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ANTISOCIAL PERSONALITY DISORDER: An Exploration and Discussion of the Experience, Impact and Opinions of the Diagnosed Individual.

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A thesis submitted to the
Department of Graduate Studies
of McGill University in
partial fulfillment of the
requirements for the
degree of Master of Social Work

August 2009

Abstract

It is important for the medical community, specifically mental health professionals, to understand the complexities that influence the diagnosis of Antisocial Personality Disorder. Social influences and experiences have a direct influence on how an individual understands his/her role within the various social systems that they will navigate throughout their lifetime.

I have undertaken a phenomological study that looks at the social experiences of three men who have been labeled with Antisocial Personality Disorder. Accounts of their experiences are contrasted and compared to draw out similarities and consistent themes that have shaped these mens' lives as they are today.

From a client-centred model of care, it is important for mental health professionals to understand these experiences and interpretations as it impacts that quality of mental health services that are providing. It also influences the manner in which mental health professionals view models of recovery when working with this specific population.

Résumé

Il est important pour la communauté médicale, plus précisément des professionnels de santé mentale, à comprendre les complexités qui influent sur le diagnostic de trouble de Antisocial Personality Disorder. Influences sociales et des expériences ont une influence directe sur la façon dont une personne comprend son rôle au sein des différents systèmes sociaux qu'ils vont naviguer dans toute leur durée de vie.

J'ai entrepris une étude de phenomological qui se penche sur les expériences sociales des trois hommes qui ont été intitulées avec trouble de Antisocial Personality Disorder Les comptes de leurs expériences sont contrastées et par rapport à attirer les similitudes et cohérentes des thèmes qui ont façonné vie ces mens ’ qu'ils sont aujourd'hui.

D'un modèle axé sur le client de soins, il est important pour professionnels de santé mentale de comprendre ces expériences et des interprétations qu'il a un impact que la qualité des services de santé mentale qui fournissent des. Elle influence également la manière dans laquelle les professionnels de santé mentale afficher les modèles de recouvrement lorsque vous travaillez avec cette population spécifique.

Acknowledgements

Foremost, I would like to express my sincere gratitude to my advisor Professor Peter Leonard, whose encouragement, guidance and support from the initial to the final level enabled me to develop a better understanding of the subject. I could not have imagined having a better advisor and mentor for my MSW study.

I offer my regards and blessings to the three men who graciously participated in this study. Their wisdom and knowledge was inspiring and their involvement in this research was truly appreciated.

I would also like to extend my appreciation to the agencies that allowed me to post my recruitment ad on their bulletin boards.

Last but not the least, I would like to thank my mother Elsie Bergen for providing constant, unconditional support throughout my life. I would also like to thank my father Victor Bergen for his love and support as well.

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CHAPTER I- Introduction

This thesis is based on interviews with men who have been diagnosed with Antisocial Personality Disorder (ASPD). I was interested in understanding the experience and perspective of men who have been diagnosed with this disorder. As part of addressing this topic, the research will look at the social experience of these men that precluded the diagnosis, the experience of these men navigating the mental health or other healthcare systems once the diagnosis was given, the treatment of these men within the professional and clinical systems, and the future trajectory of where these systems need to be headed (i.e. development of community mental health and psychosocial rehabilitation programming). It was also important to explore the myths surrounding mental illness and the cultural contamination of receiving a mental health diagnosis.

It was my goal to utilize social work theory, to determine if the unique role of social work has an important role in the development and follow-through of programming and treatment for a population of persons with the diagnosis of Antisocial Personality Disorder.

This thesis will provide both a biomedical as well as social perspective of Antisocial Personality Disorder and possible etiological basis of this disorder. I focused on literature that explored the effect of social stressors and human experience on biomedical makeup and genetic predispostioning. How does our environment affect our minds and body? It was imperative to explore the development of Antisocial Personality Disorder, the origins and the socio-cultural development of this diagnosis, current treatment perspectives and strategies, and theories and methods as to how to work with individuals who are diagnosed with this disorder.

Definition of Antisocial Personality Disorder

Antisocial Personality Disorder (in this paper identified as ASPD) is characterized as a condition of emotional and social indifference; a psychological condition in which the affected person appears indifferent to social norms or to the feelings of others (Rutter, 1997). Kiesler (1996) stated that ASPD is evident when an individual displays chronic behavior that "manipulates, exploits, or violates the rights of others". Kiesler defined antiosocial behaviors as often being demonstrated by prison populations.

The Diagnostic Model of Statistical Analysis IV (in this paper will be referred to as the DSM IV) stated that ASPD is "characterized by a lack of regard for the moral or legal standards in the local culture. There is a marked inability to get along with others or abide by societal rules. Also, individuals with this disorder are sometimes referred to as psychopaths or sociopaths." (American Psychiatric Association, 2000).

Meloy (1995) reported that ASPD can be directly tied into the development and delivery of social rules, or social norms. There are usually negative consequences when someone violates a social norm (Meloy, 1995). Norms allow us to reduce the uncertainty that we might otherwise feel in a situation, or leading up to a situation if we knew nothing about how that situation would unfold (Jenkins, 1960). The norm of obedience dictates that institutions, and persons associated with these institutions, need to be obeyed if these institutions are to hold legitimate authority (Jenkins, 1960). Authority derives from the status of a particular person (Meloy, 1995), whether this status stems from class or politics. Obedience is behavior change that is produced by the commands of authority (Hare, 1996). People are taught from birth to obey authority, not question the dominant ideologies or beliefs of authority figures and understand the importance of conforming

behaviors and interactions to expectations defined through social norms (Jenkins, 1960). ASPD is the result of an individual not following this process, and displaying attitudes and behaviors that contradict the direction and values of persons and institutions in positions or authority or power.

The "Symptoms" of Antisocial Personality Disorder

The symptoms of ASPD are representative of violating social norms and include a longstanding pattern (after the age of 15) of disregard for the rights of others (American Psychiatric Association, 2000). There is a failure to conform to society's norms and expectations that often results in numerous arrests or legal involvement as well as a history of deceitfulness where the individual attempts to "con people or use trickery for personal profit." Impulsiveness can present in persons diagnosed with ASPD and includes angry outbursts, failure to consider consequences of behaviors, irritability, and/or physical assaults (American Psychiatric Association, 2000). It is argued that a major component of ASPD is the reduced ability to feel empathy for other people (Black and Larsen, 2000). Finally, irresponsible behavior often accompanies ASPD, as well as a lack of remorse for wrongdoings (Walker III, 1997).

Terris (1984) stated that persons diagnosed with ASPD are individuals that are charged with crimes and who often have a violent past. Terris goes on to report that for "true antisocials", misbehavior starts early in life and persists even with changes in social circumstances. According to Goldberg and Huxley (1992), persons diagnosed with ASPD possess superficial charm and intelligence and possess general poverty in major affective reactions. Unlike other mental health disorders, persons with ASPD must have the absence of delusions and other signs of irrational thinking as well as absence of

nervousness or other psychoneurotic disturbances (Loehlin, 1992). Persons who have been diagnosed with ASPD have been deemed unreliable and untruthful (Weatherall, 1992). In order to be a "true Antisocial" one must possess a lack of remorse and shame. (Loehlin, 1992). According to Plomin (1989), persons diagnosed with ASPD exhibit poor judgment and fail to learn from past experiences. This disconnection between past experience and current behaviors is evident through the repetition of dangerous and irrational behaviors. Heinrichs (1993) describes persons with ASPD as "pathologically egocentric and incapacitated for love."

Edlin and Golanty (1992) stated that "central to understanding individuals diagnosed with Antisocial Personality Disorder is that they appear to experience a limited range of human emotions." This can explain the lack of empathy for the suffering of others since they cannot experience emotion associated with either empathy or suffering." Kiesler (1996) claimed that persons diagnosed with ASPD may also engage in risk-seeking behaviors and abuse substances as a means to "escape feeling empty or emotionally void." Goldberg and Huxley (1992) reported that men diagnosed with ASPD also often exhibit 'rage" and anxiety disorders which may have a direct affect on the limit of emotion experienced.

Hervey Cleckly (psychiatrist) wrote the book The Mask of Insanity. From his literature, the term psychopath was created. The term coined individuals whose abnormal behaviors seemed to be constitutionally based or imbred. Cleckley (1941) defined ASPD as a disorder that transcends social class and argued that psychopaths demonstrated low levels of depression and anxiety. Cleckly (1941) defined the psychopath as having superficial charm and intelligence. A psychopath also experiences a lack of remorse or

shame, loss of personal insight and is unreliable in their relationships and interactions with others. In order for one to be deemed a psychopath, there must not be evidence of a delusional disorder, anxiety disorder or mood disorder that may be driving the psychopathic behaviors (American Psychiatric Association, 2000).

ASPD is seldom what motivates treatment (Engel, 1997). The majority of ASPD treated persons are mandated to partake in treatment programs. ASPD is also not simply just behaviors and actions (Hall, 1996). ASPD is a blend of acts and attitudes, and how a patient views his behaviors is as important as the behavior itself (Edlin and Golanty, 1992). An ASPD individual will often perceive their behaviors in an egocentric context (Hall, 1996). Rende and Plomin (1992) stated that men who have been diagnosed with ASPD do not have the ability to feel empathic towards the needs of persons around them, and do not use empathetic insight when deciding how they will interact with their environments. This may be why men diagnosed with ASPD have very few informal social supports and experience a lack of social stimulation. Terris (1984) stated that persons diagnosed with ASPD are not prisoners of their disorders and that they are aware of their choices.

The onset of Antisocial Personality Disorder

To receive a diagnosis of ASPD, an individual must have a history of childhood/adolescent behavior that qualifies for a diagnosis of conduct disorder (American Psychiatric Association, 2000). Rende and Plomin (1995) recognized the link between adult ASPD and childhood misbehaviors. Rende and Plomin performed longitudinal studies with youth involved in criminal behavior. The two researchers interviewed and profiled male “juvenile delinquents” within the youth criminal justice

system. They then implemented follow-up studies with these juvenile delinquents within ten years of their original meetings and found that 70% were involved in criminal behaviors as adults.

Origins of Antisocial Personality Disorder

The modern day definition of ASPD was established by the French Psychiatrist, Dr. Phillippe Pinel during the early nineteenth century (Rutter, 1997). According to Rutter (1997), Dr. Pinel diagnosed a man who became "enraged at a woman" who had used offensive language toward him. The idea was that the physical abuse and anguish that this man had projected onto this woman was not congruent with the moral and cultural implications of the time pertaining to the treatment of women. Pinel's description and clinical diagnosis of this patient's atypical behavior and aggrestivity eventually led to the category of psychopathy (Rutter, 1997). Pritchard expanded on Pinel's work and coined the concept of moral insanity. (Black, 1997). Pritchard described moral insanity as when " the moral and active principles of the mind are strongly perverted or depraved: the power of self-government is lost or severely impaired and the individual is found to be incapable, not of taking or reasoning upon any subject proposed to him, but of conducting himself with decency and propriety in the business of life." The concept of moral insanity was commonly used in medicine up until the 1800's (Black, 1997). Lombroso, an Italian Physician, described the "born criminal' as a psychopath (Plomin, 1989). This meant that there were individuals born into this world who were left at a predisposition to defy society's rules and oppose authority (Plomin, 1989). These individuals were described as inherently ego-centric and without ability to empathize with those around them or understand how their motivations in certain contexts would

affect those around them. Lombroso described the born criminal as 'immoral, imbecile, guiltless, highly aggressive, boastful, impulsive and insensitive to physical pain." Koch replaced the concept of "moral insanity" in 1888. McCord and McCord, (1964) describe how Koch developed the label "psychopathic inferiority" which eventually led to the terms "constitutional psychopathic" and "constitutional psychopathic inferiority" This meant that this disorder was caused by a constitutional predisposition and was therefore a disorder that could be treated on a clinical spectrum. Psychopathology was no longer being looked at as a behavior but a biological predisposition that led to a behavior (McCord and McCord, 1964) It is important to note this as this was the first time that psychopathology was viewed separately from that of those who committed criminal acts.

Hare (1984) reported that ASPD was introduced in the 1963 edition of the Diagnostic Model of Statistical Analysis III (in this paper to be referred to the DSM III). It was at this time that more and more research was being completed to try to understand the high levels of recidivism in men who commit crimes and defy government and lawful authority. This was also following the baby boom generation where men returned home from defending their country, women returned to the homestead and the rise of the middle class lifestyle became dominant in North American society (Lykken, 1995). According to Hare (1993), the assumption was that if you led a good wholesome life, believed in family values, demonstrated integrity and followed the rules of government and law you had the right to claim middle class status. This ideology did not take into account the social problems that still existed in North America and Europe (Hare, 1996). This included poverty, racism, violence, and addiction. The dominant consensus was that if you were unable to achieve middle class status, there was something constitutionally

wrong with you (Hare 1993). This way of thinking furthered theories behind individual pathology and assumed that a person caused and imposed social problems onto themselves due to mental dysfunction.

According to Engel (1997), antisocial refers to a reaction against society and a rejection of its rules and obligations. With the introduction of the ASPD diagnosis in the DSM-III in 1968, psychopathic behavior was no longer a label attributed with subjective observations of the therapist (Lykken, 1995). In order for one to be diagnosed with ASPD, there must have also been an adult criminal record in check which would support such a diagnosis (Hall, 1996). Therefore the DSM-III created an antisocial diagnosis based on reported facts (past criminal record) and objective history. Hall (1996) stated that the DSM-III introduced the medical community to the diagnosis of ASPD, and therefore began the process of medicalizing bad behavior. The development of ASPD, is an attempt to control the behaviors of people and the development and acceptance of truth and knowledge through scientific and medical discourse (Hall, 1996).

Bad behaviors, especially within the context of dominant discourse and values, express opposition toward the social construction of values (Black and Larsen, 2000). Hare (1996) reported that the DSM-III focused on behaviors and attitudes that were commonly reflective of persons who held "lower social positions" (i.e. those living in poverty, immigrants). The DSM-III did not explore the unique experiences of persons who were afflicted with the consequences of lower social class, and how these people gained any sense of personal empowerment and power within their micro-systems given the challenges that they were enduring.

Closely related to the diagnosis of ASPD is the comorbidity of alcoholism and

narcotic addiction (Wolman 1999). Some of the criteria for a substance abuse disorder are very similar to ASPD: theft, hazardous behavior, failure to fulfill role functions in home, school, and work. Are ASPD and narcotic addiction part of the same disorder, does one lead to the other, or are they are spuriously linked together? From what little research there is, it appears that most of the time, ASPD precedes narcotic addiction, although some of the time, addiction leads to ASPD behaviors (Hall, 1996). People with such comorbid characteristics also usually have undiagnosed other Axis I and Axis II disorders (Kiesler, 1999) such as a mood disorder (i.e. Bipolar Disorder) or thought disorder (i.e. Schizophrenia).

Eisenberg (1996) stated that "antisocial refers to the reaction against society and a rejection of its rules and obligations." ASPD may cross cultural and racial boundaries, however ASPD more likely to be found among men living in poverty (Loehlin, 1996). Poor school achievement, inconsistent work histories and irresponsible behaviors lead to low wage dead-end jobs with little room for advancement or to intermittent and/or chronic unemployment (Day, Zubin and Steinhauer, 1996). "Antisocials" tend to be impulsive, unable to see beyond their immediate circumstances or learn from past consequences (Black, 1997).

Goldberg and Huxley (1992) stated that ASPD is more likely to be found within certain groups; most notably men and persons who live in poverty. Poor school achievement, dysfunctional childhoods, inconsistent work histories, poverty and homelessness are also positively associated with the diagnosis of ASPD (Lickey and Gordon, 1991).

The demographics of Antisocial Personality Disorder

Regier (1984) stated that the overall prevalence of lifetime ASPD occurs within 2-3% of the population and occurs primarily in the inner city. (5.7% of inner city core inhabiters and 3.1. % of rural citizens). McCord and McCord (1964) indicated that persons diagnosed with ASPD tend to drop out of high school before graduation and Rutter (1997) reported that rates of ASPD are lower among college graduates. The antisocial personality disorder of psychopathy is also the most frequent diagnosis given to criminals (Glueck, 1918, Cleckley, 1941, 1976 Guze, Goodwina and Crane, 1970).

McCord and McCord (1964) noted that psychopathy is most prevalent among men. The incidence of ASPD is twice as high for inner-city residents as in small towns or rural areas, as and five times higher in males than in females (Rutter, 1997). A study of psychiatric outpatients revealed that 15% of men and 3% of women manifested ASPD (Woodruff, Gluze and Clayton, 1970, Black 1997). Black reported that this led to an indication that biological makeup of men is different and leaves that at a higher predisposition to ASPD than for women. Also one may also need to consider the social experience of men in society is different than for women (Rutter, 1997). Are there more pressures or expectations placed upon men's interactions with society and transactions that may lead them to exhibit more antisocial behaviors? A report by Cadoret (1986) showed that the male to female ratio for antisocial personality disorder varies between 4:11 to 7, 8:1.

Doren (1987) indicated that the prevalence of psychopathy "seems to be about" 3 percent of American men and 1 percent of American women. He also reported that the symptomatology usually becomes overt in males during early childhood while women

display the signs of psychopathy during puberty. The DSM-IV reports that "the disorder is much more common in males that in females" (American Psychiatric Association, 2000). Furthermore, the DSM-IV (2000) also "estimates of the prevalence of antisocial personality disorder for American men are about 3 percent , and for American women, less than 1 percent. The genetic link for men that some researcher's state leads to ASPD is often seen as somatization disorder or Borderline Personality Disorder within women (Engel, 1997). The epidemiological feature of ASPD is that it is a disorder most often labeled with men (McCord and Tremblay, 1992). In fact, 80% of men in prisons would fit the criteria of ASPD (Wolman, 1999). Eisenberg (1996) reported that men are presented with a different set of social experiences and opportunities to reveal personality traits that can be more congruent to the description of ASPD.

Hall (1996) stated that ASPD affects people in all social classes, but if someone with ASPD is born into a family of wealth and privilege, they will usually manage to seek out a successful business or political career. Poorer people with ASPD tend to wind up in state prison systems. According to Engel (1997) African-Americans are seven times more likely to be represented in state prison systems. Therefore, it's tempting to speculate the incidence of ASPD among African-Americans is high. However, there are most likely other causes of crime among African-Americans (like unemployment and racism). The fact is that most of the current prison population, regardless of race, shares the ASPD diagnosis (Black, 1999). All it takes is a juvenile record, an adult offense career, aggressivity, impulsivity, a checkered work history, and/or lack of demonstrable repentance. These can be easily found in almost any prison inmate's dossier. It was reported by Robins, Helzer and Davis (1975) that the third most frequent diagnosis given

to psychiatric emergency room patients is Antisocial Personality Disorder.

Lynam (1998) stated that mothers in lower socioeconomic status report a higher percentage of perceived rejection from their families and communities. Lower socioeconomic class mothers also at times are perceived to have a "colder" parenting style and less demonstrative of their affection toward their children. Moffitt, Caspi and Herrington (2002) stated " the trend of research tentatively suggests that the incidence of psychopathy remains low in more stable, simple, and rigidly organized communities where two parent nuclear families create the norm of the community." Larger urban cities, that have higher degrees of technological advantage, also have higher rates of children who develop ASPD as adults (Robins and Price, 1991). Thus it can be hypothesized that the prevalence of ASPD will be greater in cultures or societies that are urban, technologically advanced, experiencing rapid growth, complex, and socially disorganized. A task force of the National Advisory Mental Health Council report to the US Congress concluded that "social, cultural, and environmental forces shape who we are and how well we function in the everyday world (Hare, Hart and Harpur, 1991). Other powerful factors include whether we are rich or poor, native to our county or an immigrant, resident of a city or rural area.

