

# ANTISOCIAL PERSONALITY DISORDER ABOUT ANDROPAUSE

SOURCE: AMERICAN PSYCHIATRIC ASSOCIATION (APA)

## Diagnostic criteria

- A. There is 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
  - Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - Impulsivity or the failure to plan ahead
  - Irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - Reckless disregard for the safety of self or others
  - Consistent irresponsibility, as indicated by repeated 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.

## Medical treatment

## Basic principles

- Treatment with medications has not proved helpful.
- Non-compliance or abuse of drugs interferes with their use for alleviation of peripheral symptoms.
- There is some evidence that the depression that is encountered in some patients with antisocial personality disorder late in life or during intensive treatment may have physiological features.

## Hospitalization

Definitive inpatient treatment must be carried out in a specialized unit. Deficits in the truly psychopathic patients which must be addressed during the intensive residential treatment are the inability to trust, to fantasize, to feel, and to learn.

Successful inpatient programs should involve long-term, strictly structured, hierarchical settings in which every aspect of the patient's life affects, and is affected by, his progress. Some control the patient's administrative status as well as other parts of their life from the day they enter hospital. They begin with very few privileges except that of being treated like a human being. As they slowly move through a four-or-five-step hierarchy of privileges, they acquire more and more self-esteem, awareness of their emotional life, and social and interpersonal competence, leading to less need for the antisocial character style.

In addition to the rigorous structure there should always be time for reflection, during which, particular in the early stages, the





patient may become 'emotional' without exposing themselves completely to others (although sharing one's feelings with others is a necessary later part of the treatment program).

Such inpatient/residential programs take years to complete, are moderately expensive (although far less than ineffective incarceration), and tend to have good results, particularly if the patient receives community follow-up by the same team, which treated them as an inpatient.

### **Antidepressant drugs**

There is no reported study of the use of antidepressants for this condition.

## **Psychosocial treatment**

### **Basic principles**

The importance of differentiation of the diagnosis of Antisocial Personality from other psychiatric diagnoses and non-illness conditions (e.g., Adult Antisocial Behavior,) cannot be overstated. Clinicians continue to treat antisocial symptoms and behaviors as if they represented the personality disorder itself, however. This approach interferes with adequate treatment planning and often leads to poor response of the patient.

When speaking of treatment of Antisocial Personality, one is speaking of adults (not children or 'juvenile delinquents'). It is a known fact that most characterologically antisocial persons do not actively seek therapy; however, they may come in for treatment in a variety of ways, the most familiar being within a forensic setting. The traditional need for motivation in

psychotherapy is not quite as important here as it is for neurotic disorders. It may be possible for the therapist to find reasons which will keep the patient working in treatment (e.g., to be released from incarceration). In addition, under some circumstances, the patient may begin to experience some form of dysphoria, usually either temporary anxiety about some life situation or depression. The latter may arise late in the natural course of the personality disorder, because of containment in a hospital or a prison in which self-stimulation is impossible, or during psychotherapy itself.

It is important to recognize that this is a repetitive pattern of behavior that seems to limit itself after age 40 and that has been unresponsive to most therapeutic interventions.

In trying to treat antisocial personalities, the therapist must remember that they uniformly lacked benevolent, sustained relationships with their parents. They are afraid of intimacy and of assuming responsibility for it. They cannot believe that others can tolerate their anxiety, and all devoutly fear responsibility for achieving success by open competition.

They can neither identify with authority nor accept this criticism, and they resent any thwarting of their actions, even when such intervention is clearly in their interest. Their consciences are too rigid, not too lenient and so they reject all moral standards and ideals, rather than experience their punitive self-judgment.

Before treatment can begin, firm limits are critical. The therapist must find some way of dealing with the patient's self-defeating





behavior. To overcome the patients' fear of intimacy, the therapist must frustrate the patient's wish to run from tenderness and from the honest pain of human encounter. In doing so, the therapist faces the challenge of separating control from punishment and separating help and confrontation from social isolation and retribution. Antisocial Personalities are made worse by good defense lawyers. They are not helped by being protected from their own anxiety or from the consequences of their behavior. Antisocial personalities should be encouraged to find alternate defense mechanisms. As a young child, the therapist does not tell an antisocial personality to stop doing something but provides the patient with an alternative.

### **Individual psychotherapy**

The outpatient treatment of these people is fraught with difficulty, much of which is based upon the continuing availability of ways in which the patient can escape from any exploration of his fragile core. Many of these are either seductive or frustrating for the therapist; countertransference issues are so important that intensive psychotherapists with such patients are encouraged to seek professional supervision. For those patients who do become engaged in intensive therapy, the most reliable sign of progress is the development of affect. The first affect seen is often depression, which is both surprising and uncomfortable for the patient, who is not used to experiencing such feelings. At this point the therapist should become supportive and empathic, helping the patient to understand that the discomfort is a sign of progress, that it is

bearable, and that patient and therapist will work together to understand it.

### **Group therapy**

Once the antisocial personality feels that he is among peers, the lack of motivation for change disappears. Perhaps that is why, in alleviating those disorders, self-help groups have been more useful than jails or psychiatric hospitals.

### **Family therapy**

The family of the patient deserves education and counselling. Families are often confused by the problems that the patient causes or encounters despite his superficially normal appearance. This confusion, guilt, the temptation to make restitution for the patient's criminal acts, and the frustrations of working with someone who is seen to be quite ill but who will not be treated should all be discussed openly with the family members. It is suggested that the family read Cleckley's *The Mask of Sanity* (1976).

### **Other psychosocial therapies**

Only group membership or caring for others, or both, can eventually provide adults with the parenting they never received. Antisocial personalities, so often neglected in childhood, need to absorb more of other people than one person, no matter how loving, can ever provide. Membership in altruistic but revolutionary movements, self-help groups, such as AA, and even marriage to a person as needy as the patient - all seem to be more useful to the antisocial personality than one-to-one therapy.





"The single largest barrier is  
ignorance."

