Antisocial Personality: An Interdisciplinary Approach of Implications for the Field of Criminology

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The classification of social scientists of the abnormal, destructive, individual who does not readily respond to treatment has lead to the controversy of causation and typology of this person. The diagnostic of this individual from a medical standpoint falls to psychology while criminologists must take into account external dimensions as the effects of the antisocial personality (APD). Upwards of 65 to 75 percent of convicted criminals suffer from the disorder. Criminologists have considered such a category lumping persons who do not clearly fit into other typologies. Psychologists have argued APD as an adult version of juvenile conduct disorder. Such is do to the total disregard for the rights of others and the rules of society.

The Diagnostic Statistical Manual of Mental Disorders (DSM) defines seven clinical features:

1. Failure to conform to norms;
2. Deceitfulness, manipultiveness;
3. Impulsivivity, failure to plan ahead;
4. Irritability, aggressive;
5. Reckless disregard for the safety of self and others;
6. Consistent irresponsibility;
7. Lack of remorse after having hurt, mistreat, or stolen from another person

An individual must be diagnosed with at least three more characteristics to meet the criteria for APD. Also an individual must demonstrate a) a pervasive disregard for the rights of others since the age of 15 b) the person must be at least 18 years of age c) evidence of the conduct must have onset before 15 years of age. APD first appeared in the DSM-I in 1968 and its criteria has constantly changed (Lykken, David T. 1995). In DSM-III the American Psychiatric Association (APA) distinguished between child and adult

characteristics and behavioral criteria for personality criteria. DSM-IIIR listed violent acts as fighting, and cruelty to others. DSM-IV defines APD as anything that is not sociopath, psychopath, or social personality disorder. Generally speaking the social environment consists of relations between two or more persons.

There are theorists who link APD in part to our evolutionary genetic inheritance. Evolutionary psychology accepts that primitive hominids did exist. Evolution during the Pleistocene, where skills in hunting and gathering were necessitated as adaptations for survival developed traits in these areas and such were passed along. The linking of hunting characteristics towards aggressiveness or crime in particularity is vague. This assumption is very open textured without a specific role defined. It however develops the biological or organic theory supports for APD (Lykken, David T. 1995).

Researchers in *Archives of General Psychiatry* have discovered that men with APD have 11 percent less gray matter than normal men in the prefrontal cortex. Researchers have suspected that the prefrontal cortex is related to the control of normal social behavior. Research has stated that murderers have less activity in this area than normal persons. Adrian Raine recruited 21 men from Los Angeles. These men tended to disregard the law, lie, and pick fights. Raines compared MRIs or three dimensional brain images of these persons with other men. He discovered such contained about two teaspoons less gray matter. Raine posits the prefrontal cortex as a brake that contains one from lashing out at others. He also states that he believes such individuals lack a component of fear which permits them to commit violent acts (Vogel, 2002).

Individuals with this and most personality disorders do not seek treatment on their own. Generally speaking one is mandated or referred to treatment with an order from a court. The diagnostification is often confused with simple criminal activity, and adult antisocial behavior which does not warrant the classification. Once diagnosed **Psychotherapy** is the preferred method of treatment. Group and family therapy may also compliment this approach. Even within known psychoanalytic practices treatment is limited and success is marginal.

Motivation of the patient to accept and undergo treatment and continue compliance is problematic. Treatment may occur in a confined forensic setting. In such a closed environment therapy may be difficult and a focus on goals once one is released could be emphasized. In an outpatient setting the focus should be on antisocial behavior and feelings or the lack thereof. A lack of nexus of feelings and external behavior is

characteristic. Coercion to gain compliance is never a primary resource to facilitate therapy. If the clinician is not reaching goals reporting non-compliance to the court as an aversion to not be involved in the system.

Persons with APD have difficulties with authority figures. The therapist should invoke a neutral stance. Avoidance of arguments, taking sides in control over the client, and other authority related issues should be avoided if possible. Moral and ethical discussions have shown little progress in altering behavior. Consequences of their activities may be discussed to greater success. A reference to incarceration in the penal system is acceptable.

Confidentiality issues are part of the client-therapist relationship. The client will most likely view the contents of any reporting as important. The clinician should do such in a generalized manner without details of the therapy. Honesty in stating what the therapist will reveal to the court is a genuine manner of gaining trust from the client. Limitations of progress should be dealt with in a straightforward manner.

The therapy should focus on emotional content and towards safe issues. The reinforcement of any emotion outside of anger or frustration has been useful. The client may not be familiar with content of depression and the clinician should be supportive in this respect. The greatest success lies in the discovery and labeling of appropriate emotional states for the management of long-term behavior.