For the purpose of this thesis, I have chosen to highlight the social experience of men who have been diagnosed with ASPD. This does not mean that women do not experience this disorder. Is it reflective of gender roles and gender stratification within North American society? It is of interest to note that women are more likely to be diagnosed with Borderline Personality Disorder (BPD) (Weatherall, 1992); a disorder that impacts ones ability to be and maintain interpersonal relationships. The division in

diagnosis in ASPD and BPD clients is important when taking into consideration the different social experiences of men and women.

CHAPTER II – Theories of Antisocial Personality Disorder

Biological Etiology-Biomedical Theory

Hippocrates believed that brain pathology (body-fluid imbalance) was the major cause of mental disorder. For example melancholia (unipolar disorder today) was the result of excess of phlegm (current schizophrenia) resulted from excess of blood (Cleckley, 1976).

One main theory that exists when looking at ASPD, is the biomedical theory. Many researchers root biomedical theories around the body's production of the neurotransmitter serotonin (Patrick, Cuthbert, Lang 1990, Hare 1984). Neurotransmitters are molecules that carry messages between brain and nerve cells. (Black, 1999). According to Kiesler (1999) serotonin, one of these neurotransmitters, is thought to mediate violent and aggressive behavior. The theory suggested that men diagnosed with Antisocial Personality Disorder produce low levels of serotonin. Cleckly (1976) stated that studies with men who have been diagnosed with ASPD show that not only do they become more aggressive when serotonin levels are depleted but they also become more docile when the serotonin levels are medically revved up. This study suggested that antisocial men, who are treated for lower Serotonin levels (antidepressants and mood stabilizers being the most common treatment), may continue to experience mood fluctuations and irritability despite treatment. This explained why typically this population is difficult to work with and, in some cases, deemed "untreatable".

Antisocial Personality Disorder is attributed with abnormal circulating levels of testosterone, the male hormone felt responsible for certain traits including higher levels of aggression in males (Meloy, 1995). Studies have shown that men who exhibit

abnormally high levels of testosterone are more likely to exhibit aggressive traits (Kiesler 1999). This theory also attempted to explain why 80% of individuals diagnosed with Antisocial Personality Disorder are men (Black, 1999).

Paris (1996) reported that persons diagnosed with ASPD may have central nervous systems damage. EEG tracings of brain wave activities indicate that aberrant slow wave patterns were two to three times more common in persons diagnosed with ASPD, than those that did not fit diagnostic criteria. Paris also stated that persons diagnosed with ASPD display many of the same symptoms shown by patients who have suffered strokes or injuries to the prefrontal lobes (confusion, difficulty with abstract reasoning and handling complex emotions). Damage to this region can destroy the emotional and moral compass that controls behavior.

Adult Antisocial Personality Disorder also linked to diet and the way that our body processes food (Wolman, 1999). Hypoglycemia, low blood sugar, is an example of a biomedical reaction that affects behaviors. Wolman reported that glucose levels of less than 80mg per deciliter (normal range is 80-110mg) can skew the brain's normal functioning producing anxiety, irritability and aggression. Research has shown that prison assaults peak between 11-11:30am a period where symptoms of reactive hypoglycemia are most common (Black, 1997). In looking at this theory, symptomology of ASPD can therefore be modified through dietary changes. Diets high in refined carbohydrates tend to lead to extreme fluctuations in blood glucose levels (Wolman, 1999). Past sociological research has indicated that men diagnosed with Antisocial Personality Disorder tended to live within poorer socioeconomic status as children and continue to experience this once transitioning into adulthood. (Rutter, Giller, Hagel,

1998). Research has indicated that those residing in poverty conditions are more likely to have a higher daily intake of carbohydrates (Black, 1999) Foods rich in carbohydrates (i.e. bread products) are less costly and more cost efficient to families who are living on budgets. Also individuals who utilize shelters and food banks are also more likely to have a higher daily intake of carbohydrates.

Research has also indicated that person's diagnosed as Antisocial Personality Disorder are linked with having central nervous systems that are damaged (Christopher, 1994). This idea was first expressed by Dr. Benjamin Rush-a Psychiatrist. In Dr. Rush's research, EEG tracings of brain wave activities indicate that aberrant slow wave patterns were two to three times more common in antisocials than among others. In analyzing this finding from a broader concept, it must be stated that the brain has five interconnected regions (Christopher, 1984). The most primitive is the brain stem (regulates bodily functions) then there is the diencephalon (sleep and appetite). The cerebellum controls equilibrium and movement and the limbic system governs sexual behavior and instinctual emotions. Covering these structures is the cerebral cortex where sensory messages are received and thoughts are processed. The prefrontal lobes serve to modulate the messages that surge within the brain, providing judgment, organizing behavior and rationalizing decisions. Persons diagnosed with ASPD display many of the symptoms shown by patients who have suffered strokes or injuries to the prefrontal lobes. Damage to this region can destroy the emotional and moral compass that controls behavior.

Dr. Peter Goyer of the National Institute of Alcohol Abuse and Alcoholism utilized PET images (Positron Emission Tomography) to assess brain function in Navy and Marine personnel who had assaulted others or who had made suicide attempts. The

most aggressive men showed impaired ability to produce glucose (the primary energy source for working neurons and other cells) in the right temporal lobe which is an important part of the limbic system the helps regulate mood, behavior and personality. Dr. Adrian Rine of the University of Southern California performed PET testing on 41 convicted murderers and found similar results. (Goyer, Andreason and Semple, 1994).

Another biological theory of ASPD suggested that the antisocial nervous system is strangely unresponsive; rendering the male diagnosed as chronically under-aroused (Black and Larsen, 1997). Therefore an individual seeks out a sensory fix to produce normal brain function. This sensory fix is sought through the external environment in order to trigger nervous system functions. EEG tracings of brain waves are abnormal in about half of antisocial adults, displaying patterns of slow wave activity more often seen in children and adolescents (Black and Larsen, 1997). Some researchers identify this as "brain immaturity". Antisocial children and adults typically show a slow heart rate indicating unarrousal. This may relate back to Cleckley's research which alleged that antisocials do not experience anxiety (Cleckley, 1941).

Another psycho physiological measure is skin conductance activity (Hare, 1996) Hare reported that men diagnosed with ASPD demonstrate that their skin conductance remains quite low, even when a neutral stimulus is followed by an aversive stimulus (i.e. hearing a buzzer and receiving an electrical shock –conditioning). Hans Eysenck (1964) found that conscience stems from a set of classically conditioned negative emotional responses to situations associated with punishment. A conditioning process occurs when we are able to associate feelings of fear and dread with certain behaviors that will or will not produce a positive reinforcement. This study would infer than men diagnosed with

Antisocial Personality Disorder do not experience this conditioning process and that they therefore do not fear or process negative consequences.

Another psycho physiological abnormality in ASPD is Event Related Potential (ERP) tracings of brain waves that occur in response to an interesting stimulus (Hare, Hart, Harpur, 1991). In persons diagnosed with ASPD, the amplitude of these tracings tends to be greater than in normal people. Hare (1993) found that the initial delay represents baseline low arousal but that the subsequent boost in brain activity suggests enhanced attention to stimulating events. He suggested that individuals with chronically low arousal seek out potentially dangerous or risky situations to raise their arousal to a more optimal level and fulfill their need for excitement.

The biomedical effects of stress

The structure and activity of brain patterns reflect experience, not just the biology one is born with. Our thoughts, feelings and memories occur within episodes of cortical neural firings (Day, Zubin and Steinhauer, 1987). According to Day, Zubin and Steinhauer, whatever new learning we acquire or arrive at, through maturation or pathogens, invariably is registered in ongoing cortical processes. Agents that change the state of activity in nerve cells will change the psychological state of the mind. Agents that change the state of mind will change the state of the corresponding brain cells. (Lickey and Gordon 1991).

Rutter (1997) reported that any stressful event consists of two essential processes: one that is environmental (external) and the other one occurring within the person. Engel (1997) described two particular forms of stress-formative environmental factors and precipitative environmental factors. According to Engel, formative environmental stress

factors are experiences that contribute to the predisposition of an individual to develop a specific disease or disorder. Precipitating environmental factors are factors that trigger a certain physiological reaction to stress. When looking at stress as it pertains to mental health, Eisenberg (1996) stated that the less control that an organism has over a stressor, the more severe the health outcome. Scheff (1966) supported this finding, however expanded on it by stating that the crucial factor is the person's interpretation or appraisal of the meaning of the event within a particular context of its occurrence.

On a biomedical level, the central nervous system is impacted when one is experiencing environmental stress (Goyer, Andreason and Semple, 1994). The flight or fight theory developed by Walter Cannon (1915) embodies this as the natural reaction of the human nervous system is to either fight the stress that is occurring, or avoid it. Stress hormones that are produced during this process, allows for the individual experiencing the stress to experience a higher level of energy (Goyer, Andreason and Semple, 1994). Unfortunately, the consequence of this is that many persons who secrete these stress hormones, also experience disruption within their immune systems that affects their immunocompetence .

Prolonged periods of dealing with stress have been linked to the conditioning of behaviors based on the physiological reactions that one is internally experiencing (Plomin, Lichtenstein, Pedersen, and McClearn, 1990). As stated previously, persons who are diagnosed with Antisocial Personality Disorder typically occupy a lower socioeconomic class (Kiesler, 1999). This would mean that persons with this diagnosis are naturally more exposed to stressful live events (poverty, homelessness, dealings with social institutions, lower levels of felt support) on a longer continuum. Goldberg and

Huxley (1992) reported that the way that stress effects the body is an example of how environmental (social factors) have a complex relationship with an individual internal factors (biology and hereditary)

The biomedical model places an exclusive priority on distal biologic causes of mental disorder. American Psychological Association (1996) concluded that extensive research on both animals and humans demonstrated that repeated exposures to stressful psychological experiences may result in persisting changes in brain structure and biochemistry. Psychological, environmental and socio-cultural factors can thus directly produce abnormal brain biology.

The critique of Antisocial Personality Disorder as a biomedical disorder

A critique of ASPD being treated within the biomedical model is that mental disorders do not satisfy the conditions necessary for defining a biological disorder. The characteristics of ASPD are expressed through behaviors and attitudes rather than stemming from a singular physiological root. Mental disorders, as defined by the DSM-IV, are not linked to empirical research. Hall (1996) stated that ASPD is not a clearly discovered biological abnormality

Spitzer and Wilson (1975) reported that most mental disorders do not have a specific identified etiology and are not qualitatively different from some aspect of normal functioning. Heinrichs (1993) suggested that DSM –IV classified disorders do not show a demonstrable associated physical pathology and are not an internal biological process that, once initiated, proceed somewhat independently of environmental conditions outside the body. Bloom (1988) stated that the biomedical model does not address how psychological factors interact with biomedical factors in the development of illness.

According to Bloom, chronic diseases are significantly associated with individual's health habits and ability to adapt to economic, social and cultural stressors.

When looking at the diagnosis of Antisocial Personality Disorder, one must consider that ASPD can be looked at from a multi-perspective system and therefore treatment may be holistic rather than medical (Edlin and Golanty, 1992). The biomedical model does not look at external factors as possible indicators of mental abnormality; although it does take into consideration that men diagnosed with APSD may have been raised and continue to reside in environments that have negative effects on their physical health (Lickey and Gordon, 1991). Kiesler (1996) argued that the description of mental disorder in the DSM-IV does not require mental disorders to be strictly biological disorders. Although there are theories that link mental disorder to genetics and biomedical dysfunction, these theories are based on a number of plausible theories. There is not one causation that has been linked to mental disorder; particularly in patients who have been diagnosed with personality disorders.(Rutter, 1997) The result of not having single causation theories and findings is that patients very often receive multiple diagnoses and therefore rates of co-morbidity are high (Rutter, Giller and Hagell, 1998). Hare (1993) reported that the definition of mental illness is also a social construction based on the time, politics and culture of a society.

The DSM-IV did not take into consideration that as society and culture shapes and progresses so does its definition of antisocial (Lykken, 1995). The DSM-IV also did not take into account the effects of oppression on various demographics that held lower positions of power within their culture and communities. According to Hall, the biomedical theories behind mental illness in general do not hold accountable dominant

parties of people who have created and exacerbate the social pitfalls that many people fall in. Biomedical theories also do not speak to multicultural aspects of ASPD. In North America, there are many cultures of people, who are living under the ceiling of mostly western beliefs, values and practices. Hall (1996) connects ASPD as being predominant in mostly African cultural communities in North America, where the origin of their beliefs and practices (shaped by history and experiences) are not represented in the dominant cultural and political ideologies that shape social norms.

Social and Cultural Etiology

Man behaves as a social animal (Watson, 1925). In keeping with this perspective, sociological and social work researchers seek explanations of mental disorders that reflect the cultural and sub cultural norms of society. Lykken (1995) stated that the medical model seeks out to prove the existence of biologically based brain diseases. Genetic, biochemical and neurological research put into mental health research is an attempt to prove that mental disorders transcend class, gender and race (Dearry, 1996). Sociological and social work researchers seek explanations of mental disorders that reflect the cultural and sub cultural norms that are reflective of dominant discourse and societal hierarchy (Dearry, 1996).

Black (1999) reported that almost 19% of Americans have been diagnosed with some type of mental disorder as defined by the DSM-IV. Mental disorders were more prevalent in persons under 45, in those that were unmarried and those that were uneducated. There is also a strong correlation with the prevalence of mental disorder and low socioeconomic class status. Black also stated there is a difference in prevalence of mental disorder between genders (ASPD and substance abuse higher in men; mood

disorders including anxiety and depression more prevalent in women) as well as race (overall, African-Americans had higher levels of mental illness than Caucasians or Hispanics). This would indicate that persons who may occupy certain disenfranchised demographics of the population are exposed to different social experiences and interactions that contradict those that are occupying or associated with positions of power and authority.

Behaviorism

John Watson (1925) is called the founder of behaviorist psychology. Watson felt that one's hereditary predispositions were only crucial in the development of physical traits. Watson believed that the development of ones' personality and the mold that leads to the creation of behaviors was solely dependent upon a persons' external environment and the interplay between an individual and the political, economic and cultural context of their environment at that time. Watson also hypothesized that environmental factors have a key role in dictating the biological makeup and susceptibility to disease during a person's lifetime, as physical health is a consequence of our role in society and culture, and the meanings attached to these. Drawing from this perspective, the homes and cultures that men with a diagnosis of ASPD were raised within would bring out different surface behaviors while at the same time containing a multitude of internalized motivations behind them.

Where leadership and assertiveness are on the surface seen as positive attributes to possess, one that grows up in an environment that "predisposes" them to antisocial behavior may look at these characteristics in a different light. For example instead of being the captain of the basketball team or leader of the debate team, an individual who

grows up in an antisocial environment may see that being the leader of a youth gang in their community brings similar feelings of leadership and power. We all want power within our environment; it is the means that we go to access this power that determines the difference between antisocial and healthy behaviors.

B.F. Skinner (1938, 1953) felt that all behavior is determined by "contingencies of reinforcement". Behaviors are determined by the frequency of positive and negative reinforcements that we receive in similar situations throughout our lifetime. Skinner felt that persons are apt to repeat behaviors that have been positively reinforced (through praise or retrieval of power or control of situation), and less apt to repeat behaviors that have been negatively reinforced or punished. By receiving reinforcement and assurance by others behaviors, the development of a value system occurs that directly influences the determination between what is wrong and right. According to Skinner, individuals tend to look for this reinforcement from persons who occupy parental and/or authoritative roles. The development of behavior, from this perspective, can therefore be seen as a conditioning process.

Conditioning occurs when we train our mind and bodies to act in certain away in order to achieve a desirable response (Rotter, Chance, Phares, 1992). Maladaptive behaviors are therefore seen as a lack of the conditioning process within ones' life. When describing maladaptive behaviors, you must also consider the context of how these behaviors are defined and when they occur. Wolmann (1999) stated that maladaptive behaviors are part of a continuum of behaviors which are determined by society as either acceptable or non-acceptable. According to Wolmann, society's viewpoints can be heavily influenced or brought on by a number of factors including dominant political

ideologies, economic theories and religion. These factors determine what behaviors are preferable in order to exist within a society and be successful.

If research indicates that men diagnosed with ASPD traditionally grew up in non-traditional homes one must consider that the priorities and values within that home may not be reflective of the "typical family" and therefore behaviors exhibited within were reinforced on a different value system (Black and Larsen, 1997). For example, in a home where societal oppression and degradation is the norm, behaviors that contradict dominant political and social ideologies may be accepted and valued as behaviors that meet the specific needs of the culture of the family, are representative of the individualized experience of the family and protect the family against further alienation and oppression.

Social Learning Theory

When exploring the theories of Skinner and Watson, one must also consider the relevance of the Social Learning Theory. John Rotter developed the original framework of the Social Learning Theory in 1954. However, the Social Learning Theory gained more recognition when applied to the research of Albert Bandura (1961). The major premise of the social learning theory is that an individuals' perception of their environment has more of an effect than the actual external environmental events. This would mean that two people could exist within the same culture, political environments, and socio-economic class however the realities of these environments remain to be individually interpreted. Therefore, according to Social Learning Theory, causation of human behavior is centered within the subjective environment (Rosenstock, Stretcher and Becker, 1988.)

When exploring the diagnosis of ASPD, and the prevalence of it within lower socio-economic classes, Social Learning Theory explains how poverty and oppression are risk factors, however not the root of causation; everybody interprets their environment differently (Rotter, Chance, Phares, 1972). .What influences the subjective environment? It may be persons that we have identified as role models and who have provided that sense of belongingness and protection that shapes our world and helps us to form identities within it (Rosenstock, Stretcher and Becker, 1988). From these examples, it appears individuals strive to be the reflection of the persons that have role modeled for them. We may take attributes of their personality and apply this to our own. Their actions and behaviors will act as a model in which to form our own as adults.

It is also important to look at the environmental factors that have shaped a persons life experience and development (Meloy, 1995). What were the factors that shaped these interactions with the external environments? For example, if an individual spent the majority of their developmental years involved with social services, within institutions or within a family context where necessities such as housing and food were of continual concern, how does that influence our personality and understanding of the world around us?

Environmental factors such as social class and race are reliably associated with differential exposure to stress and are well established predictors of human mortality and a variety of specific medical diseases (Plomin, Lichenstein, Pedersen and McLearn, 1990). Class, ethnicity, and gender also affect the extent and quality of social support that an individual would be able to access (Goldberg and Huxley, 1992). Social support is one of the most extensively researched of the stress "resistance" or medicating factors.

(Kiesler, 1999) These include social resources and informal social support that influence personality development, sense of belongingness and coping resources.

Cultural factors which reinforce or promote drug and alcohol addiction, sexual promiscuity, violence and acting-out or criminal behavior of any type are directly associated with societies that contain higher incidents of ASPD. (Sampson and Laub, 1994). Woodward and Fergusson (1999) argued that North American society today is directly influenced by the media which reinforces these messages especially to youth and stratified communities that are oppressed by dominant culture (i.e. African-American.) These messages suggest that by developing a criminal persona one is better able to establish some sense of control within their environment and gain social and political power. This is especially important when looking at the higher number of ASPD individuals.

The relationship between biomedical/genetic makeup and environment.

