People with antisocial personality disorders are characterized by lack of morals and affect. They often fail to conform to social norms, repeatedly break the law, are deceitful, impulsive, reckless, disregard the safety of self and others. They are also capable of being aggressive and violent without feeling guilty. According to the DSM-IV-TR Diagnostic Criteria for Antisocial Personality Disorder (301.7) antisocial personality disorders in (Axis II Cluster B) is characterized by a pervasive pattern of disregard for and violation of the rights of others. These behaviors develop by age 15. The following list allows you a glimpse into the different types of antisocial personality disorders and what they are. 3 Types of Antisocial Character Structure a) Amoral Personalities Amoral extroverts (narcissistic) – Narcissist are characterized by their inflated sense of self and their deep need for admiration. These individuals believe they are superior to others and lack social empathy. However, behind their ultra-confident mask they have very fragile self-esteem and can be quite vulnerable to criticism. Amoral introverts (schizoid) – People with schizoid personalities are often introverts. They can be withdrawn and solitary. Mostly appearing cold and socially distant they can also be self absorbed, fearing closeness and intimacy. b) Amoral Impulse Disorder – People with this disorder have a hard time resisting impulses to perform actions that maybe harmful to themselves or others. Impulsively violent, high tolerance for pain, high risk for drug use, low guilt. c) Sadistic Antisocial – Lacks caring and empathy for others, willing and even wants to inflict pain on others for their own pleasure or satisfaction. Their primary defense is dissociation and omnipotence. Also characterized by their intense need to control and dominate. According to Theodore Millon there are five subtypes of antisocial. A person with this disorder may demonstrate none, one or more than one of the following types of antisocial personality disorders: Covetous antisocial – this is a variant of the pure pattern where the individual feel that life has not given them their due. They feel denied, deprived and are therefore discontented, envious, seek retribution, are greedy and often derive more pleasure in taking than in having. Reputation-defending antisocial - this includes narcissistic features such as the need to be thought of as flawless, invincible, superior, indomitable. Overactive to slights. Risk-taking antisocial – histrionic features such as boldness, foolhardiness, impulsive, characterizes this subtype pursues danger, recklessness. Nomadic antisocial – features of this subtype includes, schizoid and avoidant characteristics such as the feelings of being jinxed, ill-fated, doomsday outlook. They feel excluded, cast aside, and peripheral. These people are often drifters, vagrants, misfits, and wanderers. 5) Malevolent antisocial – features included are sadistic and paranoid. These people are often vicious, malignant, and brutal. They anticipate betrayal and desires revenge. Usually fearless and guiltless. References Share — copy and redistribute the material in any medium or format for any purpose, even commercially. Adapt — remix, transform, and build upon the material for any purpose, even commercially. The licensor cannot revoke these freedoms as long as you follow the license terms. Attribution — You must give appropriate credit , provide a link to the license, and indicate if changes were made . You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use. ShareAlike — If you remix, transform, or build upon the material, you must distribute your contributions under the same license as the original. No additional restrictions — You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits. You do not have to comply with the license for elements of the material in the public domain or where your use is permitted by an applicable exception or limitation . No warranties are given. The license may not give you all of the permissions necessary for your intended use. For example, other rights such as publicity, privacy, or moral rights may limit how you use the material. Alegria AA, et al. (2013). Sex differences in antisocial personality disorder: Results from the National Epidemiological Survey on Alcohol and Related Conditions. Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: American Psychiatric Association.Baliousis M, et al. (2019). Executive function, attention, and memory deficits in antisocial personality disorder and psychopathy. A, et al. (2016). A randomised controlled trial of mentalization-based treatment versus structured clinical management for patients with comorbid borderline personality disorder and antisocial personality disorder. IA, et al. (2016). Classification and treatment of antisocial individuals: From behavior to biocognition. M, et al. (2019). The etiology of antisocial personality disorder: The differential roles of adverse childhood experiences and childhood psychopathology. KA, et al. (2020). Antisocial personality disorder. KJ, et al. (2013). Antisocial personality disorder in older adults: A critical review. A, et al. (2020). Characterisation of self-defining memories in criminals with antisocial personality disorder. ♦nch R, et al. (2020). Should behavior harmful to others be a sufficient criterion of mental disorders? Conceptual problems of the diagnoses of antisocial personality disorder and pedophilic disorder. L, et al. (2018). A systematic review examining the link between psychopathic personality traits, antisocial behavior, and neural reactivity during reward and loss processing. J, et al. (2016). Offenders with antisocial personality disorder display more impairments in mentalizing. A. (2018). Antisocial personality as a neurodevelopmental disorder. Dongen JDM. (2020). The empathic brain of psychopaths: From social science to neuroscience in empathy. J, et al. (2018). Prevalence of personality disorders in the general adult population in Western countries: Systematic review and meta-analysis. MM, et al. (2020). Influence of betrayal trauma on antisocial personality disorder traits. Antisocial Personality Disorder (ASPD) is a mental health condition characterized by persistent patterns of disregard for social norms, the rights of others, and a lack of remorse for harmful actions. Often misunderstood, ASPD affects not only the individual but also their relationships, communities, and personal wellbeing. For those in Boston and surrounding areas, addressing ASPD through specialized behavioral health programs, including anger management and recovery-focused treatments, is crucial for effective intervention. This guide delves into the nuances of ASPD, its symptoms, types, and the range of treatment options available to those seeking recovery, particularly through programs like those offered at Greater Boston Behavioral Health. What Is Antisocial Personality Disorder? Antisocial Personality Disorder is part of the Cluster B personality disorders, which are marked by dramatic, emotional, or erratic behaviors. Unlike fleeting poor decisions or rebellious tendencies, ASPD involves pervasive and chronic patterns of disregard for social rules and a lack of empathy. This disorder often manifests in childhood or adolescence, with symptoms continuing into adulthood. People with ASPD may have difficulties in maintaining healthy relationships, holding steady employment, or avoiding conflicts with the law. Early identification and intervention through a mental health program or behavioral health center in Boston can significantly improve the quality of life for affected individuals and their communities. Treatment Options for Antisocial Personality Disorder Although ASPD presents unique challenges, evidence-based treatments can lead to meaningful improvement. Successful treatment often involves a combination of therapeutic approaches, medication, and structured programs such as Intensive Outpatient Programs (IOPs) or Partial Hospitalization Programs (PHPs). 1. Cognitive-Behavioral Therapy (CBT) CBT helps individuals identify and change harmful behaviors by addressing the underlying thought patterns driving their actions. It is particularly effective in managing deceitful tendencies and improving impulse control. 2. Dialectical Behavior Therapy (DBT) DBT focuses on emotional regulation, distress tolerance, and interpersonal effectiveness. This approach is ideal for individuals with ASPD who struggle with emotional outbursts and anger issues. 3. Anger Management Programs For individuals prone to aggression, specialized anger management programs teach techniques to recognize triggers, regulate emotions, and develop healthier ways of responding to frustration. 4. Group Therapy Group therapy fosters a sense of accountability and provides a platform for individuals to learn from others. These programs, offered through Boston behavioral health services, create a safe space for sharing experiences and building interpersonal skills. 