New Zealand Sociology Special Issue: Theorising Mental Health
2023, Issue 38, No. 1, 29–40

Deconstructing Antisocial Personality Disorder

Gayle Jones*

Abstract
Taking a social constructionist approach, this article critically examines antisocial personality disorder (ASPD) to investigate how a mental illness with vague diagnostic criteria and a lack of solid empirical backing continues to persevere within the mental health system. It explores the sociohistorical roots of ASPD in the nineteenth century, emerging with psychiatry's interest in the moral transgressions of criminals as signs of mental disorder. This analysis then discusses the evolution of the ASPD label through the various iterations of the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* in the twentieth century, to the contemporary moment where the current classification lists criteria that can be potentially applied to almost all of those who encounter the criminal justice system. Rather than being a legitimate mental disorder, it is concluded that the ASPD classification serves as a way for psychiatry to expand their expertise and influence beyond the psychiatric institution and further into the criminal justice system.

Keywords: antisocial personality disorder; criminal justice system; DSM; medicalisation; psychopathy

Introduction

Antisocial personality disorder (ASPD) is a widely accepted personality disorder within psychiatry which is frequently used in both forensic settings (that is, places that detain those with mental disorders who have criminally offended or are 'at risk' of offending) and within the criminal justice system (CJS) (McCallum, 2001, p. 7). While this classification was once reserved for those who were judged to have committed the most serious of crimes (such as rape or murder), it can now be applied to any individual who is encapsulated within the CJS and associated with notions of danger and criminality, eliciting fear within society through the linkage of ASPD to ideas of psychopathy (Soares, 2010, p. 854). While there is no solid definition for the latter term, Hare (1993, p. xi), a renowned expert in the field, describes 'psychopaths' as charming, manipulative predators, lacking in conscience and feelings for others. They are understood to violate social norms and expectations and do so without feelings of remorse or regret. However, while it is believed that every psychopath has ASPD, not every person with ASPD is seen to be a psychopath. Thus, while the two diagnoses are similar in many respects, and often overlapping in terms of traits and symptomologies, they remain separate constructs (Abdallah-Filho & Völlm, 2020, p. 242). The discussion of ASPD and psychopathy can illustrate that the difference between the two designations has more to do with professional jurisdiction than any real qualitative difference between these terms. While this article is focused on ASPD, due to its use within the CJS (often as a proxy for ASPD, as will be shown in the official history below), it is necessary to also engage with the concept of psychopathy.

While aspects of the current ASPD classification have been noted in the American Psychiatric Association's (APA) *Diagnostic and statistical manual of mental disorders* (DSM) since its inception in 1952 (American Psychiatric Association, 1952, p. 38)—becoming an official diagnosis with the release of the third edition (DSM-III) in 1980 (American Psychiatric Association, 1980, p. 317)—there has been little research critiquing the diagnosis as a legitimate mental disorder. Much of the research into ASPD has

* **Gayle Jones** is a master's student in Sociology in the School of Social Sciences at Waipapa Taumata Rau, the University of Auckland. Her research involves the use of social constructionist theory to understand the existence of antisocial personality disorder and psychopathy, and the impact of these labels on offenders within the criminal justice system.
Email: gbro071@aucklanduni.ac.nz

involved evaluating the symptomology, which has led to the belief that ASPD may be over-diagnosed in the CJS while under-diagnosed within the general community (Widiger & Corbitt, 1993, p. 63). However, very few scholars have questioned the validity or the purpose of the psychiatric classification. The purpose of this article, therefore, is to fill that gap in knowledge through providing a sociological critique of ASPD, grounding the psychiatric classification within a social constructionist framework. It will examine the legitimacy of ASPD as a diagnosis through a historical account of the disorder, demonstrating how deviant behaviours that fall under the purview of the CJS have become medicalised by psychiatry. Further to this, it will provide the official account of the disorder through the various editions of the DSM as well as looking at the way in which an ASPD diagnosis may influence the outcome in criminal cases. The possible drivers for ASPD's continued inclusion in the DSM will also be explored, critically reflecting on psy-professional expansionism and the continued legitimation of carceral authorities. But first, the article begins by outlining the constructionist framework which will inform the subsequent analysis progressed in the discussion.

The social construction of mental disorders

The critical analysis of ASPD which follows in this article is examined through a social constructionist lens. In the sociology of mental health, social constructionism offers a way of examining how psychiatric discourse takes shape as well as exploring the consequences of the application of mental illness labels (O'Reilly & Lester, 2017, p. 19). The underlying assumption of this approach is that the knowledge and practices of the profession are predicated on dominant societal and institutional norms and values rather than empirical evidence (Georgaca, 2014, p. 56).

