is helping the patient to uncover the relevant mental states and meanings behind their behavior, allowing them to understand their feelings and maladaptive defense mechanisms. The therapeutic relationship plays an essential part in this process, because it is the therapist who directs the patient to recall memories and who will help the patient to understand and reintegrate the presented material into the present lifestyle. It is the work of the therapist to recognize similarities and patterns within the material presented and to share with the patient the meanings of these memories (Gunn and Taylor, 1993). This working alliance allows the patient to transfer feelings and attitudes, developed in earlier similar experiences, to the therapeutic session. It is this process, which Freud described as transference that provides insight for each patient and encourages greater self-awareness, self-control and empathy (Blackburn, 1993).

Group psychotherapy is intended to provide education, encouragement and support for its members, but also a secure environment in which information can be exchanged and opinions heard. The social nature of the group setting aims to provide each patient with an opportunity to examine difficulties, in a situation reflecting the family and social networks in which problems developed. Because several people are taking part, interaction is likely to be varied and complex, allowing the patient to learn greater understanding of self and others, but also, how best to develop relationships with other patients. Multiple transferences can develop, in which a patient transfers feelings not only on to the therapist, but on to fellow patients and the group as a whole. One of the most common modes of group psychotherapy used with personality disordered patients is psychodrama, which can be used to help patients work through a block in expression or communication, or to explore a key conflict in their lives. It can be particularly helpful in a hospital setting for those who are inhibited or find verbal expression difficult. As the ‘director’ the therapist can instruct a patient to step into the protagonist’s role (role reversal), in order to foster identification and improvisation.

Therapeutic communities
The therapeutic community (TC) has its origins in the changes that occurred in psychiatric hospitals after World War II, which encouraged a move away from an authoritarian doctor-patient model, to a more democratic style of staff-patient interaction (Dolan and Coid, 1993). This approach included the more active participation of patients in their own treatment as well as giving them greater responsibility for the day to day running of their hospital community. The general assumption is that the delegation of responsibility to residents in a ‘living and learning’ environment will encourage a more open expression of feelings among patients and a greater understanding and exploration of interpersonal relationships. Through a relaxing of staff-patient hierarchy and the collaboration of staff and patients in a wide range of activities, it is hoped that all interactions and relationships in the community can come under examination. The aim is that
such enquiry will lead to a better understanding of deviant or unhealthy previous behavior, which may then result in altered interpersonal behavior and improved psychosocial functioning (Dolan and Coid, 1993). Indeed it is claimed that TCs can benefit psychological adjustment, by reducing anxiety and depression and increasing self-esteem and self-perceived conformity and independence (Blackburn, 1993).

The atmosphere in therapeutic environments of this type is usually informal and regular community meetings are held between residents and staff, in order to enhance cohesion and a sense of communalism. Perhaps the most important aspect of TCs, however, is that membership of the community and engagement in therapy is voluntary. In order for the community to function and social order to be maintained, members must feel that they have actively chosen to engage in the regime. A therapeutic community maintains close contact with adjacent and relevant communities outside the therapeutic setting and usually practices an open door policy, with the patients coming and going freely and participating in activities according to a balance of personal choice and group pressures (Gunn and Taylor, 1993). Although this means that secure settings cannot be therapeutic communities in this full sense, TCs can be provided as a voluntary option for patients within secure environments. Special hospitals usually claim to offer ‘milieu therapy’, which is often used interchangeably with the concept of the therapeutic community. According to Blackburn (1993), the milieu therapy offered by secure settings usually includes a combination of pharmacotherapy, psychotherapy, cognitive therapy, group therapy and behavioral therapy. These elements of therapy are delivered by a wide range of staff from different professional backgrounds, so that different patients can receive different treatment packages, depending on their needs.

