Dissocial Personality Disorder

Synonym: antisocial personality disorder

This article refers to the International Classification of Diseases 10th edition (ICD-10) which is the official classification system for mental health professionals working in NHS clinical practice. The literature occasionally refers to the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system which - whilst used in clinical practice in the USA - is primarily used for research purposes elsewhere.

Dissocial personality disorder is one of ten personality disorders defined in the ICD-10 classification system. It is called antisocial personality disorder in the DSM-IV and DSM-5 classification systems and is still sometimes referred to as such by professionals in the UK. For more information, see separate Personality Disorders and Psychopathy article.

People with dissocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours, including irresponsible and exploitative behaviour, recklessness and deceitfulness.\(^1,2\)

People with dissocial personality disorder have often grown up with parental conflict and harsh inconsistent parenting. Their childhoods have typically featured parental inadequacies and often transfer of care to outside agencies. Associated with this is a high incidence of truancy, delinquency and substance misuse.\(^3\) This in turn results in increased rates of unemployment, problems with housing and difficulties with relationships. Many people with dissocial personality disorder have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour.\(^1,2\)

Criminal behaviour is central to the definition of dissocial personality disorder but there is much more to the disorder than just criminal behaviour. It is often preceded by other long-standing difficulties (socio-economic, educational, family, relationship). Psychopathy is considered to be a considerably severe form of dissocial personality disorder.\(^2\)

The National Institute for Health and Care Excellence (NICE) guidance exemplifies a progression from recognition and definition towards more effective management. The challenge posed by this guidance to the mental health services, substance misuse services, social care and criminal justice system is considerable.\(^1\)

Epidemiology\(^1\)

- The prevalence of dissocial personality disorder in the general population varies depending on the method used and geographical location. Two European studies reported a prevalence of 1-1.3% in men and 0-0.2% in women.
- The prevalence of dissocial personality disorder among prisoners is less than 50%.
- However, only 47% of people with dissocial personality disorder have significant arrest records.

Presentation

Features include:

- Unstable interpersonal relationships.
- Disregard for the consequences of their behaviour.
- A failure to learn from experience.
- Egocentricity.
- A disregard for the feelings of others.
- A wide range of interpersonal and social disturbance.
- Comorbid depression and anxiety.
- Comorbid alcohol and drug misuse.

It is important to note that dissocial personality disorder is not formally diagnosed before the age of 18 but there may be a history of conduct disorders before this age.

Conduct disorders may be manifested as antisocial, aggressive or defiant behaviour, which is persistent and repetitive. This includes aggressive behaviour (to people or animals), destruction of property, deceitfulness, theft and serious rule-breaking.

Diagnostic criteria\(^4\)
The DSM-IV criteria were criticised for focusing on the antisocial aspect of the disorder at the expense of the underlying personality structure. It is believed that this resulted in over-diagnosis in some settings such as prisons and under-diagnosis in the community. The insistence that conduct disorder in childhood had to be a prerequisite also presented problems. DSM-5 has addressed some of these criticisms as has the ICD-10 system on which this article is based.

The ICD-10 criteria
The general criteria of personality disorder (F60) must be met.

At least three of the following must be present:

- 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, although having no difficulty to establish them.
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
- Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.
- Marked proneness to blame others, or to offer plausible rationalisations for the behaviour bringing the subject into conflict with society.

Persistent irritability and the presence of conduct disorder during childhood and adolescence are not required for the diagnosis.

Differential diagnosis
Diagnosis can be very difficult because of overlapping features and the high frequency of comorbid conditions and problems. Premorbid and developmental history from third parties can be helpful when making a diagnosis:

- Alcoholism.
- Mental disorders secondary to medical conditions (head injuries, seizure disorders).
- Anxiety disorders.
- Other personality disorders.
- General learning disability.
- Brief psychotic disorder.
- Post-traumatic stress disorder.
- Depression.
- Schizoaffective disorder.
- Schizophrenia.
- Ganser’s syndrome.

Investigations

- Toxicology screen because substance abuse is common (as with many personality disorders). Intoxication can lead patients to present with some features of personality disorders.[6]
- Screening for HIV and other sexually transmitted infections may be appropriate because of the poor impulse control and disregard of risk associated with dissocial personality disorder.[8]
- Psychological testing may support or direct the clinical diagnosis. Those cited by NICE are:[7]
  - Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV)
  - Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II)
  - Structured Interview for DSM-IV Personality (SIDP-IV)
  - International Personality Disorder Examination (IPDE)
  - Personality Assessment Schedule (PAS)
  - Standardised Assessment of Personality (SAP).

Associated diseases[2]

- Anxiety.
- Alcohol misuse.
- Drug misuse.
- Depression.
- Attention deficit hyperactivity disorder (ADHD) in childhood.

