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A HISTORY OF ANTISOCIAL PERSONALITY DISORDER IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL ILLNESS AND TREATMENT FROM A REHABILITATION PERSPECTIVE

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A HISTORY OF ANTISOCIAL PERSONALITY DISORDER IN THE *DIAGNOSTIC AND
STATISTICAL MANUAL OF MENTAL DISORDERS* AND TREATMENT FROM A
REHABILITATION PERSPECTIVE

by

Mallory Houser

B.S., Southern Illinois University, 2012

A Research Paper
Submitted in Partial Fulfillment of the Requirements for the
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RESEARCH PAPER APPROVAL

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A Research Paper Submitted in Partial
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Approved by:

James D. Bordieri, Chair

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Mallory Houser, for the Master of Science degree in Rehabilitation Counseling, presented on April 17, 2015, at Southern Illinois University Carbondale.

TITLE: A HISTORY OF ANTISOCIAL PERSONALITY DISORDER IN THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* AND TREATMENT FROM A REHABILITATION PERSPECTIVE

MAJOR PROFESSOR: Dr. James Bordieri

This paper researched publications and articles to understand the history of antisocial personality disorder in the *DSM*. Upon gaining information regarding the history and diagnostic criteria of the antisocial personality disorder in the *DSM*, the author of this paper sought to provide knowledge of counseling techniques to be used by rehabilitation counselors and other counseling professionals when treating antisocial personality disorder. Many people diagnosed with antisocial personality disorder find themselves in the criminal justice system and have many problems involving interactions and socialization with others in the community. By delivering history and techniques, this author hopes to make available an understanding of symptoms, target populations of the disorder, preventions, and treatments that will improve the functioning and outcomes for individuals diagnosed with antisocial personality disorder. May 2015

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CHAPTER 1

Introduction, Purpose, Definition of Terms

Introduction

Antisocial personality disorder is a pervasive mental illness that often prevents people from conforming to social norms, and facing negative impacts on their daily lives as a result. People diagnosed with antisocial personality disorder are often impulsive, have accurate thoughts that others around them are acting hostile towards them, have little to no regard for rules, and have little to no regard for the consequences of their actions. Antisocial personality disorder can be very hard to treat; most people diagnosed with the disorder are being treated against their will, most likely because they are in prison. Before being labeled as antisocial personality disorder, other terms were used as labels, including psychopathy and sociopathy. Psychopathy and sociopathy each played a large role in shaping antisocial personality disorder into the mental illness it is today. They also created different ideas as to the causes and manifestations of antisocial personality disorder, sociopathy focused on the behavioral aspects of the disorder and psychopathy looked into the cognitive and personality traits associated with personality disorders. Cleckley and Hare's views on psychopathy, and Lee Robins' extensive research into sociopathy helped pave the way for decades of research and revisions to antisocial personality disorder in several editions of the *DSM*. This paper will explore changes in the diagnostic criteria and personality traits associated with antisocial personality disorder over time, and will end at the most recent changes made in Section III, *DSM-V*.

Purpose

The purpose of this paper is to gain an understanding of antisocial personality disorder and treatments used in working with the disorder. By learning about controversies and ideas involved in developing diagnostic criteria of antisocial personality disorder, one may gain insight into treatments that have better chances of reducing symptoms and behaviors of the disorder. The formulation of creating the criteria for antisocial personality disorder has existed since the first publication of the *Diagnostic and Statistical Manual of Mental Disorders*, although the disorder wasn't actually listed and defined until the third publication of the *DSM*. The history of creating the criteria for the disorder highlights that it has been used to diagnose criminals repeatedly, and some have begun to argue that much of the criteria was designed specifically to target the criminal justice population. The recidivism rate for people diagnosed with antisocial personality disorder is quite high, and many forms of therapy may not be sufficient to reduce antisocial behaviors and personality traits. Therapies aimed for reducing symptomology related to personality disorders have been created specifically for different personality disorders, but not for antisocial personality disorder. Rehabilitation counselors will have to use their judgment to decide which techniques would be most useful depending on the specific personality, history, and tendencies of their client while already having an understanding of what therapies are more likely to work for antisocial personality disorder.

Definitions

Personality- enduring patterns of perceiving, relating to, and thinking about the environment and oneself. *Personality traits* are prominent aspects of personality that are exhibited in relatively consistent ways across time and across situations. Personality traits influence self and interpersonal functioning. Depending on their severity, impairments in personality functioning

and personality trait expression may reflect the presence of a personality disorder. (American Psychiatric Association, 2013)

Personality traits- A tendency to behave, feel, perceive, and think in relatively consistent ways across time and across situations in which the trait may be manifest. (American Psychiatric Association, 2013)

Personality functioning: cognitive models of self and others that shape patterns of emotional and affiliative engagement. (American Psychiatric Association, 2013)

Personality disorder: 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. (American Psychiatric Association, 2013)

Personality disorder cluster: three clusters in which personality disorders are grouped under based on descriptive similarities. (American Psychiatric Association, 2013)

Cluster A: includes paranoid, schizoid, and schizotypal personality disorders. Individuals with these disorders often appear to be odd or eccentric. (American Psychiatric Association, 2013)

Schizoid personality disorder: a pattern of detachment from social relationships and a restricted range of emotional expression. (American Psychiatric Association, 2013)

Schizotypal personality disorder: a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior. (American Psychiatric Association, 2013)

Paranoid personality disorder: a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent. (American Psychiatric Association, 2013)

Cluster B: includes antisocial, borderline, histrionic and narcissistic personality disorders.

Individuals with these disorders often appear dramatic, emotional, or erratic. (American Psychiatric Association, 2013)

Antisocial personality disorder: a pattern of disregard for, and violation of, the rights of others.

Borderline personality disorder: a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity. (American Psychiatric Association, 2013)

Histrionic personality disorder: a pattern of excessive emotionality and attention seeking.

Narcissistic personality disorder: a pattern of grandiosity, need for admiration, and lack of empathy. (American Psychiatric Association, 2013)

Cluster C: includes avoidant, dependent, and obsessive compulsive personality disorders.

Individuals with these disorders often appear anxious or fearful. (American Psychiatric Association, 2013)

Avoidant personality disorder: a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. (American Psychiatric Association, 2013)

Dependent personality disorder: a pattern of submissive and clinging behavior related to an excessive need to be taken care of. (American Psychiatric Association, 2013)

Obsessive-compulsive personality disorder: a pattern of preoccupation with orderliness, perfectionism, and control. (American Psychiatric Association, 2013)

Personality change due to a medical condition: a persistent personality disturbance that is judged to be due to the direct physiological effects of a medical condition. (American Psychiatric Association, 2013)

CHAPTER 2

HISTORY OF ANTISOCIAL PERSONALITY DISORDER

Psychiatric Diagnosis Prior to Antisocial Personality Disorder

Antisocial personality disorder was originally labeled under the categories of psychopathy and sociopathy before earning its current title. The term antisocial personality disorder didn't even appear in the psychiatric realm until the publication of the *DSM-III* in 1980. It is common for people to use the terms psychopathy and sociopathy interchangeably in conversation, as both seem to describe someone who has no remorse. Psychopathy and sociopathy do have some similarities but professionals still argue some of the big differences that creates cause for two completely different diagnoses and disorders as opposed to one.

Major advances in technology and medicine have allowed researchers and psychiatrists to examine the etiological differences between sociopathic and psychopathic disorders. It has been shown that people diagnosed with psychopathy means that the individual has no sense of morality or empathy amongst other traits, whereas people diagnosed with sociopathy do have a sense of morality and a conscience, but their morals do not reflect the culture in which they live (Pement, 2013). Today, psychopathy and sociopathy lay within the realm of antisocial personality disorder even though many push for them to have separate diagnoses again, or to at least be understood as two completely different disorders.

Psychopathy

Although dating back to the 19th century in Europe, psychopathy gained popularity in the mid-20th century. Pinel described the psychopathic individual as someone who was insane but had no delirium, had a characteristic lack of restraint, and behavior marked by complete remorselessness (Perez, 2012). In 1941 Harvey Cleckley helped further define psychopathy and

considered them to be charming, intelligent individuals with shallow emotional depth and engaged in antisocial and sometimes violent behaviors (Pickersgill, 2012). Cleckley's framework for psychopathy appeared in the *American Journal of Pathology* (AJP) repeatedly, but was not included in the *DSM-I* in 1952 (Pickersgill, 2012).