5. Medication Management While no medication specifically targets ASPD, certain prescriptions can manage associated symptoms like anxiety, depression, or aggression. Mood stabilizers, antipsychotics, and antidepressants are commonly used in treatment plans. 6. Comprehensive Behavioral Health Programs IOPs and PHPs provide structured environments for individuals to receive intensive therapy while maintaining some level of independence. These programs are ideal for individuals requiring more support than traditional outpatient care offers but who do not need inpatient hospitalization. The Role of Behavioral Health in Boston Access to high-quality behavioral health services is critical for addressing ASPD and its associated challenges. Facilities specializing in behavioral health in Boston provide a combination of therapy, medication, and support programs tailored to the individual's needs. A mental health treatment center in Boston can also offer family support services to educate loved ones and strengthen the individual's recovery network. Programs such as Greater Boston Behavioral Health integrate evidence-based treatments with holistic approaches, ensuring comprehensive care for individuals with ASPD. Anger Management in Recovery Anger is a common challenge for individuals with ASPD, especially those in recovery from substance abuse. Anger management programs teach essential skills to manage this emotion constructively, reducing the likelihood of relapse or violent behavior. Techniques include: Identifying personal anger triggers. Developing alternative responses to frustration. Practicing mindfulness and relaxation techniques. Engaging in supportive group therapy. Such programs, particularly when incorporated into a broader mental health program, can have a profound impact on recovery outcomes. Final Thoughts Antisocial Personality Disorder is a serious and often misunderstood condition. However, with the right combination of therapies, support systems, and structured programs, individuals with ASPD can learn to manage their behaviors and build healthier lives. If you or someone you know is struggling with ASPD, reach out to Greater Boston Behavioral Health for compassionate and effective care. With options such as intensive outpatient programs, partial hospitalization programs, and specialized anger management programs, recovery and improved quality of life are within reach. Call us at (888)278-0716 to learn how we can support your recovery journey! FAQs on Antisocial Personality Disorder What is Antisocial Personality Disorder (ASPD)? Antisocial Personality Disorder is a mental health condition characterized by a persistent disregard for societal norms, a lack of empathy, and manipulative or impulsive behaviors. It often leads to difficulties in maintaining relationships and legal issues. What are the common symptoms of ASPD? Common symptoms include: Persistent lying or manipulation. Impulsive behavior and lack of planning. Aggression or violent tendencies. Lack of remorse for harmful actions. Difficulty maintaining stable relationships or employment. How is ASPD treated? ASPD treatment typically involves: Cognitive-Behavioral Therapy (CBT) for behavior modification. Anger Management Programs to address aggression. Dialectical Behavior Therapy (DBT) for emotional regulation. Structured programs like Intensive Outpatient Programs (IOPs) or Partial Hospitalization Programs (PHPs) for comprehensive care. Can medication help treat ASPD? While there is no specific medication for ASPD, mood stabilizers, antidepressants, and antipsychotics can manage associated symptoms like aggression or impulsivity. How can anger management programs help individuals with ASPD? Anger management programs teach individuals to recognize triggers, regulate their emotions, and respond constructively to frustration, reducing aggressive behaviors and improving interpersonal relationships. Antisocial personality disorder is characterized by a pervasive and enduring pattern of disregarding and violating the rights of others, typically emerging in childhood or early adolescence and persisting throughout an individual's life. This disorder significantly impacts interpersonal and occupational functioning, often leading to profound impairments in overall quality of life. Individuals with antisocial personality disorder frequently engage in criminal behavior and struggle to learn from the negative consequences of their actions. Coexisting psychiatric conditions and substance use disorders are common among those affected, adding to the complexity of this disorder. This activity on antisocial personality disorder focuses on the underlying etiology, assessment, and treatment of the disorder. The multidisciplinary team managing this personality disorder must collaborate to provide comprehensive care. By equipping healthcare professionals with the knowledge and tools needed to address this complex condition, the activity aims to enhance overall patient outcomes. Through a thorough understanding of antisocial personality disorder and its management, healthcare providers can better support individuals affected by this challenging condition and contribute to improved patient well-being. Objectives: Identify the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision diagnostic criteria for antisocial personality disorder.Differentiate antisocial personality disorder from other personality disorders.Apply evidence-based therapeutic interventions for managing antisocial personality disorder, with a focus on improving patients' quality of life and interpersonal relationships and reducing the risk of legal complications.Communicate with patients, families, and interdisciplinary team members about the diagnosis, prognosis, and management of antisocial personality disorder. Access free multiple choice questions on this topic. Antisocial Personality Disorder (ASPD) is an adult diagnosis characterized by a persistent pattern of disregard for and violation of others' rights, beginning in childhood or early adolescence. Individuals with ASPD often manipulate others for personal gain, lack empathy, and seldom feel remorse for their actions. They struggle to develop stable interpersonal relationships and experience significant impairments in social and occupational functioning throughout their lifetime. Legal issues frequently arise from their repeated failure to learn from the repercussions of their behavior, often involving criminal acts.[1]Antisocial behaviors exist on a spectrum. Conduct disorder, a condition specific to childhood, manifests as children and adolescents with a repetitive and persistent pattern of behavior violating the fundamental rights of others or significant societal norms or rules. Children with conduct disorder exhibit aggression toward people or animals, destruction of property, deceitfulness, theft, or other serious rule violations.[2] Variation exists in the trajectory of youth diagnosed with conduct disorder. In some cases, individuals with ASPD in adulthood have had these behaviors since childhood, while others develop ASPD, but conduct disorder is a risk factor for developing ASPD.[5] Psychopathy is also a distinct clinical construct.[6] Psychopathy is sometimes viewed as a subtype within the broader category of ASPD as a very severe form of ASPD with a heightened risk of violence.[6] Robert Hare's Psychopathy Checklist-Revised (PCL-R) serves as an assessment tool designed to measure psychopathic traits, contributing to a more nuanced understanding of the unique characteristics of psychopathy and its connection to ASPD.[7]The roots of our understanding of antisocial personality disorder trace back to the 19th century when Philippe Pinel (1745-1826), a French physician, and Jean Etienne Dominique Esquirol (1772-1840), a French psychiatrist, made significant observations of individuals exhibiting behaviors consistent with ASPD.[8] Chronic antisocial behaviors and a lack of empathy or remorse are notable features in their descriptions.[9] In the early 20th century, an American psychiatrist, Hervey Cleckley (1903-1984), and later Canadian psychologist, Robert Hare (1934 -), delved into the concept of psychopathy.[7] Cleckley's seminal work, The Mask of Sanity (1941), laid the foundation for comprehending psychopathy as a distinct psychological construct.[10] The terms "psychopath" and "sociopath" were often used interchangeably to describe individuals displaying traits associated with ASPD.[11] The Diagnostic and Statistical Manual of Mental Disorders (DSM) initially introduced ASPD in the third edition (1980). Initial emphasis focused on persistent patterns of antisocial personality disorder beginning in adolescence or early adulthood. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) revised the diagnostic criteria, highlighting the importance of behaviors that reflect a disregard for the rights of others, which persists through to the current version of the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision (DSM-5-TR).