

Antisocial Personality Disorder: Decoding the Dark Mind

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Antisocial personality disorder (ASPD) is defined by the American Psychiatric Association's Axis II (personality disorders) of the Diagnostic and Statistical Manual (DSM-IV-TR) as "...a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood."

Antisocial personality disorder is sometimes referred to as psychopathy or sociopathy; however, many scholars make distinctions among these terms, though there remains no academic consensus as to their definitions. Currently, for this reason, neither psychopathy nor sociopathy are valid diagnoses described in the Diagnostic and Statistical Manual of Mental Disorders, and the ICD-10 of the World Health Organization also lacks psychopathy as a diagnostic disorder. Psychopathy is normally seen as a subset of the antisocial personality disorder, but Blair believes that the antisocial personality disorder and psychopathy may be separate conditions altogether.

Diagnosis

DSM

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR = 301.7, a widely used manual for diagnosing mental disorders, defines antisocial personality disorder (in Axis II Cluster B) as:

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;
deception, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure;
impulsiveness 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 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.

New evidence points to the fact that children often develop Antisocial Personality Disorder as a cause of their environment, as well as their genetic line. The individual must be at least 18 years of age to be diagnosed with this disorder (Criterion B), but those commonly diagnosed with ASPD as adults were diagnosed with Conduct Disorder as children. The prevalence of this disorder is 3% in males and 1% from females, as stated from the DSM IV-TR.

Criticism

Researchers debate about whether psychopathy/sociopathy are incorrectly put together under ASPD. These clinicians and researchers who believe that it was incorrect to label the two in the same category are upset that an important distinction has been lost between these two disorders. In other words, the DSM-IV-TR considers ASPD and psychopathy to be the same, or similar. However, they are not the same since antisocial personality disorder is diagnosed via behavior and social deviance, whereas psychopathy also includes affective and interpersonal personality factors.

Other criticisms of ASPD are that it is essentially synonymous with criminality. Nearly 80%-95% of felons will meet criteria for ASPD -- thus ASPD predicts nothing in criminal justice populations, whereas psychopathy (using the Hare Psychopathy Checklist-Revised (PCL-R)) is found in only roughly 20% of inmates and PCL-R is considered one of the best predictors of violent recidivism. Also, the DSM-IV field trials never included incarcerated populations.

The official stance of the American Psychiatric Association as presented in the DSM-IV-TR is that "psychopathy" and "sociopathy" are obsolete synonyms. The World Health Organization takes a similar stance in its ICD-10 by referring to psychopathy, antisocial personality, asocial personality, and amoral personality as synonyms for dissocial personality disorder.

WHO

The World Health Organization's ICD-10 defines a conceptually similar disorder to antisocial personality disorder called (F60.2) Dissocial personality disorder.

It is characterized by at least 3 of the following:

Callous unconcern for the feelings of others and lack of the capacity for empathy.

Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.

Incapacity to maintain enduring relationships.

Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.

Incapacity to experience guilt and to profit from experience, particularly punishment.

Markedly prone to blame others or to offer plausible rationalizations for the behavior bringing the subject into conflict.

Persistent irritability.

The criteria specifically rule out conduct disorders. Dissocial personality disorder criteria differ from those for antisocial and sociopathic personality disorders.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Theodore Millon identified five subtypes of antisocial behavior. Any antisocial individual may exhibit none, one or more than one of the following:

covetous antisocial - variant of the pure pattern where individuals feel that life has not given them their due.

reputation-defending antisocial - including narcissistic features

risk-taking antisocial - including histrionic features

nomadic antisocial - including schizoid, avoidant features

malevolent antisocial - including sadistic, paranoid features.

Differential diagnosis

The following conditions commonly coexist with antisocial personality disorder:

Anxiety disorders

Depressive disorder

Substance-related disorders

Somatization disorder

Borderline personality disorder

Histrionic personality disorder

Narcissistic personality disorder

When combined with alcoholism, people may show frontal function deficits on neuropsychological tests greater than those associated with each condition.

Treatment

To date there have been no controlled studies reported which found an effective treatment for ASPD, although contingency management programs, or a reward system, has been shown

moderately effective for behavioral change. Some studies have found that the presence of ASPD does not significantly interfere with treatment for other disorders, such as substance abuse, although others have reported contradictory findings. Schema therapy is being investigated as a treatment for antisocial personality disorder, as well as medicinal marijuana treatments.

Epidemiology

Antisocial personality disorder is seen in 3% to 30% of psychiatric outpatients. The prevalence of the disorder is even higher in selected populations, such as people in prisons (who include many violent offenders). Similarly, the prevalence of ASPD is higher among patients in alcohol or other drug (AOD) abuse treatment programs than in the general population (Hare 1983), suggesting a link between ASPD and AOD abuse and dependence.