The emergence of consistent accurate diagnostics for APD as well as trained clinicians has hindered the use of this classification. There is a compromise between various schools of thought and social forces that went into the shaping of the classification. It is still possible for one to be misdiagnosed. There is still the realistic fact that the future will bring more change before clarification into APD and its effect on the related social sciences.

There are theorists who argue APD, sociopath, psychopath as synonymous. In continuation, the faculty at North Carolina has differentiated the categories on the following criteria. Sociopathy is characterized by abnormality in ones conscience. In general a person either possesses one or does not. Hence there is a negation of conscience or future time perspective. The sociopaths concern is the fulfillment of their own needs and desires. Egocentricity and selfishness are the norm. Sociopaths may believe they are contributing to society. There are four subtypes: a) common b) alienated c) aggressive d) dissocial.

General characteristics are as follows: Egocentricity, callousness, impulsiveness, conscience defect, exaggerated sexuality, excessive boasting, risk taking, antagonistic, deprecating attitude toward the opposite sex, and lack of bonding with a mate.

Psychopathy is more textural but is usually defined as a constellation of affective, interpersonal, and behavior characteristics. Involved are egocentricity, impulsivity, shallow emotions, lack of empathy, pathological lying, manipulativeness, and the persistent violation of expectations. Crimes of psychopaths are remorseless committed without guilt or regret. Most societies would consider their behavior criminal but a frontier or warlike culture may consider such as patriots or heroes. Most psychopaths are antisocial personalities but not all antisocial personalities are psychopaths. This perspective differentiates such on the ground that APD is defined by behaviors and does consider the affective/interpersonal dimensions.

Common personality characteristics of psychopaths are: glib and charm, grandiose sense of self-worth, pathological lying, conning and manipulativeness, lack of remorse, promiscuous behavior, and criminal versatility.

To conclude this area there is a hierarchy of severity which may distinguish an individual with a consistent history of long-term criminal abnormality and a predatory person. It is to be noted that APD persons usually represent persons with very little success early in ones life. Tyrants of political systems may be classified as APD with histories of academic ability and accomplishment, which seems to contradict the all-time loser as APD. The issue is not clear-cut and points that the diagnostics may indeed be cultural and not an objective science.

There are three major schools of criminology. They are the biological, social-structural approach, and the social-process approach. There will be a brief comparison and critique of each with a linkage to the diagnostics and treatment of APD.

Biological Approach

The study of biology states that there indeed must be a linkage in all that a living entity does, its genetics, and its anatomical structure. To what degree this relation is remains an enigma; even more so for diagnostics of abnormality as APD. As previously noted Lykken has argued a continuum of inheritance of the Pleistocene. There are no known chromosomes that can be attributed to behavior from the Pleistocene although the theory does explain the acculturation of how a mutation could enter the genetic base

of the human family. Adriane Raine, from a modern standpoint has pointed out structural deviations in very serious criminals. This approach is interesting; it however must be seriously be retested numerous times to be validated. It however does not point out an origin as the previous concept does. Lykken focuses on Androgens or growth factors as a support for APD. These hormones are onset in males from age ten in males. Abnormality in this electro-chemical co-ordination does fit one of the three additional criterions for APD; an onset of a behavior before fifteen. There is also support for a higher abnormality in the males.

The study of neuroendocrinology theory once was postulated stating, the glandular theory of crime accounts for all the discrepancies, errors, oversights, and inadequacies of the earlier explanations, *The New Criminology.* (Reid, 2003).

The above explanation of the endocrine system is in the support of the biological statement that genetics and internal anatomical structures do indeed play a role in all manifest behaviors. It is my opinion that this area will lead to large breakthroughs in the science of abnormal persons. What is interesting is the focus of APD treatment of emotional negative states of such persons. Even more intriguing is the use of psychotherapy as the main therapy. There is no doubt that some drug regimen is used for related symptoms. Still at large is a linkage to antecedents in the environment.

To compliment the very limited and verifiable work in the biological area; there are the socialization theories. They are divided into the social structure approach and the social process approach.

Social-Structural Approach

Early sociological theory, that of the late 19th century was heavily influenced by the work of two persons. They are Emilie Durkheim and Robert K. Merton. Their approach centers of the concept of *anomie.* Such is defined as without norms. Durkheim posits that society needs social cohesion in the definition of what is right or wrong to be sustainable. Hence a society has a collective *social consciousness* as to what is right or wrong. This is argued as *social solidarity*. Primitive societies were based on dominance, which lead to what Durkheim discusses as *mechanical solidarity*. As society increased the *collective conscience* turns to become *restitutive* focusing on the individual injured. Here there is a

specialization of labor that may be imposed over the individual resulting in *class stratification*. Herein is a shift towards *organic solidarity.* The individual suffers from a lack of relationship with ones social environment. There is a feeling of *alienation* from the whole. The state of *anomie* permits the growth of crime and antisocial acts.