Treatment outcome

Although numerous methods of treatment have been tried with psychopathic patients, there are a limited number of controlled outcome studies in this area, which has made it difficult to determine which are the most effective. What little research is available, however, indicates that the nature of the psychopathic condition has made it one of the most difficult mental disorders to treat, with more and more psychiatrists and psychologists becoming somewhat pessimistic about their ability to deal with this group.

The effect of pharmacological treatments

Although a number of drug studies have been conducted over the past 30 years which have monitored the effects of certain forms of medication on the mentally disordered, few of these have been carried out with patients who display the core features of psychopathy, as defined in the ICD-10, DSM-V, or in Hare’s Psychopathy Checklist. In fact, the only trials that have specifically addressed the treatment of patients whose characteristics resemble these core clinical
features, are early studies involving psycho-stimulants and a small number of trials involving the use of lithium.

There have also been reports of the positive effects of lithium with patients whose characteristics resemble the core elements of psychopathy. In an open, multiple cross-over study conducted by Sheard (1971), for instance, which involved 12 male delinquents, characterized by repeated impulsive aggressive behavior, aggressive episodes were found to decrease when sufficient lithium was prescribed for a high serum level. In a second study, Sheard, Marini and Bridges (1976) produced the same results with a sample of 66 young delinquent inmates, held in a correctional institution for violent crimes. The main criteria for selection were convictions for serious aggressive offences, including manslaughter, murder, rape and a history of chronic assaultive behavior or chronic impulsive antisocial conduct. After a one month drug-free period, subjects were randomly allocated to either lithium carbonate or a placebo for the following three months. The patients’ antisocial behavior was monitored by the number of infractions of institutional rules they committed. These were divided into major infractions, which involved threats or actual assaults and minor infractions, which consisted of less serious, non-violent offences. The researchers found that there was a significant reduction of major infractions among the active drug group. Similar results were produced in a study conducted by Rifkin, Quilkin and Carrillo (1972), who examined the effects of lithium on a group of 21 adolescents. The study involved administering lithium for six weeks in a double-blind cross-over trial. Although the subjects were described as having an emotionally unstable character disorder, many of the characteristics of this condition include behaviors similar to the core features of psychopathy, such as chronic maladaptive behavior patterns, poor acceptance of authority, poor work record and a tendency to manipulate. Of the 21 patients, it was assessed that 14 were better on lithium, four on the placebo and that three showed no improvement.

The impact of comorbidity on pharmacological treatments.
It has been suggested that if clinicians accept the classification of psychopathic disorder set out in the three most commonly used clinical categorizations, then it is not surprising that pharmacological methods with psychopathic patients have received so little attention, relative to other methods. According to the current editions of the DSM, ICD and Hare’s Psychopathy Checklist, psychopathic disorder is characterized by a gross disparity between behavior and the prevailing social norms (World Health Organization, 1992) and is a condition which develops over a very long period of time. This would imply that treatments that focus upon inner change and the renewal of interpersonal skills and relations would hold out more hope for the disordered person than a treatment modality whose effects are rapid and purely chemical (Dolan and Coid, 1993). If clinicians accept the findings produced by Coid (1992) and Walker and McCabe (1973), however, which demonstrate that psychopathy has a high comorbidity with other clinical conditions, then it becomes clearer that those diagnosed with the disorder may in fact be suffering from additional symptoms which are responsive to drug treatment.
Outcome research involving the use of pharmacological treatments suggests that drug administration could play a role in the temporary control of violence in patients with antisocial personality disorder, but also in the amelioration of other psychiatric symptoms which can be exhibited by this group.

The effect of psychosurgery
The lack of conclusive evidence for the effective use of psychosurgery with these patients, together with the high mortality rates associated with this kind of treatment and the ethical dilemma of patients undergoing such operations involuntarily, has meant that this technique has been largely abandoned by contemporary psychiatrists. However, there is still some discussion about the use of psychosurgery for patients whose psychopathy is clearly related to brain damage. Andy (1975) produced evidence that psychosurgery was successful with six psychopathic patients who all had congenital or acquired brain abnormality, through seizures or trauma.