The crucial factor when determining the development of a mental disorder, is the person's interpretation or appraisal of the meaning of the event within the particular context of its occurrence (Goldberg and Huxley, 1992). It is difficult to avoid the binary of biomedical and social etiologies of ASPD. The biomedical model tends to emphasize truth and objectivity, while the social etiologies tend to look more at the social construction of what culture and persons within that culture perceive as reality. The following though explores the impact of biomedical influences on social experience and systemic interaction of individuals.

When looking at the prevalence of ASPD, it is important to look at the impact of repeated external stress on an individual's personality makeup. A recent large scale task force of the American Psychological Society reviewed the available evidence regarding psychosocial stressors and mental disorder (Black and Larsen, 1999). The task force arrived at the following conclusions: Stress can have both transient and permanent effects on the functioning of the human central nervous system (2) Extensive research on both animals and human has demonstrated that repeated exposure to stressful experience can result in persisting changes in brain structure and biochemistry and can reduce the immune response; "these changes may contribute to the negative effects of psychosocial stressors" (3) stress is in fact associated with mental disorder. (Black and Larsen, 1999).

Appraisal of stressful events activates the nervous system, especially the sympathetic and parasympathetic branches of the autonomic nervous system (ANS) (Loehlin, 1992). Loehlin went on to report that quickly triggered within the individual internal reaction, are flight or fight physiological arousal responses. Under chronic stress, these ANS reactions can directly affect organ functioning and produce susceptibility to dysfunction. ANS reactions may also induce susceptibility to other diseases by affecting the immune response. During stress, the hypothalamus secretes stress hormones that activate additional secretions from the pituitary and adrenal glands that have widespread fueling or energizing effects (Weatherall, 1992). Under stress, individuals release more of the stress hormones cortisol, ACTH and beta endorphin. This results in decreased immune activity. The degree to which the immune system is active and effective is referred to as the individual's level of immunocompetence (Loehlin, 1992). Prolonged

and/or intense stress reduces immunocompetence, producing a suppressive effect on immune functioning which over time can affect health status (Weatherall, 1992).

Although maltreatment increases the risk of adult criminality by about fifty percent, most maltreated children do not become delinquents or adult criminals (Goldberg and Huxley, 1992). The reason for this variability in response is largely unknown, but it may be that vulnerability to adversities is conditional, depending on genetic susceptibility factors (Rutter, Giller, Hagell, 1998). Caspi, McClay, and Moffitt, (2002) looked at whether individual differences at a functional polymorphism is the promoter of the monoamine oxidase A (MAOA) gene. The MAOA gene characterizes genetic susceptibility to maltreatment. Purpose of this research was to test whether the MAOA gene modifies the influence of maltreatment on children's development of antisocial behavior.

The MAOA gene is located on the X chromosome (Bremner, Vermetten, 2001). It encodes the MAOA enzyme, which metabolizes neurotransmitters such as norepinephrine (NE), serotonin (5-HT), and dopamine (DA), rendering them inactive. Genetic deficiencies in MAOA activity have been linked with aggression in mice and humans (Rutter, Giller, Hagell, 1998). Increased aggression and increased levels of brain NE, 5-HT, and DA were observed in a transgenic mouseline in which the gene encoding MAOA was deleted. The aggression then decreased once MAOA expression was restored.

The Caspi, McClay, and Moffitt (2002) study concluded that for adolescents who had been diagnosed with conduct disorder, there was a prevalence of low MAOA genotype. In contrast, among males with high MAOA activity, maltreatment and neglect

in the external environment did not significantly lead to antisocial expression in adult behaviors. Males with low MAOA activity genotype, who were maltreated in childhood, had elevated antisocial behavioral scores as adults. Caspi, McClay, and Moffitt, (2002) stated that 85% of cohort males having a low-activity MAOA genotype, and who were severely maltreated as children, developed some form of antisocial behavior as an adult. This is an indication that genes are assumed to create vulnerability to disease, but genes are also likely to protect against long-term effects of environmental stress (Bremner and Vermetten, 2001). This is an example of the interplay between genetic makeup and environment in the development of human development and behaviors.

Personality and environment

Within the last decade, scientific findings from personality researchers have resulted in a growing consensus that five major personality dispositions or traits can be reliably identified for most people in most countries throughout the world (Daery, 1996, Wiggins and Pincus, 1992). These five personality traits are the degree to which a person is surgent (assertive, leader-like, sociable and gregarious,) agreeable (cooperative, good-natured and sympathetic), emotionally stable (calm, steady, self-confident, and cool) conscientious (hard-working, persevering, organized and responsible) and intellectually creative and open (curious, imaginative, cultured and broad minded). From this perspective, individualistic external behaviors are reflective of the need to exert these five personality structures. One must then not look at the behavior itself as deviant; but rather the meanings behind these behaviors (Daery, 1996). Daery posed the question as to whether antisocial behaviors being expressed are to exert some sense of power, control and meaning for the person exhibiting the behavior. Black and Larsen (2000) stated that

if an individual is not able to attain societal power and acceptance in what is deemed to be a socially appropriate manner, will they seek out these attributes through other methods (i.e. identifying with groups that are not reflective of dominant ideologies or establishments.).

Interactionism

According to the interactionism and interpersonal transactional perspectives (Kiesler 1996) –humans are relatively passive agents whose behaviors are governed predominantly by environmental circumstances and contingencies. The individual chooses the situations in which he or she performs, attends to and interprets significant aspects that serve as cues for his or her activities in the situations, and subsequently affects the how the individual will be portrayed in social situations (Rutter, 1997). Humans consistently attend to and perceive certain aspects of their external environments and constantly construe and interpret the meanings that are most relevant to them (Kiesler, 1999). Individual persons each have characteristic "comfortable" and "uncomfortable" settings, the former probably being those situations that we found in the past to permit easy and safe expression of our basic personality. (Rutter, 1997).

Our characteristic behaviors within settings can change those settings and shape and alter the behaviors of persons within that environment, from an interpersonal viewpoint (Engel, 1997). Interpersonal theory insists that the most important situations we respond to in life are the people with whom we interact within the environmental settings of our lives: within our homes, our jobs, our neighborhoods (Plomin and Rende, 1995). An additional aspect of selection of environments is our preference for and fit with the people most commonly found in those environments (Weatherall, 1992). Weatherall

reported that our characteristic behaviors within settings can change those settings and shape and alter the behaviors of persons within that environment, from an interpersonal viewpoint.

Persons are constantly in dynamic interaction with their environments (Plomin, 1989). Whenever possible, they select their environments and react to the meanings of environmental events as individually received and interpreted by them. While in their environments, persons tend to attended to and identify as salient the interpersonal ones (actions of other people) and while in environments they constantly transact with, evoke from, and have effects on the persons and environments, leading to ongoing reciprocal cycles of action and reaction (Plomin, Lichtenstein, Pedersen, and McClearn ,1990). Considering this dynamic, persons with mental disorders are those who develop deficiencies in their dynamic interactions with the environment (Loehlin, 1992). They develop rigid and invalid cognitive templates that result in invalid and distorted perceptions and interpretations of external events (and act from distorted, invalid, non-representative subjective environments).

Cultural factors may also influence susceptibility to ASPD (Blair and Coles, 2003). Cultural and ethnic beliefs, attitudes, customs, traditions and values may reinforce or inhibit the expression of psychopathy (Hill, 2002). Loney, Frick and Ellis (1998) reported that there are two social factors that influence the development and incidence of psychopathy. These are: 1) social crisis. This can include war and economic depression and have been linked to an increase in the development of psychopathy 2) class structure. Socioeconomic class status has been linked to parenting styles and attitudes that in turn affect the incidents of childhood conduct disorder and adult ASPD. Parents, who are

positively reinforced by culture and community, experience less stress, more support and are judged less than parents who are in lower socioeconomic and cultural brackets. (Dodge, Lochman and Harnish, 1997). It is also reported that individuals who are raised within a higher socioeconomic class structure are perceived to have higher levels of social support and have more positive interaction with their communities and culture. Those within higher socioeconomic class status also have a direct influence on dominant discourses and ethics within a culture. This influence then effects what is deemed appropriate and inappropriate behaviors in the context of which behaviors complement dominant discourse and quality of living.

Chapter III - Family, Parental Influence and Childhood Experience in the Development of Antisocial Personality Disorder

Environment can be perceived on a micro, family level as well (Suomi, 2003). Partridge (1928) is one of the first scientists to study early environmental influence on human behavior. He examined twelve psychopathic delinquents and found that all twelve individuals hated their parents. Furthermore, all of the twelve psychopaths looked that participated in this study were overtly rejected by their parents during early childhood. McCord ns McCord (1964) reviewed a number of investigations that refer to these dimensions of psychopathy. They concluded that the parents (particularly the mothers) of psychopaths are maladjusted and that the mothers of psychopaths reject their children. McCord and McCord also felt that psychopaths have been unloved by their parents and that the fathers of psychopaths are stern, rejecting and often "obsessional" fathers. This study concluded that psychopaths experience physical abuse at the hands of their parents and it was reported that emotional deprivation precipitated the development of ASPD. (Reiss and Plomin, 1995).

Olds and Cole (1998) suggested that ASPD is most likely to occur among children whose parents are emotionally cold and inconsistent in rewards and punishment practices. Parental attitudes and conflicted patterns of familial interaction and communication are positively associated with adult psychopathy (Suomi, 2003).

Familial environments in which early childhood reinforcement patterns that reward active avoidance of punishment have been linked to the development of adult antisocial personality (Wigguns and Pinkus, 1992). As children, psychopaths experience continual inconsistent overindulgence or brutal punishment which results in the same

behavioral consequence (Black and Larsen, 2000). Therefore they learn, believe and feel that their reactions and behaviors have no predictable effect on others or the environment.

Conduct Disorder in children associated with Antisocial Personality Disorder

Lykken (1995) stated that there is a link to childhood conduct disorder and ADD in ASPD diagnosed males. The social experiences, and interpretations of our experiences, during childhood shape our norms and values as adults. Meloy (1995) stated that children, who have minimal opportunities to learn and understand their communication styles, learn how to describe their feelings through behaviors rather than verbal communication. Christopher (1994) stated that one factor that moderates the eventual outcome of childhood misbehavior is a child's degree of socialization-his/her tendency to form social relationships and internalize social norms. According to Hare (1996), a large percentage of conduct disordered kids have limited exposure to their social world and limited opportunity for growth within it. This is related to parents themselves who exhibit isolative behaviors and do not expose their children to situations that would enhance their social development. Isolative behaviors can occur when the micro values do not fit into the dominant macro discourses that govern and divide cultures within society (Bloom, 1986).

Eisenberg (1996) reported that parental antisocial attitudes and behaviors are predictive of psychopathy among offspring. Black and Larsen (2000) reported that juvenile delinquents rarely experience constructive and healthy parental role modeling. To the contrary they have experienced antisocial parental role modeling. Family studies in ASP indicate that children who have parents with ASPD have a 16% chance of developing this disorder themselves (Henry, Caspi, and Moffitt, 1996) This would

support both a genetic link to ASP as well as a psychosocial connection-depending on what theoretical perspective you may choose to look at this issue from.

Plomin (1989) wrote that from his interpretation "psychopathy" is a means to attain and maintain environmental control. Plomin reported that studies that suggesting environmental factors specific to family situations, sub-cultural sets, and the societal whole are important in influencing the expression of psychopathy. Given our present state of knowledge, the most potent predictor of adult antisocial behavior seems to be the variety and types of child antisocial involvement. Family factors play a role in setting the stage for social deviance and its extent, and peer and sub cultural influences are important in contributing to such behaviors. Barry and DeShazo (2000), two child psychologists, investigated the importance of group loyalty and role modeling. They found that the majority of behavior repertoires, expressed by men in particular, were reflective of the social groups that they identified with and were accepted by.

Those favoring nurture perspective, view similar family cycles of deprivation and abuse that lead to similar patterns of behaviors in parents and children (Barry, Frick and Deshazo (2000). Blair and Coles (2003) stated that genetics may set up the potential for ASPD. However, environmental factors may determine whether this predisposition will meet full potential. Family studies of ASPD have generally shown that nearly 20% of persons diagnosed with ASPD have first degree relatives that are themselves antisocial and between one quarter and one third are alcoholic (Dodge, Lochman and Harnish 1997). Depression, drug abuse, somatization disorder, ADD, and learning disabilities are linked to run in family members of persons diagnosed with ASPD (Farrington, Loeber and Van Kammen, 1990**)**. These conditions themselves are linked to a genetic causation,

however there is an indication that there is a direct social link to these problems as well. Depression is a reaction to helplessness and lack of control in ones environment. (Fergusson, Lynskey and Horwood, 1996) Alcoholism and drug abuse are a means that one may use to cope or as a defense mechanism (Hart and Hare, 1990).

Adoption studies are interesting to look at because they consider the genetic vs. environmental causation of ASPD. Dodge, Lochman and Harnish (1997) reported that you can discount the effects of learned behavior and role modeling when it comes to children born with a genetic predisposition to ASPD. That is genetics has a more direct link to ASPD than the influence of environment. In general, children who have biological parents with ASPD are more likely to perform ASPD related behaviors even if they are removed from their biological parents. One study undertaken by Raymond Crowe at the University of Iowa found that in a group of 52 adoptees born to 41 female inmates, 13% of these children would meet ASPD criteria. This is in spite of the fact that many of these children had limited if not zero contact with their biological mothers. Combined results of twin studies in ASPD indicate a 67% correlation in identical twins and a 31% correlation in fraternal twins. By studying adoptees, researchers can learn the effect of learned behaviors and environment versus genetic disposition to ASPD (Dodge, Lochman and Harnish, 1997).

From a environmental perspective, it is interesting to note that children who develop ASPD as adults demonstrate high rates of poverty, experienced parental abuse and neglect, substandard housing, bad neighborhoods, inadequate nutrition and medical care (Blair and Coles, 2003 and Caspi and Moffitt, 2002). According to Kazdin (1997) environmental interactions for a child, and the meanings that are brought about from

these interactions, are heavily influenced by parental involvement and quality of care giving. Rates of depression and poverty are high in parents whose children who are typically harder to control (Olds, Henderson, Cole 1998). Parents of delinquent boys are more often alcoholic or criminal and their homes were frequently broken by divorce, separation or absence of a parent (Plomin, 1989). Therefore, parents who experience dysfunction in the care giving of their children based on negative external stressors, are more likely to project a message of rejection toward their children and exhume a pattern of inconsistent parenting. Parents who are hostile and rejected their kids, are more inconsistent and erratic in their discipline, and more likely to use physical punishment (Plomin, Lichtenstein, Pedersen and McClearn 1990). Physical punishment in children is not a teaching tool, but instead evokes a feeling of fear and anger in the child (Rende and Plomin,1995) These negative feelings in children can be carried over into adulthood.

Rutter (1997) stated that the most significant aspect of the future prevalence of ASPD was the absence of one or both parents during a child's upbringing. The impact of divorce or separation on a child's behavior depends on the initial quality of the parental relationship (Wolman, 1999). Woodward and Fergusson (1999) stated that when parents do not get along, children do not observe normal affection and communication. Erratic and/or inappropriate discipline turns out to be one of the most important factors that influence antisocial behavior in children (Woodward and Fergusson, 1999). Inconsistent discipline is also a factor that can lead to adult antisocial behavior (Kiesler, 1996). As inconsistent discipline usually does not work, parents escalate the intensity of punishment when they do discipline (Meloy, 1995). They alternate between permissiveness and harshness until discipline becomes irrelevant.

If a child is beaten verbally or physically regardless of their behaviors, the punishment loses its power and the child sees no point in being good (Lykken, 1995). This may be why ASPD individuals are unaffected by punishment or social sanctions are unable to consider consequences unless they are immediate (Loney, Frick and Ellis ,1998). As children they never learned the connection between breaking the rules and paying the penalty. Boys who experience abuse –and more generally, those exposed to erratic, coercive and punitive parenting-are at risk of developing conduct disorder, antisocial personality symptoms, and of becoming violent offenders (Rutter, 1997). Men who have been diagnosed with ASPD are more likely to have histories with child abuse (Kazdin, 2000). Kazdin also reported that abuse becomes a learned behavior that formerly abused adults perpetuate with their own children. Abuse also carries physical effects which impact brain functioning (Goyer, Andreason , Semple, Clayton, King, Compton-Toth, Schulz and Cohen (1994) During development, neurons in the cortex differentiate and make connections with other cells forming the neural systems which underlie behaviors. Traumatic effects like abuse according to this theory, can disrupt the wiring process and affect the brain's response to environmental stresses

Antisocial children tend to be more unsupervised by their parents (Black and Larsen, 2000). Involved parents observe their children's' behavior, then set limits and assure that they are obeyed. According to Blair and Coles (2003), this can take time and patience, while the exchange between parent and child occurs for the purpose of promoting acceptable social behavior. If statistics are congruent to reality, parents of ASPD often do not have the time to spend with their children so that these "life lessons' can take place (Eisenbergn, 1996). Parents may be working, or caught up in their own

emotional stressors and subsequent defense mechanisms that stem from poverty. There is not enough of a consistent time period for parents to bond with their children. If antisocial children do not develop strong bonds, they can become self-absorbed and indifferent to others (Engel, 1997). Without having experienced consistent discipline, there is little regard for rules and little ability to delay gratification. Lacking appropriate role models, children with absentee parents learn to use aggression to solve disputes and fail to develop empathy for those around them (Kiesler, 1999). A child, who as at high risk of developing ASPD as an adult, may view society very much the way they view their home-as a source of conflict rather than comfort. Antisocial children often choose similar children as playmates (Loehlin, 1992). Peer influences then may contribute to antisocial behavior and help nurture conduct disorder and later ASPD

CHAPTER IV – RESEARCH STUDY

Description of Research

My original intent was to do a thesis on the social experience of men who live with the diagnosis of Antisocial Personality Disorder. In order to carry this study through, I interviewed three men who had been diagnosed with Antisocial Personality Disorder at some point in their lives. It is important to note that these men had experienced the diagnosis itself, and did not necessarily agree or validate it. I wanted to know as to how they felt they had benefited and been challenged because of this diagnosis, and what is their perception of the way others (family, friends, professionals, treatment professionals) treat them and to what degree is it felt that this diagnosis effects the way others treat them.

I felt that it was important to listen to the opinions of diagnosed individuals, and how they have managed to experience their lives whilst attached to the label of ASPD. I was also interested to know opinions about the current state of community based mental health and social programs, as well as the future of these programs. My aim was to explore, from the perspective of individuals who have been diagnosed with Antisocial Personality Disorder, how community programs should be structured and what issues these programs should be addressing. The definition of programming could be based on defining future community programs that are needed, as well as critiquing community programs that had already been utilized.

I feel that there is a benefit to this research. It could contribute to the understanding of the experience of the social world of men diagnosed with Antisocial Personality Disorder, and whether it may be desirable to incorporate these experiences

when planning treatment and rehabilitation. Could this population require more of an emphasis on the social aspect of psychosocial rehabilitation?

I have worked with this population and have found that treatment planning, accessibility to programming, gaining rapport, predicting success and maintaining follow-up is difficult. This is especially so within the mainstream mental health system, because the interactions and meanings of the social world for these individuals seem to be a large predictor of behaviors. Overall, this is a population who I fear is not always understood within the mainstream mental health system. This research, I felt, encouraged their voices to be heard, and possibly contribute to suggesting how professionals can more effectively work with them.

The Recruitment of Subjects/ Location of Research

I went about to recruit legally competent adult males, over the age of 18 and under the age of 50, who have been diagnosed with Antisocial Personality Disorder as their primary DSM-IV diagnosis. I posted recruitment ads to determine interest for this study (Appendix 1).