[12]The DSM-5-TR divides personality disorders into clusters A, B, and C. Each cluster encompasses a distinct set of personality disorders with commonalities regarding symptoms, behaviors, and underlying psychological patterns.[13]Cluster A Personality disorders with odd or eccentric characteristicsParanoid personality disorder, schizoid personality disorder, and schizotypal personality disorderOften exhibit social withdrawal, peculiar or paranoid beliefs, and difficulties forming close relationships Cluster B Comprises personality disorders with dramatic, emotional, or erratic behaviorsAntisocial personality disorder, borderline personality disorder (BPD), histrionic personality disorder, and narcissistic personality disorder (NPD)Often display impulsive actions, emotional instability, and challenges in maintaining stable relationships Cluster C Personality disorders with anxious and fearful characteristicsAvoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorderOften experience significant anxiety, fear of abandonment, and an excessive need for control or perfectionism Although the historical context involves employing the cluster system, the literature does not consistently validate this approach when addressing personality disorders, revealing limitations.[14]The development of ASPD is multifactorial. Research on the etiology of ASPD is limited, and high-quality studies specifically investigating its causes are scarce. Several factors likely contribute to the development of ASPD, including genetic predisposition, childhood experiences, and environmental influences. However, the clinical significance of these factors is unclear.[15] Personality Development Personality is a complex summation of biological, psychological, social, and developmental factors; therefore, each personality is unique, even amongst those affected by a personality disorder. Personality is a pattern of behaviors that an individual develops uniquely in response to constantly changing internal and external stimuli. A person's temperament broadly refers to consistent biologically based individual differences in behavior and a relatively independent of learning.[16][17] However, temperament evolves further through epigenetic mechanisms, namely through life experiences such as trauma and socioeconomic conditions. These are adaptive etiological factors in personality development.[18] [19] Temperament domains Harm avoidance: Involves a bias towards inhibiting behavior that would result in punishment or non-reward.[20] Individuals with ASPD have low harm avoidance.Novelty seeking: An inherent desire to initiate novel activities likely to produce a reward signal.[21] Individuals with ASPD have a high amount of novelty-seeking behaviors. Reward dependence: Describes the amount of desire to cater to behaviors in response to social reward cues.[22] Individuals with ASPD have low reward dependence. Persistence: Refers to the ability to maintain efforts and continue with behaviors despite obstacles, frustration, fatigue, or limited reinforcement.[22] Individuals with ASPD have low persistence and are prone to abandon their pursuits when encountering challenges. Genetics Genetic studies propose a hereditary component of personality disorders, including ASPD. Twin studies find a monozygotic concordance rate of 67% compared to a 31% concordance rate in dizygotic twins.[23] Family studies estimate that 20% of individuals with ASPD have a first-degree relative with ASPD.[24] A twin study involving 1048 subjects investigating substance use disorder, ASPD, and disinhibition found a shared common heritability factor of 0.81.[25] Another twin study involving 2794 subjects reveals a 51% common-factor heritability for ASPD behaviors.[26] A large sample of male children who experienced childhood abuse reveals a functional polymorphism in the gene encoding monoamine oxidase A (MAO-A) that moderately predicts the development of ASPD, with low levels of MAO-A expression more likely to lead to the development of ASPD.[27] Children experiencing the same levels of abuse with the high-activity variant of the gene are not more likely to develop ASPD.Serotonin may inhibit impulsive and violent behaviors and may mediate some antisocial behavior. A genetic variant in tryptophan hydroxylase is thought to influence 5-hydroxyindoleacetic acid (5-HIAA) concentrations, contributing to low 5-HIAA concentrations in the cerebrospinal fluid.[28] Low cerebrospinal fluid levels of the major metabolite of serotonin, 5-HIAA, are associated with violent, suicidal, and impulsive behaviors.[29][30] Neurodevelopment Medical conditions, specifically those damaging neurons, are often associated with antisocial personality disorders or changes. Examples include head trauma, cerebrovascular diseases, cerebral tumors, epilepsy, Huntington disease, multiple sclerosis, endocrine disorders, heavy metal poisoning, neurosyphilis, and AIDS.[31] Subclinical injury to the brain in utero due to maternal tobacco smoke exposure or drug use and maternal starvation has been proposed as a predisposing factor for antisocial behavior.[32] Chemicals generated from tobacco and lower oxygen levels may contribute to injury in the developing fetus.[33][32] Family and Psychosocial Factors Various psychosocial factors contribute to the development of personality traits and disorders. These include unconscious processes, early childhood experiences, and the influence of internal conflicts.[34]Psychoanalyst Wilhelm Reich (1897-1957), an Austrian physician, contributed significantly to understanding defense mechanisms and their relationship to personality types. He introduced the concept of "character armor," which refers to defense mechanisms that develop within individuals to alleviate cognitive conflict arising from internal impulses and interpersonal anxiety.[35] For instance, those with antisocial tendencies tend to develop the defense mechanisms of displacement, denial, projection, rationalization, and regression.[36]Parenting styles are likely to contribute to the development of ASPD. Adult antisocial personality traits are associated with experiences of parental neglect and abuse.[37] Children who experience abuse or neglect may be more predisposed to the development of ASPD.[38]One study estimates that 14% to 21% of adults who report abusing their children are affected by ASPD.[39] Child and adolescent peer relations also impact personality development. Youth with traits of conduct disorder are more likely to engage with peers with similar qualities, with peer conflict identified as a key mechanism for future antisocial behavior.[40][41] The role of exposure to violent media through television, music, and video games is a common concern. Current data is conflicting but suggests patients who are prone to developing ASPD will likely develop ASPD despite exposure to violence in media.[42][43][44]The estimated prevalence of ASPD in the general population is 2% to 3%. These estimates lack data on individuals who are incarcerated or institutionalized. Studies of incarcerated individuals in the late 1990s reveal rates of ASPD in male inmates of 80% and up to 60% among female inmates.[45] The prevalence of ASPD in prisons may be declining in the US due to increasingly harsh sentencing laws. A recent study reveals an incidence of ASPD of 35% in incarcerated males.[46] The National Epidemiologic Survey on Alcohol and Related Conditions found the rate of ASPD was 3 times greater in males than females.[47] Some estimates place the risk at 5 times greater.[48] The prevalence of ASPD in patients with alcohol use disorder ranges between 16% and 49%.[45] Homelessness is also associated with ASPD. Possibly, a consequence of the inability to pay rent, maintain a job, and national starvation has been proposed as an etiological factor in antisocial behavior.[32] Research into a lower socioeconomic status. Higher education has a negative correlation with ASPD, with a higher prevalence of ASPD among those with lower IQs and reading levels.[48][49][50]Additional psychiatric disorders like substance use disorder, mood and anxiety disorders, attention deficit hyperactivity disorder (ADHD), learning disorders, gambling disorders, and other personality disorders like BPD are commonly associated with ASPD. Underarousal of the autonomic nervous system is the suggested underlying pathophysiology for some individuals with ASPD. This hypothesis proposes that individuals with ASPD require higher sensory input in abnormal brain functioning than normal subjects, causing affected individuals to seek higher sensory input to raise their arousal levels to more tolerable amounts. The result may be a higher risk tolerance for situations with higher arousal.[51][52] Findings to support this suggestion are lower pulse rates, lower skin conductance, and increased amplitude on event-related potentials in patients with ASPD.[30][53] Furthermore, nearly 50% of individuals with ASPD exhibit various electroencephalogram (EEG) abnormalities, including more slow-wave activity.[52][54] Individuals with ASPD have a higher occurrence of minor brain abnormalities and, in childhood, have a higher occurrence of learning disorders, attention deficit and hyperactivity disorder, and enuresis.