The effect of cognitive and behavioral treatments
Although few studies have monitored the long-term effects of cognitive and behavioral treatments, there is evidence that an increasing number of mental health institutions are employing this type of approach with personality disordered patients. Studies have had encouraging results with cognitive behavioral treatments and advocate their use with aggressive and antisocial patients. There are also several reports of the successful use of cognitive-behavioral anger control treatment with aggressive patients.

One of the problems associated with cognitive and behavioral methods of treatment, is that in line with their underlying philosophy, most programs only target specific behavioral deficits, such as social skills and problems with anger, and very rarely address the treatment of psychological disorders in their entirety. There is also a lack of agreement among behaviorists about what constitutes an improvement in certain skills and very few of the studies in this area have provided a behavioral baseline for the evaluation of performance. It is also concerning that because of the degree of organization and monitoring required by some cognitive-behavioral methods and most particularly the token economy, many have failed to survive in the long term. Perhaps the biggest problem with cognitive and behavioral methods, with regard to psychopathic patients, is the question of whether it is possible for subjects to transfer their behavioral training to conditions of real life.

The effect of psychotherapy
There have been very few evaluations of the effectiveness of psychotherapy with patients diagnosed with antisocial personality disorder, even though psychodynamic therapy, and particularly group treatments, is often employed in mental health settings. As Snowden (1995)
points out, this is in spite of the fact that there are only a handful of psychotherapists working in the forensic psychiatry services.

Most psychotherapists have found that keeping psychopathy patients in out-patient psychotherapy is very difficult, unless clients are on probation, or under a court order of treatment. For instance, Carney (1977) reports the moderate success of an out-patient group program with aggressive personality disordered male offenders, who attended as a condition of probation. After an average of 13 months treatment, significant improvements were found in ratings of community adjustment and the recidivism rate was a relatively low 28%. However, no changes were found on psychological tests administered to the group, such as the MMPI. Carney suggested that while therapy did not change personality, it did at least achieve control over violent behavior.

Woody et al (1985) found that among out-patient drug abusers undergoing psychotherapy, antisocial personality disordered patients showed little change on a variety of psychiatric and psychological measures, in comparison to antisocial personality disordered patients who were also depressed. The authors conclude that although counseling may reduce drug use, it is not beneficial to employ psychotherapy to treat opiate-dependent patients who have antisocial personality disorder alone. It is worth noting, however, that on average each patient only received 11 psychotherapy sessions, whereas most clinicians would recommend a much longer course of treatment.

A study carried out by Persons (1965) which monitored the effect of individual eclectic psychotherapy on sociopathic personalities and one or two studies that involve individual therapy as backup to group therapy, information is sparse on experiments which evaluate the impact of individual psychotherapy on patients with psychopathy. The lack of evidence for the positive effect of individual and out-patient psychotherapy with psychopathy patients has lead most psychiatrists to consider them inappropriate for antisocial personalities and to regard group therapy as a preferable option. More outcome studies have been conducted using group methods and a greater number of these have had a positive effect on their subjects. In one of the largest outcome studies concerning psychotherapy with adults, Jew, Clanon and Mattocks (1972) found that imprisoned personality disordered offenders who had received group therapy had significantly better success on parole than untreated offenders. The study involved giving 257 male subjects psychoanalytically oriented group therapy over a minimum of one year, for eight hours a week. These men were matched on criminological and demographic factors with 257 men also in the prison, but who had not received therapy. During the first year of parole, the rate of parole revocation for the treated offenders was 24%, compared to a rate of 40% for the untreated group. However, at four year follow-up, the difference in the number of returns to prison had disappeared. Maas (1966) had an equally successful outcome with a group of 46 sociopathic female prison inmates. Women were randomly divided into two groups, one of
which had a three month course of twice weekly group therapy, which combined action procedures such as psychodrama with more conventional reported feeling more independent and 45% had increased self-esteem.