This research started off when I was living in Montreal, Quebec. I had made connections with several workers from four Mental Health Inpatient facilities in Montreal. I had chosen not to pinpoint any one agency directly, or identify the name of the agencies in this research paper, as it could not be connected to any treatment or programming that the subject had already be receiving in the community. All four agencies work with populations of men with Antisocial Personality Disorder, and have agreed to have recruitment advertisements in their organizations (Appendix II), subsequent to review and ethics approval by the McGill University Ethics Review Board.

It is important to note that the facilities and workers themselves did not directly refer potential interview subjects. Instead, the workers posted the recruitment ads at their respective workplaces as to allow traffic coming into the building to see my ad. Any interested individuals were to contact the researcher themselves.

The aim was that all interviews were to take place in an office setting. It was planned to interview men who had been diagnosed with ASPD in interview rooms at McGill University. To limit confusion about the connection of the research to community agencies, interviews with diagnosed subjects would not take place at community organizations. Halfway through the research process, life circumstances led to my relocation to Winnipeg, MB. Once in Winnipeg, I established connections with several community organizations that would likely have a larger population of men that had been diagnosed with ASPD traveling through their space. I also arranged with a contact of in Winnipeg to have space available to conduct interviews in a safe and secure setting at the University of Manitoba.

I provided $20.00 per interview. This was to cover transportation costs ($5.00) and the cost for one meal ($15.00). I sought and attained funding through Behrens River First Nations Band (Southeast Education in Winnipeg, MB) to cover costs of the interviews.

Methodology/Procedures

As the researcher, I carried out a small phenomenological study in exploring this research topic. The reason that I am chose to work within a qualitative framework is that it was important to draw out the individual narrative experience of each interview subject,

and compare and contrast interpretations, themes, and ideas that speak to the voices of my research subjects.

The process began with the researcher starting a bracketing or "epoche" process. By doing this, any preconceived notions about this population or working with this population would hopefully be addressed. I had to be consciously not interpreting other's experiences, meanings and values through my own experiences of working with this population.

I then conducted three separate interviews: three interviews with three persons diagnosed with Antisocial Personality Disorder. All subjects were made aware of their role as a voluntary interview subject, their right to withdraw, and their right to confidentiality (Appendix 3). The purpose of the research, and the importance that I felt this research served, was also explained to interview subjects. This was also covered adequately in a recruitment advertisement and consent forms; both forms were reviewed in discussion between researcher and interview subject prior to interview. I had hoped that each interview would last approximately 1 hour. Interviews were also to be audio taped. Interview subjects were notified of their right to "speak off the record" at any time prior to audio recording.

My aim was to follow in the interviews a guided conversation model, although a list of interview questions had been attached. These questions provided a framework as to potential topics for discussion. After each interview was transcribed, audiotapes were destroyed.

I intended to follow the steps in phenomenological data analysis that are described by Moustakas (1994) and Polkinghorne (1989). Once interviews are transcribed, data was

divided into statements through a horizonalization process. I participated in an open coding process initially in order to begin the analysis of the data. Open coding allowed for the representation of information in terms of meanings; expressed in both psychological and phenomenological concepts. After potential themes in the data had been drawn out, I then implemented an axial coding process, where similar and contrasting themes were placed into more specific categories. This process allowed for underlying subjects, concepts and arguments to be attributed to the data set. Any patterns, similarities and differences of narratives were explored and compared, both within and between the two groupings. Due to the small size of the sample, it was possible to explore individual statements and opinions, as this was evidence of individual lived experience.

Once analysis was completed, dominant themes and perspectives were contextualized for comparison with the relevant literature on the same topic. Within the data analysis process, it was important for me as the researcher to incorporate my own personal meaning and experience, and identifying it as this. The reason for me in doing the data analysis in this style was to hopefully allow the reader of this research to come away with a better understanding of what it may mean to be diagnosed with this mental disorder and/or what it may be like to work with this population-including both challenging and positive experiences.

It is important to note that research subjects were notified of their right to see any copies of transcriptions of their specific interview, as well as their right to see the final research thesis. All names of participants were changed in the final research report to ensure confidentiality.

CHAPTER V ANALYSIS OF RESEARCH INTERVIEWS

Terry

I met Terry in Winnipeg, Manitoba at the University of Manitoba. Terry responded to an advertisement that I had posted up at a local men's shelter in Winnipeg. Terry missed the first interview time that we had agreed to meet upon. I was disappointed as Terry was my first interview and I was contemplating if this was an indication of things to come. To my surprise, Terry contacted my office one week later. According to Terry, he had to go up North to his home community on the spur of the moment and that this was the reason he had missed the first interview time.

That evening, I had gone to the University, again, anticipating the arrival of my first interview subject. Terry eventually came to the University, although he was 45 minutes late, after I had almost decided that the evening was going to be another letdown. Terry walked in, appearing to be dressed in layers of clothing (although it was Mid-August at the time). Terry acknowledged that he was late for out meeting and apologized for this. According to Terry, he had waited for his friend to pick him up and this is why he was late.

I explained the reasons as to why I was interested in this research to Terry and why I felt that this research was important. Terry and I reviewed the ethic guidelines pertaining to confidentiality and privacy. He asked for the interview not to be tape recorded. I attempted to explain to Terry the reasons as to why it was important to tape record the interview However, Terry simply stated that he would not participate in a tape recorded interview. Terry agreed that I could take notes and quote him in the final research paper if necessary.

Terry reports that he was born in Winnipeg, MB in 1975. At the time of his birth, he said that his biological parents were together and "happy" and that he was not aware of any complications or problems that his mother experienced as part of her pregnancy. Terry was born into a sibship of two- having two older brothers two years older than him. According to Terry, his mother was a nursing aide and father worked as a factory worker. Terry describes his childhood as an "okay" one up until he reached eight years of age. Terry admits that his parents argued, and that his father was often drinking alcohol. Terry reported the when his father drank, he could at times be physically abusive. Terry acknowledged that his family struggled financially, however they were able to keep and maintain their own home in a mostly middle class neighborhood for the first eight years of Terry's life.

Terry reported that he and his older brother currently have a "horrible" relationship and he believes that this started as a young child. Terry remembers his older brother and him having fist fights in their backyard and house and at one time his older brother throwing a hammer at Terry's head. Terry could not identify any reasons as to why the relationship was bad, just that "[they] didn't get along". He said that he and his mother also do not talk currently. He stated that he always "hated" his mother and feels that this is due to the way he perceived how she treated her family. He reports believing that his mother always saw him as a "burden and mistake." His mother, he said, did not spend time with him as a child and was often yelling at him for "things [he] didn't do." Terry reports that his parents were often fighting (both physical and verbal) and his mother would leave the home for extended periods of time to stay with friends. Terry and his brother would then be left in the care of his father. Terry says that neither of his

parents spent time with him or his brother when they were children and remembers feeling lonely as a child.

When Terry was eight years old, his parents decided to separate and Terry's father moved out of the family home. Terry states that he was "mad" when his parents divorced because he had wanted to live with his father and he felt that this matter was not even discussed between the two parents. ("It was automatically assumed for me to stay with her.") After his mother and father separated, the family moved to his mother's home reservation in Northern Manitoba. According to Terry, this was very difficult for him and his brother because they were accustomed to living in an urban setting and moving to "the sticks" posed adaptability issues. He acknowledged that he was "disappointed" that his father did not fight to allow his children to stay in Winnipeg. Terry reports that he and his father shared a distant relationship after this time as Terry claims that his father's alcohol problems became worse.

It was when Terry and his family moved from Winnipeg (approx age 9) that his difficult behaviors began to escalate. Terry, his brother and mother moved into the home of his grandmother. He reports that numerous cousins and an uncle also lived with his grandmother. Within a year of Terry moving to the North, his mother decided to leave the family home and relocate back to Winnipeg without Terry and his brother. Terry reports that he was very angry with his mother about this decision. His grandmother was apparently physically ill, and the other adults in the home struggled with alcohol and drug abuse. Terry remembered that an uncle of his who lived in the home often became violent and suicidal when drinking.

When he moved to the reservation, Terry began attend Grade 4 with the other kids from the community. Because Terry was half Caucasian and half Aboriginal, he reports a belief that he was treated differently by peers and teachers than the other Aboriginal kids in his classroom. Terry reports that he was bullied by his peers during his elementary school years. Terry recalled an incident where he was held down by a number of his peers and spit and urinated on. Terry states that he did not feel supported during this time by his family or the school system. According to Terry, for many years he felt that he was "totally alone."

Terry said that his brother on the other hand thrived in the new environment. Apparently he played hockey and was all together good at sports. Terry reported feeling that the other kids on the reservation "worshipped" his brother and parents and teachers praised him. According to Terry, the more popular his brother became the more distant he and his brothers relationship ended up being and eventually the only interactions they had would be violent ones when Terry and his brother would fight.

Until he reached Grade 8 Terry did not have any friends. He would spend long times in his room listening to music and "writing shit." Terry would avoid going to school and he missed large amounts of school time which had a detrimental effect on his grades. He says that it was during this time that he wished to move to Winnipeg to live closer to his father, however his grandmother would not let him move back. Terry's mother was still not directly involved with her children's care. However, Terry said that she did telephone and visit her kids sporadically. Eventually, Terry began acting out against his grandmother, reportedly calling her names and engaging in physical fights

with her. Terry reports that when this occurred, his uncle and brother would often intervene and Terry would get his " ass kicked".

When Terry was approximately 12 years of age, his mother took him to Winnipeg to be assessed by a Psychiatrist to see why he was experiencing mood swings and avoided school. According to Terry, the Psychiatrist told his mother that she was the problem and that she needed to be there more for her kids; especially Terry. Despite this advice, Terry's mother continued to choose not to return to the North or move her children back to Winnipeg.

According to Terry, in his Grade 8 year he began experimenting with cigarettes, alcohol and marijuana. Terry reports that it was at this time, he met a new friend named "Seth". Terry said that often him and Seth would skip school and get drunk off school property. In Grade 8, Terry reports that he was suspended from school for being intoxicated on school property and he was sent to see a drug and alcohol counselor. In Grade 9, Terry states that he "really began" smoking large amounts of marijuana and he eventually decided to deal marijuana to the other local kids on the reservation. Terry admits that "[he] wasn't very good at it" and was caught by the local RCMP and charged with trafficking drugs at age 15. Terry states that he was let off with a charge and community service.

As a teenager Terry ran away from his grandmother's home several times. He admits that he did not do well in school; and in fact dropped out of school in Grade 11. It was at this point that he states he engaged in "a lot" of criminal activities including car theft, break and enters and getting into fights. Terry stated that at one point he spent some time in youth detention for assault charges.

Terry reports that as a teenager he suffered from a variety of mental health problems. He "always" felt depressed and angry. He reports that this was connected to his poor relationship with his family and being bullied at school. Terry said that when he was seventeen he spent some time at a youth psychiatric facility for attempting to take an overdose of pills. Terry also states that when he was in the youth psychiatric facility he was given a diagnosis of bipolar; something which he has never believed. He was not aware of any other psychiatric history in his family.

When Terry was 19, he claims that he went to jail for a crime related to drug trafficking. While he was in jail, he attempted suicide and so an assessment was undertaken by the court psychiatrist. This is when Terry claims he first heard of the diagnosis of Antisocial Personality Disorder. He met with the Psychiatrist only twice and finds it difficult to understand how the doctor was able to diagnose him based on the basis of these two interviews. Terry completed his prison sentence and was remanded to the community probation program.

Terry maintained that he is happy with his life. He says that he has moved a lot and has spent large amounts of time homeless. In fact, he sees himself as quite familiar with the homelessness resources in Western Canada. Terry is currently on Social Assistance Disability and receives approximately $650/month. He says that in most cities this does not cover even the basic costs of living. He said that he has a large friend base and utilizes this resource when necessary. Currently, Terry says that his goal is to find a job. He says that throughout his lifetime has held down a number of jobs including: construction, customer service and tree planting. He says that he finds it incredibly difficult to get a job because of his criminal record.

Although Terry would not elaborate on his criminal past, he did admit that he is currently serving a community probation and has a parole officer involved in his supervision. Because of this, he is required to see a court appointed psychiatrist and a mental health worker on a monthly basis. The psychiatrist provides Terry with medications to help him with his anxiety.

Terry says that because of the diagnosis of ASPD, he was able to attain Disability status that in turn has helped him to receive a small amount more in terms of money than being on a regular form of social assistance. However, he claims that the disability welfare is different depending on what province you decide to reside in. And in some provinces, Terry felt that the Disability welfare was only a small portion higher than people who were on regular assistance. Terry also stated that he disagreed with the diagnosis of Antisocial Personality Disorder; but commented that he really did not know what this diagnosis meant. Terry reported that his doctor had tried to explain the diagnosis to him, but got into a "fight" with Terry when Terry questioned the authenticity of the diagnosis.

Terry acknowledged that he had endured many hardships in his life. This included parental-child conflict, a breakdown of the family system, perceived abandonment by biological parents, drug addiction, prison time and helplessness within the education system. Terry alluded to the social label and stigma attached to having a diagnosis of Antisocial Personality Disorder and how this label makes unaccountable those persons in his life that treated him poorly and was neglectful and instead puts the blame on Terry that he is the supposed cause of all his problems.

I asked Terry what his opinions were about current healthcare programs that were

available to him. Terry clearly, in my opinion had trouble answering this question for a number of reasons. He initially stated that he did not feel that Antisocial Personality Disorder should be seen as a medical illness requiring "healthcare" support. Terry felt that he does not have a mental illness, and therefore should not be labeled as psychiatrically unstable.

I asked Terry what type of programming he felt should be available for persons "in his position." He reported that housing and employment were huge challenges for him. He believed that the boarding house that he currently lived in was not sufficient to ensure his safety and support his plan to abstain from drug and alcohol use, as well as stay away from criminal influences. Terry says that he cannot afford to live in more stabilized housing because his Disability cheque did not allow enough money to pay for this housing each month. Terry also reported that Disability did not assist him with bus fare to seek out jobs, outside of the core area of Winnipeg, or take a bus to go on interviews.

Because of the environmental stressors in the apartment complex that he was residing in, Terry believed that it was difficult to structure your day and get proper sleep because of the noise and chaos that was surrounding him by his neighbors. Terry reported that the bus service that was provided to his neighborhood was slow and inconsistent and Terry did not feel safe waiting for a bus on the evenings or mornings. He also voiced frustration that he could not have people over to his room, because he was embarrassed by his apartment, the size of the room that he lived in, and that many people in his life did not want to venture to the "bad part of the city." Terry did not have extra money to buy "nice clothes" and he felt that his appearance hindered him in getting a good job.

Terry felt that the mental health system should be less focused on medications and counseling and more proactive at developing safe housing programs and employment opportunities for persons with ASPD. He believed that when an individual leaves prison, there needs to be a place where they can go to access safe housing immediately. Otherwise, the risk of the individual going back to antisocial environments is high. Also, he felt that employment and housing programs should be offered together rather than on separate terms. The example that Terry provided is that when someone is released from prison, they have an address that they can go to where they can live without conditions put on them as to how long they can live there. Also, these housing programs should have a built in employment program where automatically everybody who is living there is also working.

Terry commented that he "wished" that there were more services available to him and his family when he was a youth. He felt that if counseling and support services were available, especially for his father, this his life would have "turned out differently." He also continues to feel anger toward his mother for abandoning him and his brother, and he commented that there should have been more services to help out single moms who are feeling overwhelmed. He spoke of the lack of services and resources available to him and his family due to the social isolation that is experienced by persons living in northern communities. Terry felt that the "healthcare system" and social service agencies "did not care about Native people" and therefore he was not provided any assistance when it was necessary. Terry felt that there continues to be a lot of youth that live in northern communities who are "heading down [his] path."

Ed

I met Ed when he responded to my ad which had been placed at the Vocational Rehabilitation Centre. Ed phoned me and agreed to meet me at the University to conduct the interview. Ed inquired as to whether the twenty dollars would be given to him up front which I replied that it would be and he would not have to wait for this. I met Ed in the evening at the University. I was looking forward to meeting with him as Ed sounded quite pleasant and down to earth during our telephone conversation.

At our initial meeting Ed shook my hand and followed me into the interview space. Once in the room, Ed shared with me that he was having some second thoughts about having the interview, although he felt that he should still receive the twenty dollars as he had made it down to actually meet with me. I asked Ed what his concerns were, and Ed replied that he was not interested in the subject and had forgotten that he had former plans that evening. I explained the reasons I felt the research was necessary and tried to reinforce the idea that the research could potentially change the way that professionals look at the diagnosis of ASPD and persons who are diagnosed with this. Ed agreed that he would stay for the interview although clarified that he felt he had the right to only answer questions that he felt comfortable with answering. I understood this request and Ed and I mutually agreed that if there were questions that he did not wish to answer he could have simply stated "move on".

Our interview started with a review of the ethical conditions around confidentiality and privacy. Ed questioned the purpose of tape recording the interview. Ed advised me that he had felt betrayed before by professionals who "promised" him that his responses would be kept confidential but then in fact were not. I reinforced to Ed that the difficulty with not tape recording the interview would that it would take longer and,

because I was handwriting information, I might not be able to actively listen as well as I could. Ed agreed, but requested that a copy of the transcripts be mailed to him once transcribed.

I started the interview out by asking Ed questions related to his childhood. I found that Terry, the previous interviewee, was more than willing to discuss his childhood and I had made an assumption that Ed would have the same attitude. As soon as I asked him, "tell me about your childhood?", Ed became visibly irritated. He asked, "what does that have to do with anything? " Ed advised that he was not willing to discuss his childhood as nowhere in the recruitment form did it stipulate that discussion around childhood needed to take place. Ed also confirmed that even though he was unwilling to discuss his childhood he was still expecting the twenty dollars for the interview.

I asked Ed if I could just ask some basic questions about his childhood and Ed agreed that he would only answer with limited responses. Ed told me that his mother died of cancer at age 5 and that he and his brother and sister were raised by his father. Ed also reported that his childhood was not good, but would not elaborate as to why this was. Ed reported that he continues to be close to his siblings and that they play a major factor his life.

Ed was visibly disinterested (and possibly annoyed) with talking about his childhood so I decided to focus Ed's current situation. I had advised Ed on the telephone earlier that I would need to ask him questions about how he became diagnosed with having Antisocial Personality Disorder. Therefore, it did not seem a surprise to Ed when my line of questioning geared toward this subject.

Ed stated that as a young adult he decided to join a carnival company so that he would have the opportunity to travel and not always be in the same location. According to Ed, it was during this summer that he was accused, charged and eventually convicted of sexual assault. Ed then went to a Federal Penitentiary to serve his sentence. While at the Penitentiary, Ed reported that he attempted to hang himself in his cell and he was sent to the "prison hospital". It was at the prison hospital that Ed first heard of the diagnosis of ASPD and was treated for this diagnosis. Ed claimed that he had known about his diagnosis for approximately 10 years; however he was quick to note that he does not think he has it.

I asked Ed if he any other run-ins with the law over the last ten years. Ed replied "here and there" but he refused to elaborate on what these accusations or convictions were. Ed also refused to answer questions around his current address, occupation, drug use/alcohol use (although Ed claimed that he received drug testing as per his probation conditions), relationships, and family situation. He admitted that he is currently on probation and has to see his probation officer weekly for updates. He complained that his probation officer was a "hard-ass"; particularly around where Ed can and cannot live. Ed was not willing to discuss why there is a current probation condition in place that prohibits him from being around children. Ed was visibly becoming inpatient with my line of questioning so I asked Ed for a list of all the different types of treatment that he has received since receiving this diagnosis.