Merton's extension of *anomie* involves an argument where *social structures* dictate outcomes. In this configuration abnormality is present as normality. Two elements support the position. One is *goals*, the other is *methods*. Merton argues that a society dictates goals by the imposition of norms. If such behaviors exist to the exclusion of some, criminality will develop to obtain ends.

Merton defines four modes of adaptation. They are as follows:

Type of Adaptation	Goals	Means
1. Conformity	Accept	Accept
2. Innovation	Accept	Reject
3. Ritualism	Reject	Accept
4. Retreatism	Reject	Reject
5. Rebellion	Accept	Accept

The concept of *anomie* and alienation of the individual from the collective is critical to the formation of the bulk of criminological theory. The society defines normative goals and the means to obtain such. One either accepts or rejects a combination of the two. The *conformist* is normative for society. The *innovator* accepts the goals but not the means. This in general covers a large degree of deviance in modern culture. *Ritualists* reject the goals but accept the means. One who superficially is adhering to a process to obtain an illegal goal is such. *Retreatists* have been largely studied within the drug subculture. *Rebels* are unique in that they may pertain to a counter-culture. They are attempting to change the social structure. Their acceptance may come to change over space and time.

The DSM diagnostics for APD begins with failure to conform to norms. The above theories overwhelmingly have played a major role in all social science thinking as well as the APA. This work must be considered a point of departure into a descent of more particular specialization. While not discounting genetics, the emphasis is on the adaption and relationship one has with prevailing structures antecedent to one. The intellectual repertoire

of APD persons is not impressive and must be taken into consideration. *Anomie* or alienation appears to be part of the APD individual.

An interesting addition to theories of anomie is strain theory. Agnew has proposed such. The emotive conditions and corollaries that are addressed by psychotherapy of APD individuals are related to the platform that Agnew has proposed leads to deviance. The macro side of *anomie* is that society has imposed goals and the means to such over the individual. The micro side is strain theory. This is that the disintegration of society and its normative regulations increase pressure to commit deviant acts. (Agnew & Passas, 1997).

According to Agnew an increase in expectations and aspirations should lead to an increase in deviance. Research has proven delinquency in all class levels. Hence when persons are maltreated they respond accordingly. There are three major types of strain: a) failure to achieve positively valued stimuli b) the loss of positively valued stimuli c) the presence of negatively valued stimuli.

Recent thought into strain theory is gender based. On the emotional level. Females are more likely to respond with anger and depression. They are also more likely to blame themselves and worry about the effects of their anger. Males respond with anger. They are quick to blame others and are concerned about hurting others. In summary Agnew and Broidy state that females lack the self-esteem and confidence to commit crimes. They employ escapism and methods to avoid breaking serious codes. Females may also have valued relationships that constrain their behaviors. Males are said to be lower in social control. Males socialize and form hierarchical groups to commit crime. Thus males are most likely to respond to strain with crime.

I could not locate any collective study on ADP. What is interesting is that the majority of the prison population has been diagnosed with such and they are males kept in close quarters. Generally speaking by logic a gang must contain symptomology of ADP.

Summary

The success of identifying, treating, preventing the emergence of the APD person, and legislation is increasingly an interdisciplinary study. An integrated approach that factors in the boundaries particularly of the demonstratable and social sciences are emerging as a force in both psychopathology and criminology. An origin model dictates causation. Lykken is positing mutations from the Pleistocene and Androgen growth

factors as a cause. Raine has cited brain size differences or anatomical variations. The DSM cites normlessness, poor emotions and goals as psychic structures that are prominent in APD persons.

The Social Structure Approach points out that persons adapt to conditions outside their person. The repertoire of these individuals is limited. Even in an ideal state it is logical to argue that these persons would not achieve normative success. Hence, this approach must consider biology and intervention past manipulating social structures. The Social Process Approach of labeling factors in intervention but not scientifically. The problem here is in the greater culture writ large and in the lack of specialization of experts.

In close, there needs to be a unified integrated approach to APD. These are the worst, most problematic offenders. The current trend is to incarcerate such under various theories of punishment. The severity of the problem is more than scientific discovery and academic problem solving. Integration and eclecticism, not competion, is what is needed. APD population projections are large and should give the rational individual concern over their casework and public policy.

Other links of interest:

http://powereality.tripod.com

http://nollmeyer.tripod.com

http://powereality.tripod.com/euthanasiahome.htm

http://mitglied.lycos.de/nollmeyer/

Law and Social Science:

http://members.tripod.com/nollmeyer/index.htm