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Antisocial Personality Disorder and Delinquency Treatment and Outcomes

Dr. Jasbir Rishi

Associate Professor,Department of Psychology,HMV, Jalandhar

ABSTRACT

*Antisocial personality disorder (**ASPD**) is the name of the disorder as defined in the Diagnostic and Statistical Manual (DSM). **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 behavior. The use of the term antisocial disorder dates back only to DSM-III in 1980, but many of central features of this disorder have long been labeled as Psychopathy or SociopathyAntisocial personality disorder is 70 percent more prevalent in males than females. The 12-month prevalence rate of this disorder is between 0.2 and 3.3 percent.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.*

The delinquent behavior includes such acts as destruction of property, violence against other people, and various behaviors contrary to the needs and rights of others and in violation of society's law (Henggeler,1989). The term juvenile delinquency is a legal one; it refers to illegal acts committed by individuals under the age 16, 17, or 18 (depending on state law).The term juvenile delinquency applies to violation of criminal code and certain patterns of behavior that are not approved for children and young adolescents. Of the total delinquencies committed by the juveniles, hardly 2 per cent come to the notice of the police and the courts

ASPD is considered to be among the most difficult personality disorders to treat. Gabbard, and John(2000), Because of their very low or absent capacity for remorse, individuals with ASPD often lack sufficient motivation and fail to see the costs associated with antisocial acts. Therapists of individuals with ASPD may have considerable negative feelings toward clients with extensive histories of aggressive, exploitative, and abusive behaviors. Rather than attempt to develop a sense of conscience in these individuals, therapeutic techniques should be focused on rational and utilitarian arguments against repeating past mistakes.In this paper various therapeutic techniques are evaluated and the conclusion is that the best treatment or combination of treatments depends on each person's particular situation and severity of symptoms.

Key-words: Anti-social personality disorder(APSD), Deliquency, Therapeutic techniques, Treatment and DSM

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INTRODUCTION

Antisocial personality disorder is a type of chronic mental condition in which a person's ways of thinking, perceiving situations and relating to others are dysfunctional — and destructive. People with antisocial personality disorder typically have no regard for right and wrong and often disregard the rights, wishes and feelings of others.

Those with antisocial personality disorder tend to antagonize, manipulate or treat others either harshly or with callous indifference. They may often violate the law, landing in frequent trouble, yet they show no guilt or remorse. They may lie, behave violently or impulsively, and have problems with drug and alcohol use. These characteristics typically make people with antisocial personality disorder unable to fulfill responsibilities related to family, work or school.

Antisocial personality disorder (**ASPD**) is the name of the disorder as defined in the *Diagnostic and Statistical Manual* (DSM). **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 behavior.

The use of the term antisocial disorder dates back only to DSM-III in 1980, but many of central features of this disorder have long been labeled psychopathy or sociopathy. Although several investigators identified the syndrome in the nineteenth century under such labels as ‘ moral insanity” (Prichard, 1835), psychopathy was first carefully described by Cleckley (1941,1982) in the1940s. In addition to the defining features of antisocial personality in DSM-III and DSM-IV, Psychopathy also includes such traits as lack of empathy, inflated and arrogant self-appraisal, and glib and superficial charm**.**

INCIDENCE

Antisocial personality disorder is 70 percent more prevalent in males than females. The 12-month prevalence rate of this disorder is between 0.2 and 3.3 percent.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.

ASPD is seen in 3% to 30% of psychiatric outpatients. The prevalence of the disorder is even higher in selected populations, like prisons, where there is a preponderance of violent offenders. A 2002 literature review of studies on mental disorders in prisoners stated that 47% of male prisoners and 21% of female prisoners had ASPD. Fazel et.al(2002). 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.Moeller, F.Gerad,D,Donald,M(2008).

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society's law (Henggeler,1989). The term juvenile delinquency is a legal one; it refers to illegal acts committed by individuals under the age 16, 17, or 18 (depending on state law).

The term juvenile delinquency applies to violation of criminal code and certain patterns of behavior that are not approved for children and young adolescents.

Of the total delinquencies committed by the juveniles, hardly 2 per cent come to the notice of the police and the courts. The statistics compiled by the National Crime Records Bureau, Delhi give some indication of the incidence of juvenile delinquency in India. Up to 1987, every year about 50 thousand delinquencies were committed under the Indian Penal Code (IPC) and about 85 thousand under the local and special laws.

But the new definition of a juvenile delinquent after the enforcement of the Juvenile Justice Act in October 1987 (passed in 1986) excludes males in the age-group of 16 to 21 years and females in the age-group of 18 to 21 years. Crime cases attributed to juveniles naturally have been reduced now. This is why juvenile delinquency in and after 1988, compared to 1987 and earlier years has decreased both under the IPC and the local and special laws.