Ed reported that he had been seen by a court appointed Psychiatrist for approximately eight years, as well as having regular follow-up with a mental health worker for approximately the last seven years. Ed indicated that he and his current mental

health worker shared a good relationship and that she was able to assist him with getting financial assistance and arranging " a place to stay" when Ed found in the past that he was without a fixed address. Ed reports that his mental health worker also buys him coffee and doughnuts and that he is appreciative of this. Ed states that his Psychiatrist retired about two years ago, and he has not had regular follow-up with a Psychiatrist since. Ed claims that got along with his Psychiatrist and that the Psychiatrist was most helpful in giving him medications to help control his anger and alleviate chronic pain. Ed relies on his community mental health worker and walk-in clinic doctor to provide him with mental health care. Ed has recently become involved with the Vocational Rehabilitation Program and states that he is hoping to find work so that he can "get off assistance."

Ed stated that he did not feel that his life was affected positively or negatively as a result of receiving the diagnosis of Antisocial Personality Disorder. Ed, as did Terry, did not know what ASPD meant. Ed defined ASPD as having a lot of "fucked up things happening to you in life" and "becoming angry at the world."

Ed reported that his former Mental Health Worker and Probation Officer "discriminated" against him and he felt that it may have had something to do with the diagnosis that he was given. Ed reported that when he went to visit these workers, security guards were "always" called to monitor Ed and "take care of [him] if [he] stepped out of line." Ed stated that he felt angry that people assumed that he was dangerous and resented the fact that it was felt necessary for him to take medications to protect himself and other people. Ed stated that he would "never hurt anyone that [he] cared for" and it made him irate that professionals felt he was capable of this.

It appeared as if Ed was currently on a community probation order. Ed admitted that even though he does not see his Psychiatrist anymore, he does have regular follow-up with a General Practitioner monthly and that it is still required by the courts that Ed take his medications. Ed was not aware of the names of the medications that he takes. He reported that the medications made him "drowsy and drooly." He said that he was embarrassed with the amount of drool his medications cause, and reported that often people cannot understand him. Ed stated that the medications that he was on were helping with his "anger and mood swings."

It is important to note that during our interview, Ed did become tearful at one point. He stated that he is currently not allowed in his sister's home because she and her husband do not trust him around their children.

I felt that Ed became defensive when I started to ask him about his opinion on current mental health program delivery. Ed felt that it "sucked" and he began the pattern of posing the question back to me, repeating "aren't you the professional here". Ed was appearing agitated, and I felt that I was not going to attain genuine responses from Ed given his demeanor. As this was not a therapy session, and I did not know Ed, I chose not to confront him about his apprehension in answering questions and instead decided to end the interview.

Joe

Joe responded to the ad that was placed at a local men's shelter. He called my office on a Friday and agreed to meet with me on the following weekend. I admit that I was somewhat apprehensive as I had previously dealt with two other interviewees who were not able to meet me on time or at all. I decided that, to avoid any confusion or

uncomfortable feelings upon our meeting, that I advise Joe that the interview was to be tape recorded. To my relief, Joe agreed to this condition and the interview to proceed.

Joe was born into a two parent family in a sibship of four; with Joe being the youngest. He grew up in the United States and his family immigrated to Canada (British Columbia) when he was nine as his parents attempted to open an ostrich farm and business. Joe describes his father as a business man who "ruled the roost with an iron fist." He stated that his father had a temper and would "often" use corporal forms of punishment on his children. Joe attributed this to his father's own upbringing as a child. Joe describes his mother as a "lovely lady" who "tried to raise [her kids] the best way she knew how."

According to Joe, he did not have much contact with external informal family supports, as Joe's parents families did not agree with them moving to Canada. Joe admits that his family struggled financially and at one point his father declared bankruptcy when his business venture proved unsuccessful. Joe reports that when he was eight years of age his father "went away" as his mother described it. Joe indicated that he felt that his father at this time "could have" spent some time in a psychiatric facility and that this is what possibly prompted his parents moving to Canada. Joe admitted that both his parents were "eccentric" and used alcohol and marijuana "pretty regularly". Joe could not identify any other psychiatric or significant medical history in his family's history. At one point he stated that his father went to jail and was on probation "it seemed like a lot." Joe could not recall what his father went to jail for. Joe recalls that his father had "regular drinking buddies" and would often engage in physical fights with them in front of his children when he was intoxicated.

Joe states that he was a normal kid, related well socially with peers, and did "average" in school. Joe began to experiment with drugs and alcohol around the age of 14, particularly marijuana and LSD. Joe states that it was around this time that his older siblings began to separate from the family causing, in Joe's opinion, a family breakdown. Joe feels that his older siblings moved back to the United States and maintained limited contact with the nuclear family. Joe reports that once the ostrich farm venture was closed, his parents were not able to maintain regular employment, and he and his parents moved out of the family home to live in a series of apartments. Joe described the apartments as small and crowded. He stated that his parents "did not care" about keeping the apartments clean, and as a result suffered a pattern of evictions from rented and subsidized homes. According to Joe, his parents drinking behavior became worse after the failure of the ostrich farm, and family finances were often spent on alcohol.

At age 15, Joe was removed from his parents' home under a voluntary agreement with child and family services because his parents were not able to look after him. Joe attributes this to poverty, his parents' inability to maintain a regular home for him and their drinking pattern. Joe states that between the ages of 15-17 he lived in foster homes where he admits that he was exposed to physical and sexual abuse. At age 16, Joe was involved in a motor vehicle accident and sustained trauma to his head. Joe reported that this accident affected his coordination, concentration and memory ever since. After the accident, Joe dropped out of school, started drinking alcohol and smoked marijuana excessively. He states that it was also at this time that he experienced his first "manic episode" and was taken to the hospital after attempting to take his life after a drinking party. Joe stated that his first hospital stay was "horrible" because he was locked in a

room and only had contact with other people when they were bringing him medications and/or food. Joe reported that while he was in hospital he felt like a "caged animal" that was unable to speak with his family and perceived that hospital staff treated him like "an idiot who did not know what he was talking about." Joe reported that he stayed in the hospital for three months during his first hospitalization and left the hospital with a diagnosis of Bipolar Disorder.

According to Joe, after his first hospitalization he was able to go into an alternative high school program and complete his Grade 12 education. He stated that he had not many friends in high school because everyone perceived him as "weird." He attributed this to the way that he looked and his attitude about life. He also admitted that while he was in high school he did "crazy things" like set his hair on fire and gave himself homemade tattoos. Joe remembers that he did not get along with his teachers as they all felt that he was 'crazy" and that he ended up working with the resource teachers at his school to finish his Grade 12 education.

Once he graduated high school Joe decided to get a job as a gas station attendant and move out of the family home and live independently. With transitional planning through the child and family service that he was connected to, he was able to do this at the age of 19. Joe reports that between 16-19 years of age he was seen by a Psychiatrist on a regular basis. Joe felt that this service was not necessary and admits that he did not take the medications that were being prescribed to him during this time. Joe reported that the medications made him lazy and ""droggy"" and did not help with his moods. He admitted that during his young adulthood he drank alcohol and used marijuana on a regular basis. Joe also stated that he experimented with cocaine as well.

Joe stated that when he was 25 he was involved in an accident at his job where he fell off a ladder. Joe reported that at this time he had to leave work as he was not able to work on a regular basis. Joe reported that in this same year he was involved in another motor vehicle accident that left him with "bad whiplash". According to Joe, he was put on pain medication at this time that he eventually developed an addiction for.

Joe stated that in his mid twenties his father passed away from cancer. Previous to this Joe had limited contact with his family. He admitted to feeling "bad' about not having contact with his father prior to him passing away. Joe admitted that he did held some resentment toward his parents for having to enter into the foster care system and this is why he "drifted away." After the death of his father Joe tried to reconnect with his mother. According to Joe, his mother attempted to use him for him money and did not want to have a genuine relationship with him. Joe reported that he has little to do with his siblings.

Joe went to prison and hospitals several more times over the last ten years. He has gone to prison for break and enters, assault with a deadly weapon, assault causing bodily harm and drug possession and trafficking. He stated that he was given "every single diagnosis that you can throw at me." These included Bipolar Disorder, Schizophrenia, Depression and finally Antisocial Personality Disorder. Joe was given the diagnosis of Antisocial Personality Disorder by a Psychiatrist that he saw in Alberta. Joe indicated that he was mandated to see this Psychiatrist after one of his prison sentences as while he was in jail he became "suicidal" and was required to be seen at the prison hospital. According to Joe, he has lived in every province in Western Canada and describes himself as a "loner".

Joe reports that spending time in prison was difficult "depending on what your there for and how long." Joe maintained that an experience in prison depended on what type of prison you were in. The longest amount of time that Joe has spent in prison was 9 months in 2000. He stated that he has been exposed to physical violence and "extreme" hostility while in prison. He stated that you can also meet "worthwhile" people while you are in prison and create connections and bonds with those around you. He stated that this was why so many guys end up back in prison is because they meet way more connections while there than they do when they get out.

Joe reported that his number one priority right now is to get a job. He has had a number of jobs in the last few years but they have all been minimum wage and found through his welfare worker. Joe maintained that he works well independently but does not get along well when there is "someone on his back." He indicated that he has traditionally had problems with authority figures and admits that he has lost his temper at jobs before that have ended his position. He also said that in the past he had been accused of stealing money and possessions from his places of work. He stated that at times he had been on psychotropic medications and that this has hindered his ability to get up in time in the morning, so his attendance record at jobs was poor.

Joe has been in long-term relationships in the past but is currently not in one. Joe reported that he had traditionally picked women that "treat [him] like shit" and he attributes this to his own poor self-esteem. Joe would like to have a partner one day and continues to feel that this may happen.

Joe stated that for the last five years he has been in engaged in regular therapy and follow-up with a Psychiatrist in order to continue to meet the eligibility requirements of

his Employment and Income Assistance Disability benefits. According to Joe, in order to receive more monies through the Disability program it was required that his Psychiatrist send monthly reports to the EIA office in order to support his Disability claim. Joe reported that this arrangement is what motivates him to continue seeing a Psychiatrist. He admitted that at times he has not been compliant with medications. Joe would not disclose if he continues to actively use street drugs or alcohol.

CHAPTER VI - RESULTS

Experience of childhood

One theme that seemed relevant in all three interviews had to do with poor experiences as a child-specifically around the relationship between child and parent. Terry grew up in several different cities, under the supervision of several different caregivers. Each of these caregivers provided a different quality of nurturance, attention and stability. There may have also been different behavioral intervention used by these caregivers in order to try to control and manage child conduct behaviors. None of these strategies were consistent, as Terry went from being in passive environments to harsh ones. If there was any effort to provide healthy structure and limits, parents did not reinforce personal strengths or promote abilities to maintain a sense of self-control or self-regulation. Above all, Terry was forced as a family system that did not reinforce love but instead responsibility and containment.

Joe grew up in a household where there were different caregiver roles within the nuclear family. The majority of caregivers that were looking after Joe were siblings, and caregiver roles changed as siblings left the home. Also, as these siblings aged, their commitment to Joe's upbringing wavered. Eventually, Joe was left solely in the responsibility of his parents, two people who had not been actively involved in Joe's early development. The ability of these parents to provide a positive parental role in Joe's life, was influenced and compromised by the parents own mental health issues and inability to take care of themselves properly. Joe could not rely on his parents to provide him with a sense of safety and assurance that he was important and loved.

All three men appear to have received the majority of attention as children and teenagers when they were involved in activities that were considered wrong. From this perspective, these men may have initially acted out antisocially in their external environments to fulfill their own internal need for attention from and time with their caregivers.

Joe reports feeling that as a teenager, his parents and siblings were afraid of him and simply avoided addressing his behaviors so that conflict (which at times included physical violence) could be avoided. Joe indicated that because of his parents own legal struggles, being attentive toward their kids was just something that was not on top of the list of parental priorities. Terry reports believing that his mother suffered from "emotional issues" and that she defined these emotional issues within the context of her first failed marriage. Terry stated that his mother channeled and projected her own personal mental issues onto him, as she identified Terry as a reminder of her ex-husband. Terry had his own issues related to his parent's marriage; however he reports not feeling that he had permission to speak about these issues in his grandmother's home. Instead Terry acted his pain out in behaviors that his family refused to explore further and possibly understand. In retrospect both Terry and Joe have considered that their bad behaviors were cries for attention that were not met from their parents. Eventually these bad behaviors turned into a pattern that led to a destructive and harmful lifestyle. It was also difficult for Joe to accept the help of other persons, because he so wanted this help to come from his parents.

As Terry stated, when he was punished he was mostly spanked or hit. Terry was also "lectured" and made to feel inferior to his parents when he was being punished. Joe's

brothers made attempts to discipline Joe by intimidating him and telling him that he "better" act in a certain way. Nelson (1981) stated a key step in positive parenting is seeing through with your children possible solutions to bad behaviors or dealing with environments that can cause bad behaviors. Once children are a part of the solution of problems, they appear to have more of an investment in making positive changes. Once children make these positive changes, it is also very important for parents to reinforce the positive behaviors. Otherwise children will grow up thinking that the only method that can use to attain adult attention is my misbehaving. This thinking will carry over likely to peer groups once the child becomes older and starts to relate more to his friends.

Nelson, Erwin and Delzer (1999) wrote about the importance of parents understanding the motivations behind their children's misbehaviors. According to these researchers, they feel that children misbehave for four different reasons:
1) Undue Attention- The child is looking for attention from their adult care providers and will do whatever necessary to get this attention. This is important when looking at parents who only put their parental attention toward negative behaviors and tend to overlook and ignore positive behaviors. 2) Misguided power. Children wish to engage in a power struggle with their parents so that a sense of control can be established. Children may feel this need for power if they are feeling invalidated or unworthy of attention without acting out in some extreme way. 3) Revenge. Children are feeling hurt and scared by behaviors of parents or situations within home. 4) Assumed inadequacy. Children feel inferior toward parents/siblings and assume that they lack capability.

Peri-natal and infant development is also important to look at. Both Terry and Joe alluded that there parents were essentially dealing with stressors prior to their birth, and

that both sets of parents presented with serious mental health and addiction problems from the time that they brought their children into the world. Shalev, Yehuda, McFarlane, (2000) stated that when a child is an infant, this is when the majority of neurological development occurs. The child uses their parent's nervous system as a template to develop their own parasympathetic nervous system and learns to deal with stressors in their environment. Therefore the child learns how to deal with stressors in their environment from a very early age based on how parents cope with stressors. The development of the nervous system also begins in-utero when the reticular activation system (RAS) comes online. If a mother is activated through stress, or if the mother is being impacted by external influences (i.e. poor coping, anxiety, alcohol, drugs) that are having an impact on their own nervous systems, this will also play a major role in the development of their child's nervous system and subsequent ability to cope once they introduced to the world. Also, if an individual is being under stimulated or emotionally neglected as a child, there are high rates of anxiety experienced as an adult.

Attachment disorder is a broad term intended to describe disorders of mood, behavior, and social relationships arising from a failure to form normal attachments to primary care giving figures in early childhood, resulting in problematic social expectations and behaviors. Such a failure would result from unusual early experiences of neglect, abuse, abrupt separation from caregivers after about six months but before about three years, frequent change of caregivers or excessive numbers of caregivers, or lack of caregiver responsiveness to child communicative efforts. Attachment Disorder is a mental and emotional condition occurring during the first three years of life where a child does not attach, bond, or trust his or her mother. Again, it stems from the lack of

connectedness in the person's most significant relationship and manifests itself as fear of connection taken to the extreme. Humans need attachments with others for their psychological and emotional development as well as for their survival. Infants need to be physically close to the mother and be able to receive and give affection to form an enduring emotional bond. Children need to feel that they are safe, that they will not be abandoned, and that they are loved and valued. The unique and exclusive relationship between a mother and child colors the person's relationships for rest of his or her life. If the relationship is close and secure, then the child learns to trust and love. If the relationship is emotionally distant and inconsistent, then the child learns not to trust or care and believes that one is all alone in the world.

Poverty and Antisocial Personality Disorder

All three men that were interviewed for this research project commented heavily on the social effects and hardships of living a life in poverty. At least two of the men reported that they came from childhood homes where they also became accustomed to a life of living in poverty. Poverty is defined as deprivation of those things that determine the quality of life, including food, clothing, shelter and safe drinking water, but also such "intangibles" as the opportunity to learn, to engage in meaningful employment, and to enjoy the respect of fellow citizens (Diamond, 1997). Having your physical needs met adequately, and feeling a sense of belonging and respect in your community and culture all can contribute to a sense of positive well-being (Greenberg and Leitch, 1993). As stated previously, many men who have been diagnosed with ASPD feel that they are not acknowledged as citizens worthy of basic neccessities or entitled to experience feelings of self-worth in their communities (Black, 1997). In fact, once the ASPD diagnosis is

known, many of these men feel rejected and shut out of opportunities that provided them with positive and healthy avenues to gain self-esteem (i.e. employment, housing, relationships).

Analysis of social aspects of poverty links conditions of poverty to the unequal distribution of resources and power in a society (Iceland, 2003). Firebaugh (2000) recognizes that poverty may be a function of the diminished "capability" of people to live the kinds of lives they value. Poverty may also be understood as an aspect of unequal social status and inequitable social relationships. This can result in social exclusion, dependency, and diminished capacity to participate, or to develop meaningful connections with other people in society. Gordon (1972) identified a range of factors which poor people identify as part of poverty. These include: precarious livelihoods, feeling excluded, problems in social relationships, lack of security, abuse by those in power, disempowering institutions, limited capabilities, and weak community organizations.

Iceland (2003) stated that in most developed countries, rates of mental illness are highest among the poor. The most common disorders associated with poverty are depression and anxiety disorders. Without meaningful, well-paying work and the resources and social affirmation that come with it, many poor people develop low self-esteem and feelings of worthlessness. People who are stressed by the uncertainty of where they will get their next meal, how they will pay their bills, and where they will be living month to month will likely experience very high levels of stress and anxiety. Because the poor experience high rates of severe mental illness, they also have high rates of suicide (Cox and Alm, 1999). It can be said though that if the poor are often occupied

with problem-solving around how they are going to be meeting their basic needs, that their ability to manage their time to involve themselves and seek out resources that will help them to "better themselves" (i.e. employment resources, anti-poverty resources) and build better coping skills is diminished.

Widiger et al. Thomas (1999) stated that high rates of poverty for persons who have been diagnosed with mental illness, demonstrates the difficulties of distinguishing between poverty's causes and its effects. Mentally ill tend to have trouble holding steady jobs and maintaining relationships, causing them to fall into poverty. They may also have difficulty lifting themselves out of poverty. At the same time, in some cases poverty itself appears to promote mental illness and drug dependence as poverty reinforces and defines you as a individual of lower class status that is not deserving of respect and acknowledgement of need. Poverty is necessary in order to continue to establish a class system within an capitalistic economic framework. (Cox and Alm, 1999).

Two of the interview subjects in this study admitted to living in poverty as children. The effects of poverty in childhood are serious. Children who grow up in poverty suffer more persistent, frequent, and severe health problems than do children who grow up under better financial circumstances (Simmel, 1965). Many infants born into poverty have a low birth weight, which is associated with many preventable mental and physical disabilities as they grow through life developmental stages (Ainsworth, Blehar, Waters, Wall, 1978). Children raised in poverty tend to miss school more often because of illness. These children also have a much higher rate of accidents than do other children, and they are twice as likely to have impaired

vision and hearing, iron deficiency anemia, and higher than normal levels of lead in the blood, which can impair brain function (Bretherton and Munholland, 1999).

