Personality Disorders
Antisocial Personality Disorder

DSM-IV-TR Diagnostic Code: 301.70 Antisocial Personality Disorder

Diagnostic Guidelines:

1. Establish Diagnostic accuracy as defined in DSM-IV-TR/ICD-9.

2. Identify differential diagnoses and co-morbid problems: Rule out substance related disorders and other Cluster B personality disorders. Use psychological testing to assist with rule outs when treatment based on standard clinical evaluation and treatment approaches is ineffective or fails to improve the client's mental status and related life experiences.

3. Establish accurate diagnosis through continued assessment of diagnosis over time and rule out of other diagnoses as necessary.

4. Obtain external corroboration of diagnosis when possible through review of past treatment history, legal history, etc. Individuals with antisocial personality disorder often have a history of antisocial behavior and conduct problems during childhood and adolescence. The research literature also suggests a link between antisocial personality traits and childhood abuse. A triad of childhood symptoms that includes bedwetting, fire setting, and cruelty to animals has also been linked to the presence of antisocial personality disorder during adulthood. Antisocial personality disorder is much more common in males than in females, and it is known to be prevalent in correctional settings.

5. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains.

Treatment Guidelines

1. A careful and thorough assessment should be done to ensure that the person has antisocial personality disorder. Criminal behavior is often one indication of antisocial personality disorder; however it cannot be concluded that all criminals are antisocial. It is necessary to have clear diagnostic evidence of an antisocial personality disorder diagnosis versus having an individual who happened to engage in a criminal activity.

2. As with other personality disorders, antisocial personality disorder is typically resistant to treatment, and the affected individual is often poorly motivated for change. Entry into treatment is often based on the hope or promise that legal

consequences might be mitigated if the individual cooperates with therapy. If an antisocial individual is in a confined setting, it may be very difficult to establish any motivation for treatment. Therapy should then focus on goals for when they are released from custody, improvement in social or family relationships, learning new coping skills, etc. In an outpatient setting, the focus of therapy can also be on these types of issues, but a part of the therapy should be devoted to discussing the antisocial behavior and the lack of feelings. It is common in the population who suffer from antisocial personality disorder for there to be a lack of connection between these behaviors and feelings. Cognitive interventions of challenging distorted beliefs may be useful in highlighting how unlawful activities were perceived as successful or unsuccessful leading to further consequences. Utilize Rational Emotive Therapy to confront extreme beliefs that can lead to conflict with others and replace them with ones that can get the client's needs met. Explore negative assumptions that the client may have regarding the therapist as well as others in comparison to those held in previous significant relationships. Identify how projection can reinforce our perceptions of self and others leading to highly consequential decision making.

3. If the only way to motivate the patient is to threaten to report their noncompliance with therapy to the courts or warden, it is highly unlikely the clinician will make any type of gains in therapy. It is appropriate, however, to try and help the individual with this disorder find good reasons that they may want to work on this problem further.

4. Approaches that reinforce appropriate behaviors and attempt to make connections between the person's actions and their feelings are the most beneficial. Emotions are usually a key aspect of treatment of this disorder. Patients often have had little or no significant emotionally-rewarding relationships in their lives.

5. As the individual learns to experience various emotional states, one of the first may be depression. The client will likely be unfamiliar with the feelings associated with depression, and so it is beneficial for the clinician to be supportive and empathetic to the individual during this time. The clinician should reinforce any emotions, outside of anger or frustration. Experiencing intense affect is usually a sign of progress in therapy. Staying on safe issues and discussing more real-life concerns, while one way of treating this disorder, is not likely to be as effective in long term behavioral change as an approach emphasizing the discovery and labeling of appropriate emotions.

6. The clinician should avoid arguments and taking sides on authority issues and those who hold authority over the client. Usually one of the more effective ways for a person with this disorder to learn to change their ineffective behaviors is to have to face up to the consequences of their behavior. This sometimes means dealing with courts and jails, but it can also eventually be a motivating factor in the client's treatment.

7. Groups which are devoted exclusively to this disorder, though rare, are the best choice. In such a group, the patient is given a greater reason to contribute and share with others. Group leaders must maintain tight, structured control of the group so as to avoid deterioration of the group to focus on criminal behavior. Psychodrama and role-reversal techniques can highlight for the participants the impact of exploitation. Continued group work may lead participants to achieve emotional identification with victims. Psycho-education may interrupt negative compulsive behavioral cycles and allow for alternative behaviors to emerge that are more respectful to self and others.

8. Family therapy can be helpful to increase education and understanding among family members. Families often misunderstand and are confused about the cause of the antisocial behaviors and the idea that it is a mental disorder.

9. The use of psychotropic medications is not indicated for this disorder. Medications should only be utilized to treat clear, acute and serious Axis I concurrent diagnoses. No research has suggested that any medication is effective in the treatment of this disorder.

10. It is especially important to establish, maintain, and model clear boundaries with clients with personality disorders. Utilize straightforward language avoiding anything that can be misconstrued.

REFERENCES

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