[52][54]Researchers have uncovered additional findings on central nervous system (CNS) imaging, unveiling abnormal CNS functioning associated with ASPD. The prefrontal cortex, the superior temporal cortex, the amygdala-hippocampal complex, and the anterior cingulate cortex are likely involved.[55] Examples of these findings include:Individuals with a violent military history exhibit low glucose metabolism in the right temporal lobe on positron emission tomography (PET).[56]A study comparing 21 individuals with ASPD to 34 control subjects showed reduced prefrontal gray matter compared to control subjects on structural magnetic resonance imaging (MRI).[57]In a study comparing 18 men with ASPD and psychopathy to healthy controls, a smaller orbitofrontal cortex volume was observed using structural MRI.[47]The presentation of ASPD is variable. Therefore, obtaining a thorough history of the condition, medical history, and social history is essential. A history of childhood behavior is necessary as there must be evidence of conduct disorder by age 15. Approximately 80% of patients with ASPD exhibit antisocial traits by age 11, although some occur as early as preschool years.[58] Common childhood behaviors include fighting, conflict with parents and teachers, stealing, vandalism, fire setting, cruelty to animals, school behavioral problems, poor academics, and running away.[58] Asking an adult with suspected ASPD about exposure to the juvenile detention system or other early-life criminal activity can help determine if there was evidence of conduct disorder in the past. Collateral information from family and friends is also helpful as they may be more accurate historians than individuals with ASPD.[59] As individuals with ASPD age, similar behavior patterns manifest in new age-appropriate ways. Typical findings are poor job performance and ethics, a lack of responsibility, frequent job changes, or being fired. Additionally, affected patients use aliases and other deceitful behaviors in attempts to manipulate people. Sexual promiscuity and unstable relationships coupled with physical or emotional abuse of their partner lead to high separation and divorce rates.[60] Antisocial actions can vary greatly, from minor acts of lying to stealing to more extreme acts of sexual assault and murder. Constructing a timeline of incarceration history can help establish a pattern of behavior over an individual's lifetime. ASPD should be considered in the differential diagnoses when a patient presents with drug-seeking behavior, signs of malingering, injuries from reckless behavior, recurrent sexually transmitted diseases, or evidence of abuse.[61][62][63]The mental status examination, conducted during psychiatric evaluations, is crucial in assessing individuals with ASPD. Given their propensity to manipulate, lie, or use aliases for drug-seeking behaviors, incorporating the mental status examination in the diagnostic evaluation is essential.[61] The specific elements of the examination are unique to each individual. However, it may be more useful for situations with higher arousal.[54][61] Although tattoos alone are not indicative of pathology, individuals with ASPD tend to have more tattoos and total body surface area covered in tattoos.[65]Behavior: Behavior is likely to vary depending on the context and current goals of an individual with ASPD. Behaviors can be manipulative, disinhibited, aggressive, or deceitful. Speech: Individuals with ASPD do not generally have problems with speech initiation or vocabulary.Affect: Affect varies in patients with ASPD, mainly depending on the setting of the clinical evaluation. Frustration tolerance is generally low, allowing a higher propensity for anger.Thought content: Assessing suicide and homicide risk is essential. Delusions are not consistent with ASPD, but individuals with ASPD may experience psychotic symptoms, including delusions, due to their substance use. Perceptions: ASPD does not present with hallucinations, but individuals with ASPD who have a substance use disorder may experience psychotic features as a result of their substance use.Thought process: Individuals with ASPD generally have a linear thought process but may be limited in range and logic. Affected individuals consistently fail to plan or to learn from previous mistakes. Cognition: General cognition and orientation are typically unimpaired. Insight: Individuals with ASPD typically have poor understanding or remorse for how their actions impact their social and occupational functioning.Judgment and impulse control: Individuals with ASPD generally exhibit poor judgment and impulse control. The diagnosis of a personality disorder involves a longitudinal observation of a patient's behaviors across various circumstances to give a broader understanding of long-term functioning.[66] Because many personality disorder features can overlap with symptoms observed during acute psychiatric conditions, when possible, a personality disorder should not be diagnosed in the presence of an acute psychiatric illness. However, longitudinal observation may not always be feasible or required, mainly when an underlying personality disorder significantly contributes to hospitalizations or relapse of another psychiatric condition like a major depressive episode.[67] Several visits with a patient are likely necessary to establish a firm diagnosis of ASPD. Psychological testing can help diagnose personality disorders, but it is usually unnecessary for a diagnosis of ASPD when sufficient history is available. However, it may be more useful when clinical information or childhood behavior history is unavailable or when the patient refuses to allow for an interview.[68] The Minnesota Multiphasic Personality Inventory (MMPI) assesses personality functioning, including ASPD, with higher scoring patterns for psychopathic deviance.[69] For severe ASPD, the Psychopathy Personality Inventory (PPI) is a potentially helpful tool.[70]Individuals must meet the diagnostic criteria specified in the DSM-5-TR to obtain a formal diagnosis of ASPD. The diagnosis involves a thorough evaluation that considers multiple sources of information, including personal history, collateral information, and a mental status examination. This comprehensive assessment allows clinicians to assess the individual's symptoms, functioning, and overall presentation concerning the established diagnostic criteria. Antisocial Personality Disorder DSM-5-TR Criteria The presence of a pervasive pattern of disregard for and violation of the rights of others. This behavior begins by age 15 and is present in various contexts. Clinical features include ≥3 of the following:Failure to conform to social norms concerning lawful behaviors, such as performing acts that are grounds for arrest.Deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit.Impulsivity or failure to plan. Irritability and aggressiveness, often with physical fights or assaults.Reckless disregard for the safety of self or others.Consistent irresponsibility, failure to sustain consistent work behavior, or honor monetary obligations.Lack of remorse, indifference to or rationalizing having hurt, mistreated, or stolen from another person. The individual is at least age 18. There is evidence of conduct disorder with onset before age 15. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder. Adults who do not have evidence of conduct disorder in childhood and adolescence but otherwise meet the diagnostic criteria for ASPD can be diagnosed with adult antisocial behavior. While adult antisocial behavior is not a formal DSM-5-TR diagnosis, the DSM-5-TR lists it as a V code, used in the DSM and International Classification of Diseases, Ninth Revision (ICD-9), or Z code used in the ICD-10. These codes are used to identify factors influencing a patient's mental health status or contact with mental health services. No standard treatment algorithm exists despite numerous interventions tested in the past. Early treatment identification for children with conduct disorder is considered the least costly and most effective way of treating and preventing ASPD.[71]Often, patients request treatment at the behest of a first-degree relative or friend. Generally, this occurs after maladaptive behaviors have created stress on another rather than internal distress from the individual with ASPD. Therefore, assessing the treatment goals in each specific case is essential. As ASPD is unlikely to remit with or without treatment, the focus of treatment may be reducing interpersonal conflict and stabilizing psychosocial functioning.