Therapeutic Communities
As with so much of the treatment outcome research for patients, most of the studies conducted with therapeutic community (TC) models have some methodological shortcomings, including the inadequate use of controls, a lack of uniform criteria for improvement, short follow-up periods and an over reliance on the use of recidivism as a measure of long-term success. Most therapeutic communities have developed their own personal schemes of management and selection, and it can be challenging to make comparisons between these models or to generalize from the findings of one setting (Dolan and Coid, 1993). The patients taken in by TCs can also be considered unrepresentative of the psychopathic population as a whole, because they are voluntary. In spite of these shortcomings, therapeutic communities are receiving an increasing amount of support as the preferred models of treatment for psychopathic patients. It appears that the humane and democratic style advocated by these systems are deemed preferable to the punitive and degrading features of many custodial institutions (Blackburn, 1993).

Treatment Success

There is an argument that rather than being the fault of the treatment modality itself, it is the patient’s condition that is responsible for their lack of progress in therapy and the ‘untreatable’ nature of their underlying disorder that makes it impossible to reform. The ‘untreatability’ of ASPD has been discussed at great length. The features of the disorder that have given rise to responses described here.

- **The threat of danger** - The perceived risk of danger presented by psychopathic patients is central to the argument that they are ‘untreatable’. A large number of psychopathic subjects will not exhibit any violence during their stay at any one institution. Monahan (1984) estimates that for every three patients detained by psychiatrists on the grounds of dangerousness, only one will subsequently commit a violent act and that the severity of a patient’s disorder is a poor predictor of their potential for danger. However, staff are put under a great deal of emotional pressure at times when violence does occur, because it is they who are often the focus of a patient’s anger and hostility (Faulk, 1994). A number of clinicians have described how their perception of this risk has encroached upon the clinical management of the disorder.

- **Deceit**. There is some concern among clinicians that a great many of the core characteristics of psychopathy make it very difficult for the therapist to develop a rapport with those suffering from the disorder. For example, ASPD patients have been frequently found to lie about their behavior, which may take the form of denying or minimizing the
seriousness of their offence, or even deceiving members of staff about their therapeutic progress (Blackburn, 1993).

- **Poor motivation.** A number of clinicians have encountered psychopathic patients who lack the motivation to change or who refuse to believe that they need to. In his review of social skills training with violent offenders, for instance, Howells (1986) suggests that the practitioner soon encounters the patient who does not regard him or herself as deficient in certain skills and who judges their own behavior as both effective and desirable. Antisocial patients usually only enter therapy under pressure from families or the courts and even among involuntarily detained patients, attendance may be erratic and dropout rates high (Blackburn, 1993). Although in cases of this kind, group therapy can provide a suitable option, patients have been known to passively resist therapeutic involvement or to deceive the therapist with superficial gestures of enthusiasm and self-awareness.

- **The Treatment Environment.** When it is considered that it is a disorder directly related to how an individual interacts with his or her social environment, it becomes apparent that the environment in which that patient is treated could have a crucial bearing on rehabilitation. It has been suggested that ASPD patients who are required to live in prisons or hospitals which are at odds with their normal social environment will find it difficult to apply what they have learnt in therapy to situations outside that institution. Grounds et al (1987) note, for instance, that in special hospitals there is little integration of the sexes and that patients are kept away from their families, alcohol and drugs, even though these play an important role in their psychological disturbance. Studies have demonstrated that psychopaths are more likely than non-psychopaths to have lifetime diagnoses of alcoholism or drug disorder (Smith and Newman, 1990) and that these conditions probably contribute to their violent and destructive behavior. It seems that even TC’s can pose problems for those suffering with the disorder. Whiteley (1970) pointed out that TCs are only appropriate for a certain, very carefully selected group of subjects and most particularly those who have demonstrated their ability to cope with competition from peers and who have a relatively high capacity for occupational and interpersonal achievement.