Related terms

Psychopathy and sociopathy are terms related to ASPD, considered by many scholars to be obsolete terms. Psychopathy once referred to ASPD in general, but is now (like sociopathy) occasionally classified as a subset of ASPD. No scientific or academic consensus exists as to the specific differences between the three terms.

Psychopathy

Psychopathy (/sa'pʰɪkə'pəθi/) was, until 1980, the term used for a personality disorder characterized by an abnormal lack of empathy combined with strongly amoral conduct but masked by an ability to appear outwardly normal. The publication of DSM-III changed the name of this mental disorder to Antisocial Personality Disorder and also broadened the diagnostic criteria considerably by shifting from clinical inferences to behavioral diagnostic criteria. However, the DSM-V working party is recommending a revision of Antisocial Personality Disorder to include "Antisocial/Psychopathic Type", with the diagnostic criteria having a greater emphasis on character than on behavior. The ICD-10 diagnostic criteria of the World Health Organization also lacks psychopathy as a personality disorder, its 1992 manual including Dissocial (Antisocial) Personality Disorder, which encompasses amoral, antisocial, asocial, psychopathic, and sociopathic personalities.

Sociopathy

Hare writes that the difference between sociopathy and psychopathy may "reflect the user's views on the origins and determinates of the disorder."

In the preface to the fifth edition of *The Mask of Sanity*, Cleckly stated, "... revisions of the nomenclature have been made by the American Psychiatric Association. The classification of psychopathic personality was changed to that of sociopathic personality in 1958", suggesting that he did not recognize any difference between the conditions.

David T. Lykken proposed psychopathy and sociopathy are two distinct kinds of antisocial personality disorder. He believed psychopaths are born with temperamental differences such as impulsivity, cortical underarousal, and fearlessness that lead them to risk-seeking behavior and an inability to internalize social norms. On the other hand, he claimed that sociopaths have relatively normal temperaments; their personality disorder being more an effect of negative sociological factors like parental neglect, delinquent peers, poverty, and extremely low or extremely high intelligence. Both personality disorders are the result of an interaction between genetic predispositions and environmental factors, but psychopathy leans towards the hereditary whereas sociopathy tends towards the environmental.

Antisocial Personality Disorder: Summarized

Antisocial Personality Disorder

Antisocial personality disorder is characterized by a long-standing pattern of a disregard for other people's rights, often crossing the line and violating those rights. It usually begins in childhood or as a teen and continues into their adult lives.

Antisocial personality disorder is often referred to as psychopathy or sociopathy in popular culture.

Individuals with Antisocial Personality Disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy and may be particularly distinguishing of Antisocial Personality Disorder in prison or forensic settings where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships.

Symptoms of Antisocial Personality Disorder

Antisocial personality disorder is diagnosed when a person's pattern of antisocial behavior has

occurred since age 15 (although only adults 18 years or older can be diagnosed with this disorder) and consists of the majority of these symptoms:

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 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 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

As with all personality disorders, the person must be at least 18 years old before they can be diagnosed with it. There should also be evidence of Conduct Disorder in the individual as a child, whether or not it was ever formally diagnosed by a professional.

Antisocial personality disorder is more prevalent in males (3 percent) versus females (1 percent) in the general population.

Like most personality disorders, antisocial personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

How is Antisocial Personality Disorder Diagnosed?

Personality disorders such as antisocial personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. There are no laboratory, blood or genetic tests that are used to diagnose antisocial personality disorder.

Many people with antisocial personality disorder don't seek out treatment. People with personality disorders, in general, do not often seek out treatment until the disorder starts to significantly interfere or otherwise impact a person's life. This most often happens when a person's coping resources are stretched too thin to deal with stress or other life events.

A diagnosis for antisocial personality disorder is made by a mental health professional comparing

your symptoms and life history with those listed here. They will make a determination whether your symptoms meet the criteria necessary for a personality disorder diagnosis.

Causes of Antisocial Personality Disorder

Researchers today don't know what causes antisocial personality disorder. There are many theories, however, about the possible causes of antisocial personality disorder. Most professionals subscribe to a biopsychosocial model of causation -- that is, the causes of are likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible -- rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children.

Antisocial Personality Disorder Treatment

Introduction

Antisocial personality disorder is often misunderstood by both professionals and laypeople. Confused with the popular terms, "sociopath" or "psychopath," someone who suffers from this disorder can be discriminated against within the mental health system, because of the symptoms of their disorder. Because there is usually a pervasive lack of remorse, and many time any feelings at all, they are assumed not to have any real feelings by many professionals. This can lead to difficulties within treatment.

Psychotherapy is nearly always the treatment of choice for this disorder; medications may be used to help stabilize mood swings or specific and acute Axis I concurrent diagnoses. There is no research that supports the use of medications for direct treatment of antisocial personality disorder, though.