In between publications of the *DSM-I* and *DSM-III*, researchers started investigating differences in people diagnosed with psychopathy and people who did not have a psychiatric diagnosis. Studies performed prior to 1968 showed the autonomic functioning in people with psychopathy were different than that in people who were not diagnosed with the disorder, as well as unique physiological changes when people with psychopathy were introduced to fear imagery (Pement, 2013). Studies that induced fear or resting states were not the only ones being conducted. Some scientists discovered that people with psychopathy had asymmetry seen in the hippocampi, something that usually corrects itself in the fetal state of life (Pement, 2013).

In the 1970s, the construct of psychopathy became the focus of psychological attempts at standardization, led by Robert Hare (Pickersgill, 2012). Prior to Hare, psychopathy was still being published in the *American Journal of Pathology*, but less often than when Cleckley initially released his psychopathic characterizations decades earlier. Hare was strongly influenced by Cleckley's work and characterization of psychopathy in the 1940s; he eventually developed the Psychopathy Checklist-Revised (PCL-R), a diagnostic tool that would fuel interest into the construct of psychopathy (Yildirim & Derksen, 2013). The PCL-R has helped make many advances in understanding psychopathy, but it should not be seen as a diagnostic tool, rather a tool for classifying the disorder. Hare's checklist is composed of 20 items measuring 2 dominant factors in an underlying structure of psychopathic traits (Yildirim & Derksen, 2013). A person must score high on both dominant factors in order to be clinically diagnosed with

psychopathy. The first factor is the interpersonal/affective factor and it focuses on insensitive, immoral, and unemotional use of others; the second factor looks at antisocial lifestyles and the items contained within the second factor are very similar to the traits under the antisocial/borderline personality disorder in the *DSM-IV* (Yildirim & Derksen, 2013). The creation of the PCL-R has impacted prevalence rates of psychopathy significantly. One on hand, psychopathy may be over-diagnosed or under-diagnosed depending on criminal backgrounds and how closely the patient's traits match different personality disorder traits.

Psychopathy's impact on antisocial personality disorder in the *DSM-III*.

Hare's research in psychopathy and creation of the PCL-R laid the foundation for plans regarding the *DSM-III*. Robert Spitzer was given the responsibility of managing the reorganization of the new *DSM*; he was a neo-Kraepelinian who aspired to have a descriptive approach for mental disorders that was based around symptoms as opposed to etiology (Pickersgill, 2012). George Winokur, Samule Guze, and Eli Robins assisted Spitzer in studying personality disorders and diagnostic criteria. Washington University School of Medicine, St. Louis, became headquarters for empirical studies surrounding psychopathy for Spitzer's colleagues (Pickersgill, 2012). Robin's wife, Lee, had previously studied antisocial personality disorder and lit the way for Spitzer's peers to investigate her criteria and better understand some of the disorders they were trying to categorize. In 1972, Robins and other colleagues at Washington University School of Medicine, St. Louis, worked together to develop diagnostic criteria for 14 different mental disorders, one of them being antisocial personality disorder (Pickersgill, 2012).

The DSM-III Personality Disorder Advisory Committee was comprised of many professionals who had the same ideologies surrounding pathological anti-sociality; they were

responsible for writing a new standard for antisocial personality disorder (Pickersgill, 2012). Known for her work and research in the field of antisocial personalities, Lee Robins was one of the more prominent figures in creating the diagnostic criteria for antisocial personality disorder. Despite Spitzer's nepotism, Robin's work on standardizing antisocial personality disorder in the *DSM-III* was met with resistance; she saw antisocial personality disorder through a sociopathic perspective whereas others such as John Lion wanted to include psychopathic aspects into the diagnostic criteria (Pickersgill, 2012). Lion aspired to have some antisocial traits included in the *DSM-I*, to be included as well in the *DSM-III*. Lion believed that psychopathy should be its own diagnosis under personality disorders. Unfortunately, Lion was informed by the Associate Editor of the *AJP* that doing so would be almost impossible due to conflicts of interest and unreconcilable differences within the *DSM-III* Personality Disorder Advisory Committee (Pickersgill, 2012).

John Lion preferred Cleckley's view of antisocial psychology and cognitions over perspectives of antisocial personality based on behaviors. Lion believed that unlike sociopathic antisocial personality disorders, which he saw as unstable and aggressive, psychopathic antisocial personality disorder consisted of someone who was unaggressive and unwilling to conform to social lies while having a disregard for others and no moral values (Pickersgill, 2012). John's ideas of diminished affect in personalities of people with psychopathy did not translate well into Spitzer's desire for specific operational criteria to be used for diagnosis in the *DSM-III*. From this point on, psychopathy would no longer be seen as its own operating diagnostic entity.

Although not listed as a consultant for the *DSM-III*, Richard Jenkins was a consultant for the *DSM-IV* and had many discussions with Spitzer regarding psychopathy and antisocial

personality disorder. Jenkins, like Lion, was opposed to including antisocial personality disorder under the umbrella of sociopathy (Pickersgill, 2012). As with many changes that occur in different editions of the *DSM*, these ideas did not go uncontested. Lee Robins disputed Jenkin's views of psychopathic attributes to antisocial personality disorder, but it caught Spitzer's attention and started to raise questions about the possibility of separating antisocial personality disorder into 2 separate categories, sociopathic and psychopathic (Pickersgill, 2012).

Jenkin's attempts to include psychopathy as an individual component of antisocial personality disorder would be futile like his predecessors, Lion and Cleckley. Jenkins spent his time working with criminal clients with aggressive histories who seemed to be experiencing antisocial personality disorder from a psychological perspective. He used his professional background as a major arguing point against Robins in favor of dividing antisocial personality disorder into sociopathic and psychopathic categories. He learned from experience that the courts tended to view repeat offenders as definitely having some mental disorder, if they could not find one that perfectly fit the offender, the offender would most likely be diagnosed with something else (Pickersgill, 2012). He saw many racist undertones in the classification of antisocial personality disorder in the *DSM-III*. In addition to racist undertones, Jenkins also believed that the criteria for antisocial personality disorder be improved upon so that no one could be diagnosed with the disorder simply for having a disadvantaged background (Pickersgill, 2012).

To Jenkins, keeping the diagnostic criteria for antisocial personality disorder as it was had a strong likely hood for retaliation and criticism from professionals. Jenkins' concerns aside, the diagnostic criteria for antisocial personality disorder in the *DSM-III* was focused more so on behavior than psychopathy. That being said, the criteria were made so that the diagnosis could

not be given too liberally (Pickersgill, 2012). Jenkins and Robins started including other professionals more privy to their individual arguments. After several attempts at division and change in the antisocial personality disorder category, a final revision was created and sent for publication. The *DSM-III* was published and included a very behaviorist categorization of antisocial personality disorder, very different from Cleckley's visions of a psychopathic antisocial personality disorder (Pickersgill, 2012). As Jenkins and Lion foretold, the American Psychiatric Association was heavily criticized for having such behavior-oriented criteria for antisocial personality disorder. Despite heavy criticism, the sheer influence of the *DSM-III* in the psychiatric field caused antisocial personality disorder to become a permanent fixture in the field of psychiatry, without psychopathy being an individually recognized component of the disorder (Pickersgill, 2012). Within 3 years of publication of the *DSM-III*, Spitzer and his colleagues set out to revise the manual. Still not recognized as an individual identity, more aspects of psychopathy were included in diagnostic criteria for antisocial personality disorder in the *DSM-III R*.

Psychopathy today

It has been noted before that psychopathy and sociopathy share many similarities, but what specifically sets these two paradigms apart in diagnostic terms? Besides the fact that the sociopathic views of antisocial personality disorder are focused more so on behavior, scientists studying the psychopathic aspects of antisocial personality disorder believe it goes deeper than that. Psychopaths are incapable of feeling guilt or remorse for their actions, unlike sociopaths. Many psychopaths have the same environmental backgrounds as people who fit under the sociopathic range of antisocial personality disorder, as well as a completely different brain chemistry (Perez, 2012).

As mentioned in the above paragraphs, Hare's creation of the PCL-R provided the opportunity to learn more about psychopathy than ever before. Used as a screening tool, The PCL-R helped clinicians discover that psychopaths have reduced grey matter in their frontal lobes, increased striatal volume, abnormal symmetry in the hippocampus, a larger corpus callosum, a lack of structural integrity in the uncinate fasciculus, abnormal activity in the anterior cingulate cortex, and deformations within the amygdala (Pemment, 2013). Deficiencies or deformities in these areas of the brain can impact hormonal balances and output for the rest of the body. Many researchers that believed there was a difference in psychopathy and sociopathy were seeing their hypotheses being proven.