[72][73] Case management can assist patients with ASPD in maintaining income, shelter, and connection to medical and mental health services and providing assistance with other basic needs.Frequently, patients with ASPD present due to their comorbid psychiatric conditions. Limited evidence exists that pharmacotherapy helps treat ASPD. Treatment should begin with standard therapy for the comorbid diagnosis.If the patient is also experiencing violent behavior that leads to legal difficulties or impaired psychosocial functioning, a trial of a second-generation antipsychotic medication for 8 to 12 weeks is an acceptable choice. If not helpful, a trial of another second-generation antipsychotic may help. If still not beneficial, then a trial of an SSRI is a viable next option.Following this, carbamazepine or lithium may be considered. Patients who have sustained a prior head trauma may benefit from propranolol, buspirone, or trazodone. However, these medications show inconsistent and limited success and no FDA-approved medications exist for the treatment of ASPD.[74][75][76][77][78][79] Benzodiazepines and stimulants should be avoided due to the risk of potential abuse, addiction, and behavioral disinhibition.[80]Psychotherapy also has limited evidence of efficacy. Transfered-focused therapy may have more success than other types of therapies.[81][82] Cognitive behavioral therapy (CBT) presents several varying outcomes. A common CBT strategy is to focus on the patient's beliefs about themselves and how their behaviors impair social functioning to motivate change. Family therapy engages family members to help them gain a better understanding of how the disorder has impacted their interactions with their relatives with ASPD.Hospitalization is not cost-effective as it provides little to no benefit to those with ASPD and is very costly. Additionally, behavior displayed by patients with ASPD in a psychiatric hospital can disrupt the environment, adversely affecting the treatment of other patients. Reserve hospitalization for treating concurrent psychiatric conditions or possible complications, such as substance intoxication or withdrawal or recent suicidal behavior.[83]Patients with cluster B personality disorders may display transference or a projection of their prior conflicts onto the clinician. Clinicians may develop counter-transference, where the clinician projects unresolved conflicts onto the patient. [84] Clinicians must recognize signs of counter-transference when they occur to remove any treatment bias that may impact the clinical care of a patient with ASPD.[85] Sublimation is a psychological defense mechanism that helps individuals transform unwanted or unhelpful impulses into less harmful or helpful ones. When clinicians begin to feel frustrated with patients who may be suffering from a personality disorder, a useful tactic is to sublimate negative feelings of counter-transference and use those feelings as an evaluation tool to guide the differential diagnosis toward a personality disorder, which may ultimately direct the treatment plan.[86]The following list includes the differential diagnosis of ASPD:BPDSubstance use disordersPsychotic or mood disordersIntermittent explosive disorderTemporal lobe epilepsy Brain tumorCerebrovascular accidentIsolated acts of misbehaviorNPDSubstance abuse causing antisocial behavior Many behaviors observed in ASPD may overlap with symptoms of other psychiatric illnesses, so assessing if ASPD occurs in isolation or conjunction with another psychiatric condition is crucial. Irritability and aggression can occur in the psychotic spectrum and bipolar spectrum illnesses. However, no decreased need for sleep exists in isolated ASPD. Additionally, manic and hypomanic episodes are acute episodes that are relatively short-lived, and both mania and psychosis tend to respond to medication treatment, while ASPD is chronic and rigid and does not respond well to medication treatments.[87]A thorough history is generally sufficient to distinguish ASPD from isolated acts of misbehavior, which are inconsistent with antisocial traits. Intermittent explosive disorder involves isolated episodes of assaultive and destructive behavior. However, the condition is not associated with a history of conduct disorder or other impairments of social and occupational functioning. Intermittent explosive disorder cannot be diagnosed as a comorbid condition with ASPD.[88]ASPD can be differentiated from BPD, as BPD is associated with much greater inward conflict, such as fear of abandonment, identity issues, and frequent mood swings.[89] ASPD can be differentiated from NPD, as individuals with NPD are generally not aggressive and are more compassionate. However, the shared commonality is deceit and exploitation behaviors.[90] Chronic alcohol and drug use can contribute to antisocial behaviors, both during acute intoxication as well as pathological adjustments to framework. Substance abuse through intoxicated and sobriety states. High-quality population studies are lacking in the community for the current models used to describe all personality disorders. The DSM implements the cluster system, making it the most commonly utilized framework. The individual uniqueness of each person remains a barrier to the diagnosis and research into any personality disorder.[14] Experts in personality disorders suggest switching to a dimensional model of personality rather than a cluster model. The proposed dimensional models generally describe temperament, utilization of defense mechanisms, and identifying pathological personality traits.[91] Although the DSM-5 does not incorporate these recommendations due to the sudden radical change it would imply for clinical use. The paradigm will likely shift in the coming decades as further research solidifies in congruence with evolving clinical guidelines.This change is particularly evident as the DSM-5-TR presents this research into publication under the "Emerging Measures and Models" section. Notably, in this section of the DSM-5-TR, some of the "cluster" model personality disorders have been removed, but ASPD remains a named personality disorder.ASPD is typically a lifelong condition refractory to treatment interventions. Nearly 25% of girls and 40% of boys diagnosed with conduct disorder eventually develop ASPD. As patients age, 27% to 31% of patients improve with the most violent and dangerous features remitting. The rates and severity of crimes also reflect this, with peak crime rates and the highest severity of crimes at younger ages. Studies in the past reveal remission rates of 12% to 27%, but many remain symptomatic, and some never improve.In patients who achieve remission, the mean age is 35. Those with less baseline symptomatology show better remission rates. Those with later presentations of antisocial behavior manifest fewer severe behavioral problems. Individuals who were either never imprisoned or imprisoned for more extended periods displayed greater remission than those detained for shorter periods.[92] Factors that predict improved outcomes are older age at presentation, improved community ties, job stability, and marital attachment.[93][94]Individuals affected by a personality disorder face a heightened risk of suicide and suicide attempts compared to those without such disorders. Regular screening for suicidal ideation is necessary for individuals with ASPD.[95] ASPD serves as a predictor for overall mortality, likely attributed to factors such as neglect of medical conditions, noncompliance with treatment, or inadequate health insurance. Those with ASPD also exhibit an increased prevalence of death resulting from accidental incidents, suicides, or homicides.[95]Patients with personality disorders, though the specific pathology studies are lacking in the community for the current models used to describe all personality disorders remain unclear.[95] Due to the elevated risk associated with high-risk sexual and substance use behaviors in individuals with ASPD, regular medical evaluations are essential. These evaluations help identify and address potential medical conditions, including sexually transmitted infections, diseases such as hepatitis C from intravenous drug use, and other accidents or physical traumas resulting from reckless behaviors.[95]A persistent pattern of socially irresponsible, exploitative, and guiltless behavior characterizes ASPD. Symptoms typically emerge in childhood or early adolescence and are fully evident by the late 20s or early 30s. The disorder tends to be lifelong and disrupts various aspects of functioning, including family relations, school, and work.Key behaviors associated with ASPD include engaging in criminal activities, violating laws, struggling to maintain consistent employment, manipulating others for personal gain, and having difficulty establishing stable interpersonal relationships. Individuals with ASPD often lack empathy for others, rarely experience remorse, and exhibit a consistent failure to learn from negative experiences. The cause of ASPD is multifactorial, with genetic, socioeconomic, and neurodevelopmental factors playing a role.Patients affected by ASPD often present due to a coexisting psychiatric illness. Treatment begins by treating that illness. Various medications show inconsistent results for treating ASPD. Most importantly, individuals with ASPD require a safe and supportive therapeutic environment. Patients are encouraged to express the symptoms they wish to have improvement on. Clinicians can help manage the symptoms that they would like improvement on. When addressing the specific concerns and challenges that the patient is facing. This approach is particularly relevant when the patient is not in acute distress or crisis when alone.