Psychiatric science has long been criticised for its lack of validity (Fernando, 2018, p. 195; White, 2018, p. 24). In the 1960s, for example, the anti-psychiatry movement and associated critics argued that psychiatry lacked the scientific support for the diagnostic labels it applied to 'mentally ill' individuals (Cooper, 1967; Szasz, 2010; Timimi, 2014, p. 209). While psychiatry continues to champion the doctrine of absolute knowledge in its area of 'expertise', legitimised by the DSM and its ever-expanding mental illness categories (Whooley, 2018, p.179), indications regarding this position point to the contrary. This is evidenced in the way in which these constructs have changed over time and across culture (Conrad & Schneider, 1992; Foucault, 1967). Canino and Alegría (2008, p. 237) have further noted the lack of universality to the diagnostic categories, with the DSM varying in operationalisation and classification between each iteration. Allsopp et al.'s (2019) assessment of the latest addition of the DSM (DSM-5) concluded that the different decision-making criteria, along with significant overlap between diagnoses, meant that the manual was a "disingenuous categorical system" (Allsopp et al., 2019, p. 21). As reported by the University of Liverpool (2019), the results of Allsopp et al.'s study suggested the DSM classifications were "scientifically worthless as tools to identify discrete mental health disorders".

This lack of validity and legitimacy of psychiatric science can be exemplified through considering the previous 'mental disorders' of hysteria, drapetomania and homosexuality (Cohen, 2016, p. 11). These 'conditions' have all disappeared from psychiatric discourse, not due to any scientific breakthrough, but rather through mounting social pressure upon the professional community (Cohen, 2016, p. 157; Conrad & Schneider, 1992, p. 206). The fact these pathologies have been unceremoniously deleted from such medical nosology brings into question the rationale and purpose for their original inclusion. The groups affected by these labels (namely, women, African Americans and homosexuals) have been disenfranchised populations which dominant forces in society have sought to dominate and suppress. By framing these groups as 'mentally ill' and denouncing their behaviour as symptoms of madness, psychiatry has served as an institution of social control—in this case, reinforcing dominant patriarchal, racist and heteronormative norms (Foucault, 1967; White, 2018, p. 24). Thus, according to social constructionism, psychiatric labels represent moral rather than scientific judgements, which has allowed the psychiatric profession to advance

as a group of 'moral entrepreneurs' (Becker, 1966, p. 147). As Scull (1975, p. 200) proposes, through their authority to label people, psychiatry had been able to exert control over various forms of social deviance. As psychiatry is considered a legitimate medical profession, the labels psy-professionals apply to individuals are enduring and can become a social reality (Scull, 1975, p. 221).

The way in which social constructionism tends to be most readily used in contemporary scholarship is through critical discussions of medicalisation. *Medicalisation* refers to the labelling of non-medical events, emotions and behaviours as medical conditions (McGann & Conrad, 2007, p. 1110). As Pitts (1968, p. 391) stated over 50 years ago, "medicalization is one of the most effective means of social control" and he predicted that in the future it was "destined to become the main mode of formal social control". Scholars have tended to agree that medicalisation has recently expanded and that enshrined within this increase is the definition and response to an increasing array of socially deviant behaviours (McGann & Conrad, 2007, p. 1110). For example, while those engaged in criminal acts were previously only viewed as 'bad', with the expansion of medicalisation, they are increasingly being viewed as also 'mad' (Cohen, 2021; Conrad & Schneider, 1992; McBride, 2022, Rafalovich, 2020).

Conrad and Schneider (1992) have discussed this process, whereby aspects of criminality are increasingly medicalised through the CJS. For example, Rafalovich (2020, p. 868) notes medicalisation has occurred with regards to drug-related crimes—those involved can now be diagnosed with 'substance use disorder', defining these crimes as a psychiatric issue. Similarly, Weare (2013, p. 344) discusses the medicalisation of infanticide, remarking that women who commit this crime are often pathologised and labelled as 'mad'. These women are viewed as mentally ill, despite the fact they often do not have a diagnosable mental disorder (Weare, 2013, p. 345). Conrad and Schneider (1992, p. 35) argue that these designations are social judgements, they are inextricable interlinked with the moral ideals of dominant society, and they continue to act as a way for those in power to exercise control over various groups of social deviants. Scholars have further noted that, typically, the acts that tend to be medicalised are those associated with blue collar criminality and the working classes (for example, violent crimes such as grievous bodily harm) and carry with them not only a moral judgement and a psychiatric label, but also a criminal conviction (Cohen, 2021; Conrad & Schneider, 1992, p. 182; Measham & Moore, 2008, p. 284). It is with this understanding of social constructionism that a critique of ASPD will be made through this article, with a specific focus on the medicalisation of criminality. However, before this analysis is undertaken, the article will address the official definition of ASPD as well as its prevalence and aetiology, followed by the official history of the disorder.