Psychotherapy

As with most personality disorders, individuals with this disorder rarely seek treatment on their own, without being mandated to therapy by a court or significant other. Court referrals for assessment and treatment for this disorder are likely the most common referral source. A careful and thorough assessment will ensure that the person that the person has antisocial personality disorder. This can often be confused with simple criminal activity (all criminals do not have this disorder), adult antisocial behavior, and other activities which do not justify the personality disorder

diagnosis. As with a thorough assessment of any suspected personality disorder, formal psychological testing should be considered invaluable.

Because many people who suffer from this disorder will be mandated to therapy, sometimes in a forensic or jail setting, motivation on the patient's part may be difficult to find. In a confined setting, it may be nearly impossible and therapy should then focus on alternative life issues, such as 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 feelings (or lack thereof). Common in the population who suffer from antisocial personality disorder is the lack of connections between feelings and behaviors. Helping the client draw those lines between the two may be beneficial.

Threats are never an appropriate motivating factor in any sort of treatment, and least of all with this disorder. 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 within therapy anyway. 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. For instance, ensuring that they not come into contact with the court system again, be incarcerated, have to submit themselves to additional psychological examinations, etc.

Effective psychotherapy treatment for this disorder is limited. It is likely, though, that intensive, psychoanalytic approaches are inappropriate for this population. Approaches that reinforce appropriate behaviors and attempting to make connections between the person's actions and their feelings may be more 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. The therapeutic relationship, therefore, can be one of the first ones. This can be very scary for the client, initially, and it may become intolerable. A close therapeutic relationship can only occur when a good and solid rapport has been established with the client and he or she can trust the therapist implicitly.

Trust brings up the issue of confidentiality, since often the patient with antisocial personality disorder is mandated to therapy. This means that the clinician may have to occasionally report on the patient's progress in therapy. While this can usually be done in a very general way which reveals no significant details of the content of therapy, it is still an important issue for the client. He or she may be suspicious and distrustful of the clinician at first, since it will be unclear as to who has the highest priority -- the patient or the court. This fear can only be alleviated with an honest disclosure as to what the therapist will reveal to the courts, and with time, as the client learns that what he says in the therapy session does not become common knowledge. The limitations of therapy should be discussed with the patient up-front, in a clear and matter-of-fact manner, so

there are no misunderstandings later.

The content of therapy should focus on the patient's emotions (or lack thereof). 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. Reinforcing any emotions, outside of anger or frustration, is usually beneficial. 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 emotional states.

People who have antisocial personality disorder often experience difficulties with authority figures. The therapist should usually take a neutral stance in this matter, since it is a firmly held belief by the client. The clinician should avoid arguments and taking sides on authority issues and those who hold authority over the client. Their moral and ethical makeup may leave a lot to be desired as well. While this may be an appropriate topic for discussion in therapy, it will also likely be one of little progress. 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.

Other modalities of psychotherapy, such as group and family therapy, can be helpful. Often people with this disorder find themselves in a group setting, because they aren't given any treatment choices. This is usually not conducive to their treatment, since in most groups, the individual can remain emotionally-closed and has little reason to share with others. It also doesn't help that these groups are often made up of people suffering from a wide range of mental disorders. 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. Care must be utilized by group leaders to ensure the group doesn't become a "How-to" course in criminal behavior. 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. Phillip W. Long, M.D. adds, "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 family members."

While there are many theories, as with all personality disorders, research has found little significant causative factors.

Hospitalization

Rarely is inpatient care appropriate or necessary for this personality disorder. Like most personality disorders, most people will go through their lives with little realization of the difficulty they have. In this case, though, the person is more likely to be seen as a criminal and have a history of difficulties with the law. Loss of freedom may be more of a motivating factor than in other personality disorders, so some specialized treatment facilities have started to treat people with this disorder.

One such program we've read about is the Patuxent Institute, located in Jessup, Maryland in the U.S. This hospital utilizes a strict behavioral approach of placing patients on a token economy based upon their treatment progress. This is a relatively new and radical approach to this sort of disorder and little research has been conducted to confirm its long-term effectiveness.

As with any treatment, the focus on feelings and connecting antisocial behavior to appropriate feeling states is appropriate. Since inpatient programs tend to be more intensive and expensive, they are rarely sought out by the patient themselves. Community followup and support, either by the hospital or professionals, or with the use of self-help support groups, is imperative to maintaining treatment gains.

Medications

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.

Self-Help Strategies

Self-help methods for the treatment of this disorder are often overlooked by the medical profession because very few professionals are involved in them. Groups can be especially helpful for people with this disorder, if they are tailored specifically for antisocial personality disorder. Individuals with this disorder typically feel more at ease in discussing their feelings and behaviors in front of their peers in this type of supportive modality. Leaders of such self-help support groups, though, must be wary of individuals who come to group just to brag about their exploits and who may seek to use the group inappropriately. Usually a group can be very helpful and beneficial to most people with this disorder, once they overcome their initial fears and hesitation to join such a group. Many support groups exist within communities throughout the world which are devoted to helping individuals with this disorder share their common experiences and feelings.