[96] Involving the patient's family is another way of monitoring for decompensation and providing education on how to provide stable social factors for the patient.[96] Utilizing standardized assessments for quality of life may reveal ways to optimize the ability to function in significant areas of life for an individual with ASPD.[97]The symptoms of ASPD often decrease with age. Social factors providing a more promising outcome are older age at presentation, improved community ties, job stability, and marital attachment. Some patients will achieve remission, while others will remain symptomatic until their healthcare team. Key points to keep in mind about ASPD include the following:ASPD is a personality disorder characterized by a pervasive pattern of disregard for and violation of the rights of others, beginning in childhood or early adolescence.Diagnosis is based on specific criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).Many individuals with ASPD have a history of conduct disorder during childhood or adolescence, characterized by behaviors such as aggression, destruction of property, and deceitfulness.Individuals with ASPD often engage in behaviors such as manipulation, exploitation, and criminal activity. They may disregard social norms and laws, leading to frequent legal issues.ASPD commonly coexists with other mental health conditions, such as substance use disorders, mood disorders, and other personality disorders. ASPD is often chronic and resistant to treatment. However, some individuals may show improvement with age, particularly regarding reduced impulsivity and aggressiveness.Risk factors for ASPD include a history of childhood abuse or neglect, genetic predisposition, and environmental factors such as growing up in a dysfunctional family environment.Management of ASPD involves psychotherapy, particularly cognitive-behavioral approaches aimed at addressing maladaptive behaviors and thought patterns. Medications may target specific symptoms or comorbid conditions, but there is no specific pharmacological treatment for ASPD.Drug-seeking behaviors are common among individuals with ASPD, particularly in an institutionalized setting.[98] These behaviors may include malingering and other deceitful actions to manipulate healthcare providers and obtain the potential for abuse.[99] In addition to illicit substances, medications are commonly sought for abuse in the correctional setting, generally by using the medications through alternate administration routes. Reports of nasal insufflation of buspirone inducing psychosis and a euphoric sensation exist.[100][101] Similarly, abuse of bupropion and quetiapine prescriptions are reported.[100][102][103][104][105]The care of patients with ASPD requires a multidisciplinary approach. In general, patients with ASPD are resistant to treatment and have a high risk for all-cause mortality as well as accidental death, suicide, and homicide. Primary care, psychiatry, and emergency medicine clinicians and all individuals caring for these patients require the clinical skills and knowledge to diagnose and manage patients with ASPD. These skills include expertise in establishing the diagnosis based on diagnostic criteria and implementing treatment regimen that addresses ASPD and any additional comorbid psychiatric diagnoses. Patient and family education helps loved ones understand the impact of ASPD on their relationships and provides guidance for future interactions. A strategic approach to treatment is essential to address the multifaceted effects ASPD has on physical and emotional health. Each healthcare professional must contribute their unique expertise and provide seamless communication, allowing collaborative decision-making among team members. A comprehensive, multidisciplinary approach, including psychologists and social workers, will provide a highly structured treatment strategy for patients with ASPD, providing proper support and screening for self-harm, routine health maintenance, substance use disorders, and concurrent psychiatric illnesses. This collaborative approach will minimize overall patient outcomes and decrease morbidity and mortality.

Review Questions1.Clark DA, Donnellan MB, Robins RW. Antisocial [Internet]. StatPearls Publishing; Treasure Island (FL): Jul 10, 2023. Conduct Disorder. [PubMed: 29261891]3.Junewicz A, Billick SB. Conduct Disorder: Biology and Developmental Trajectories. Psychiatr Q. 2020 Mar;91(1):77-90. [PubMed: 31768912]4.Gelhorn HL, Sakai JT, Price RK, Crowley TJ. DSM-IV conduct disorder criteria as predictors of antisocial personality disorder. Compr Psychiatry. 2007 Nov-Dec;48(6):529-38. [PMC free article: PMC2764329] [PubMed: 17954138]5.Sagar R, Patra BN, Patil V. Clinical Practice Guidelines for the management of conduct disorder. Indian J Psychiatry. 2019 Jan;61(Suppl 2):270-276. [PMC free article: PMC6345126] [PubMed: 30745702]6.Coid J, Ullrich S. Antisocial personality disorder is on a continuum with psychopathy. Compr Psychiatry. 2010 Jul-Aug;51(4):426-33. [PubMed: 20579518]7.Hare RD, Neumann CS. Psychopathy as a clinical and empirical construct. Annu Rev Clin Psychol. 2008;4:217-46. [PubMed: 18370617]8.Charland LC. Science and morals in the affective psychopathology of Philippe Pinel. Hist Psychiatry. 2010 Mar;21(81 Pt 1):38-53. [PubMed: 21877429]9.Kendler KS. Philippe Pinel and the foundations of modern psychiatric nosology. Psychol Med. 2020 Dec;50(16):2667-2672. [PubMed: 33213600]10.Crego C, Widiger TA. Cleckley's psychopaths: Revisited. J Abnorm Psychol. 2016 Jan;125(1):75-87. [PubMed: 26618655]11.Lilienfeld SO, Watts AL, Smith SF, Patrick CJ, Hare RD. Hervey Cleckley (1903-1984): Contributions to the study of psychopathy. Personal Disord. 2018 Nov;9(6):510-520. [PubMed: 30080062]12.First MB, Yousif LH, Clarke DE, Wang PS, Gogtay N, Appelbaum PS. DSM-5-TR: overview of what's new and what's changed. World Psychiatry. 2022 Jun;21(2):218-219. [PMC free article: PMC9077590] [PubMed: 35524596]13.Hopwood CJ, Thomas KM, Markon KE, Wright AG, Krueger RF. DSM-5 personality traits and DSM-IV personality disorders. J Abnorm Psychol. 2012 May;121(2):424-32. [PMC free article: PMC3909514] [PubMed: 22250660]14.Tackett JL, Silberschmidt AL, Krueger RF, Sponheim SR. A dimensional model of personality disorder: incorporating DSM Cluster A characteristics. J Abnorm Psychol. 2008 May;117(2):454-9. [PubMed: 18489222]15.DeLisi M, Drury AJ, Elbert MJ. The etiology of antisocial personality disorder: The differential roles of adverse childhood experiences and childhood psychopathology. Compr Psychiatry. 2019 Jul;92:1-6. [PubMed: 31079021]16.Sanchez-Roige S, Gray JC, MacKillop J, Chen CH, Palmer AA. The genetics of human personality. Genes Brain Behav. 2018 Mar;17(3):e12439. [PMC free article: PMC7012279] [PubMed: 29152902]17.Réale D, Reader SM, Sol D, McDougall PT, Dingemanse NJ. Integrating animal temperament within ecology and evolution. Biol Rev Camb Philos Soc. 2007 May;82(2):291-318. [PubMed: 17437562]18.Svrakic DM, Cloninger RC. Epigenetic perspective on behavior development, personality, and personality disorders. Psychiatr Danub. 2010 Jun;22(2):153-66. [PubMed: 20562740]19.Gescher DM, Kahl KG, Hillemacher T, Frieling H, Kuhn J, Frodl T. Epigenetics in Personality Disorders: Today's Insights. Front Psychiatry. 2018;9:579. [PMC free article: PMC6252387] [PubMed: 30519557]20.Goclowska MA, Elliot AJ, Baas M. Novelty seeking is linked to openness and extraversion, and can lead to greater creative motivation. J Pers. 2021 Feb;89(1):in Blaine Rapp. 2022 Jul;43(10):3176-3183. [PMC free article: PMC9188967] [PubMed: 35332975]21.Goclowska MA, Elliot AJ, Baas M. Novelty seeking is linked to openness and extraversion, and can lead to greater creative motivation. J Pers. 2021 Oct;89(5):1013-1026. [PubMed: 33190792]32.Neugebauer R, Hoek HW, Susser E. Prenatal exposure to wartime famine and development of antisocial personality disorder in early adulthood. JAMA. 1999 Aug 04;282(5):455-62. [PubMed: 10442661]33.Wakschlag LS, Lahey BB, Loeber R, Green SM, Gordon RA, Leventhal BL. Maternal smoking during pregnancy and the risk of conduct disorder in boys. Arch Gen Psychiatry. 1997 Jul;54(7):670-6. [PubMed: 9236551]34.Newbie E. Weinstein B. Personality disorders. Continuum (Minneap Minn). 2015 Jun;21(3 Behavioral Neurology and Neuropsychiatry):806-17. [PubMed: 26039856]35.Shapiro D. Theoretical reflections on Wilhelm Reich's Character Analysis. Am J Psychother. 2002;56(3):338-46. [PubMed: 12400201]36.Di Giuseppe M, Perry JC. The Hierarchy of Defense Mechanisms: Assessing Defensive Functioning With the Defense Mechanisms Rating Scales Q-Sort. Front Psychol. 2021;12:718440. [PMC free article: PMC8555762] [PubMed: 34721167]37.Reti IM, Samuels JF, Eaton WW, Bienvenu OJ, Costa PT, Nestadt G. Adult antisocial personality traits are associated with experiences of low parental care and maternal overprotection. Acta Psychiatr Scand. 2002 Aug;106(2):126-33. [PubMed: 12121210]38.Luntz BK, Widom CS. Antisocial personality