In 1988, about 25 thousand to be delinquencies under the IPC and about 25 thousand delinquencies under the local and special laws were committed. About 14,500 juveniles are apprehended (about 8,500 or 59% under the IPC and about 6,000 or 41 under the local and special laws) in a year for different crimes (Crime in India, 1994).

The percentage of juvenile crime to total cognizable crime in India in 1994 was about 0.5% (in 1988 it was 1.7%). Before 1988, this percentage (of juvenile delinquency to total cognizable crime) was about 4.

In India the highest number of delinquencies committed by the juveniles under the IPC is against property, that is, theft, burglary, robbery, and dacoity. In 1994, these four crimes accounted for 44 per cent of the total cognizable crimes under the IPC committed by the juveniles (theft-28%, burglary-15.1%, robbery-0.6%, and dacoity-0.4%). This was 9.7 per cent more as compared to the percentage of similar crimes committed by the adult criminals. Apart from property crimes, 7.4 per cent juveniles were apprehended for riots, 3.4 per cent for murder, 2.1 per cent for rape, and 1.1 per cent for kidnapping and abduction.

The largest contribution under the local and special laws in 1994 was from offences under the Prohibition Act (11.1%) and the Gambling Act (6.1%) (upto 1987, it was 27% and 21% respectively). The incidence of juvenile delinquency varies widely in different states. Four states—Maharashtra (22.9%), Madhya Pradesh (23.7%), Bihar (10.6%) and Gujarat (11.9%)—account for 69.1 per cent of the total juvenile delinquencies under the IPC in the entire country. For crimes under the local and special laws, two states—Tamil Nadu (59.1 %) and Maharashtra (10.2%) account for 69.3 per cent of the total offences (Crime in India, 1994).

Out of about 17,203 juveniles apprehended and sent to the courts in 1994 for delinquencies under the IPC and LSL, 22.9 per cent were sent to their homes after advice/admonition, 19.7 per cent were released on probation, 5.5 per cent were sent to special homes, 7 per cent were fined and 6.5 per cent were acquitted. About 38.4 per cent cases remained pending.

Constant exposure to violence, no fear of law and lack of understanding about the consequences of committing a crime have made children prone to violence. Quoting a study, mental health

experts said there has been a 300% increase in the number of children committing heinous crimes in the past three years, and most of them were found to be influenced by their surroundings. In 2013, juveniles in conflict with law were found to be involved in 163 cases of rape and 76 cases of murder.

Times of India reported that 18% rise in crime by juveniles (20 Aug 2015). It further stated that an increasing involvement of juveniles in crime has been a major cause of concern for Delhi Police for the past few years. According to the NCRB data, cases involving juvenile offenders have gone up by 18%--2,876 minors were tracked down in 1,946 criminal cases registered in 2014.In 2013, the figure was 2,140 against 1,590 cases. Last year, 585 juveniles were charged with theft. Like 2013, they were found to be involved in more rape cases than murders.

Of the 2,876 juveniles apprehended, 2,547 were found to be involved in cognizable offences; 1,001 were sent home after admonition and advice, while 474 were released on probation. As many as 382 juveniles were sent to special homes, 40 faced fines and 146 were acquitted. The number pending cases stood at 648.

Among those apprehended, 771 had dropped out of school at the higher secondary level; 122 were primary school dropouts, and 767 were illiterate. As many as 2,118 were found to be living with their parents, while 84 were homeless. A total of 1,252 children came from families with an annual income below Rs 25,000, while 687 belonged to the income group of Rs 25,001-Rs 50,000 per annum.

In 2014, juveniles were involved in 1,007 cases of theft, burglary or snatching, followed by 134 cases of rape and 70 murder. Of the total number of apprehended juveniles, 1,500 were in the age-group of 16-18 years.

Treatment and Outcomes in Antisocial Personality Disorder and Delinquency

ASPD is considered to be among the most difficult personality disorders to treat Gabbard, and John(2000), Because of their very low or absent capacity for remorse, individuals with ASPD often lack sufficient motivation and fail to see the costs associated with antisocial acts. They may only simulate remorse rather than truly commit to change: they can be seductively charming and dishonest, and may manipulate staff and fellow patients during treatment. Studies have shown that outpatient therapy is not likely to be successful, however the extent to which persons with ASPD are entirely unresponsive to treatment may have been exaggerated.

Those with ASPD may stay in treatment only as required by an external source, such as a parole. Residential programs that provide a carefully controlled environment of structure and supervision along with peer confrontation have been recommended. There has been some research on the treatment of ASPD that indicated positive results for therapeutic interventions. However this treatment requires complete cooperation and participation of all family members, Gatzke, Raine,(2000), Some studies have found that the presence of ASPD does not significantly interfere with treatment for other disorders, such as substance abuse Darke, Blatt,(1996), although others have reported contradictory findings.