- **Factors associated with re-offending.** Studies have been conducted which compare the rate of re-offending among discharged psychopathic patients with other mentally disordered offenders and which have also isolated the determinants of recidivism within this group of offenders generally. In a five year study conducted by Black (1982), for example, which examined male discharges from Broadmoor Hospital in Britain during 1960 and 1965, it was discovered that the best predictors of low rates of recidivism were having fewer previous psychiatric admissions and fewer previous criminal convictions, while being classed as a psychopath was a positive determinant of re-conviction.

In his review of studies of discharged special hospital patients, Murray (1989) also identified younger age, shorter length of stay in hospital and absolute, as opposed to
conditional discharge, as correlates of subsequent re-offending. Like Black (1982), he also discovered that re-offending is more likely to occur among those diagnosed with antisocial personality disorder. Although it is not possible to relate this research to specific treatment modalities, it has been suggested that such studies indicate that it is a patient’s pre-admission criminal record that is the best indicator of their likelihood to re-offend and that hospital treatment has little or no bearing on this occurrence (Grounds, 1987; Chiswick, 1992). It is possible, however, that this research also indicates the desperate need for mental health institutions to review the effectiveness of the treatment methods currently in use with patients and that, at this point in time, this area of therapy is still in its infancy. (Lee, and Phil. Retrieved 8/4/2013)

Summary

Within the U.S. more of the discussion about antisocial personal disorder and psychopathy falls under the category of Personality Disorders section within the DSM-V, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association in 2013. The diagnosis of Antisocial Personality Disorder incorporates Psychopathy, with variant characteristics. The diagnosis is also outlined in the ICD or International Classification of disorders.

In the newer version, the DSM-V outlines typical features of antisocial personality disorder as “a failure to conform to lawful and ethical behavior, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, along with maladaptive traits in the domains of Antagonism and Disinhibition.”

While the exact causes of this disorder are unknown, environmental and genetic factors have been implicated. Genetic factors are suspected since the incidence of antisocial behavior is higher in people with an antisocial biological parent. Environmental factors are believed to contribute to the development of antisocial personality disorder since a person whose role model had antisocial tendencies is more likely to develop the disorder.

About 3 percent of men and about 1 percent of women have antisocial personality disorder, with much higher percentages among the prison population.

Psychopathy, although not a mental health disorder formally recognized by the American Psychiatric Association, is considered to be a more severe form of antisocial personality disorder. Specifically, in order to be considered a psychopath, also called a sociopath, an individual must experience a lack of remorse or guilt about their actions in addition to demonstrating antisocial behaviors.
Both the DSM-IV and ICD-10 regard psychopathy as a longitudinal condition, which usually manifests in childhood. This implies that psychopathic symptoms are detectable before the condition gets to the adult stage and that it might be possible to treat pre-disposed signs in childhood or adolescence before they have had a chance to develop. There is a growing amount of evidence that childhood conduct problems are related to adult psychopathy.

Patients with the condition present clinicians with an unusual number of treatment difficulties. ASPD patients have been reported to lie about their behavior, to minimize its seriousness, and to deceive therapists about their therapeutic progress. Although it is important not to make generalizations about patients, they have acquired such a poor reputation for themselves throughout the mental health system that in many hospitals are now refusing to take them, for reasons that they are ‘untreatable’. Some believe that the nature of the psychopathic condition is such that clinicians cannot be expected to change the behavior of those suffering with the syndrome. Arguably, psychopathy is characterized by behavioral features which, in themselves, imply the failure of the individual to respond to normal sanctions on his or her behavior.

Even though no one method has been found universally affective with psychopathic patients, some patients do at least show improvements when the right treatment is identified for them. For this reason, it would also be more appropriate to use a combined and long-term treatment approach with those suffering from the disorder. Although traditional models of treatment are based on the assumption that one form of therapy can be administered to a patient for a certain period, after which time the problem is eliminated (Dolan and Coid, 1993), psychopathy, in particular, clearly does not respond to this type of intervention and requires multiple methods over a long time span. One of the more positive findings of the research conducted in this area, was that longer periods of therapy often produced better results in psychopathy patients. Effective after-care might also be helpful for psychopathy patients. It is extremely important to make sure that the patient is able to transfer what has been learned in therapy to their day to day encounters, and not just to assume that this will happen. In fact, follow-up research has shown that even if some degree of psychological change can be produced in therapy, this is not always maintained beyond release.

