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Antisocial Personality Disorder – Case Study

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Antisocial (or **dissocial**) **personality disorder** is characterized by a pervasive pattern of disregard for, or violation of, the rights of others. There may be an impoverished moral sense or conscience and a history of crime, legal problems, and impulsive and aggressive behaviour.

I. Case Study Of Mr. X

Mr.X a 25 yrs old is admitted in the psychiatric ward diagnosed with anti social personality disorder presenting with clinical complaints such as impulsivity, repeatedly harming others, violating social norms, irritability and aggressiveness. He undergoes treatment for his psychiatric symptoms.

Incidence

The prevalence of the disorder is even higher in selected populations, like prisons, where there is a preponderance of violent offenders. A 2023 literature review of studies on mental disorders in prisoners stated that 47% of male prisoners and 21% of female prisoners had ASPD. Similarly, the prevalence of ASPD is higher among patients in alcohol or other drug (AOD) abuse treatment programs than in the general population.The APA's Diagnostic and Statistical Manual of Mental Disorders,(DSM IV-TR), defines antisocial personality disorder:

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three or more of the following:

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

B) The individual is at least age 18 years.
C) There is evidence of conduct disorder with onset before age 15 years.

D) The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.Antisocial Personality Disorder (ASPD) falls under the dramatic/erratic cluster of personality disorders, the so-called "Cluster B."

ICD-10

The WHO's *International Statistical Classification of Diseases and Related Health Problems*, tenth edition (ICD-10), has a diagnosis called dissocial personality disorder

It is characterized by at least 3 of the following:

- Callous unconcern for the feelings of others;
- Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations;
- Incapacity to maintain enduring relationships, though having no difficulty in establishing them;
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
- Incapacity to experience guilt or to profit from experience, particularly punishment;
- Marked readiness to blame others or to offer plausible rationalizations for the behaviour that has brought the person into conflict with society.

Causes

Personality disorders seem to be caused by a combination of these genetic and environmental influences. Genetically, it is the temperament and the kind of personality a person is born with, and environmentally, it is the way in which a person grows up and the experiences they have had.

Hormones and neurotransmitters

Traumatic events can lead to a disruption of the standard development of the central nervous system, which can generate a release of hormones that can change normal patterns of development. Aggressiveness and impulsivity are among the possible symptoms of ASPD. Testosterone is a hormone that plays an important role in aggressiveness in the brain.

Cultural influences

The socio-cultural perspective of clinical psychology views disorders as influenced by cultural aspects; since cultural norms differ significantly, mental disorders such as ASPDare viewed differently. Robert D. Hare has suggested that the rise in ASPD that has been reported in the United States may be linked to changes in cultural mores, the latter serving to validate the behavioral tendencies of many individuals with ASPD.

Environment

Some studies suggest that the social and home environment has contributed to the development of antisocial behavior. The parents of these children have been shown to display antisocial behavior, which could be adopted by their children.

Head injuries

Researchers have linked physical head injuries with antisocial behavior.Since 1980s; scientists have associated traumatic brain injury, including damage to the prefrontal cortex, with an inability to make morally and socially acceptable decisions

Treatment

Anger control:

Usually offered to children who are aggressive at school, anger control includes a number of cognitive and behavioural techniques similar to cognitive problem-solving skills training (see below). It also includes training of other skills such as relaxation and social skills.

Brief strategic family therapy:

An intervention that is systemic in focus and is influenced by other approaches. The main elements include engaging and supporting the family, identifying maladaptive family interactions and seeking to promote new and more adaptive family interactions.

Cognitive problem-solving skills training:

An intervention that aims to reduce children's conduct problems by teaching them different responses to interpersonal situations. Using cognitive and behavioural techniques with the child, the training has a focus on thought processes. The training includes:

• Teaching a step-by-step approach to solving interpersonal problems
• Structured tasks such as games and stories to aid the development of skills
•Combining a variety of approaches including modelling and practice, role-playing and reinforcement.

Functional family therapy: a family-based intervention that is behavioural in focus. The main elements include engagement and motivation of the family in treatment, problem-solving and behaviour change through parent-training and communication-training, and seeking to generalise change from specific behaviours to positively influence interactions both within the family and with community agencies such as schools.

Multidimensional treatment foster care: using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people in foster care and other out-of-home placements.

Multisystemic therapy:
Using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people.

Parent-training programmes: an intervention that aims to teach the principles of child behaviour management, to increase parental competence and confidence in raising children and to improve the parent/carer–child relationship by using good communication and positive attention to aid the child's development.

Self-talk: the internal conversation a person has with themselves in response to a situation. Using or changing self-talk is a part of anger control training

Social problem skills training: a specialist form of cognitive problem-solving training that aims to:
• Modify and expand the child's interpersonal appraisal processes through developing a more sophisticated understanding of beliefs and desires in others
• Improve the child's capacity to regulate his or her own emotional responses.

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