Today researchers believe that an imbalance in neurotransmitters can explain many of the behaviors exhibited by people with a psychopathic diagnosis. Many people with the psychopathic diagnosis can be seen going through similar criminal phases. The person with a psychopathic disorder is generally driven by desire, possibly caused by an imbalance in neurotransmitters. These desires create predatory appetites, causing the psychopath to search for something to fulfill that desire or phase (Perez, 2012). Scientists have been studying specific hormone imbalances that could cause psychopathic personalities, and have come up with several possible answers. Serotonin, dopamine and norepinephrine are three of the most commonly studied neurotransmitters, and people with psychopathic diagnoses show deficits in all three of these neurotransmitters (Perez, 2012).

Characteristics of someone diagnosed with psychopathy include a strong need for stimulation, complete lack of guilt and remorse, conning and manipulative behaviors, and a parasitic lifestyle (Perez, 2012). Besides having a complete lack of guilt or remorse, people diagnosed with psychopathy are unlikely to care about the consequences of their actions on

others, or themselves. Psychopaths are also often recognized as being impulsive, aggressive and opportunistic, easily bored, demanding of instant gratification and easily frustrated (Perez, 2012). Some people with the diagnosis may actually seek arousal from harming or bringing pain to others.

Sociopathy

While psychopathy was yet to make its premiere in the *DSM*, sociopathic personality disturbance, or sociopathy, was included in the *DSM-I*. Sociopathy was developed in the 1930s and consisted of antisocial and dissocial reactions and sexual deviation (Pickersgill, 2012). Differences and similarities existed between sociopathic personality disorder and psychopathy, however psychopathy would not have its own category in the *DSM* until the publication of the *DSM III*. In *DSM-I*, sociopathic personality disturbance, antisocial reaction was defined as a diagnosis for chronically antisocial individuals who didn't profit from experience or punishment and maintained no real loyalties (Pickersgill, 2012).

The publication of the *DSM-II* showed criteria that were less psychoanalytically driven than the previous edition. The *DSM-II* brought with it a reconstruction of the APA, removing sociopathic personality disturbance, dissocial reaction from the diagnostic realm and creating a completely separate category for dissocial reactions and behavior (Pickersgill, 2012). Sociopathy became referred to as personality disorder, antisocial personality. These individuals became to be known as lacking empathy and exhibiting callous behaviors (Pickersgill, 2012). Even after the publication of the *DSM-II*, many clinicians still referred to sociopathy or sociopathic personalities as diagnostic categories. Richard Jenkins believed that the *DSM-II* never even included sociopathy in the list of diagnoses, but instead listed a sociopathic personality disturbance with 3 subtypes (Pickersgill, 2012).

Eventually, sociopathy would meet the same fate as psychopathy, becoming part of a completely different diagnosis and losing the opportunity to have individual diagnostic criteria. Although sociopathy became encompassed by antisocial personality disorder, many of the early models for determination and diagnosis of antisocial personality disorder were based on many sociopathic perspectives. Lee Robins had done extensive research on antisocial personality disorder through a more behavioral perspective, and it was her research that inspired Spitzer's colleagues to create the diagnostic criteria for antisocial personality disorder (Pickersgill, 2012). Robins' criteria for antisocial personality disorder wound up differing from the committee's in a few ways. Robins had listed 'lack of guilt' as a criterion for diagnosis but it was rejected from the committee's final list of criteria because it couldn't be reliably evaluated; her different criteria surrounding socioeconomic status were also removed from the final list in order to show a sensitivity to the general public (Pickersgill, 2012).

In the move towards a more psychopathic perspective for antisocial personality disorder, many professionals in the field started debating about the merits of each paradigm. After Lion called for the inclusion of psychopathy as an official component of antisocial personality disorder, professionals outside of the Personality Disorder Advisory Committee were called to rearrange the components of the *DSM-II*'s 'personality disorder, antisocial personality' (Pickersgill, 2012). Spitzer was looking for an available compromise to make between Richard Jenkins and Lee Robins regarding the segregation of antisocial personality disorder. Spitzer wanted to reopen the idea of desegregating antisocial personality disorder into socialized or under-socialized forms of sociality; the socialized subtype would involve individuals whose major antisocial activities take place with other individuals, whereas the under-socialized

subtypes better described individuals with little to no capacity for loyalty to others and preferred to spend time alone (Pickersgill, 2012).

The *DSM-III* published criteria for antisocial personality disorder with a sociopathic perspective. The sociopathic influence on antisocial personality disorder was so strong that even one of Cleckley's characteristics of psychopathy, 'inability to experience guilt', and one of the criteria for personality disorder, antisocial personality in the *DSM-II*, was removed from the list of criteria for diagnosis in the *DSM-III* (Pickersgill, 2012). Many psychopathic components were taken out of criteria for antisocial personality disorder if it did not meet behavioral standards or could not be easily evaluated for. Eventually, more psychopathic criteria started to become included into diagnosis for antisocial personality disorder in the emergence of the *DSM-III R*. Sociopathy's strong start in the development of antisocial personality disorder as it is known today has started to lose some of its early influence to more psychopathic ideas and views in more recent editions of the *DSM*.

Sociopathy today

Antisocial personality disorder can be caused by genetic and environmental influences. Twin studies have shown that while there is a genetic predisposition for the personality disorder, development of the disorder can be prevented by good parental care and stable mothering (Mohl, 2013). Scientists believe that sociopathy is the interaction of plasticity genotypes and abuse/maltreatment during childhood, resulting in emotional dysregulation and related to disturbed socio-emotional development and negative outcomes (Yildirim & Derksen, 2013). Hare's PCL-R does not measure for sociopathy as well as psychopathy, and there aren't too many assessment tools or procedures available to evaluate for sociopathy.

Unlike psychopathy, sociopathy is recognized showing heightened emotional responsiveness to perceived threats, and have a normal to high prevalence of internalizing disorders such as anxiety and depression; sociopathy is also associated with antisocial lifestyles, impulsivity, and behavioral dis-inhibition (Yildirim & Derksen, 2013). One of the biggest differences between psychopathy and sociopathy is that people who are diagnosed with sociopathy are able to feel guilt for their actions and have some form of moral code. Psychopaths do not have a moral code, but the moral code of a sociopath may not match the culture they live in, and may be completely disregarded at a moment's notice in order to fulfill desires (Pemment, 2013). Previous studies performed using the PCL-R to determine and classify psychopathy revealed that people with psychopathy have portions of the brain that are physically different than people without the diagnosis. The PCL-R also pointed out that the chemistry and creation of hormones and neurotransmitters in the brain are also different from the brain chemistry in people without a diagnosis. The fact that sociopaths indeed have moral compasses or codes and are capable of feeling guilt indicates that their brain chemistry is different than that of a psychopath, and means that areas of the prefrontal cortex in a sociopath are at least partially functional (Pemment, 2013).

A unique aspect of sociopathy is that it can be diagnosed as an acquired disorder. Traumatic brain injuries and dementia located in the frontal lobes can often result in behaviors mimicking that of antisocial personality disorder. This diagnosis of sociopathy is vastly different from the one described by Hare and can be viewed as an umbrella-type term for antisocial behaviors resulting from dementia (Pemment, 2013). Studies examining acquired sociopathy in dementia have hit barriers because of the wide range of dementias and the unpredictable behaviors stemming from both types of dementias and unique personalities.

Psychopathy can be diagnosed in individuals as young as 18 years under the label extreme antisocial personality disorder, but many people who develop sociopathic behaviors from dementia are usually over the age of 40, making acquired sociopathy less prevalent in young adults and offenders than psychopathy (Pement, 2013). The prevalence is still not extremely high in older adults; not every adult diagnosed with Alzheimer's or other forms of dementia will experience acquired sociopathy. Because of the low prevalence of sociopathy and high crime rate in young adults, acquired sociopathy is not utilized in criminology like psychopathy (Pement, 2013).

Antisocial Personality Disorder as a Diagnostic Entity in the *DSM*

The groundwork laid by research in psychopathy and sociopathy created antisocial personality disorder as its own diagnostic personality disorder in the *DSM-III*. The newly discovered personality disorder was yet to undergo many more revisions as editions of the *DSM* continued to be published. Less than 5 years after its debut, the first revisions to antisocial personality disorder were underway. An important consideration to keep in mind when looking at revisions to antisocial personality disorder are the different classifications and assessment procedures employed by the American Psychiatric Association during each publication of the *DSM*.