Therapists of individuals with ASPD may have considerable negative feelings toward clients with extensive histories of aggressive, exploitative, and abusive behaviors. Rather than attempt to develop a sense of conscience in these individuals, therapeutic techniques should be focused on rational and utilitarian arguments against repeating past mistakes.

The best treatment or combination of treatments depends on each person's particular situation and severity of symptoms.

Psychotherapy

Psychotherapy, also called talk therapy, is sometimes used to treat antisocial personality disorder. Psychotherapy is not always effective, especially if symptoms are severe and the person can't admit that he or she contributes to problems.

Psychotherapy may be provided in individual sessions, in group therapy, or in sessions that include family or even friends.

Medications

There are no medications specifically approved by the Food and Drug Administration to treat antisocial personality disorder. However, several types of psychiatric medications may help with certain conditions sometimes associated with antisocial personality disorder or with symptoms such as aggression. These medications may include antipsychotic, antidepressant or mood-stabilizing medications. They must be prescribed cautiously because some have the potential for misuse.

Skills for family members

If you have a loved one with antisocial personality disorder, it's critical that you also get help for yourself. Mental health professionals with experience managing this condition can teach you skills to learn how to set boundaries and help protect yourself from the aggression, violence and anger common to antisocial personality disorder. They can also recommend strategies for coping.

Complications, consequences and problem in treatment of antisocial personality disorder include:

- Aggressiveness leading to verbal or physical violence
- Gang participation
- Reckless behavior
- Risky sexual behavior
- Child abuse
- Alcohol or substance abuse
- Gambling problems
- Being in jail or prison

- Homicidal or suicidal behaviors
- Relationship difficulties
- Occasional periods of depression or anxiety
- School and work problems
- Strained relationships with health care providers
- Low social and economic status, and homelessness
- Premature death, usually as a result of violence

Traditional psychotherapeutic approaches have not proven effective in altering psychopathic and antisocial personalities. For example, in a treatment program for opiate addicts, those individuals with diagnosed psychopathy were the most difficult to treat and had the most negative outcomes-that is they got worse or failed to improve (Woody et al., 1985).

Therapists must be vigilant for the possibility that the psychopathy patient may attempt to manipulate them, and that the information provided about and fabrications (Lion,1978). Even biological treatment measures for psychopathic personalities-including electroconvulsive therapy or drugs have not done much better. Antianxiety drugs may also have some beneficial effects in lowering hostility levels (Kellner, 1982), and drugs used to treat bipolar disorder such as lithium and Carbazemine had good results.

Behavior therapists have dealt successful with specific antisocial behaviors, and their techniques appear to offer some promise of more effective treatment. (Bandura, 1969, Sutker, Archer,& Kilpatrick,1979).On the basis of a now- classic review of research findings, Bandura (1969) Suggested three steps that can be used to modify antisocial behavior through the application of learning principles.

(a) The withdrawal of meaningful reinforcements for antisocial behavior, and where appropriate, the use of punishment for such behavior.

(b) The model of desired behavior by charge agents- the therapist and other behavior models who are admired and the use of a graded system of rewards or reinforces for imitating such behavior.

(C) The reduction of material incentive and rewards as the individuals behavior is increasingly brought under the control of self administered, symbolic rewards.

Many psychopathic and antisocial personalities improve after the age of 40 even without treatment, possibly because of weaker biological drives, better insight into self-defeating behaviors, and the cumulative effects of social conditioning. Such individuals are often referred to as burned-out psychopaths. Hare Mc Pherson, and Forth (1988) confirmed the hypothesis that psychopaths tend to burn out over time. They followed up a group of male psychopaths and tracked their criminal careers beyond age 40. They found a clear and dramatic reduction in criminal behavior after age 40.they were quick to note, however, that even with this reduction in criminal behavior, over 50 percent of these people continued being arrested after age 40. Even with the prospect that they might eventually engage in less destructive behavior, psychopaths can

create a great deal of havoc before they reach 40-as well as afterward if they do not change. Moreover, Harpur and Hare (1994) have also shown that it is only the antisocial behavioral dimension of psychopathy that diminishes with age; the egocentric, callous, and exploitative affective and interpersonal dimension does not.