Many mental health professionals would agree that not all persons with the disorder can be deemed untreatable, until all methods of psychiatric intervention have been tried with this group. And little in the way of preventative methods has been tried with those suffering from the disorder.

The research material in this area is scarce and of poor methodological quality, with few experiments using controls and adequate follow-up periods and too many relying upon recidivism statistics as a measure of success, when these can be inaccurate. It has also been difficult to make comparisons between the different studies carried out in this field, because so
many of them use different diagnostic criteria for their subjects and monitor their progress with incompatible assessment devices. There continues to be an urgent need for well controlled, long-term treatment outcome research to be conducted in this area.

**Final Examination Questions**

1. Antisocial personality disorder tends to make the prognosis of other conditions:
   a. Less problematic.
   b. Easier to diagnose.
   c. Within the DSM-V Adjustment section difficult.
   d. More problematic.

2. Psychopathology is:
   a. The same as psychopathy.
   b. The same as psychotherapy.
   c. A severe diagnosis.
   d. Not the same as psychopathy.

3. DSM-V general criteria for personality disorders include:
   a. Moderate or greater impairment in personality (self/interpersonal) functioning.
   b. Four or more pathological personality traits.
   c. The individual’s personality trait expression are better explained by another mental disorder.
   d. The individual’s personality trait expression are solely attributable to the physiological effects of a substance or another medical condition.

4. Personality disorders are clustered into:
   a. Distinct brain interfacing areas.
   c. A, B or C descriptive similarities.
   d. Distinct and different categories.
5. According to the ICD-10 Revision, personality disorders:
   a. Are defined as deeply ingrained and enduring attitude and behavior patterns that deviate markedly from the culturally expected range.
   b. Are superficial behavior patterns that do deviate from other disorders outline in the ICD.
   c. Are defined as behavior patterns that do not deviate from the culturally expected range.
   d. Are defined as attitudes that affect others without affecting themselves.

6. According to the DSM-V antisocial personality disorder:
   a. Begins in late adolescence and continues into adulthood.
   b. Begins in childhood and ends by late adolescence.
   c. Has no time when the disorder emerges.
   d. Begins in childhood or early adolescence and continues into adulthood.

7. According to the DSM-V, ________ and ________ are central features of antisocial personality disorder.
   a. Deceit and manipulation.
   b. Depression and social phobia.
   c. Grandiosity and manipulation.
   d. Remorse and deceit.

8. According to the DSM-V antisocial personality disorder cannot be diagnosed:
   a. When someone is undergoing a hospitalization.
   b. At the same time someone is suffering from depression or when engaging in criminality.
   c. At the same time people are suffering from schizophrenia or when having a manic episode.
   e. While someone is in a locked facility.

9. Complications of antisocial personality disorder include:
   a. Mania, hyper-thyroid, and drug abuse.
   b. Alcoholism, divorce, and lack of motivation.
   c. Imprisonment, drug abuse, and alcoholism.
   d. Insomnia, lethargy, and depression.

10. The term ‘psychopath’ means:
   a. “pathologically impaired”.
   b. “neurologically damaged”.
   c. “psychotherapeutically impaired”.
   d. “psychologically damaged”.
11. The DSM-V states that psychopathy:
   a. Is very much different from anti-social personality disorder that is marked by a greater capacity for remorse.
   b. Is a distinct variant of antisocial personality disorder that is marked by a lack of anxiety or fear.
   c. Has no distinction and the terms can be used interchangeably.
   d. Is a distinct variant of antisocial personality disorder that is marked by grandiosity and self-identification.