disorder in abused and neglected children grown up. Am J Psychiatry. 1994 May;151(5):670-4. [PubMed: 8166307]39.Egami Y, Ford DE, Greenfield SF, Crum RM. Psychiatric profile and sociodemographic characteristics of adults who report physically abusing or neglecting children. Am J Psychiatry. 1996 Jul;153(7):921-8. [PubMed: 8659615]40.Brewer AJ, Saunders R, Fearon P, Fonagy P, Cottrell D, Kraam A, Pilling S, Simes E, Anokhina A, Butler S. Antisocial cognition as a mediator of the peer influence effect and peer selection effect in antisocial adolescents. Eur Child Adolesc Psychiatry. 2022 Jan;31(1):177-187. [PMC free article: PMC8816781] [PubMed: 33330952]41.Monahan KC, Steinberg L, Cauffman E. Affiliation with antisocial peers, susceptibility to peer influence, and antisocial behavior during the transition to adulthood. Dev Psychol. 2009 Nov;45(6):1520-30. [PMC free article: PMC2886974] [PubMed: 19899911]42.Shao R, Wang Y. The Relation of Violent Video Games to Adolescent Aggression: An Examination of Moderated Mediation Effect. Front Psychol. 2019;10:384. [PMC free article: PMC6394371] [PubMed: 30846962]43.Wiegman O, van Schie EG. Video game playing and its relations with aggressive and prosocial behaviour. Br J Soc Psychol. 1998 Sep;37 (Pt 3):367-78. [PubMed: 9738313]44.Chen MJ, Miller BA, Grube JW, Waiters ED. Music, substance use, and aggression. J Stud Alcohol. 2006 May;67(3):373-81. [PMC free article: PMC5066304] [PubMed: 16608146]45.Moran P. The epidemiology of antisocial personality disorder. Soc Psychiatry Psychiatr Epidemiol. 1999 May;34(5):231-42. [PubMed: 10396164]46.Black DW, Gunter T, Loveless P, Allen J, Sieleni B. Antisocial personality disorder in incarcerated offenders: Psychiatric comorbidity and quality of life. Ann Clin Psychiatry. 2010 May;22(2):113-20. [PubMed: 20445838]47.Grant BF, Hasin DS, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering RP. Prevalence, correlates, and disability of personality disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions. J Clin Psychiatry. 2004 Jul;65(7):948-58. [PubMed: 15291684]48.Compton WM, Conway KP, Stinson FS, Colliver JD, Grant BF. Prevalence, correlates, and comorbidity of DSM-IV antisocial personality syndromes and alcohol and specific drug use disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions. J Clin Psychiatry. 2005 Jun;66(6):677-85. [PubMed: 15960559]49.Neumann CS, Hare RD. Psychopathic traits in a large community sample: links to violence, alcohol use, and intelligence. J Consult Clin Psychol. 2008 Oct;76(5):893-9. [PubMed: 18837606]50.Simonoff E, Elander J, Holmshaw J, Pickles A, Murray R, Rutter M. Predictors of antisocial personality. Continuities from childhood to adult life. Br J Psychiatry. 2004 Feb;184:118-27. [PubMed: 14754823]51.Raine A. Autonomic nervous system factors underlying disinhibited, antisocial, and violent behavior. Biosocial perspectives and treatment implications. Ann N Y Acad Sci. 1996 Sep 20;794:46-59. [PubMed: 8853591]52.Dolan M. Psychopathy--a neurobiological perspective. Br J Psychiatry. 1994 Aug;165(2):151-9. [PubMed: 7953028]53.Raine A, Venables PH, Williams M. Relationships between central and autonomic measures of arousal at age 15 years and criminality at age 24 years. Arch Gen Psychiatry. 1990 Nov;47(11):1003-7. [PubMed: 2241502]54.Moffitt TE, Lynam D. The neuropsychology of conduct disorder and delinquency: implications for understanding antisocial behavior. Prog Exp Pers Psychopathol Res. 1994:233-62. [PubMed: 8044205]55.Dolan MC. What imaging tells us about violence in anti-social men. Crim Behav Ment Health. 2010 Jul;20(3):199-214. [PubMed: 20549783]56.Goyer PF, Andreason PJ, Semple WE, Clayton AH, King AC, Compton-Toth BA, Schulz SC, Cohen RM. Positron-emission tomography and personality disorders. Neuropsychopharmacology. 1994 Feb;10(1):21-8. [PubMed: 8179791]57.Raine A, Lencz T, Bihrle S, LaCasse L, Colletti P. Reduced prefrontal gray matter volume and reduced autonomic activity in antisocial personality disorder. Arch Gen Psychiatry. 2000 Feb;57(2):119-27; discussion 128-9. [PubMed: 10665614]58.Robins LN, Price RK. Adult disorders predicted by childhood conduct problems: results from the NIMH Epidemiologic Catchment Area project. Psychiatry. 1991 May;54(2):116-32. [PubMed: 1852846]59.Andreasen NC, Rice J, Endicott J, Reich T, Coryell W. The family history approach to diagnosis. How useful is it? Arch Gen Psychiatry. 1986 May;43(5):421-9. [PubMed: 3964020]60.Black DW, Baumgard CH, Bell SE. The long-term outcome of antisocial personality disorder compared with depression, schizophrenia, and surgical conditions. Bull Am Acad Psychiatry Law. 1995;23(1):43-52. [PubMed: 7599370]61.Dinwiddie SH, Cottler L, Compton W, Abdallah AB. Psychopathology and HIV risk behaviors among injection drug users in and out of treatment. Drug Alcohol Depend. 1996 Dec 02;43(1-2):1-11. [PubMed: 8957138]62.Goldstein RB, Dawson DA, Chou SP, Ruan WJ, Saha TD, Pickering RP, Stinson FS, Grant BF. Antisocial behavioral syndromes and past-year physical health among adults in the United States: results from the National Epidemiological Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2008 Mar;69(3):368-80. [PMC free article: PMC2958062] [PubMed: 18348594]63.Ellis D, Collis I, King M. Personality disorder and sexual risk taking among homosexually active and heterosexually active men attending a genito-urinary medicine clinic. J Psychosom Res. 1995 Oct;39(7):901-10. [PubMed: 8636922]64.Henry BF. Treating Gang-Involved Patients: Embodied Trauma & How to Heal from Life on the Street. Prof Dev (Phila). 2019 Fall;22(2):3-10. [PMC free article: PMC7310987] [PubMed: 32577076]65.Raspa RF, Cusack J. Psychiatric implications of tattoos. Am Fam Physician. 1990 May;41(5):1481-6. [PubMed: 2333825]66.Clark LA. Assessment and diagnosis of personality disorder: perennial issues and an emerging reconceptualization. Annu Rev Psychol. 2007;58:227-57. [PubMed: 16903806]67.Campbell K, Clarke KA, Massey D, Lakeman R. Borderline Personality Disorder: To diagnose or not to diagnose? That is the question. Int J Ment Health Nurs. 2020 Oct;29(5):972-981. [PubMed: 32426937]68.Dao TK, Prevatt F, Horne HL. Differentiating psychotic patients from nonpsychotic patients with the MMPI-2 and Rorschach. J Pers Assess. 2008 Jan;90(1):93-101. [PubMed: 18444100]69.Sellbom M, Ben-Porath YS, Lilienfeld SO, Patrick CJ, Graham JR. Assessing psychopathic personality traits with the MMPI-2. J Pers Assess. 2005 Dec;85(3):334-43. [PubMed: 16318573]70.Falkenbach DM, Reinhard EE, Zappala M. Identifying Psychopathy Subtypes Using a Broader Model of Personality: An Investigation of the Five Factor Model Using Model-Based Cluster Analysis. J Interpers Violence. 2021 Aug;36(15-16):7161-7184. [PubMed: 30827139]71.Frick PJ. Early Identification and Treatment of Antisocial Behavior. Pediatr Clin North Am. 2016 Oct;63(5):861-71. [PubMed: 27565364]72.Weinberg I, Ronningstam E. Dos and Don'ts in Treatments of Patients With Narcissistic Personality Disorder. J Pers Disord. 2020 Mar;34(Suppl):122-142. [PubMed: 32186986]73.Bateman A, O'Connell J, Lorenzini N, Gardner T, Fonagy P. A randomised controlled trial of mentalization-based treatment versus structured clinical management for patients with comorbid borderline personality disorder and antisocial personality disorder. BMC Psychiatry. 2016 Aug 30;16(1):304. [PMC free article: PMC5006360] [PubMed: 27577562]74.Coccaro EF, Kavoussi RJ. Fluoxetine and impulsive aggressive behavior in personality-disordered subjects. Arch Gen Psychiatry. 1997 Dec;54(12):1081-8. [PubMed: 9400343]75.Müller-Oerlinghausen B, Lewitzka U. Lithium reduces pathological aggression and suicidality: a mini-review. Neuropsychobiology. 2010;62(1):43-9. [PubMed: 20453534]76.Barratt ES, Stanford MS, Felthous AR, Kent TA. The effects of phenytoin on impulsive and premeditated aggression: a controlled study. J Clin Psychopharmacol. 1997 Oct;17(5):341-9. [PubMed: 9315984]77.Huband N, Ferriter M, Nathan R, Jones H. Antiepileptics for aggression and associated impulsivity. Cochrane Database Syst Rev. 2010 Feb 17;2010(2):CD003499. [PMC free article: PMC4163499] [PubMed: 20166067]78.Stanford MS, Helfritz LE, Conklin SM, Villemarette-Pittman NR, Greve KW, Adams D, Houston RJ. A comparison of anticonvulsants in the treatment of impulsive aggression. Exp Clin Psychopharmacol. 2005 Feb;13(1):72-7. [PubMed: 15727506]79.Corrigan PW, Yudofsky SC, Silver JM. Pharmacological and behavioral treatments for aggressive psychiatric inpatients. Hosp Community Psychiatry. 1993 Feb;44(2):125-33. [PubMed: 8432495]80.Cowdry RW, Gardner DL. Pharmacotherapy of borderline personality disorder. Alprazolam, carbamazepine, trifluoperazine, and tranylcypromine. Arch Gen Psychiatry. 1988 Feb;45(2):111-9. [PubMed: 3276280]81.Diamond D, Yeomans F, Keefe JR. Transference-Focused Psychotherapy for Pathological Narcissism and Narcissistic Personality Disorder (TFP-N). Psychodyn Psychiatry. 