Antisocial Personality Disorder in the *DSM-III* and *DSM-III R*

The *DSM-III* used a multi-axial system to categorize mental disorders on a hierarchal level. Personality disorders fell under the second axis. Personality disorders were defined in the *DSM-III* as 'personality traits that are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress' (American Psychiatric Association, 1980). The *DSM-III* allowed for clinicians to use Axis II (American Psychiatric

Association, 1980) as a place to fill personality traits in for an Axis I disorder where no personality order may actually exist.

Antisocial personality disorder is defined in the *DSM-III* as ‘a personality disorder in which there is a history of continuous and chronic antisocial behavior in which the rights of others are violated, persistence into adult life of a pattern of antisocial behavior that began before the age of 15, and failure to sustain good job performance over a period of several years’ (American Psychiatric Association, 1980). Antisocial personality disorder also corresponded to a category of disorders that were diagnosed or made evident at an early age such as childhood or adolescence. Early signs in childhood included lying, resisting authority, and truancy; adolescence marked the way for early and/or aggressive sexual behavior continuing into adulthood alongside inconsistent employment and parental shortcomings (American Psychiatric Association, 1980). The more extreme features of antisocial personality disorder were predicted to disappear by the time the person turned 30, but some of the symptoms persisted into later years of life such as dysphoria and the accurate belief that others are hostile towards them. Antisocial personality disorder is labeled as an incapacitating disorder that usually results in some form of institutionalization in the *DSM-III*.

Predisposing for antisocial personality disorder included conduct disorder and attention deficit disorder (ADD) during pre-pubescence. The onset for the disorder was prior to the age of 15, with males being diagnosed much more often than females, and often showing signs and a much earlier age than females. Under the diagnostic criteria for antisocial personality disorder in the *DSM-III*, an onset before the age 15 was indicated by a history of 3 or more of the following behaviors prior to that age: truancy; suspension or expulsion from school for misbehavior; delinquency; running away from home overnight at least twice; persistent lying; repeated sexual

intercourse in a causal relationship; repeated drunkenness or substance abuse; theft, vandalism; school grades below expectations in relation to IQ; chronic violations of rules at home and/or at school besides truancy; initiation of fights (American Psychiatric Association, 1980). In addition to meeting criteria for an onset before the age of 15, evaluatees had to also exhibit 4 manifestations of antisocial personality disorder after reaching the age of 18. The following behaviors represented criteria for diagnosis after the age of 18: Inability to sustain consistent work behavior, lack of ability to respond as a responsible parent, failure to accept social norms with respect to the law, inability to maintain enduring attachment to a sexual partner, irritability and aggressiveness, failure to honor financial obligations, failure to plan ahead, disregard for honesty, and recklessness (American Psychiatric Association, 1980).

The diagnostic criteria highlight the sociopathic background in this particular categorization of antisocial personality disorder. Along with paying close focus to sociopathic backgrounds, the multi-axial model used stirred criticism because the *DSM-III* had started using a medical model and now listed criteria as symptoms of a disease or illness that could be cured. Instead of being described as a series of personality traits, one had to meet a certain amount of diagnostic criteria exhibited through behaviors (Gurley, 2009). Because of the shift in diagnostic criteria, antisocial personality disorder looked very different from the personality disorders that encompassed it in the *DSM-II*. The diagnostic criteria and components shifted drastically in the *DSM-III* because of the drive the American Psychiatric Association had to improve the reliability of psychiatric diagnosis (Gurley, 2009). While the medical model offered more observable traits to observe for diagnosis in antisocial personality disorder, the reorganization of the disorder resulted in a large percentage of people no longer fitting the criteria for the disorder. The criteria

change was met with resistance by Hare, who believed that psychiatrists were being too liberal with the diagnosis, especially for people in the prison setting (Gurley, 2009).

3 years after the publication of *DSM-III*, the American Psychiatric Association announced that it had been tasked with contributing to the 10th edition of the ICD. The contributions would mean that the American Psychiatric Association would have to review and make suggestions for updating the *DSM-III* in order to provide the best recommendations for the ICD (Gurley, 2009). The revision was completed similarly to the original publication of the *DSM-III*. Advisory committees were created and assigned a different classification of disorders for revision. Many disorders did not necessitate revision, and although antisocial personality disorder did wind up with some changes, many of them were minimal in the *DSM-III R*.

Antisocial personality disorder had undergone serious revisions for publication of the *DSM-III*. As a result, many of the criteria were left alone during the revision process of the *DSM-III*. Criterion B underwent the most change, because it dealt with conduct disorder and many changes were made to the diagnosis of conduct disorder in the *DSM-III R* (Gurley, 2009). Criterion C (antisocial behavior) also had some changes as well. In Criterion C, Criterion C4 was changed to a more general term, from “an inability to maintain enduring attachment to a sexual partner as indicated by two or more divorces and/or separations with a legally married or not, desertion of spouse, promiscuity” to “has never sustained a totally monogamous relationship for more than one year” (Gurley, 2009). ‘Lacks remorse’ was also added to Criterion C for antisocial personality disorder (American Psychiatric Association, 1987). Different theories exist about why the inclusion of ‘lacks remorse’ was made in the *DSM-III*, but many believe it was re-introduced to the criteria because not including it negatively impacted the validity of the diagnosis for the sake of reliability and moving away from Cleckley’s psychopathic criteria

(Gurley, 2009). Jenkins' concern that the sociopathic criteria for antisocial personality disorder targeted criminals was being noticed by other professionals in the field. As with *DSM-III*, antisocial personality disorder in the *DSM-III R* was criticized because many people in the prison system met the criteria for the disorder, but less than a third of those incarcerated met the criteria necessary for psychopathy (Gurley, 2009).

Antisocial Personality Disorder in the *DSM-IV* and *DSM-IV TR*

A year after the publication of the *DSM-III R*, a new committee was organized by the American Psychiatric Association to start working on the fourth edition of the *DSM*. This reorganization consisted of 3 different stages during the process: the task force and appointed work groups conducted literature reviews, they then analyzed previously collected data, and then conducted field trials to examine utility of alternative criteria for various disorders (Gurley, 2009). Antisocial personality disorder was up for its first field trial since revision in 1986 for the *DSM-III R*. The information used in the *DSM-III R* was the only information used in the trial for antisocial personality disorder, Criterion B (evidence of conduct disorder) was not evaluated at all during field trial, so no current criteria wound up being assessed during the trial phases (Gurley, 1986).

For the *DSM-IV* and the *DSM-IV TR*, the criteria was shortened greatly and took up only half a page as opposed to two pages of different manifestations (Gurley, 2009). Although it did initially look like drastic changes had been made due to cutting out some of the criteria, it became known that many of the criteria listed in the *DSM-III* and *DSM-III R* were simply too long. In reality, very few changes were made to antisocial personality disorder in the *DSM-IV*. The ages of diagnosis and revealing of behavioral manifestations remained at 18 and 15, but individuals no longer had to meet a minimum number of manifestations or criteria before the age

of 15 to be diagnosed with the disorder. In the *DSM-III* and *DSM-III R*, adults over the age of 18 had to meet 4 out of 10 criteria; in the *DSM-IV* and *DSM-IV TR* individuals only had to meet 3 out of 7 criteria (Gurley, 2009). One of the more noticeable changes was that the criteria for conduct disorder were not listed within the realm of antisocial personality disorder (Gurley, 2009). Another change included removing 2 criteria that were used in the *DSM-III R*, lacking the ability to function as a responsible parent and the inability to maintain a monogamous relationship for over a year (Gurley, 2009).

While the criteria maintained few changes during publication and revision of the *DSM-IV*, and the criteria is still used today by many practicing clinicians, most of the changes to antisocial personality disorder in the *DSM-IV* occurred in the text preceding the diagnostic criteria (Gurley, 2009). One of the changes to the preceding text that were made during revision of the *DSM-IV* was to add different personality traits that an individual with antisocial personality disorder may possess. The traits used in this section (lacking empathy, callousness, cynicism, glibness, and superficial charm) are very similar to the traits that Cleckley used to describe individuals with psychopathy decades before (Gurley, 2009). For the first time since the creation process of the *DSM-III*, antisocial personality disorder was viewed as being very similar to psychopathy. In fact, authors of the *DSM-IV* stated that antisocial personality disorder had been previously referred to as sociopathy, dissocial personality disorder, and psychopathy; leaving little room for doubt that antisocial personality disorder is meant to be an equivalent diagnosis to psychopathy (Gurley, 2009).