Levels of stress in the family of origin have also been shown to correlate with economic circumstances (Mercer, 2006). Studies during economic recessions indicate that job loss and subsequent poverty are associated with violence in families, including child and elder abuse. Poor families experience much more stress than middle-class families (Prior and Glaser, 2006) Besides financial uncertainty, these families are more likely to be exposed to series of negative events, including illness, depression, eviction, job loss, criminal victimization, and family death.

Parents who experience hard economic times may become excessively punitive and erratic, issuing demands onto their children backed by insults, threats, and corporal punishment (Ainsworth, Blehar, Waters, and Wall, 1978) Parents who are raising their children in poverty stricken conditions tend to not have the time or ability to adequately develop a sense value and self-worth in their children (Mercer, 2006). Often children who have parents living in poverty, communicate their needs through their behaviors in order to attain parental attention. The more extreme (and perhaps negative) the behavior is, the more chance that they will receive this attention. Unfortunately negative attention-seeking behaviors as children can lead to ASPD characteristics in adults.

The effects of imprisonment

A theme that held relevance for all three of the interview subjects in this study was that all three men had spent consecutive time in the federal and provincial prison systems. All three men maintained that their time and experience in the prison system was very difficult and all three men felt that the prison system had changed their

personality long-term in some way. Flanagan (1980) stated that "imprisonment necessitates a substantial curtailment of an individual's freedom and many other basic rights, and that deprivation is an inherent feature of being incarcerated." Flanagan reports that a study was carried out in 1980 to examine the attitudes and perspectives of long term inmates, where they asked inmates serving sentences of 10 years or more to prioritize what they saw as the most serious effects of deprivations of imprisonment. The five problems they listed, from most to least serious, were missing somebody, missing social life, worrying about how they will cope when released, feeling that their lives are being wasted and feeling sexually frustrated. When asked to describe the single most important or serious problem that they had encountered since being incarcerated, loss of relationships with family and friends outside the prison was consistently mentioned as the most serious deprivation. Some long term inmates cut themselves off from these relationships as a means of avoiding the anxiety and despair that accompany separation.

However, for the majority of inmates who do not use this strategy, family ties become a two-edged sword over the years, providing encouragement and support and at the same time, making it more difficult to serve time. All three interview subjects who participated in this study spoke about their families at some level. At least two of the interviewees (Terry and Joe) felt that the poor relationship bond with their families impacted their personal awareness of how they got along with the world. There was a sense of rejection and hostility as children, which was heightened as adults due to these men's inability to resolve conflict they that had with their family.

Sabbath and Cowles (1992) reported that the prison system is reflective of the masculine role model that many inmates attempt to emulate. According to Moffit, Caspi,

Harrington and Milne (2002), this bravado role was not a matter of choice in the prison, but rather a matter of survival. If is it is considered natural to on some level exert a sense of power and authority within your external environment, the experience within the prison system would definitely skew your ability to do so. In dominant North American culture, power and authority is achieved through capital and class status. In the prison system, power and authority is achieved through intimidation and violence. The basis of each means to gain control is to target "the weak" and normalize behaviors and attitudes that elevate those in power, and make it impossible for those who are oppressed to achieve equality. This may be why persons that have spent long periods of time in prison find it so difficult to reintegrate into society and adapting to the values and cultural practices of the macro society. This could be an indicator as to why recidivism rates are so high.

The interviewees also provided a picture of prison as an environment where you are crowded with other inmates, however you are not able to trust anyone around you. This would naturally lead to a heightened sense of personal awareness, paranoia, and the need to be defensive and impulsive that would stay with you when you interact with persons outside of the prison environment. Few of the conditions imposed on inmates are as severe the loss of liberty (Grassian, 1983). Prison inmates must live in a world where their freedom of movement is rigidly restricted and regulated. Johnson (2004) reported that the inmate's loss of liberty occurs at two levels; first by confinement to the correctional institution and second, by confinement within the institution. At the first level, inmates are cut off from contact with family, relatives and friends, producing what can be a painful deprivation and frustration in terms of lost emotional relationships,

loneliness and boredom. Kaminski (2004) stated that for prison inmates, most of their waking hours are spent within the confines of their cells. The second level of loss of liberty occurs when offenders are put in solitary confinement and do not have contact with any social stimuli whatsoever. Johnson (2004) reported that an inmate who suffered from mental illness, are often initially seen as having negative behavioral attributes and needing to be a solitary confinement environment. When looking at the effects of confinement and loss of freedom, it is impossible to ignore the reality that these experiences would have an long-term effect on you once out of prison.

The world of the inmate is characterized by a multitude of rules and commands designed to control his or her behavior. Braithwaite (1989) stated that prison rules and regulations for prisoners are defined through a bureaucratic process of trusting prison staff to carry out rules. In social communities, rules and regulations are defined through cultural custom and social norms. Most prisoners express an intense hostility against this system, which is what makes their restricted ability to make choices one of the major deprivations of imprisonment (Sykes, 1966). Grassian (1983) stated that inmates often lose their sense of self efficacy once autonomy is taken away. Offenders are told where to live and when and what to eat, they are required to wear regulation clothing, perform certain jobs and follow numerous rules (Santos, 1995). Self motivation and personal achievement are neither facilitated nor reinforced among inmates.

Rigid and sometimes incomprehensible rules have always been basic features of incarceration (Sykes, 1966). The rules, commands and decisions that are imposed on inmates are not accompanied by explanations, as many corrections officers feel that they do not need to justify their demands and actions; inmates are to do what they are told and

not ask questions. Being in a prison environment, presents a profound threat to the inmate's self image by reducing the inmate to the weak, helpless, dependent status of childhood (Sykes, 1966). Loss of autonomy can also entail a serious threat to the inmate's self esteem as a fully accredited member of adult society. Treating inmates as if they were children is contrary to the best interest of society: when long term prisoners are released they may have lost the ability to make decisions for themselves and are less likely to be able to live productive lives in the community.

Social Stigma

For all three men in the study, it was universally felt that the social stigma of mental illness interfered with the quality of their lives and the choices that they made. Social stigma is an social ideology that affects many persons who have been inflicted with any type of physical/mental/social disability that makes them appear different than the "normal population" (Heatherton, Kleck, Hebl, & Hull, 2000). Ed, Terry and Joe all reported feeling that the occurrence of social stigma got in the way of them finding regular work, maintaining a safe place to live, having a healthy relationship or building a family.

In fact, both Joe and Ed felt that their involvement within the mental health system created the stigma, and that instead of support, they received a label of resistance. Due to the stigma associated with mental health issues many people have found that they lose part of their self-esteem and have difficulty making friends (Kurzban & Leary 2001). Joe reports that other persons do not trust him and are paranoid that he is "unstable". Joe also claimed that the majority of his life experiences have been negative ones, and that people tend to be "put off" by his stories. Joe states that he is "comfortable" with not

having friends, but continued to perseverate on feeling alone in his life. If a person does not have individuals or groups in their life that are able to positively reinforce and provide a feeling of being accepted, one's self esteem is directly effected in a negative manner.

Individuals with a mental health issue and their relatives have reported that increased isolation and loneliness followed the diagnosis of their mental health issue. Ed reported that he does not leave his apartment unless he has to and his family will only speak with him during holidays and "when they have to." Joe admitted that he was lonely and "really wanting" a relationship in his life. It appeared that with two of the three interview subjects, they were discouraged to confront any type of social interaction as they reported feeling that they were setting themselves up for rejection. Instead, these men chose to avoid social situations that the mainstream mental health system saw as healthy (i.e. applying for jobs, going to outpatient programming).

The typical reaction encountered by someone with a mental health issue is fear and rejection. Joe reported that he has been unsuccessful in being able to maintain a healthy relationship with his family, make friendships or keep a job. Joe was also "so tired" of "professionals" putting an expectation on him to achieve success in relationships and employment when "there is a target on your straight away." Terry had also experienced hardship and rejection from his siblings, and blames being involved with the mental health system for ending his common law relationship. Ed is also not able to see his niece and nephew. This form of rejection is extremely difficult for Ed to handle, as he reports feeling that others do not trust that he has the child's best interest at heart, and in fact imply that he is at high risk to hurt his sibling's children.

Individuals with a mental health issue experience stigma in all areas of their life; some have been denied adequate housing, access to education, job opportunities, and relationships due to their history of mental health issues. Ed reported that at one point in his "treatment" his mental health worker left her card for the landlord in the event that there were any troubles. According to Ed, the landlord then looked for reasons to evict him and would not address any concerns with Ed, but instead insisted on calling his worker. Many persons who are mandated to partake in mental health treatment also are assigned outreach workers to work with them out of their homes in the community. In the event that their buildings do not allow strange visitors, mental health clients are then supposed to advise the owners of the building of the possibility of treatment workers being around. This violates the confidentiality and privacy of mental health clients. Ed reported feeling that when mental health workers are involved, the landlord will often defer any questions or concerns to them, instead of dealing with the actual tenant. Also, landlords were concerned that having a mental health client in their building would mean that there is a higher risk of tenants damaging the building or not taking care of their suites. Because many persons diagnosed with mental health issues have difficulty finding work, they are often left to seek out apartments in areas and buildings that are run down and already damaged. Joe reported that he was often blamed for other tenants' activities. When Joe tried to defend himself, the landlord would often look at him as "crazy."

The most damaging effect of stigma is the unwillingness of people to seek help (Heatherton, Kleck, Hebl, & Hull, 2000) Individuals may be reluctant to define themselves as having mental health issues, while families may delay seeking help for

their child because of their fears caused by the stigma placed on people with mental health issues.

Labeling theory, also known as social reaction theory, is concerned with how the identity and behavior of an individual is created and influenced by how that individual is categorized and described by others in their society (Akers, 1997)

The theory hypothesizes that the labels that are applied to individuals influence their behavior, particularly the application of negative or stigmatizing labels. These labels may promote deviant behavior, and can put someone at risk of becoming a self-fulfilling prophecy. This means that an individual who is labeled has little choice but to conform to the essential meaning of that judgment. Consequently, labeling theory postulates that it is possible to prevent social deviance by limiting social shaming reaction and replacing moral indignation with tolerance (Akers, 1997). Emphasis needs to be placed on the rehabilitation of offenders through an alteration of their labels.

George Herbert Mead (1934) wrote that that the self is socially constructed and reconstructed through the interactions that an individual has with their community and culture. Each individual is aware of how they are judged by others because he or she has attempted many different roles and functions in social interactions and has been able to gauge the reactions of those around them. This builds a subjective conception of the self, but as others intrude into the reality of that individual's life, this represents objective data which may require a re-evaluation of that conception depending on the authoritativeness of the others' judgment.

If deviance is a failure to conform to the rules observed by most of the group, the reaction of the group is to label the person as having offended against their social or

moral norms of behavior (Akers, 1997). This is the power of the group: to designate breaches of their rules as deviant and to treat the person differently depending on the seriousness of the breach. The more differential the treatment, the more the individual's self-image is affected.There are also problems with stereotypes (Phelan and Link, 1999). The breach of a rule may be treated differently depending on personal identity factors such as the age, gender, race, or there may be relevant structural factors such as the offender's social class.

In terms of the labeling theory and mental illness, Phelan and Link (1999) stated that mental illness is manifested solely as a result of societal influence. They argued that society views certain actions as deviant and, in order to come to terms with and understand these actions, often places the label of mental illness on those who exhibit them. Certain expectations are then placed on these individuals and, over time, these individuals unconsciously change their behavior to fulfill them.

Phelan and Link (1999) reported that expectations of labeling can have a large negative effect on the mentally ill, that these expectations often cause patients to withdraw from society, and that the mentally ill are constantly being rejected from society in seemingly minor ways but that, when taken as a whole, all of these small slights can drastically alter their self concepts. It is obvious that the mentally ill both anticipate and perceive negative societal reactions to them, and that this can potentially damage their quality of life.

Braithwaite (1989) claimed that people who are labeled as mentally ill are stereotypically portrayed as unpredictable, dangerous, and unable to care for themselves. He also claims that "people who are labeled as deviant and treated as deviant become

deviant. This statement can be broken down into two processes, one that involves the effects of self-labeling and the other differential treatment from society based on the individual's label.

Dual Diagnosis and Co-Morbidity

Another theme that was evident for all three interview subjects was that of dual diagnosis. A dual diagnosis is given to an individual who has both a mental disorder and an alcohol or drug problem. Berman and Noble (1993) stated these conditions occur together frequently. Two of the three men that I had interviewed spoke about their own alcohol and drug problems. Trying to manage just one of these problems can be extremely stressful. All three men that I had interviewed also reported receiving multiple diagnoses in the past as well including bipolar disorder and Schizophrenia. This is reflective of the medical model critique in that it is difficult to define and categorize mental health disorders because the characteristics of the disorder is relative to the interpretation of the professional who is providing the assessment.

To complicate things further, add to the mix multiple symptoms that overlap and mask the ability to make a diagnosis, and what you are left with is a difficult and complex challenge to find a successful treatment. Drake and Wallach (1993) stated that often persons with mental health disorders use alcohol or drugs to help cover up or mask symptoms of a mental health problem that is going unrecognized.

Wright, Gournay, Glorney and Thornicroft G (2000) stated that anxiety is the number one symptom that is often not acknowledged or treated by the professionalized mental health community. Anxiety is a physiological state characterized by cognitive, somatic, emotional, and behavioral components. These components combine to create the

feelings that we typically recognize as fear, apprehension, or worry. Anxiety is often accompanied by physical sensations such as heart palpitations, nausea, chest pain, shortness of breath, stomach aches, or headache**.** Anxiety complicates ones ability to properly cope and problem solve in a logical way. Very often to goal for alleviating anxiety is symptomatic and countertherapeutic to the source that is actually causing the anxiety.

Alcohol and street drugs are commonly used by people as a means to control their anxiety and help them to feel calm. For example, if a person's mind is racing because of mania, a drink of alcohol may slow it down. If a person has intense sadness or hopelessness because of depression, a street drug or alcohol may help him or her feel happy or hopeful for a period of time. This "self-medication" may appear to be beneficial on a short-term basis. However, the reality is that it actually makes things worse as a pattern of use of alcohol and drugs can turn into an addiction. Mueser, Essock, Drake, Wolfe and Frisman L (2001) stated that after the temporary effects of the alcohol or drugs wear off, a person's symptoms are often worse than ever causing a relapse in self-destructive behavioral patterns.

When looking at the issue of dual-diagnosis, a common question is what comes first- the addiction or the psychiatric problem? Mueser, Essock, Drake, Wolfe and Frisman L (2001) stated that often it is the psychiatric problem that occurs first. In an attempt to feel better the individual self-medicates with alcohol or drugs which can lead to chemical dependency. Wright, Gournay, Glorney and Thornicroft G (2000) reported that it is the alcohol or drug dependency that is the primary condition which over time can lead to depression, anxiety and more severe emotional and mental problems.

For persons who have been diagnosed with ASPD, it often seems that alcohol and chemical dependency is a characteristic of the disorder itself. Addictive behavior is viewed as the large repertoire of behaviors that persons with ASPD are assumed to have. This perspective lays blame on the individual themselves at making conscious choice around abusing substances. It may be rarely seen that persons who have been diagnosed with ASPD suffer from and are exposed to a variety of complications that cause stress and raise anxiety levels. These include dealing with traumatic memories of childhood, trauma experienced within the prison system, poor physical health, the social effects of poverty and poor social relationships.

As stated, all three men who partook in this study also reported that they had been diagnosed with thought and mood disorders in the past. Therefore, they may still be struggling with extreme mood lability and perceptual problems that are being untreated because of the diagnosis of ASPD. When looking at the issue from this perspective, it may be easier to understand why there does tend to be higher rates of alcohol and drug use for persons who have been diagnosed with ASPD. The "treatment" that persons with ASPD are receiving may not be targeting all symptoms or address all psychosocial stressors. Using and street drugs is a means to cope and to self-medicate to deal with high anxiety levels related to other factors that the ASPD diagnosis fails to really look at.

It is also important to note that men who have been diagnosed with ASPD are typically exposed to and socialized in environments where rates of alcoholism and drug use are high. Therefore the act of using alcohol and drugs are normalized and justified. Especially when these men have witnessed their caregivers and role models utilize alcohol and drugs in the past. Alcohol and drugs is also much more accessible than other

forms of "help" to assist someone with coping or alleviating anxiety. Many of the men I have worked with who have been diagnosed with ASPD live alone, and do not have a support system that is accessible to them when they are going through a crisis. Often, the more formal types of support (i.e. mental health workers) are limited as to when they can see their clients and to what extent they can help their clients. Alcohol and drugs is a means to cope with a situation as it is happening. Avoidance of the situation, although non-productive, is a manner in which many people deal with crisis. As stated, once a pattern of alcohol use begins, this pattern turns into a physical and mental addiction to the substance. People who have alcohol and drug problems rarely perceive that they have any control over their lives of decisions once they become addicted. Large amounts of external supports are necessary when someone is addicted to alcohol or drugs. It is very rare that an individual would be able to manage and overcome the addiction on their own.

Trauma and Antisocial Personality Disorder

All three interview subjects identified aspects of their childhood that were harmful and continued to have an impact on them in the present. Joe and Terry spoke in depth about their childhood. Both men experienced violence in their home, alcohol abuse, and neglect from their parents.

Trauma is any experience that overwhelms the nervous system and can occur at any time in your lifetime (Van der Kolk, Bessel, McFarlanee, Alexander and Weisaeth,1996). Because the nervous system acts in an all or none fashion, an event need not to be life threatening, it only need to be perceived as life threatening for the nervous system to have a full response (Scaer, 2005). Thus when we look at trauma, not only do

we need to look at the traumatic event itself, but also the effect this trauma has on the nervous system.

All three men in this study likely suffered some form of trauma as children, and were like retraumatized as adults. As stated previously, it is essential during early childhood development that children form a strong bond of trust with their parents. If a parent is not provided with this continual 1-1 support and attention to their child, the child will likely constantly be in state of distress as the child will not feel safe in the world around them (Scaer, 2005). Mcnally, Bryant and Ehlers (2003) stated that adults who have reported childhoods where parents were not providing constant emotional nurturance and support, develop a "kindling pattern"in which there nervous system is in a continuous state of hyperarousal.

Van der Kolk, Bessel, McFarlanee, Alexander and Weisaeth (1996) stated that once an infant becomes a toddler and seeks more independence from their parents they start to develop a parasympathetic nervous system. The parasympathetic nervous system allows the child to experience internal and external sensation (including stress) within their nervous system and interpret this sensation as something that is safe or unsafe and modify their behavioral presentation accordingly. It is important to note that prior to toddlerhood, the parasympathic nervous system is not developed and the parents are the template as to how the child responds to stress. Van der Kolk, Bessel, McFarlanee, Alexander and Weisaeth (1996) wrote that if the parents do not spend time with their children as infants, the parasympathetic nervous system is greatly under-developed and the child is in a constant state of dysregulation. Dysregulation is the inability to self-regulate your emotions and your nervouse system constantly being in a state of

hyperarousal (Scaer, 2005). This internal complex, if not treated in childhood can turn into maladaptive, hostile and antisocial behaviors as adults as the individual is always feeling at threat regardless of the reality of external circumstances and interactions.

I feel that Post-traumatic stress disorder (PTSD) is important to look at for men who have been diagnosed with ASPD. PTSD is believed to be caused by psychological trauma and it is a severe and ongoing emotional reaction to this trauma (Shalev, Yehuda, McFarlane, 2000). Men who have been diagnosed with ASPD have higher rates of physical and emotional abuse and neglect as children (Feldner and Friedman, 2007). One can interpret then that the ability for these individuals to interpret stress, and manage sensations related to this stress in a healthy manner is hindered. They likely have developed characteristics of attachment disorder as a child, and experienced trauma at a very young age because their emotional needs were not being met by their parents.