12. Other conditions, thought to be risk factors for antisocial personality disorder, include:
   a. Substance abuse, attention deficit hyperactivity disorder (ADHD), reading disorder, or conduct disorder.
   b. Substance abuse, adult hyper-activity, mania, or alcohol dependence.
   c. Attention deficit hyperactivity disorder (ADHD), learned helplessness, or substance abuse.
   d. Short temper, substance abuse, reading disorder or aggressiveness.

13. Antisocial personality disorder is diagnosed when a person’s pattern of antisocial behavior has occurred since age:
   a. 17
   b. 15
   c. 10
   d. 12

14. It is important that the mental-health professional know to assess the symptoms (of antisocial personality disorder) in the context of the individual's:
   a. Culture
   b. Gender.
   c. I.Q.
   d. Criminality.

15. The Hare Psychopathy Checklist-Revised (PCL-R) is a diagnostic tool used to rate a person's:
   a. Psychopathology and psychopathy characteristics.
   b. Ability to express remorse and empathy.
   c. Attitude and deceitfulness.
   d. Psychopathic or antisocial tendencies.
16. Core elements of psychopathy make it one of the:
   a. Most difficult (within antisocial personality disorder) to treat.
   b. Easiest disorders to identify and treat.
   c. Most confusing diagnosis in the personality disorder section of the DSM-V.
   d. Most sophisticated disorders that is hugely over diagnosed.

17. Many people with antisocial personality disorder:
   a. Are attention seeking introverts.
   b. Don’t seek treatment.
   c. Become remorseful when they recognize the impact of their behavior.
   d. When flattered, often agree to treatment.

18. The disorder (ASPD) has:
   a. Not been recognized as a treatment challenge.
   b. Is easily diagnosed with one face to face interview.
   c. A high comorbidity with other clinical syndromes.
   d. A tendency to be confused with mood disorders.

19. While medications do not directly treat the behaviors that characterize antisocial personality disorder, they can be:
   a. Useful in addressing conditions that co-occur with this condition.
   b. An impairment to addressing co-occurring issues with the condition.
   c. Useful in addressing grandiose thinking and brain dysfunction.
   d. A placebo in facilitating change within the people who suffer from this disorder.

20. The most common forms of medication used with personality disordered patients are:
   a. Over the counter – easily obtainable medications recommended by a psychiatrist.
   b. Neuroleptics, antidepressants, lithium, benzodiazepines, psycho-stimulants and anticonvulsants.
   c. Medications that address stomach and migraine conditions.
   d. Anti-depressants and other mood stabilizers.

21. Lithium is often used in the treatment of psychopathic patients because:
   a. It can bring about a reduction in impulsive, explosive and emotionally unstable behaviors.
   b. It can address the depression most often found within this population.
   c. It is a stimulant.
   d. Many people respond to it as a cognitive mood reducer.
22. Psycho-stimulants are known to:
   a. Enhance the ability to control impulsive and explosive behavior.
   b. Control grandiose thinking and enhance remorseful behavior in patients.
   c. Reduce feelings of tension and dysphoria in patients with disturbed behavior.
   d. Reduce the ability to react in aggressive ways in patients with disturbed feelings.

23. One of the most well-known cognitive behavioral techniques is:
   a. Therapeutic modeling.
   b. Innovative thought processing.
   c. Grandiose replication.
   d. Aggressive intervention.

24. Perhaps the most important aspect of TCs, however, is:
   a. That it is an open and accepting community of individuals.
   b. It is usually held in an informal and casual setting.
   c. There are no formalized facilitators.
   d. Membership of the community and engagement in therapy are voluntary.

25. There continues to be an urgent need for:
   a. Well controlled, long-term treatment outcome research to be conducted in this area.
   b. Other professionals to weigh in on this condition.
   c. More subjects to study in this area.
   d. Well controlled, short-brief treatment outcome research to be studied in this area.