Unfortunately for the authors of the *DSM-IV* and *DSM-IV TR*, criticisms still arose over the high rate of diagnosis of antisocial personality disorders in prisoners and a lack of diagnostic validity. In a study performed by researchers looking to understand the validity of antisocial

personality disorder as diagnostic criteria for psychopathy in the *DSM-IV TR*, it was discovered that using the PCL-R as an assessment tool yielded better and more valid results for determining and diagnosing psychopathy in individuals than the *DSM-IV TR* (Gurley, 2009).

The model created in the *DSM-IV TR* is currently recognized for clinical practice for diagnosis of personality disorders by the APA Board of Trustees and is listed under Section II of the *DSM-5* and takes a categorical approach for defining and diagnosing personality disorders as distinct clinical syndromes (American Psychiatric Association, 2013). Personality disorders listed in Section II of the *DSM-5* are guided by a common definition of personality disorder that applies to each individual diagnosis in Section II. A personality disorder is defined 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 (American Psychiatric Association, 2013).

Antisocial Personality Disorder in the *DSM-V*

In the *Diagnostic and Statistical Manual of Mental Disorders-fifth edition (DSM-5)* all the diagnoses and disorders in the group of personality disorders went through some drastic changes and reorganizations. The DSM-5 Personality and Personality Disorders Workgroup made several different proposals for change to personality disorder diagnostic criteria in the *DSM-5*. In order to reflect the decision made by the American Psychiatric Association (APA) Board of Trustees to preserve continuity with clinical practice, the proposals made by the DSM-5 Personality and Personality Disorders Workgroup appear in Section III of the *DSM-5* so that a new approach can still help compensate for shortcomings in the current diagnostic criteria (American Psychiatric Association, 2013). This does not mean that only one model should be or

can be used during diagnosis; the new model proposed by the DSM-5 Personality and Personality Disorders work group was created so that it could be used along with the current model.

Although the changes made to criteria of antisocial personality disorder was met with its fair share of criticism after the release of the *DSM-IV TR*, criticisms have now arose surrounding changes made to diagnostic criteria in the *DSM-V*, stating that the authors have traded a validated system of diagnosis for one that doesn't have much empirical data to back it up (Lynam & Vachon, 2012). Compared to previous diagnostic criteria in earlier editions of the *DSM*, the *DSM-V* only has 5 specific criteria required for a diagnosis with antisocial personality disorder. These criteria include significant impairments in personality functioning as manifested by impairments in self-functioning and interpersonal functioning; the presence 7 specific pathological personality traits (manipulativeness, deceitfulness, callousness, hostility, irresponsibility, impulsivity, and risk-taking); the impairments in personality functioning must be relatively stable across time and situations, can't be better understood as developmental or culturally normative, and cannot be due to the direct physiological effects of any substance or medication (Lynam & Vachon, 2012). It is no wonder that many may complain about the lack of a complete set of criteria for accurate diagnosis of antisocial personality disorder, explanations for areas surrounding diagnosis such as prevalence, gender differences, associated factors, development and course, culture-related issues and differential diagnosis have all been left out of the section for antisocial personality disorder under Section III, *DSM-V*. Other professionals are critical because the *DSM-V* had the opportunity to reunite psychopathy and antisocial personality disorder.

Positive aspects about changes made to antisocial personality disorder in the *DSM-V* include using personality traits as a tool for assessing antisocial personality disorder. Continuing on the path towards psychopathy again, many clinicians in the field have long since supported using personality traits instead of behaviors as signs of disorder (Lyman & Vachon, 2012). Clinicians are also supportive of the fact that the personality traits used in Section III, *DSM-V* are very similar to the 7 symptoms listed in Criterion A for antisocial personality disorder in the *DSM-IV TR*.

CHAPTER 3

PROGNOSIS, PREVALENCE AND TREATMENT

Prevalence and Prognosis of Antisocial Personality Disorder

Like the determination of whether antisocial personality disorder is more psychopathic or sociopathic, treatment modalities of the disorder have also been met with much controversy. Different associations and psychiatric professionals have debated on the ability to treat individuals with ASPD, and whether or not it is even possible. As mentioned above in the history of diagnosis of ASPD, the personality disorder tends to manifest itself in many individuals with criminal histories. Not only does this show a potential bias in the diagnostic criteria, but it also leads to preconceived notions that people with the disorder will be violent or criminals by nature. Such generalizations and stereotypes have led many to believe that this disorder is not treatable, or at the very least, incredibly difficult to treat. More optimistic professionals strive to show evidence that such beliefs are not the case, and the disorder is in fact treatable.

Prevalence of Antisocial Personality Disorder

It is not easy to track diagnosis of antisocial personality disorder without seeing evidence of other disorders or a criminal history, because many of these individuals are unlikely to seek treatment independently. The diagnosis of antisocial personality disorder usually results in the diagnosis of another mental disorder, or comes as a result of a diagnosis of a separate disorder. The prevalence is also much higher in the criminal justice population. The population of people with antisocial personality disorder in society is actually quite low, with a prevalence rate of about 2-3%; the prevalence of people with antisocial personality disorder in the criminal justice population is about 50% (Hatchett, 2015). For rehabilitation counselors, it is important to

understand this information because many counselors will be working with individuals incarcerated or transitioning from incarceration into society.

Studies have been done to look at the prevalence of the diagnosis and some interesting discoveries were made regarding diagnosis of ASPD. For instance, while a study found that about half of the criminal population met the criteria for ASPD, 90% of that population also had another mental illness (Hatchett, 2015). Most of these co-occurring disorders fell under the categories of substance use disorders, mood disorders, or an anxiety disorder. It is more likely for people diagnosed with ASPD to have a co-occurring anxiety disorder than a depressive disorder, and it was also found that women are more likely to have a co-occurring disorder than men (National Collaborating Center for Mental Health, 2010). Co-occurring disorders include substance use disorders. A study was performed that discovered that people with a diagnosis of ASPD were three to five times more likely to have a substance use disorder than someone without ASPD (National Collaborating Center for Mental Health, 2010). Another interesting aspect about these findings is that women were more likely to have the substance use disorder than men.

Prevalence of antisocial personality disorder is much higher in men than women. Two studies performed in North American showed slightly different results but still indicated that men were more likely to be diagnosed with ASPD than woman; one study showed that antisocial personality disorder was present in 4.5% of men and .8% in women while the second study showed a presence in 6.8% of men and .8% of women (National Collaborating Center for Mental Health, 2010).

Prognosis of Antisocial Personality Disorder

Early studies of treatment looked at reducing criminal recidivism rates and characteristics of antisocial personality disorder with a focus on those that fit in the psychopathic range; many of these studies declared psychopathic interventions to be unsuccessful and ineffective (Hatchett, 2015). These studies were conducted in different settings and yet still had the same conclusion. Even though the studies did not seem to focus as much on clients with a more sociopathic diagnosis of ASPD, the prognosis was still negative for those diagnosed with the personality disorder; psychiatric hospitals, therapeutic communities, and sexual offender treatment programs all offered the same data predicting negative outcomes after treatment (Hatchett, 2015). Much of the research done on prognosis of ASPD has been performed using individuals with criminal histories, substance use disorders, and histories of sex offenses. In fact, some believe that antisocial personality disorder is seen and experienced more in the judicial system than in mental health surroundings (Hatchett, 2015).

As mentioned above, the prevalence of diagnosis of ASPD is higher in men than women. While women tend to have more extreme symptoms and are more likely to have a co-occurring disorder, men are more likely to have persistent symptoms of the disorder. Studies reveal that while men may be able to reduce their impulsive traits and thus criminal behaviors over time, they are still more likely to engage in other anti-social behaviors and have continual interpersonal problems throughout life (National Collaborating Center for Mental Health, 2010). Studies have also looked at the effect of treatment of both men and women in the criminal justice system over time. Men were more likely to engage in antisocial behaviors than women after incarceration periods. One study that did three, six, and nine year follow ups discovered that men were more likely to continue offending and breaking the law as a result of antisocial personality. In fact, 87% of men were found to engage in antisocial behaviors at three years post-

incarceration, and 72% at nine years post-incarceration; in comparison only 33% of women had antisocial behaviors after three years, and 18% engaged in antisocial behaviors at six years (National Collaborating Center for Mental Health, 2010).