As stated previously, men who have been diagnosed with ASPD were more likely to experience physical abuse, parental drug and alcohol abuse, and poverty as children- all factors which would likely cause an inordinate amount of stress to the nervous system. However, because the parasympathetic nervous system has not evolved, the interpretation and experience of this stress may lead to traumatic memories. Many men who have been diagnosed with APSD have spent time in prisons, continue to struggle with their own personal addictions, and have generally been exposed to a poorer quality of life (i.e. povertous conditions). Men who have been diagnosed with ASPD continue to be retraumatized on a ongoing basis throughout their life, as their interpretations of events and experiences may be heightened and skewed because they’re in a constant state of dysregulation.

When trauma happens there is a loss of integrity and cohesion of self, resiliency and trust (Breslau, 2001). Trauma has a negative impact on an individual's ability to feel a sense of safety and control in their lives. People who are interacting with the social world, while at the same time dysregulated because of trauma, will find it difficult to make positive social connections.

Housing

One theme that was consistent when talking with the men who had been diagnosed with ASPD was that of safe housing and access to housing. Ed, Terry and Joe all felt that housing was or has been an issue in their lives. That is, housing did not provide stability nor was safe. Housing is important because it provides persons with a sense of stability and security in their lives. Having a decent house or apartment motivates people to take more pride and therefore responsibility in their lives. Adequate housing is important because it also provides persons with a higher sense of self-worth and capability. The housing that the men I interviewed lived in tended to be in areas of the city that were run down, impacted by high rates of crime and had little access or promotion of community resources.

Ed stated that housing authorities "always" required past references to clear applicant. Ed indicated that people who live in low income housing tend to move constantly, and have little to no contact with landlords or housing authorities. When applying for an apartment, it is difficult to remember who your references were, and contact information for landlords tended to be inconsistent. Also, when references were available, reference sources tended to avoid providing references based on past relationships with tenants.

Joe mentioned that in the past he has had problems with housing as he has mostly lived in "ghetto" neighborhoods where it was "too easy" to be connected and become involved with other activity that was occurring in buildings. It is difficult to initiate positive change in one's life when you are constantly being exposed to and being left vulnerable to activities and persons that evoke feelings and motivated behaviors that had been damaging in the past. For example, it would be difficult for an individual to stay away from drugs and alcohol, when drug and alcohol use is a common occurrence in the building that you are living in.

Joe reported feeling at times that he was "blamed" by housing authorities for taking part in parties and causing damages to his building and suite that he was not responsible for. Joe went on to say that persons who live in "ghetto" housing are often pigeonholed and stereotyped as a certain kind of person and that this reputation follows you wherever you go. Joe reported believing that persons who live in low income housing are often taken advantage of as building owners do not prioritize the need to maintain the building to health and safety codes, including being proactive at ensuring heating and water is in proper working condition. When tenants express their concerns, Terry reported a belief that landlords do not take him seriously as "they know [he has] no choice but to live in the building."

Ed reported that the housing that he was "forced" to reside in was not safe, as there were reportedly constant fights and crime that had occurred in his building. Also, the police were often at this building and it was well known in the media as a building that persons who were considered criminals resided in his block. Again, this reputation followed Ed when he attempted to find safer housing in a residential neighborhood. Ed

also said that he hesitated to provide inner city addresses when he applied for employment, as employers often did not want to "deal with this kind people."

As a worker, I have also found that housing is often a problem with the clients; particularly those clients who had received a diagnosis of ASPD. Housing tended to be in poorer neighborhoods, where criminal activity was more habitual, normalized and therefore acceptable in the community culture. You are socialized to the environment that you live in, and to change the socialization process and promote internal change at times requires first a change to the external environment. I feel that the housing problem for persons that have been diagnosed with ASPD can also be linked to the employment problem for persons with ASPD. The majority of persons who have chronic mental health diagnosis, including ASPD, are in receipt of some form of Provincial Assistance because there is either poor access or lack of community programs that help persons with mental illness find meaningful work and employment.

It is evident that provincial assistance rates, including that Disability rate, is not congruent with the high cost of living, and therefore persons who have a mental health diagnosis are forced to live in cheaper forms of housing. It seemed to me as that as the cost of living increased, this population was forced to be more creative at finding homes, often needing to sacrifice their privacy by living in boarding home situations or co-habitating with persons who were not encouraging of any rehabilitative process that may had been occurring.

Many of my clients who have been diagnosed with ASPD grew up in neighborhoods with higher levels of poverty. These men have formed a connection with these neighborhoods. Unfortunately there are not enough incentives by community

organizers and politicians to provide assistance and funding to help restore these neighborhoods that have become rundown. As a result the morale in these neighborhoods tend to be low, and many of the persons who live in them, feel labeled, oppressed and unsatisfied with their lives.

Mental illness and employment

Another theme that was relevant amongst interview subjects was employability of persons who have been diagnosed with a mental illness. Gainful employment within a capitalist model of economy is crucial when determining class status and privilege, power, and overall quality of life. We expect persons to contribute to our economy by finding employment that is sustainable and long-term. Persons who are employed experience a justification of their bad behavior simply for the fact that they are not unemployed. This may me why antisocial acts are often demonized amongst citizens that occupy lower class status and upper class antisocial acts (i.e. corporate fraud, embezzlement) are often overlooked.

For persons who are not employed, they are scrutinized by society in general and made to think that they are less than because they are personally responsible for their hardship and unworthy for respect and attention as they are not able to contribute to the capital of society. Unemployed persons may think that they are a burden to society, because "taxpayer's money" is going toward paying for social programs that support persons who cannot provide for themselves. In fact, this burden is carried out through systemic shame as a distorted way to motivate unemployed persons to get jobs. Persons who access support social programs are made to feel that they need to appreciate what is

offered to them, and not complain as to how these services are offered. It is easy to stand by these social programs when you yourself do not use them.

One theme that was referenced by all three interview subjects was that of social isolation. Many of these men have not played an active role in their communities and culture, and have in fact been kept away from being able to integrate themselves effectively into mainstream society. Prison time, stigma and discrimination have all led to people not being able to develop the social skills, coping skills and work related skills that are needed to get a job. Prison environments also teach and ingrain a whole repertoire of interpersonal communication skills that, although relevant in prison, may not be conducive to being successful in mainstream society. Many of these men have spent large amounts of time in prison and have not the experience with finding work, or the ability to gain skills that employers would find beneficial. Men who have been diagnosed with ASPD are not seen as a commodity within the work force because it is considered that more time and energy needs to be to put toward training these persons, than hiring someone who already has work experience.

In my experience as a Social Worker, I found that it was difficult for her clients to access vocational programs because their applications and commitment to the process is deluded because of their criminal past. These men are seen as a liability and social programs and levels of government support this discrimination, rather than providing incentive programs and support to employers that would assist men who have had involvement with the criminal system to integrate into the work system.

The type of employment that are available for consumers of mental health services are typically low wage jobs, that are manual in nature and have a history of high

turnovers in employees because of the repetitive nature of the work and also the incongruence between the amount of work you do and the wage that you are paid. Many of these jobs are also seasonal and are connected with companies and organizations that have a tendency to not provide steady work and do not have reliable work histories. It was in me experience, that often my clients would be hired into a company that exploits their workers, and then ends up going belly-up within the year- causing these men to have to start the process over again.

CHAPTER VII - Discussion

Discussion

This study was not an easy study to do.. The participants in the study were not hopeful that the results of this study, or even a larger scale study on the same topic, would lead to any long-term changes. As one participant stated, " the world would have to end and recreate itself for anything to happen." These men had suffered long-term oppression and stigmatization within their communities and culture, and they projected an attitude that the professionalized mental health system pigeonholed them as persons that were dangerous, inaccessible, dispensable and not worthy of advocacy for better services. It was difficult for me to access this population. When I was finally able to do so, my optimism about the topic and importance of the findings were not reciprocated back by my interview subjects. I was also disappointed with the lack of research material that was available on this topic that addressed any alternative forms of healing and rehabilitation. Instead, the information that was available was mostly through medical journals that tended to focus on medication trials for persons with APSD and the professional containment of persons who had been diagnosed with ASPD that was necessary in order to protect the greater society.

I left my interviews feeling down, questioning to myself why complete the study if the persons themselves that were being interviewed were not optimistic of any changes. I sensed that these men were constantly being told by mental health professionals to try "their best" at working within the system, and to accept the reality that the consequences of their past actions and life choices were permanent and not interchangeable or forgivable. Attitudes for hope and new beginnings, as well as promoting the ability for

someone to change and learn positive lessons from past decisions a desire to change, were not held with great relevance when these men entered "treatment contracts" with professional agencies and workers. I am also guilty of reinforcing this pattern, as when I was working with this population I spent more time being scared of my clients and contributing to their hardship. I would "red flag" these clients when a new Psychiatrist was about to see them, and I would constantly be on the phone with Probation Officers advising them of my concerns of my clients. I would advise community facilitators of social skill based groups and self-help groups of not allowing these men into their group environments as I assumed that these specific clients were unpredictable and they would upset the balance of the group dynamic. In retrospect, I realize my fear was more embedded with the reality that these men existed in a world that was oppressive to them and did not provide them with opportunities so that they could have a decent quality of life. I was fearful that these men were going to hurt themselves or hurt others, without addressing the reasons as to why these men resorted to such extreme ways to communicate their needs, and express their pain. I was afraid of how these men would respond to the continual rejection that they were faced with. Extreme circumstances, coupled with humiliation, can lead to extreme behaviors.

I worked with the population of men who had been diagnosed with ASPD when I was working as a psychiatric social worker in northwestern British Columbia. Because of the reality of working in a northern agency, the social workers and nurses who worked for mental health programs tended to provide assessment and case management to a large variety of persons who had a multitude of mental health problems (from acute and short-term treatment to chronic and persistent mental illness). I had the good fortune of being

assigned as a "forensics consultant". This meant that I provided the majority of case management services under the supervision and consultation of forensics case managers who resided in Vancouver. I recall my co-workers not being too envious of my position, stating that accessibility and establishment of therapeutic rapport was difficult with this population. Nevertheless, I decided to take the plunge. The first area that struck me when working with this population was how difficult it was to establish a rapport. The majority of clients with ASPD diagnoses that I saw were mandated to attend mental health appointments through their community probation conditions. This meant that right away I needed to start establishing a connection, and therefore alignment, with the probation officers that were working in the community. The men that saw me were angry, resentful and did not trust me. They were adamant that they did not have a mental illness, and were resentful of the fact that their "bad behaviors" were being pathologized and medicated.

Any type of empathy that I tried to project toward this population in attempting to connect with them was met with resistance, as who was I to try to understand their problems. And these men had their problems. The majority of them came from broken homes, where the family lived under the poverty line. The children of these families were exposed to a different type of reality that contradicts what dominant discourses dictate to society life should be like. This reality included lying to various social systems, parentification, family violence and substance abuse. There appeared to be attachment issues, as many of these men were abused by parents, were victim to inconsistent and unreasonable parental interventions and had little or no relationship with their families in the present. They seemed lonely, desperate for attention and needing to feel taken care of

and worthwhile. It hurt them to see other people happy because it reminded them of unhappy they were.

These men reported a feeling that they were being discriminated against. As a professional, it was too easy for me to say to clients that their actions and decisions led to their current situation. I have never experienced what it's like to live in poverty, and to have my community view my family as degenerates and burdens to the system. I have never experienced what it is like to be looked down upon and be considered less than worthy simply because of the social class that I was attached to. This impacts an individual's ability to form relationships outside of their family, to have a positive experience in their community, to be provided with opportunities and to be successful in school, and enjoy successful stability (housing, employment, relationships) in their adult lives.

I felt that as time went on in this position, I did eventually reach some level of success at connecting with these men. By utilizing a narrative approach to therapy, I listened to these men account for their own experiences in life. I was interested in knowing why they felt they were in the position that they were in. I did not base their interpretations on a background of medicalized pathology and then summarize their own beliefs as delusional or distorted. I took their word for how they understood their existence, and I was able to then create an individualized treatment plan with these men that addressed what they felt their needs were. Most of the needs were around housing, education, and employment. Stability is what these men wanted. They felt that if they were to have stability their attitudes and presenting personalities would change. Community organization, education and advocacy were the primary ways that I was able

to develop rapport with this client base. These men needed to see, in a concrete format, that as a professional I was committed to help their cause.

Limitations of the study

The biggest limitation of this study was the sample that was interviewed. There were only three men involved with this study, and it is likely that the general population that has been diagnosed with ASPD are dealing with a variety of psychosocial and personal issues that are not being represented from this study. Also, all three men that were being interviewed responded to an ad that had been placed at the local men's shelter, so all three men shared poverty in common. It is important to note that the general population who utilize housing resources such as shelters do not necessarally share characteristics of men that have been diagnosed with ASPD. It is also essential to be aware that poverty is not directly related to ASPD and that there are likely persons who have been diagnosed with ASPD that are not living in povertous conditions. The three men who had been interviewed presented with an ambivalent or negative attitude toward the formal mental health system. It would have been interesting to interview men who had been diagnosed with ASPD and have had a positive experience with the mental health system. This study also focused on three male subjects under the guise that ASPD is most commonly associated with men. That is not to say that women are not diagnosed with ASPD as well, and it would have been interesting to explore the experiences of women that had been diagnosed with ASPD.

The men that were interviewed provided a rather narrow perspective of social programming that is offered for the ASPD diagnosed population. They found programming inaccessible and non-existent at times. As a researcher I focused more on

individualistic experiences and did not provide an inventory of programs that are available and that are being created for men who have been diagnosed with ASPD. I am aware of several programs that due help men and women who have spent time in prison with accessing housing and employment once they leave their prison environment. Most of these programs that I am aware of are linked into the formal mental health system (for what seems because of funding) and the individual participant is required to submit to the diagnosis and agree to formalized mental health treatment before these programs are available to them. It was difficult for me the researcher to also really understand the amount of programming that was currently being offered and was offered in the past to these men, as all three men admitted that they were ambivelent toward the mental health system and therefore not likely to research or access programming through the mental health system on a voluntary basis.

As stated, the majority of academic research on this topic tended to come from medical journals and articles. It was frustrating as a Social Worker not to be able to find a wealth of information on this topic stemming from social work or sociological journals. This may be the fault of the profession, as it is important to obviously research topics that are relevent to your field. It was also indicative that social work practice and theory is not directly linked when researching and developing programming for men who have been diagnosed with ASPD. The majority of research was based upon the belief that the diagnosis of ASPD was real and something to be studied under a medical label. Therefore, I felt that the majority of research I read that I was able to collect empiracal evidence from was biased by the root of the research coming from a medical prespective.

The label of Antisocial Personality Disorder

When you start to examine the experiences of men who had been diagnosed with ASPD, it is important to first look at the actual diagnosis of Antisocial Personality Disorder itself and the meanings behind this label. The DSM IV defines the diagnosis of ASPD as a pattern of disruptive behaviors over an extended period of time. The diagnosis description tends to look at behaviors and outcomes and does not identify any biomedical causations of the disorder. Although there appears to be biogenetic roots and theories pertaining to the development of ASPD, the diagnosis itself does not suggest any link between dysfunctional systemic interaction between individual and environment, and the consequences these experiences have an individual's psychosocial development, adaptive skill building and behavioral output. All three client interviewees made it known that they did not believe that they had Antisocial Personality Disorder. Two out of the three interviewees were not told what the diagnosis of ASPD was, or how they seemed to suddenly appear to develop this order. There was a general sense of frustration expressed that there was no explanation around specific causations of ASPD; specifically biomedical rationale. Dysfunction and neglect in childhood was perceived as a "characteristic" of ASPD rather than a contributing factor. All three men were offered services to assist them in understanding their ASPD. However, these services seemed to be more focused on defining of ASPD rather than creating and assisting goals as to how to manage ASPD.

The diagnosis of ASPD at times left the clients feeling powerless. The diagnostic description of ASPD does not lead to hope as to how one can survive the illness itself. The very fact that the ASPD diagnosis is viewed as a long-term medical

illness, emphasizes the position that someone who has been diagnosed from ASPD cannot recover from the disease but instead will surcom to it. The disease description separates men who have been diagnosed with ASPD from those around them, it alienates them. The diagnosis of ASPD is based on a professional body of research and development. Although there appears to be inconsistencies behind how one develops this disorder, and no identifiable causation, the diagnostic label is taken very seriously by people who really do not understand the definition behind it. There is research and discussion around alternative ways of looking at ASPD and a movement toward directing responsibility toward societal and political systems that have contributed to the maladaptive development of men who had been diagnosed with this disorder. However, the reality that exists is that it is unlikely that persons who work frontline with these men will ever have access to this information or the time to critically examine the real meaning behind ASPD. Instead, front line workers of mental health agencies and social programming, as well as families of men that have been diagnosed with ASPD, trust that the medical description of ASPD is true and without inconsistency. Therefore, the diagnosis of ASPD often justifies discriminatory acts against the persons that have been diagnosed with it. They often lose out on housing, employment and opportunities for social growth and wellness.

The three men that I interviewed addressed the diagnosis as something that was separate from them. They did not feel that the diagnosis adequately described them, or offered any support in how they could overcome there past misfortunes. The diagnosis does not indicate how the individual that is the recipient of it can learn to cope with past pain and neglect, or understand how to live in a world that, at times seems so relentless in

undermining their efforts in overcoming and truly understanding the effects of oppression. The diagnosis also does not address the deficits that occur and the challenges that effect persons who have not had healthy childhoods, positive experiences in school or who have lost essential opportunities of positive socialization because they have been in institutions or a part of the prison system.

As stated previously, a large majority of men who have been diagnosed with ASPD have spent time in prisons. A different socialization process occurs in prison that focuses on the interpersonal and coping skills needed to adapt to a prison environment (where the prisoner has no sense of control or power except over other men in the prison population.) Unfortunately, the modes of communication and behavior that can lead to power within a prison environment is not reflective of the interpersonal skills needed to successfully socialize and adapt to the outside world. This may be why recidivism is so high with this population.

The medical model proves to pathologize these men's behaviors and attempt to promote change through medications, cognitive therapy and close supervision. Medications are used to subdue symptoms that do not exactly exist in a physical sense. These men are angry an agitated that they do not have a place to live, a proper job or people that love and care for them. Instead of letting these men experience this anger, their 'temperament" is instead drugged up and stoned. Many of the men that I have interviewed are on medications that they do not even know the proper name for. They were told that if they did not take the medication, they would either end up back in jail or hospital. Threats of calling the judge or probation officers also loom over these men if they choose not to take the medications prescribed to them by their Physicians. The type

of therapy that these men are in a sense forced to engage in are cognitive based and look at setting up routine to promote time management and cognition to promote self awareness and therefore change in behaviors. This type of therapy does not take into consideration these men narrative experiences, and hold accountable to dysfunctional micro and macro systems that they have been exposed to.

These men are to be supervised weekly if not daily, and are given the message that any entrance into what would seem to be "mainstream society" needs to be done with caution. The participants in my study have been advised that they need to be "realistic" about their hopes and dreams, and not aim too high and enter a state of 'grandiosity" where their expectations are set too high and they ultimately are at risk of achieving failure. These men have been told that they need to stay working within the welfare system, that they are not suited to be into any type of relationship and that they are lucky to not be in prison. But in a sense, if you use the term "imprisonment' in a relative context without implying physical imprisonment, these men ARE indeed still imprisoned through their oppression. These men do not see the dominant powers and authority called to task and held accountable foe their role in poverty, mental illness, cultural contamination and violence.

