PERSONALITY DISORDERS

Antisocial Personality Disorder

ASPD

DSM-5-TR 301.7 | ICD-10-CM F60.2

Pervasive disregard for and violation of the rights of others since age 15, with deceit, impulsivity, aggression and absent remorse.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1-4% (US adults)	Conduct sx before age 15	~3-5:1 male:female	Peaks in 20s, declines 40s

CLINICAL PICTURE

- Patients arrive through court mandates, incarceration, or employer pressure rather than seeking help voluntarily for internal distress.
- History reveals early conduct problems including truancy, fighting, cruelty to animals, fire setting, theft and running away before age 15.
- Repeated unlawful acts, deceitfulness, use of aliases, and conning others for personal profit or pleasure characterize the adult pattern.
- Impulsivity and failure to plan ahead produce unstable employment, financial irresponsibility, unpaid debts and repeated relocation.
- Irritability and aggressiveness drive assaults and intimate partner violence alongside reckless disregard for the safety of self and others.
- Remorse is absent or superficial, with harm rationalized, minimized or blamed on the victim, and surface charm often masks this in interview.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires three or more adult features since age 15 among unlawful acts, deceit, impulsivity, aggression, recklessness, irresponsibility and lack of remorse.
- Evidence of conduct disorder with onset before age 15 is mandatory, which makes a detailed childhood history essential rather than optional.
- The individual must be at least 18 years old, and conduct disorder remains the appropriate diagnosis for anyone younger than that.
- The antisocial behavior must not occur exclusively during the course of schizophrenia or during bipolar manic episodes.
- Psychopathy is not a DSM diagnosis; DSM-5-TR notes it as a related construct assessed with the **PCL-R** using affective and interpersonal traits.

NEUROBIOLOGY & PHYSIOLOGY

- Heritability of antisocial behavior approaches 50%, and the interaction of low-activity **MAOA** genotype with maltreatment is well replicated.
- Reduced prefrontal gray matter, especially orbitofrontal and ventromedial, correlates with poor inhibition and disadvantageous decision-making.
- Amygdala hypoactivity to fearful faces and to distress cues underlies deficient fear conditioning and impaired empathic responding.
- Low resting heart rate and reduced skin conductance reactivity are among the best-replicated biological markers of antisocial behavior.
- Serotonergic hypofunction with low CSF 5-HIAA correlates with impulsive aggression rather than with premeditated instrumental violence.
- Traumatic brain injury, obstetric complications, childhood lead exposure and prenatal alcohol exposure each raise risk substantially.

PSYCHOLOGICAL MECHANISMS

- Callous-unemotional traits in childhood predict a more severe, persistent and treatment-resistant adult antisocial trajectory.
- Deficient passive avoidance learning means punishment fails to shape behavior, while reward dominance sustains approach despite consequences.
- Hostile attribution bias in social information processing makes ambiguous cues read as threat, which appears to justify preemptive aggression.
- Early attachment disruption, harsh and inconsistent discipline, and coercive family process modeling shape the developmental pathway.
- Moral reasoning stays instrumental, so rules are followed only when surveillance and contingencies make compliance personally profitable.

DIFFERENTIAL & COMORBIDITY

- Distinguish substance-related criminality, where antisocial acts occur only during intoxication or in the service of sustaining drug use.
- Differentiate narcissistic, borderline and histrionic personality disorders; exploitation without impulsivity or aggression favors narcissistic PD.
- Comorbidity is heavy: alcohol and drug use disorders in over half, plus ADHD, depression and gambling disorder; anxiety is often underrecognized.
- Assess violence risk with structured instruments such as the **HCR-20** and **PCL-R**, and consider duty-to-protect obligations where indicated.
- Screen for malingering and secondary gain in forensic contexts, and clarify the limits of confidentiality before beginning any assessment.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is approved for ASPD, so pharmacotherapy targets comorbid conditions and aggression rather than the personality structure itself.
- Treat comorbid substance use aggressively with **naltrexone**, acamprosate or buprenorphine, since sustained sobriety measurably reduces offending.
- Mood stabilizers including **lithium** and valproate have reduced impulsive aggression in correctional trials; monitor serum levels and adherence.
- Second-generation antipsychotics such as risperidone may reduce aggression, but metabolic risk and thin evidence argue against routine use.
- Avoid benzodiazepines and stimulants where possible, given disinhibition, diversion and high misuse potential in this population.

PSYCHOTHERAPY

- NICE recommends group-based cognitive and behavioral offending-behavior programs for adults under community or institutional supervision.
- **Multisystemic therapy** and functional family therapy for adolescents with conduct disorder carry the strongest preventive evidence base.
- Contingency management and structured therapeutic communities outperform insight-oriented work, which can inadvertently sharpen manipulation skills.
- Motivational interviewing engages ambivalence about consequences, so frame change around self-interest rather than empathy for victims.
- Maintain firm limits, thorough documentation and regular consultation, since boundary testing and clinician manipulation are predictable.

ADJUNCT & SUPPORTIVE

- Coordination with probation, parole and the courts creates external contingencies that outperform voluntary clinical structure on its own.
- Prioritize substance use treatment, vocational rehabilitation, stable housing and literacy programs, all of which measurably reduce recidivism.
- Early intervention for conduct disorder through parent management training remains the only approach with strong preventive evidence.
- Use structured risk assessment at defined intervals rather than clinical impression, and document threats and protective actions carefully.
- Attend to clinician safety through interview room setup, alarm access and team debriefing whenever threats or intimidation occur.

CLINICAL PEARLS

- No conduct disorder before age 15 means no ASPD; the childhood history is a hard requirement.
- Psychopathy is a PCL-R construct, not a DSM-5-TR diagnosis, and the two only partly overlap.
- Antisocial behavior often declines after age 40, but callous traits tend to persist.

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NOTE

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