Research performed has shown that early manifestations of antisocial personality disorder occur in adolescence and early childhood, this manifestation is used as one of the diagnostic criteria for antisocial personality disorder. Studies have also revealed that childhood abuse and neglect can be a good indicator of whether someone will develop antisocial personality disorder. Other indicators of the development of ASPD in adolescents and young adults include temperament and low effort control (Jovev, McKenzie, Whittle, Simmons, Allen, & Chanen 2013). Recent research has been conducted to determine the effect of ASPD in individuals who are in the geriatric stage of life. Reaching the later years in life can be a difficult experience for anyone to endure. For people with personality disorders it can be even harder. The geriatric stage of life includes losing loved ones to illness and death, having to transfer to nursing homes or other care facilities, and learning to rely on new people to provide care and services that an individual did not need before. All these changes can result in the perception of a diminished sense of power, and the stress can be too overwhelming for someone with antisocial personality disorder to cope with in a healthy way; many individuals who have stabilized the behaviors and perceptions as a result of ASPD may experience an increase in symptomology and engage in unhealthy coping mechanisms (Rosowsky & Molinari, 2014).

Treatments of Antisocial Personality Disorder

Treatment of antisocial personality disorder does not come with its own brand of therapy or community outreach like many other personality disorders or mental illnesses. The personality traits associated with ASPD make it difficult for someone with the disorder to engage or stay in

treatment, and it may be difficult to create a trusting therapeutic relationship with these individuals. Considerations for treatment can include prevention, co-morbidity, recidivism, available therapies, and available resources. While many recommendations for treatment have been made, it is difficult to gauge which one is most appropriate until the counselor has had time to gain an understanding of the individual and also which personality traits they possess. This section of the paper will look at two different aspects of treating individuals with personality traits of antisocial personality disorder or a diagnosis of antisocial personality disorder: prevention therapies and outreach of at-risk populations, and techniques and counseling skills aimed at those who already have a diagnosis.

Treatment as a Form of Prevention of Antisocial Personality Disorder diagnosis

As noted, manifestations of antisocial personality disorder start in adolescence and is a key part in diagnosing an individual with antisocial personality disorder. Although the development of a conduct disorder or other manifestations of antisocial personality disorder do not mean that the individual will automatically develop the disorder, institutes and studies are beginning to look at the benefits of treating the adolescents with early signs of antisocial personality disorder with prevention treatments in order to reduce the likelihood of developing ASPD.

Prevention treatment for infants and pre-school aged children.

Risk factors for children and adolescents include exhibiting behavioral problems as a child, having a diagnosis or showing symptoms of ADHD, parental antisocial behaviors, harsh parenting styles, and low socioeconomic status (National Collaborating Centre for Mental Health, 2010). Pediatricians and other professionals have started to assess the needs of children at risk for developing antisocial personality disorder by identifying the population of children at

risk with needs for services to prevent them from receiving a diagnosis of the disorder. Although diagnostic criteria usually looks at adolescents from the age of fifteen, established prevention programs have been created to help at-risk children in the infant stage. Other programs have been established for children in the pre-school age and older.

The program for healthy infants looks at infants in the population who were delivered with a low birth weight. This program was created by McGauhey and colleagues in the 1980s and implemented home visits, parenting groups and daycares that provided a higher level of education than what was usually seen in day-care centers (National Collaborating Centre for Mental Health, 2010). This program had favorable outcomes in prevention of a personality disorder, especially antisocial personality disorder. The children in the program were re-visited after 18 years and results showed that over two-thirds of those in the program were still adhering to the protocol set for them (National Collaborating Centre for Mental Health, 2010). The program is expensive and there have not been studies to determine if the benefits outweigh the costs yet.

The Nurse-Family Partnership (NFP) consists of mothers being visited at home by nurses and making services and strategies more readily available for families. Nurses share child-rearing techniques and work with parents or single mothers to reduce substance use and incarceration. This program had favorable results, and reduced the chances of children being abused by parents, and by parents being incarcerated; children were also higher functioning and scored higher in intellectual tests and studies (National Collaborating Centre for Mental Health, 2010).

Prevention strategies are also being aimed at children in pre-school. The High-Scope Perry Pre-school Project is aimed at socioeconomically disadvantaged children in minority

groups and works to equip them with the skills necessary to succeed in elementary school and beyond (National Collaborating Centre for Mental Health, 2010). Like many pre-schools, this one offered two years of training for children, but the children were taught skills differently than pre-school programs aimed towards the general public. The teachers for this project were highly trained and lessons focused on self-esteem and training for independence (National Collaborating Centre for Mental Health, 2010). Graduates of this program were interviewed until they were forty years of age, and many benefits were noticed. Graduates were less likely to be arrested for drug-related reasons, less likely to be involved in teenage pregnancy, more likely to graduate from high school, own homes, and have social benefits (National Collaborating Centre for Mental Health, 2010).

Other programs were created for children in the pre-school age but did not necessarily fare as well as the children in the High-Scope Perry Pre-school Project. The Syracuse University Family Development Research Program focused on infant development, homecare and parenting skills, which helped make the children take more initiative and develop a sense of self-efficacy for children from six months of age to five years of age (National Collaborating Centre for Mental Health, 2010). Many of the families were hard to locate for follow-up in this project after the first study was conducted, and those that were hard to find had high delinquency rates, even though the outcomes of the study said that only 6% were involved in delinquency charges (National Collaborating Centre for Mental Health, 2010).

The Abecedarian project had higher risks of delinquency and therefore the implementations are not as positive on children at risk as the implementations put in place by previous studies. The Abecedarian Project also served children from infancy to five years of age, and focused on: nutritional supplements, social service assistance, and educational

intervention in day care centers, development of cognitive and fine motor skills, social and adaptive skills, language skills, and high parental involvement (National Collaborating Center for Mental Health, 2010). The Chicago Longitudinal Study of the Child-Parent Center Program looked at the effectiveness of the Child-Parent Program, which focused on pre-school age children and established parenting education, classroom volunteering, low staff-to child ratios and home visitation (National Collaborating Center for Mental Health, 2010). The students in this program fared rather well compared to other studies that looked at the effect of prevention in the form of early intervention and family services. Most of the children at follow up were seen to be less likely to be placed in foster homes, less likely to be arrested for felony charges, and less likely to commit violent crimes (National Collaborating Center for Mental Health, 2010).

Children who are identified at an early age to be at risk for developing conduct disorders and personality disorders have a better chance of leading a life that does not involve personality disorders if the correct prevention strategies are implemented. Some recommendations to identify these children include focusing on vulnerable parents, such as: parents with mental health problems or substance use problems, teenage mothers, parents who have been in residential care, parents who have been involved in the criminal justice system or are currently involved in the criminal justice system (National Collaborating Centre for Mental Illness, 2010). Once these children are identified, it is very important to start them with early intervention to reduce the likelihood of them having criminal records or a diagnosis of antisocial personality disorder later in life. Some of these services include day care for children younger than one year, interventions to improve parenting skills for children younger than one year, well-structured programs that are followed closely, and programs that target multiple risk factors at once (National Collaborating Centre for Mental Illness, 2010).

Prevention interventions for children with conduct disorders.

Prevention for children in the infant stage has been shown to be effective in reducing the likelihood of a personality disorder diagnosis. Much like the infant stage, many prevention strategies implemented in children diagnosed with conduct disorders is aimed at helping to train the parents to change their parenting styles and to give them the skills needed to have a positive impact on their children, even if they live in settings or have backgrounds that put the children at risk. Strategies that have been reviewed in preventing the diagnosis of antisocial personality disorder include strategies focused on the children, focused on the parent, focused on the family as a whole, and focused on the family along with the social environment that the child is brought up in (National Collaborating Center for Mental Illness, 2010).

Child focused interventions offer training for children to learn new skills and abilities that will help them have a more successful childhood and educational experience, hopefully limiting their chances to develop antisocial personality disorder or a different personality disorder. One intervention is cognitive problem-solving skills training. This intervention views the child's thought processes and how they behave in interpersonal situations and includes: teaching different approaches to solving interpersonal conflict, offering structured tasks to increase skill development, and combining different approaches such as reinforcement, role-playing, and practicing newly learned skills (National Collaborating Centre for Mental Illness, 2010). Studies show that this particular intervention offers some moderate improvement in interpersonal problem solving. Anger control training is another intervention used, but many of the techniques and skills taught are similar to those taught in the cognitive problem-solving skills training. A difference between anger control training and cognitive problem-solving skills training is that anger control training offers skills that help guide the child towards relaxation and social skills

that help children learn how to manage their anger in a healthier way. Anger control training has been shown to be effective when used only on children, when the intervention was used with parents also, it did not appear to be effective in study results (National Collaborating Centre for Mental Illness, 2010). Social problems skills training is another type of cognitive problem-solving skills training that works on interpersonal processes and helps children develop a better understanding of aspirations and ideas of other people. This intervention also allows children to learn to regulate emotional responses; the results from studies appeared to be about the same from anger control interventions (National Collaborating Centre for Mental Illness, 2010).