The experience of the mental health system

The prognosis of ASPD is not good, as many men labeled with this disorder fall victim to recidivism in crime, institutionalization, violent death, drug and alcohol overdose, as well as suicide. Why is this prognosis the way it is? Is there something inherent inside these men that drive to this dismal destiny regardless of the opportunities that are presented to them? Or, is it a lack of services and resources accessible in the

communities that focuses on building a better quality of life, and teaching healthy communication and social skills? I feel that there are two points to address. The first one is that many consumers of mental health services, not just those diagnosed with ASPD, oppose the idea of their "mental illness" being a part of the disease model. The interventions that are established when you medicalize antisocial behavior are not necessarily addressing the needs that these men may have when developing a rehabilitative plan and identifying goals. I feel that the manner in which the mental health system treats ASPD, also sets limits and imposes differences between client and worker that complicate the helping relationship. I have seen many times that the relationship goal between client and mental health professional are often at opposite ends of the spectrum. While the client's goal may be experiencing positive change in their life, and making sense of their life experience, the goal of the professional may be more around containment and treatment of symptoms that are not conducive to the well-being of dominant society.

Another aspect of the diagnosis of ASPD was that these men felt trapped. Many of these men were expected to meet with community Psychiatrists and mental health workers on a monthly basis as mandated by their parole officers or court systems. If these men do not comply, the doom cloud of returning back to jail looms over their heads. These men also had to advise their parole officers of where they were living, what their intentions were behind looking for employment, and what crowd of persons they were keeping company with.. These men were also under the microscope in a sense that they were expected to divulge personal information about their lives when asked. If this

information was divulged, judgments were made (not always accurate ones) and the social systems that were meant to help them would also impose consequence.

The professional mental health system is set up in manner in which ultimately the opinion of the professional overrules the opinion of the client. For men who had been diagnosed with ASPD, individualized motivations behind certain behaviors are perceived within the context of the diagnosis itself. You don't intimidate and manipulate because you feel inferior and disempowered; you present this way because you are antisocial. This information is then relayed to other systemic players, without taking into consideration the interpretation of the individual who is actually expressing the behavior. The term "antisocial" is also important because it is the medical community and mental health agencies that usually define what is considered proper and improper social behavior. The definition is being identified by persons who likely fall within non-stratified sectors of the population that compliment dominant political and cultural ideologies. One must be reminded that these ideologies also socially constructed in manner to promote specific sections of the population into power roles, and oppress other communities. The term antisocial itself may be different depending on the demographic you are asking. I feel that it is likely that individualized definitions are based on individualized interpretations of life experience. The structure of the professional mental health system is at risk of not allowing for much autonomy or self-empowerment of the clients that it is meant to serve and provide services for. One can argue that the professional mental health system does not allow for a multi-perspective analysis of events. If a relationship is to end, this is the fault of the person with ASPD. The fault of the second party in the relationship seems to automatically be eliminated. If an ASPD

diagnosed individual loses his employment, it is pathologized as part of his illness. This may not allow then for accountability of the employer who may have in fact let the individual ago under false or unfair circumstances. It also is a problem, that when an ASPD diagnosed person attempts his actions within a situation, which he is viewed as untrustworthy and this account of the situation is seen as dishonest or distorted.

From my own experience as a Social Worker, it was difficult to work with these men on a supportive level within a system that is also punitive. The two men that were able to stay for the entire interviews, were both aware that the mental health worker is connected to the Doctor who is connected to the Probation Officer who is connected to the judge. Although these men were given promises of privacy and confidentiality when they originally entered into the mental health system; this was not the case. Confidentiality is only honored as so far that the "treatment team" consisted of more than just the mental health worker or the Psychiatrist. The two men felt that the mental health system is not to be trusted, and that clinicians within the mental health system are further representations of the criminal justice systems. This mistrust affects the client's ability to properly engage in a therapeutic contract and form a positive relationship with the professionals that are supposed to be helping them. It also limits the quality of assistance that the mental health professional can offer the client. As a social worker with this population, I also felt that key target areas (i.e. counseling around childhood issues and effects of micro and macro systemic oppression) was not the focus of the interventions that I was implementing. Client "goals" focused more around medication adherence, and avoidance of situations where the client could potentially put the population at risk (i.e. making sure that housing fell within the conditions of probation agreements).

The mental health system is very often "roped into" this system, and mental health workers and Psychiatrists are aware that their credibility is compromised with this "agreement' that is assumed to go on between the mental health system and criminal justice system. It appears that the mental health system itself is not allowed autonomy when it is mandated to treat an individual through another system. From this perspective, both the individual being treated and the treatment workers themselves do not have the freedom to work together in an honest open context. What is then the goal of the mental health system? Is it to work from a client centred approach and help clients establish and reach short-term and long-term therapeutic goals? Or is to compliment the power and authority of another system. It would be interesting to see what would happen if a mental health clinician or Physician questioned the motivations of the criminal justice system in mandating treatment onto individuals.

The men that I had interviewed did not feel that they required psychotherapy or medications. They did not need to be seen by a doctor or mental health worker once a month and sit in a meeting where "[we] answer the same questions over and over again." These men do not need to be told that life could be better or only they would be compliant and cooperate. These men needed opportunities. These men needed stable, safe and healthy places to live. These men needed someone to look beyond the labels and the past and offer them a job. These men needed their families back in their lives again. Because it was once these opportunities were taken away that these men turned their backs on society. What these men also needed was proper intervention and protection and nurturance when they were children, not supervision and a label as adults.

Implications for Program Delivery

The results of the research of this study, as limited as they are, appear to point to the same direction. There needs to be more social programs specifically for men who have been diagnosed with ASPD that focuses on: 1) housing 2) employment 3) education and 4) relationship building and repairing. All four of these areas are important in life to have because they promote positive self-actualization and assists in the determination of individual potential.

Housing is important because housing has the ability to influence the safety that one experiences in their lives. Housing is also something that can be difficult for someone to access, especially men who have been diagnosed with ASPD, as they have lost essential communication skills necessary in order to attain housing. Communication skills are important, because these men face more challenges than normal when looking for housing, as for many of them their past negative behavioural pattern precedes them. It is important for these men to feel safe and secure, and this influences their internal anxiety which is important because they need to have the strength to manage their external stress. Safe housing is reflective of a new start and helps to promote change in ones life. Housing needs to also be in areas that are affordable and full of valuable resources. Housing needs to go beyond the physical containment and also focus on ensuring that there is minimal risk of exposure to stimuli that could potentially trigger the relapse of past behavioural patterns. For example, communities with high crime rates and high street drug and access and use can be detrimental to men who have been diagnosed with ASPD.

Safe and affordable housing is also not the easiest resource to find and these men

may need assistance in doing this. I feel that it can be the job of the mental health system to not only help men access housing resources, but also play a large role in developing housing programs for men who have been diagnosed with ASPD. By having the mental health system involved, you are also able to address the clinical and psychiatric aspects of ASPD, and subsequently implement appropriate interventions, that often regular landlords and housing authorities are left to do. It is important to note that the men that were interviewed were adamant that if the mental health system was to become involved with the creation of housing programs, that it focus on providing consumers with apartments and dwellings that reflect a sense of normalcy and privacy. There are mental health group homes that people do live in when dealing with a mental health crisis. Although I feel that supported living environments are beneficial for some, they take away a sense of independence and autonomy that men who have been diagnosed with ASPD require in order to repair damage that has occurred in their lives.

Housing that is offered in conjunction with the mental healthy system, possibly managed through the works of social workers, could also deal with the stigma of mental illness that many of these men face when go out to seek appropriate housing. There is not the shock value that is associated often with criminal and antisocial pasts. Instead, there is the awareness that change is needed in order to stop perpetuating harmful behavioural cycles. Housing that is managed through the mental health system can be transitional as well in the sense that occupants can choose when to transition to alternate forms of housing. But if the mental health system providing these men with some initial stability in housing, I feel that these men would be better able to organize their responsibilities and relationships in a manner that would impose positive change. There could be employment

programming, counselling services, legal services and other psychosocial rehab programming (i.e. addictions) that is linked to housing programs so that these men have better access to them.

Employment is also an important area to target when working with a population who has been diagnosed with ASPD. Employment can be looked at reintegration into society, and the starting blocks at building a life that can be successful. Employment reinforces self-worth and personal strength, and acts as a motivator in avoiding pitfalls that can cause long-term challenges and destruction in an individual's life. Employment is essential in a capitalistic economy and builds status and power in North American culture. Employment also acts as a means for one to start climbing their way out of poverty. All three men in the study admit that they have been employed, but the majority of their employment was sporadic in nature. Ed felt that more programs should be in place to assist persons who are receiving mental health services to access educational programs which in turn could assist in attaining more steady employment. Terry shared that it is difficult to attain employment because the type of employment that is available does not pay enough to provide a higher quality of life. It does not pay enough for one to be able to live in an apartment or house that they can be proud of. Transportation is difficult because this employment cannot cover the cost of a vehicle. Terry feels that is some ways, it is simpler to stay on Disability Social Assistance, rather than look for work.

Joe states that many individuals who were formally on social assistance, and who do go back to work, end up losing out on benefits that are offered through their social assistance programs. These benefits could include medication and other medical coverage

(glasses, dental). This could be especially difficult for men who have left the prison system and are mandated by law to follow recommendations (i.e. medication compliance) of mental health professionals.

It is my opinion that federal and provincial government need to be making more of an effort in funding and implementing employment programs that specifically help mental health consumers integrate into various employment environments. The funding could also go toward education reintegration programs, where individuals would have an opportunity to return to a formal educational environment. Ed did not feel that he will ever have this opportunity because of the difficulty for persons who are part of the social assistance programs to go to school which is not publically funded.

Terry felt that part of the problem is also the employers themselves. He felt that many of the employment opportunities that are out there for persons with mental illness leave them vulnerable to working for employers that do not respect their employees or have a professional code of ethics to follow. Terry stated that some employers remind these men of characters that they have encountered in prison or in the community (i.e. probation officers). Men who have been diagnosed with ASPD have learned to defy authority and rebel against them. They are accustomed to a power-over dynamic with authority figures and they have not been exposed effective leadership and support in their lives.

Joe provided a critique of some of the job-related programs that are available. In order to access these programs, you must become a part of the mental health system. As stated earlier, it can be difficult for men who have been diagnosed with ASPD to surcom to the pressures of being a part of the mental health system. These men, and persons that

work with them, do not necessarily see ASPD as a mental illness. Therefore, men with ASPD may be more reluctant to access programs that are under the mental health wing as they do not want to be viewed and treated like a consumer of mental health services.

The final, and I feel most important change, that needs to occur within the mental health system is the attitude that the professionalized mental health system portrays when assisting persons who have been diagnosed and labelled with a mental illness. I feel that mental health programs need to address the social and cultural consequences that occur when someone has been labelled with a mental illness. Mental health professionals need to educate the public about the resiliency that comes out of mental illness, and dispel any myths about mental illness that create a social atmosphere of fear, and subsequent rejection, against individuals who have been diagnosed with mental illness. Social work is important in this endeavour because advocacy, community organization and support are essential for persons who have been diagnosed with mental illness to experience

Men who have been diagnosed with ASPD, as well as any other mental illness, report that they feel powerless in their current situation as they often have no control over their treatment, or how other persons in positions of power or institutions view them. Persons who have been diagnosed with mental illness often feel weak as their "illness"acts as a detriment against them as what they can offer their families and communities (resilience, knowledge, experience) is almost always foreshadowed by their pathology and illness (Amartya, 1992). The symptoms and prognosis of these "illnesses"are very often defined by persons that are in positions of power and authority and have little to no first hand experience as to what it may be like to experience a mental illness.

The men who were interviewed certainly did not feel that they themselves were intrinsically bad persons. However, they did feel that the diagnosis of ASPD often led persons around them, particularly family and professionals' working with them, into thinking this was the case. When a label of ASPD is attached to you, the experience of these men was that society saw them as distrustful, dangerous and not capable of caring. For many of these men, the diagnostic label often preceded them before entering into various societal systems such as mental health agencies, and social programs for housing, employment and other forms of social support. From this perspective, the diagnosis of ASPD appears to be more "beneficial" for professionals and other people who have to interact with these men. It warns them and sets them up to assume that their interactions with these men will be negative and the input and experience that these men can offer will be poor and inconsistent. This of course leads to missed opportunities around proper housing, job skill development, educational and employment opportunities. From this perspective, the diagnosis of ASPD appears to do more damage for the individual by setting them up and imposing challenges that these men themselves are not equipped to overcome. If these do question the authenticity and meaning behind their psychiatric diagnosis, they are viewed as non-compliant, a threat and their antisocial tendencies are only reinforced. The men that had been diagnosed with ASPD felt that one of the best methods for them to gain any sense of power and authority for themselves was to display a pattern of oppositionality and disregard for society's rules and code of conduct. The behaviors and choices that these individuals made in their lives were more based on survival of poverty, overcoming their own adversity and establishing some sense of personal power in a culture that perceived them as weak. This power and control came

from interacting systemically in a way that makes persons and institutions fearful of them. Antisocial behaviors could then be viewed as these men's way of communicating their need for respect and acknowledgement.

Identifying families and children at risk is also an important factor when looking at the prevention of ASPD characteristics as adults. As noted, many individuals who exhibit antisocial behaviors are modeling them after a significant figure in their life. Antisocial behaviors are also relative to who defines normal vs. abnormal behaviors. What behavior that a person in a position of power may define as defiant and obstinent, the person in a position of disadvantage may see as a means of survival and getting their needs met. You need to look at the motivation behind the behavior and what end result is trying to be achieved. All too often, we look at the behavior as a choice to go against dominant discourse and practice for the sake of being defiant. If you do not have the opportunity to get your needs met in a "socially appropriate manner" one can argue that it is human nature to get these basic needs met in alternative ways. This pattern repeats itself from parent to child if the next generation is presented with as few opportunities and with a lowered status as their parents. Therefore interventions at school and child welfare agencies that work with children and families at risk need to be proactive rather than reactive. Income assistance agencies need to be allowed the funding and manpower to work with populations at risk by creating programs for housing, education and employment. Children do not benefit from witnessing their parents begging and being ostracized for needing a "hand up." Easy access to social programs is essential as well as lots of education to communities at risk of social programs that are available to them. Children need to witness their parents being empowered, as this is a powerful tool when

the child goes through the process of self-actualization and develops an individualized identity as an adult. Rather than these children perceiving their adulthood as a time enduring constant despair, possibly they can look at their lives and see hope.

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Appendix 1

Participant Recruitment Form

To Whom It May Concern:

My name is Steven Bergen and I am a full-time Master of Social Work student at McGill University.

I am conducting a research study on men who have been diagnosed with Antisocial Personality Disorder. I am hoping to interview three male participants who are between the ages of 18-50, and have been diagnosed with Antisocial Personality Disorder at one point in their lives.

The interview will take three parts. First, I would like to know what your world has been like since receiving this diagnosis, and how you feel you are treated in society. I am also interested in knowing what your experience has been like when accessing social programs in your community, including both positive experiences and challenges that you have faced. Finally, what is your opinion of the current state and delivery of community-based social programs and organizations? Are these programs helping you, and in what ways could they assist you better?

There would be one-1 hour interview per participant. Participation is voluntary, and you are able to stop your involvement with this study at any time. All participant involvement is confidential.

Meeting places/times will need to be arranged according to my and your schedule. All participants will be reimbursed $20.00 upon completion of the interview as well as any transportation and/or meal costs.

All interviews will be conducted in English.

This research interview will allow you the opportunity to get your voice heard about what it is like to live with this diagnosis. Also, you will be able to share your ideas around community-based program delivery. What should areas should these programs cover and what is important for professionals to know about when working with you?

If you are interested in taking part in this study or if you have any questions please feel free to contact me at (204) 467-8123 or email at steven.bergen@mail.mcgill.ca. You may also contact Dr. Peter Leonard, my research advisor on this project, at 514-398-7061 or peter.leonard@mcgill.ca.

Thank you

Sincerely

Steven Bergen

Appendix II

Agency Recruitment Form

To Whom It May Concern:

As a student in the Master of Social Work Program at McGill University, I am conducting a research study on what it is like to live with a diagnosis of Antisocial Personality Disorder and how one perceives their treatment from others because of this diagnosis. It is important to also know what persons, who have this diagnosis, feel are important elements for professionals to be aware of when working with them.

In order to recruit participants for this study, I am requesting permission to leave the attached recruitment forms with your organization. There is an increased likelihood for individuals who are diagnosed, or who have worked with diagnosed individuals, with Antisocial Personality Disorder to see this recruitment form at your agency.

It is important to note, that this research will not identify your agency within the final research report. I am conducting this research on my own and it is not reflective of involvement, either as professional and/or client, with your or any other specific agency. It is not my intention to critique or evaluate services of a specific organization. Although research subjects may be asked of their experiences with community agencies, these will be identified in general terms (i.e. community agency, hospital).

This research has been approved by the Research Ethics Board at McGill University and I have attached a copy of the approval letter.

If there are interested persons who are willing to participate in this subject, these persons must contact me directly. I am not looking for your agency to recruit any individuals through a referral process.

If you have any questions or concerns, please feel free to contact me at 204-467-8123 at steven.bergen@mail.mcgill.ca. You may also contact my research advisor on this project, Dr. Peter Leonard, at 514-398-7061 or peter.leonard@mcgill.ca.

Thank you

Sincerely,

Steven Bergen

Appendix III

Consent Form

Dear Sir:

As a student in the Master of Social Work Program at McGill University, I am conducting a research study on what it is like to receive a diagnosis of Antisocial Personality Disorder and how others may treat people because of this diagnosis. I am also interested in knowing what persons who have this diagnosis feel are important elements for professionals to know about when working with this population.

You are invited to partake in this study. By agreeing to participate in this study, you have agreed and are aware of the following:

1) Participation in this study consists of one 1 hour interview that is to be tape recorded.

2) Once interview is complete, tape-recorded interviews will be transcribed to a computer. All tapes will then be destroyed.

3) You will be reimbursed $20 for participation in this study. This will cover transportation and meal costs. You will be reimbursed once interview is complete.

4) All information will be kept confidential. Your name will not be used in the final research report and other identifying information (for example your age) will also be changed.

5) Only Steven Bergen (researcher) and Dr. Peter Leonard (research advisor at McGill University) will have access to confidential information.

6) Your participation in this research is voluntary. You are able to withdraw your participation from this research at any time.

7) This research is being done outside of any treatment or services you may already be receiving and will therefore not affect the services you receive.

8) You may request a copy of transcription records pertaining to your interview, as well as the final copy of the thesis.

9) You will receive a copy of this consent form for your records.

By agreeing to participate in this study, you are stating that the following is true:

1) You are an adult over the age of 18.

2) You are currently residing independently in the community

3) You have at one point in your life been diagnosed with Antisocial Personality Disorder.

If you are willing to participate in this research study, upon reviewing this letter please provide your signature below as well as the date.

If you have any questions or concerns regarding this consent form or any other part of the research process please contact Steven Bergen at 204-467-8123 or Dr. Peter Leonard at 514-398-7061. You can also email us at steven.bergen@mail.mcgill.ca and peter.leonard@mcgill.ca respectively.

Thank you

Steven Bergen

I hereby acknowledge that I have read the description of the research project and:

☐ Yes, I have agreed to be tape recorded.

☐ No, I have not agreed to be tape recorded.

I hereby acknowledge that I have read the description of the research project and have agreed to participate.

Name: _____ Signature: _____
Phone Number (optional):_____ Date: _____