Management[1, 8]

Dissocial personality disorder poses a big challenge to the different agencies which frequently and, almost inevitably, have to manage individuals with this disorder. Management by any single agency is not usually possible or recommended. Management in general practice alone is not recommended and referral to psychiatric services is essential.

Practice tips

- Such patients can create very difficult and frightening problems for staff in primary healthcare.
It is important to identify patients who have dissocial personality disorders and enlist help with appropriate referral. It is also important to identify patients at risk of violent behaviour. Assessing risk of violence is not routine in primary care but, if such assessment is required, consider:

- Current or previous violence, including severity, circumstances, precipitants and victims.
- The presence of comorbid mental disorders and/or substance misuse.
- Current life stressors, relationships and life events.
- Additional information from written records or families and carers (subject to the person's consent and right to confidentiality) because the person with dissocial personality disorder might not always be reliable.

Once identified, a tailored management plan can be used to avoid crises and violent episodes. This will involve staff training and collaboration with other agencies. Use of 'panic buttons', chaperones and other measures should be considered.

The treatment of people with dissocial personality disorder must involve a wide range of services including particularly:

- Mental health services.
- Substance misuse services.
- Social care.
- The criminal justice system and associated forensic mental health services.[2]

Drug treatment

No drug has UK marketing authorisation specifically for the treatment of dissocial personality disorder. However, antidepressants and antipsychotics are often used to treat some of the associated problems and symptoms in a crisis situation. NICE recommends that medication should be used for no longer than a week.[7] A Cochrane review studied bromocriptine, nortriptyline and phenytoin but could come to no firm conclusion. However, the authors recommended further research on these drugs.[9]

Psychological treatments

Psychotherapy is at the core of care for personality disorders generally. In theory, psychotherapy aims to help patients cope with the disorder by, for example:

- Improving perceptions of social and environmental stressors.
- Improving responses to social and environmental stressors.

Different types of psychotherapy have been used to try to achieve such aims. Cognitive behavioural therapy (CBT) and group psychotherapy are perhaps the most widely used and available forms of psychotherapy. These should target reduction in offending and antisocial behaviour.[1]

Other considerations[1]

- Good communication is essential between all concerned but especially between healthcare professionals and people with dissocial personality disorder.
- NICE recommends that services should consider establishing dissocial personality disorder networks, where possible linked to other personality disorder networks. They may be organised at the level of primary care trusts, local authorities, strategic health authorities or government offices. These networks should be multi-agency.
- Treatment and care should take into account people's needs and preferences. People with dissocial personality disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the person is aged under 16, healthcare professionals should follow the guidelines in 'Seeking consent: working with children'.[10]
- If the person agrees, carers (who may include family and friends) should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

Complications[2]

- Suicide
- Substance abuse
- Accidental injury
- Depression
- Homicide

Prognosis[2]

The disorder used to be thought of as lifelong. However, a growing body of research suggests that positive changes can be seen over time. Many patients no longer meet the diagnostic criteria for the condition after a decade. It is acknowledged that the condition is difficult to diagnose and that misdiagnosis may be partly to blame for this 'improvement' but it is also considered that many patients do respond to therapeutic interventions. Core characteristics such as lack of empathy do not lessen but evidence suggests that patients develop more control over their impulsivity and cultivate a sense of responsibility.
Prevention

The incidence of dissocial personality disorder is reduced during times of war and in many Asian cultures. This suggests that social cohesion and an emphasis on communities rather than individuals are significant preventative factors.\(^2\) Families or carers are thus important in prevention and treatment of dissocial personality disorder.\(^1\) NICE suggests that services should establish robust methods to identify children at risk of developing conduct problems and that vulnerable parents could be identified antenatally. For example, identifying:

- Parents with other mental health problems, or with significant drug or alcohol problems.
- Mothers aged younger than 18, particularly those with a history of maltreatment in childhood.
- Parents with a history of residential care.
- Parents with significant previous or current contact with the criminal justice system.

The interventions employed after identification of at-risk parents are many and varied according to the problems identified and the age. Examples include:

- Parenting courses
- Anger management
- Cognitive problem solving
- Family therapy
- Multi-systemic therapy
- Multidimensional treatment
- Foster care

Further reading & references


1. Antisocial personality disorder; NICE Clinical Guideline (January 2009)
2. Working with offenders with personality disorders - a practitioners guide; National Offender Management Service and NHS England (September 2015)
4. The ICD-10 Classification of Mental and Behavioural Disorders; World Health Organization
5. First M et al; Clinical Guide to the Diagnosis and Treatment of Mental Disorders, 2011.
10. Reference guide to consent for examination or treatment (second edition); Dept of Health

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