Parent training programs are geared towards teaching the parents about communication skills and improving the relationship between the parent and child. Structural or systemic family therapy helps parents understand how their interactions towards each other and their children impact their child's development, and to change the interaction style to something that is more healthy and will teach the child better coping skills in the future (National Collaborating Centre for Mental Health, 2010). Functional family therapy focuses on behaviors and changing behaviors within family members in order to have positive results in the child's upbringing. Brief strategic family therapy is focused on systematic approaches and works on identifying maladaptive family interactions (National Collaborating Centre for Mental Health, 2010). While it is important to work with the family in making interpersonal and behavioral changes to benefit the child, that may not be the best solution in preventing a diagnosis with antisocial personality disorder in the future. Results from the studies researching effectiveness of parent focused strategies showed that cognitive interventions focusing on children were more effective in curbing maladaptive thoughts and behaviors than interventions aimed at parents (National Collaborating Center for Mental Health, 2010). Results also showed that the age of the child has

an impact when working with the parents on skills training, some of the studies had inconsistent results due to the different ages of children involved in the studies.

Multi-component interventions look at the child, the parents, the rest of the family, and the environment to come up with solutions that will help the child form healthy interpersonal skills and a better understanding of their peers. Multi-systemic theory uses strategies from family and behavioral therapies to reduce antisocial behaviors by working directly with processes and systems involved in the development of those behaviors; multidimensional treatment foster care does the same thing but works with children in foster care settings and includes immediate family members and foster parents (National Collaborating Centre for Mental Health, 2010). While working with children directly seems to have the most positive effects on the child's behaviors, multi-systemic interventions are nothing to scoff at. Many studies looking at the effectiveness of multi-systemic interventions have shown that the results are effective, especially for adolescents (National Collaborating Centre for Mental Health, 2010).

The results from the previous interventions and studies show the importance of identifying and working with children whose environments put them at risk for developing a conduct disorder or antisocial personality disorder later in life. By using early intervention, children and adolescents are able to learn healthy coping skills and strategies to keep them from engaging in antisocial behaviors. The strategies also help the parents to create stronger bonds with their children by allowing them to model proper coping mechanisms and interpersonal communication skills. Working with children directly is one of the most effective ways to prevent antisocial behaviors, but looking at the family and environment and developing strategies for those is also effective in curbing maladaptive coping skills.

Treatment for Antisocial Personality Disorder Diagnosis

For individuals diagnosed with antisocial personality disorder, a counselor has many considerations to make regarding best course of treatment. Most individuals diagnosed with ASPD will have another mental illness that may need treated in order to reduce antisocial behaviors, and many of them will also have substance use disorders. There is currently no pharmaceutical drug that has been formulated to treat characteristics of antisocial personality disorder, however some are prescribed medications for other mental illnesses that can sometimes aid in the treatment of antisocial personality disorder. Not much research has been done on the psychological treatment of individuals with antisocial personality disorder. In fact, most psychological treatments have been focused on working with individuals diagnosed with borderline personality disorder. While antisocial and borderline personality disorder are listed under the same cluster in the *DSM-5*, there are differences in the disorders that make it difficult to generalize one particular treatment from one disorder to the other without some difficulty.

Many people with antisocial personality disorder living in communities are undiagnosed and untreated, thereby effecting study results and the ability to provide treatment to those that need it. One of the reasons people in the community remain undiagnosed is that they simply do not believe that they need psychological or medical interventions because they do not think there is anything wrong with their personalities or interpersonal communication styles. If there are individuals with antisocial personality disorder receiving treatment in the community, chances are they are receiving treatment for drug or alcohol use problems; these treatments will focus on the substance use and not the personality disorder (National Collaborating Centre for Mental Health, 2010). In other cases, people are being treated in the community are being treated for a different mental health issue, such as depression or anxiety. Many people receiving services for

the diagnosis of antisocial personality disorder are currently in the criminal justice system, or have been in the criminal justice system (National Collaborating Centre for Mental Health, 2010).

Treatment for clients with a diagnosis of another mental or substance use disorder.

There is not an exact number to pinpoint the amount of people with antisocial personality disorder receiving services for another mental illness in the population. Many people with antisocial personality disorder receive treatment for another mental illness and the interventions they are given are not completed because the client does not adhere to the program or simply does not show up. There is a small number of mental health facilities and services that provide treatment specifically for personality disorders, but many of these interventions are aimed towards borderline personality disorder, and not many focus on antisocial personality disorder (National Collaborating Centre for Mental Health, 2010). People with antisocial personality disorder who are receiving treatment for substance use disorders may be more likely to adhere to their programs. This is beneficial because for individuals with ASPD, substance use disorders are linked to higher rates of violence.

Treatment for individuals with a co-morbid substance use disorder.

Individuals with antisocial personality disorder and a substance use disorder are able to benefit from treatment if done correctly. The most popular forms of treatment used for people with a co-morbid diagnosis of antisocial personality disorder and a substance use disorder include: contingency management, cognitive-behavioral therapy (CBT), an integrated form of CBT and contingency management, or control therapy (National Collaborating Centre for Mental Health, 2010). The most effective form of treatment for substance use disorder and antisocial personality disorder appears to be contingency management. One of the reasons contingency

management may work better than other forms is the use of methadone scheduling and also scheduling treatment around availability of clients (National Collaborating Centre for Mental Health, 2010). Cognitive-behavioral therapy results show that many people with substance use disorders fared well from the use of CBT *if* they did not also have a diagnosis of antisocial personality disorder.

Differences in adherence to treatment and effectiveness will of course depend on the drug being used. Methadone in treatment isn't always an option, and is usually reserved for the misuse of opioids. That being said, there are several recommendations for professionals treating individuals with antisocial personality disorder and substance use disorder. Three recommendations stand out for professionals to keep in mind. For individuals with ASPD and a substance use disorder concerning opioids or stimulants, professionals should offer psychological interventions, especially contingency management programs (National Collaborating Centre for Mental Health, 2010). Individuals with antisocial personality disorder and a substance use disorder pertaining to alcohol would benefit with treatment focused on the use of alcohol and empirically proven pharmacological and psychological interventions. People who have antisocial personality disorder and meet the criteria for psychopathy should receive treatment for comorbid disorders regardless of whether or not they are already receiving treatment for psychopathy because treatment of comorbid disorders can reduce the risk of psychopathy (National Collaborating Centre for Mental Health, 2010).

Treatment for individuals with a co-morbid mental disorder.

Despite naysayers' beliefs, individuals who have antisocial personality disorder and a diagnosis of another mental illness are able to benefit from treatment. That being said, antisocial personality disorder has been known to have a negative effect on the psychological treatment of

mental disorders. Adults diagnosed with antisocial personality disorder may also have additional comorbid diagnoses, and these mental health problems can add to the chance of having poor long-term outcomes (National Collaborating Center for Mental Health, 2010). Even though studies have shown chances for poor long-term outcomes related to the treatment of antisocial personality disorder and mental illnesses such as depression and anxiety, there are factors that will impact the chances of someone having poor outcomes. Factors include the different personality disorders and their impact on other forms of mental illness, and the different variables in personality that could also impact the outcomes of therapeutic treatment (National Collaborating Centre for Mental Health, 2010).

There are some recommendations for counselors to consider when working with individuals with antisocial personality disorder and other mental illnesses. The first recommendation is that people with antisocial personality disorder should be offered treatment for any other disorder they have been diagnosed with whenever those treatments are available (National Collaborating Centre for Mental Health, 2010). Even if the individual is already receiving treatment for their antisocial personality disorder diagnosis, the additional treatment should be implemented. This helps increase positive outcomes as a result of treatment. The second recommendation is that individuals receiving treatment for antisocial personality disorder may require longer periods of treatment or higher levels of intensity (National Collaborating Centre for Mental Health, 2010). Although individuals may drop out as a result, this also helps increase positive outcomes. Antisocial personality disorder can cause individuals to have more issues with trust and adherence, and more intense treatment can help balance the dual services they are receiving and give them more availability to adjust to those services.

Treatment for individuals with a criminal history.