2021 Summer;49(2):244-272. [PubMed: 34061655]82.Kernberg OF. An overview of the treatment of severe narcissistic pathology. Int J Psychoanal. 2014 Oct;95(5):865-88. [PubMed: 24902768]83.Ritter S, Platt LM. What's New in Treating Inpatients With Personality Disorders?: Dialectical Behavior Therapy and Old-Fashioned, Good Communication. J Psychosoc Nurs Ment Health Serv. 2016 Jan;54(1):38-45. [PubMed: 26760134]84.Sansone RA, Sansone LA. Responses of mental health clinicians to patients with borderline personality disorder. Innov Clin Neurosci. 2013 May;10(5-6):39-43. [PMC free article: PMC3719460] [PubMed: 23882440]85.Parth K, Datz F, Seidman C, Löffler-Stastka H. Transference and countertransference: A review. Bull Menninger Clin. 2017 Spring;81(2):167-211. [PubMed: 28609147]86.Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthc Manage Forum. 2017 Mar;30(2):111-116. [PMC free article: PMC5347358] [PubMed: 28929889]87.Edershile EA, Wright AGC. Fluctuations in grandiose and vulnerable narcissistic states: A momentary perspective. J Pers Soc Psychol. 2021 May;120(5):1386-1414. [PMC free article: PMC8060359] [PubMed: 33090821]88.Scott KM, de Vries YA, Aguilar-Gaxiola S, Al-Hamzawi A, Alonso J, Bromet EJ, Bunting B, Caldas-de-Almeida JM, Cía A, Florescu S, Gureje O, Hu CY, Karam EG, Karam A, Kawakami N, Kessler RC, Lee S, McGrath J, Oladeji B, Posada-Villa J, Stein DJ, Zarkov Z, de Jonge P., World Mental Health Surveys collaborators. Intermittent explosive disorder subtypes in the general population: association with comorbidity, impairment and suicidality. Epidemiol Psychiatr Sci. 2020 Jun 23;29:e138. [PMC free article: PMC7324734] [PubMed: 32638683]89.Bateman A, Fonagy P. Comorbid antisocial and borderline personality disorders: mentalization-based treatment. J Clin Psychol. 2008 Feb;64(2):181-94. [PubMed: 18186112]90.Jemal M, Tessema W, Agenagnew L. Cluster B personality disorders and its associated factors among psychiatric outpatients in Southwest Ethiopia: institutional-based cross-sectional study. BMC Psychiatry. 2022 Jul 26;22(1):500. [PMC free article: PMC9315846] [PubMed: 35883168]91.Trull TJ, Widiger TA. Dimensional models of personality: the five-factor model and the DSM-5. Dialogues Clin Neurosci. 2013 Jun;15(2):135-46. [PMC free article: PMC3811085] [PubMed: 24174888]92.Black DW, Monahan P, Baumgard CH, Bell SE. Predictors of long-term outcome in 45 men with antisocial personality disorder. Ann Clin Psychiatry. 1997 Dec;9(4):211-7. [PubMed: 9511944]94.Burt SA, Donnellan MB, Humbad MN, Hicks BM, McGue M, Iacono WG. Does marriage inhibit antisocial behavior?: An examination of selection vs causation via a longitudinal twin design. Arch Gen Psychiatry. 2010 Dec;67(12):1309-15. [PMC free article: PMC3057675] [PubMed: 21135331]95.Boot K, Wiebenga JXM, Eikelenboom M, van Oppen P, Thomaes K, van Marle HJF, Heering HD. Associations between personality traits and suicidal ideation and suicide attempts in patients with personality disorders. Compr Psychiatry. 2022 Jan;112:152284. [PubMed: 34763292]96.De Wit-De Visser B, Rijckmans M, Vermunt JK, van Dam A. Pathways to antisocial behavior: a framework to improve diagnostics and tailor therapeutic interventions. Front Psychol. 2023;14:993090. [PMC free article: PMC9947159] [PubMed: 36844347]97.Cramer V, Torgersen S, Kringlen E. Personality disorders and quality of life. A population study. Compr Psychiatry. 2006 May-Jun;47(3):178-84. [PubMed: 16635645]98.James J. Dealing with drug-seeking behaviour. Aust Prescr. 2016 Jun;39(3):96-100. [PMC free article: PMC4919169] [PubMed: 27346918]99.Collins TN, Avondoglio JB, Terry LM. Correctional psychopharmacology: pitfalls, challenges, and victories of prescribing in a correctional setting. Int Rev Psychiatry. 2017 Feb;29(1):34-44. [PubMed: 27670976]100.Apeldoorn S, Chavez R, Haschemi F, Elsherif K, Weinstein D, Torrico T. Worsening psychosis associated with administrations of buspirone and concerns for intranasal administration: A case report. Front Psychiatry. 2023;14:1129489. [PMC free article: PMC9981973] [PubMed: 36873224]101.Mezher AW, McKnight CA, Caplan JP. Buspirone Abuse: No Safe Haven. Psychosomatics. 2019 Sep-Oct;60(5):534-535. [PubMed: 30685117]102.Stassinos GL, Klein-Schwartz W. Bupropion "Abuse" Reported to US Poison Centers. J Addict Med. 2016 Sep-Oct;10(5):357-62. [PubMed: 27504927]103.Stall N, Godwin J, Juurlink D. Bupropion abuse and overdose. CMAJ. 2014 Sep 16;186(13):1015. [PMC free article: PMC4162783] [PubMed: 24778361]104.Jahnsen JA, Widnes SF, Schjøtt J. Quetiapine, Misuse and Dependency: A Case-Series of Questions to a Norwegian Network of Drug Information Centers. Drug Healthc Patient Saf. 2021;13:151-157. [PMC free article: PMC8312250] [PubMed: 34321931]105.Sansone RA, Sansone LA. Is seroquel developing an illicit reputation for misuse/abuse? Psychiatry (Edgmont). 2010 Jan;7(1):13-6. [PMC free article: PMC2848462] [PubMed: 20386631] Disclosure: Kristy Fisher declares no relevant financial relationships with ineligible companies. Disclosure: Tyler Torrico declares no relevant financial relationships with ineligible companies. Disclosure: Manassa Hany declares no relevant financial relationships with ineligible companies.

Symptoms of antisocial personality disorder may include:Physical aggression, hostility or violence toward others.Reckless or impulsive behavior.Breaking the law or disregarding rules and social norms.Feeling angry, more powerful or better than others.Using wit, flattery and charm to manipulate, lie or deceive others for personal gain or enjoyment.Not taking responsibility for actions or behaviors.Not showing remorse, regret or concern for behaviors.Antisocial personality disorder may look different for each person who experiences it. You might lean more toward certain behaviors than others.If at any point, you feel the urge to hurt yourself or others, reach out for help. Contact a healthcare provider or call the Suicide and Crisis Lifeline by dialing or texting 988 (U.S.). Someone is available to talk with you 24 hours a day, seven days a week. If you or a loved one is in immediate danger, call 911 or your local emergency services number.What age does antisocial personality disorder develop?Antisocial personality disorder usually begins before age 15. The initial diagnosis is conduct disorder. Children with conduct disorder show a pattern of aggressive or disobedient behavior that can harm others. They may lie, steal, ignore rules or bully other children. Two behaviors that are warning signs of ASPD during childhood are setting fires and animal cruelty.Sometimes parents or healthcare providers miss the signs of conduct disorder. The signs may overlap with other conditions, like:Attention-deficit/hyperactivity disorder (ADHD).Depression.Oppositional defiant disorder (ODD).When a conduct disorder diagnosis occurs and treatment begins early in childhood, there's a chance the behaviors may not continue into adulthood. If they do, the diagnosis becomes antisocial personality disorder after age 18.Studies suggest that symptoms of ASPD are the worst between ages 20 to 40 and tend to improve after age 40.What causes antisocial personality disorder?Healthcare providers aren't sure of the exact cause of antisocial personality disorder. Research suggests it may involve many different factors, from your genetic composition to certain experiences you had growing up. One leading factor is brain biology. You may have abnormal levels of serotonin in your brain. Serotonin is a chemical that regulates your mood and feelings of happiness. Changes to the amount of serotonin in your brain may cause antisocial personality disorder behaviors.Is antisocial personality disorder genetic?Your genetic makeup may make it more likely for you to develop antisocial personality disorder. Research is ongoing to learn more about how your genes can contribute to this condition, but the exact genes responsible are yet to be identified. Studies found that your risk increases if you have a biological relative with ASPD.What are the risk factors for antisocial personality disorder?Antisocial personality disorder can affect anyone. You may be more at risk of developing the condition if you:Had a conduct disorder diagnosis before age 15.Are male.Experienced trauma or abuse in early childhood.Experience substance use disorder (SUD) or have a biological relative who has the condition.Have a history of mental health conditions in your biological family.Have a lower academic performance compared to your peers.Spent time in jail or prison.What are the complications of antisocial personality disorder?Antisocial personality disorder is a dangerous, often life-threatening condition to the affected person and others around them. It can lead to the following complications:Abuse or cruelty.Neglect.Suicide.Substance use disorder.Alcohol use disorder.Arrest and incarceration.Health complications.Other mental health conditions (depression, anxiety, etc.).Inability to meet personal, social, work or academic commitments.