REFERENCES

i. American Psychiatric Association (2000). "Diagnostic criteria for 301.7 Antisocial Personality Disorder". BehaveNet. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Retrieved 8 July 2013.

ii. Beck, Aaron T., Freeman, Arthur, Davis, Denise D. (2006) Cognitive Therapy of Personality Disorders. Second Edition. The Guilford Press. ISBN 978-1-59385-476-8

iii. Dissocial personality disorder – International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)

iv. David P. Farrington, Jeremy Coid (16 June 2003). Early Prevention of Adult Antisocial Behavior. Cambridge University Press. p. 82. ISBN 978-0-521-65194-3. Retrieved 12 January 2008.

v. Gabbard, Glen O., Gunderson John G. (2000) Psychotherapy for Personality Disorders. First Edition. American Psychiatric Publishing. ISBN 978-0-88048-273-8.

vi. Darke, S; Finlay-Jones, R; Kaye, S; Blatt, T (1996). "Anti-social personality disorder and response to methadone maintenance treatment". Drug and alcohol review **15** (3): 271–6. doi:10.1080/09595239600186011. PMID 16203382.

vii. Fazel, Seena; Danesh, John (2002). "Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys". The Lancet **359** (9306): 545. doi:10.1016/S0140-6736(02)07740-1

viii. Gatzke L.M, Raine A. (2000). Treatment and Prevention Implications of Antisocial Personality Disorder [1] Current Science Inc. Department of Psychology, University of Southern California. 2:51–55

ix. Hare, R. D. (2003). Manual for the Revised Psychopathy Checklist (2nd ed.). Toronto, ON, Canada: Multi-Health Systems

x. Hare, R.D., Hart, S.D., Harpur, T.J. Psychopathy and the DSM—IV Criteria for Antisocial Personality Disorder

xi. Kendler Kenneth S., Muñoz Rodrigo A., George Murphy M.D. (2009). "The Development of the Feighner Criteria: A Historical Perspective". Am J Psychiatry **167**: 134–142. doi:10.1176/appi.ajp.2009.09081155

xii. Patrick, Christopher (2005). Handbook of Psychopathy. Guilford Press. ISBN 9781606238042. Retrieved 18 July 2013.

xiii. "Psychopathy and Antisocial Personality Disorder: A Case of Diagnostic Confusion". Robert D. Hare, PhD Psychiatric Times. Vol. 13 No. 2. 1 February 1996.

xiv. Mayo Clinic staff (12 April 2013). "Antisocial personality disorder: Treatments and drugs". Mayo Clinic. Mayo Foundation for Medical Education and Research. Retrieved 17 December 2013.

xv. Millon, Theodore, Personality Disorders in Modern Life, 2004

xvi. Moeller, F. Gerard; Dougherty, Donald M. (2006). "Antisocial Personality Disorder, Alcohol, and Aggression" (PDF). Alcohol Research & Health. National Institute on Alcohol Abuse and Alcoholism. Retrieved 20 February 2007.

xvii. Millon, Theodore – Personality Subtypes. Millon.net. Retrieved on 7 December 2011.

xviii. "Antisocial personality disorder". Mayo Foundation for Medical Education and Research. 13 July 2013. Retrieved 25 October 2013.

xix. Moore TM, Scarpa A, Raine A. (2002). "A meta-analysis of serotonin metabolite 5-HIAA and antisocial behavior". Aggressive Behavior. **28** (4): 299–316. doi:10.1002/ab.90027. :10.1192/bjp.bp.110.078485. .

xx. Sutker, Patricia B., and Albert N. Allain, Jr. "Antisocial Personality Disorder." Comprehensive Handbook of Psychopathology. Vol. III. : Springer US, 2002. 445-90. Google Scholar. Web. 13 March 2013

xxi. Stone, Michael H. (1993) Abnormalities of Personality. Within and Beyond the Realm of Treatment. Norton. ISBN 978-0-393-70127-2

xxii. Semple, David (2005). The Oxford Handbook of Psychiatry. USA: Oxford University Press. pp. 448–449. ISBN 0-19-852783-7.

xxiii. Skeem, J. L.; Polaschek, D. L. L.; Patrick, C. J.; Lilienfeld, S. O. (15 December 2011). "Psychopathic Personality: Bridging the Gap Between Scientific Evidence and Public Policy". Psychological Science in the Public Interest **12** (3): 95–162. doi:10.1177/1529100611426706.

xxiv. WHO (2010)ICD-10: Clinical descriptions and diagnostic guidelines: Disorders of adult personality and behavior .

xxv. Simonoff E, Elander J, Holmshaw J, Pickles A, Murray R, Rutter M (2004). "Predictors of antisocial personality Continuities from childhood to adult life". The British Journal of Psychiatry **200** (2): 118–127. doi:10.1192/bjp.184.2.118. PMID 14754823.

xxvi. World Health Organization (1992). International Statistical Classification of Diseases and Related Health Problems-10th revision.