Most individuals receiving treatment for antisocial personality disorder are currently involved in the criminal justice system, and receive interventions aimed at reducing criminal behavior from probation officers or therapists involved in the prison systems (National Collaborating Centre for Mental Health, 2010). Availability of services impacts whether or not an individual in the criminal justice system will be able to receive treatment. Most interventions in the criminal justice system focus on cognitive and developmental psychology and include: behavior modification, problem-solving skills, cognitive therapy, and moral reasoning therapy (National Collaborating Centre for Mental Health, 2010). People outside the criminal justice system are unlikely to receive care out of concern to other participants in the community. These services include housing and welfare services. As far as clinical evidence goes, cognitive and behavioral interventions have moderate success in treating individuals in the criminal justice system (National Collaborating Centre for Mental Health, 2010). Group settings offered different results than studies that focused on individual therapies. Young offenders did not fare with positive results from cognitive and behavioral interventions in the group settings; other individuals had small but positive effects (National Collaborating Centre for Mental Health, 2010).

Many recommendations have been established when working with adults diagnosed with antisocial personality disorder who have criminal records. For adults with an ASPD diagnosis, counselors should consider group programs that focus on cognitive and behavioral interventions that look at problems like impulsivity, interpersonal difficulties, and antisocial behaviors; cognitive and behavioral intervention group therapies also assist in reducing criminal recidivism and antisocial behaviors (National Collaborating Centre for Mental Health, 2010). When using

cognitive and behavioral interventions, counselors should first assist the risk and then determine how often therapy should be implemented and support participants to attend and engage in the therapy as often as possible. Individuals with criminal histories who are in the community or institutionalized that meet criteria for ASPD, cognitive and behavioral group therapies should be monitored closely. Young offenders with a diagnosis of antisocial personality disorders may not benefit as well from group interventions, but if the interventions are aimed at young offenders and focus on reducing recidivism and other antisocial behaviors, outcomes should be more positive (National Collaborating Centre for Mental Health, 2010).

Pharmacological treatment for individuals with antisocial personality disorder.

Many professionals believe that a biological approach can be taken to treat individuals with antisocial personality disorder. However, there is no pharmacological treatment available specifically for symptoms and behaviors associated with ASPD. Medications prescribed for other mental illnesses and symptoms are able to reduce some of the symptoms and behaviors for antisocial personality disorder. Selective serotonin reuptake inhibitors (SSRIs), venlafaxine, and monoamine oxidase inhibitors (MAOIs) can be used to reduce mood dysregulation (National Collaborating Centre for Mental Health, 2010). While all of these medications have been shown to work, an emphasis on SSRIs and lithium have been placed when it comes to treating mood dysregulation. SSRIs can also be used to treat other symptoms such as aggressive behavior. Low doses of antipsychotic medications can help reduce any cognitive abnormalities (National Collaborating Centre for Mental Health, 2010).

Many symptoms of antisocial personality control can be targeted by pharmaceuticals but there are difficulties with prescribing medications to keep in mind when working with antisocial personality disorder. Sometimes it can be hard to determine which mental illness is being

targeted when the individual is comorbid and therefore the right medication may not be prescribed as a result (National Collaborating Centre for Mental Health, 2010). Individuals receiving pharmaceutical treatment for antisocial personality disorder that also use substances for self-medication may reduce the impact the pharmaceutical prescription has on their symptomology. The last consideration is that complex conditions like antisocial personality disorder are most likely producing neurotransmitters that help produce dysregulation, making it very difficult to prescribe the correct medication (National Collaborating Centre for Mental Health, 2010). Most prescriptions made to individuals with antisocial personality disorder have been prescribed to treat symptoms and behaviors of the disorder, not the disorder itself.

Since there is no specific pharmaceutical treatment for individuals with antisocial personality disorder, health professionals should be weary of what they are prescribing. Health professionals should also figure out if their client is using any substances as a form of self-medication and how those substances may interact with the prescription. If an individual with ASPD does have a substance use disorder, the health professional may try to avoid prescribing potentially addictive medications. Individuals receiving pharmaceutical treatment for antisocial personality disorder are at a risk for poor concordance, high attrition, misuse of prescribed medications, and adverse drug interactions (National Collaborating Centre for Mental Health, 2010). Recommendations for treatment for counselors or health professionals to keep in mind would include prescribing medications that do not mix well together in order to reduce as much symptomology as possible, and determining what disorder they are prescribing medications for.

Community treatment for individuals with antisocial personality disorder.

Community treatment offers a different perspective on therapy techniques for individuals with antisocial personality disorder. In the community treatment programs, individuals can seek

help from peers and peer influences help guide individuals through treatment. Peer influence can help individuals learn social skills and norms, and to take on more responsibility than they would in one-on-one therapy interventions (National Collaborating Centre for Mental Health, 2010). These community intervention programs can be found in a variety of settings. Many interventions take place in health fields, education and social work fields, and prison settings. There are also many community approaches that specifically work with individuals diagnosed with antisocial personality disorder and many residential facilities consider themselves to be therapeutic communities (National Collaborating Centre for Mental Health, 2010). These settings can treat antisocial personality disorder, as well as comorbid substance abuse, and comorbidity with other mental illnesses. Most community intervention programs work with criminal offenders and individuals addicted to substances. A recommendation for professionals working with people with antisocial personality disorder in the community would be to refer them to a therapeutic community specializing in drug and alcohol treatment if they have a substance use disorder (National Collaborating Centre for Mental Health, 2010).

CHAPTER 4

DISCUSSION AND CONCLUSION

Discussion

There are many considerations for rehabilitation counselors to keep in mind when working with clients with antisocial personality disorder. Psychopathy and sociopathy used to be the diagnoses for antisocial personality disorder before the mental illness was created in the *DSM-III*. Many controversies occurred over determining whether or not antisocial personality disorder fit psychopathy or sociopathy more. Newer editions of the *Diagnostic and Statistical Manual for Mental Illness* have put psychopathy and antisocial personality disorder in the same category even though psychopathy is not the same as antisocial personality disorder. Many professionals that make diagnoses may give someone a diagnosis of antisocial personality disorder because the person fits criteria for psychopathy, even though they don't fit the criteria for antisocial personality disorder.

While antisocial personality disorder affects a very small percentage of the population, about 50% of people incarcerated or involved in the criminal justice system have a diagnosis of antisocial personality disorder. This means that many rehabilitation counselors will work with at least one client with antisocial personality disorder throughout their careers. Men with antisocial personality disorder are more likely to continue engaging in antisocial behaviors than women, but women have a higher chance of having a comorbid mental illness, and are more likely to have a substance use disorder.

While it is possible to treat individuals with antisocial personality disorder and another mental illness, their outcomes are rated as poor compared to people with mental illnesses that do not also have antisocial personality disorder. There are more treatments proven to work for

preventing antisocial personality disorder than treatments for the actual disorder. There is no pharmaceutical medication to work for antisocial personality disorder, although some pharmaceuticals can be taken to reduce symptoms of ASPD. Rehabilitation counselors should be ready to send their clients with ASPD into community and group therapies; they seem to work better compared to individual therapy for people with antisocial personality disorder.

Rehabilitation counselors should be alert for clients with antisocial personality disorder who may have additional mental illnesses, especially substance abuse disorders. Any clients with substance abuse disorders may have adverse reactions to any medications prescribed to them to treat the symptoms of antisocial personality disorder. Sometimes it is hard for physicians to figure out if the medications are being prescribed for antisocial personality disorder or a different mental illness that the client may also have.

Conclusion

In conclusion, antisocial personality disorder made its debut as its own personality disorder in the *DSM-III*. Inspired by research studying personality disorders in psychopathy and sociopathy, antisocial personality disorder has gone through many changes. Some of these changes gave it criteria that focused more so on behavior than cognition, current editions of the *DSM-V* have gone back to a psychopathic view of antisocial personality disorder. Over the years the diagnostic criteria has been shortened since its premiere in 1980 in *DSM-III*. This paper has examined many of the changes made to the personality traits and diagnostic criteria associated with antisocial personality disorder. It has discussed reasons for change and criticisms as a result of those revisions. The *DSM-V* has only been available for purchase for a couple of years, however as noted several times in this paper, that does not mean that there is not already a group of people working on revisions for the release of the next *DSM*.

With the changes in the *DSM* over the years, there haven't been many breakthroughs in treatment for antisocial personality disorder. Many of the treatments that are used for people with the disorder have been created for individuals with borderline personality disorder. This paper discussed treatment in the form of preventing a diagnosis for antisocial personality disorder. It also described different treatment options available that have been shown to have some success, even though the treatments weren't created for the specific personality disorder. Recommendations were also made throughout the treatment section for rehabilitation counselors to use to keep in mind when working with clients with antisocial personality disorder.

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A HISTORY OF ANTISOCIAL PERSONALITY DISORDER IN THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* AND TREATMENT FROM A REHABILITATION PERSPECTIVE

Major Professor: James A. Bordieri