Definition, aetiology and prevalence of ASPD

The most recent version of the DSM (the DSM-5) defines ASPD as "a pattern of disregard for, and violation of, the rights of others that begins in early childhood or early adolescence and continues into adulthood" (American Psychiatric Association, 2013, p. 659). The DSM-5 notes that this pattern has also been referred to as "*psychopathy, sociopathy,* or *dyssocial personality disorder*" (American Psychiatric Association, 2013, p. 659, emphasis original). For a diagnosis of ASPD to be made, the DSM-5 (American Psychiatric Association, 2013, p. 659) gives the following diagnostic criteria:

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
    1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
    2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.

3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least 18 years old.
C. There is evidence of conduct disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

The exact aetiology of ASPD is unknown (DeLisi et al., 2019). The DSM-5 notes a biological component to the development of ASPD, with twin studies showing the importance of biological factors in its development (American Psychiatric Association, 2013, p. 661). While there is some evidence to suggest ASPD may result from abnormal neurological functioning, it is not clear whether these abnormalities can be attributed to other conditions; therefore, the relevance remains unclear (Glenn et al., 2013, p. 427). It is important to note that the overwhelming majority of research regarding ASPD (and psychopathy) tends to be carried out in prison or forensic hospital settings with inmates who demonstrate psychopathic traits. Glenn et al. (2013) have pointed out that the current diagnostic criteria for ASPD is predominantly behavioural based while psychopathy is diagnosed on both behavioural and interpersonal and affective elements. So, while there are distinct differences between these two conditions, they are frequently conflated by researchers and mental health professionals alike, even though psychopathy is not a recognised mental disorder in the DSM-5.

The DSM-5 notes a 12-month prevalence rate of anywhere between 0.2 per cent to 3.3 per cent, with the highest rates being found amongst men within substance treatment clinics, prisons or forensic settings, and those affected by poverty (American Psychiatric Association, 2013, p. 661). The manual further notes that the diagnosis is much more common in males than females (American Psychiatric Association, 2013, p. 662). Houser (2015, p. 25) notes that the rate of ASPD within prisons is around 50 per cent, while Russell (1985, p. 21) suggests this figure could be as high as 75 per cent. What these figures reveal is that those enveloped within the CJS have a significantly higher chance of being diagnosed with ASPD than the general population.

Official history of ASPD

In the early eighteenth century, the understanding of criminality was largely guided by the idea of enlightened rationality (Augstein, 1996, p. 311). Included within this doctrine was the belief that people were rational beings who possessed the potential to behave in ways that were socially acceptable (Augstein, 1996, p. 311). For example, Beccaria suggested that all people possessed free will and that those who committed crimes were rational agents; that is, they were in control of their actions (Beccaria, 1764). However, not all individuals who committed crime appeared to fit this theory.

The overarching theme as psychiatry was established as a profession in the nineteenth century was the notion of immoral behaviour in the face of sanity. Philip Pinel, the founding father of Western psychiatry, was a pioneer in the effort to humanely treat those suffering from mental illness (Black, 2013, p. 22). In the early nineteenth century, Pinel noted there was a type of patient who was prone to fits of rage and violence that was both irrational and explosive (Black, 2013, p. 22). He observed these patients were

otherwise sane—they were fully cognisant and comprehended the nature of their actions. Early psychiatry struggled to understand how someone who bore the hallmarks of sanity could commit crimes that eluded a logical explanation. As this behaviour could not be explained within the current framework of mental disorders (Black, 2013, p. 22), Pinel instead used the term *manie sans delire´* (mania without delirium) (Black, 2013, p. 22). Here we see the origins of ASPD in psychiatry's attempt to understand otherwise sane individuals who committed crimes considered abhorrent.

Around the same time, other psychiatrists such as Benjamin Rush and James Pritchard were also observing patients who were otherwise sane but acted in ways that were considered 'morally depraved' and deliberately in violation of social norms (Arrigo & Shipley, 2001, p. 330; Black, 2013, p. 22). Rush stated that these patients were suffering from a defect of the mind that was either present from birth or caused by disease (Arrigo & Shipley, 2001, p. 330). In classifying these patients as 'morally deranged', Rush is recognised as one of the first to bring about social condemnation of these individuals (Arrigo & Shipley, 2001, p. 30). Pritchard coined the term 'moral insanity' in 1835. This term was used to make a distinction from the idea of 'normal insanity'—that is, those whose mental disorder was characterised by reduced intellectual functioning. Pritchard noted that the intellectual faculties of the 'morally insane' were intact—they knew the difference between right and wrong and yet they engaged in behaviours that contravened socially acceptable behaviour. For these individuals, there appeared to be an altered state in their feelings and dispositions that was manifested in their behaviour (Black, 2013, p. 23). While many associated this type of 'immoral' behaviour with lower-class society (Beier, 2005, p. 500), Pritchard believed that moral insanity could be experienced by anyone regardless of class and did not necessarily have to involve acts of violent behaviour (Jones, 2017, p. 226). He further proposed that moral insanity should be employed as a legal defence, as those who were deemed morally insane were not able to control the impulse to engage in immoral behaviour (Arrigo & Shipley, 2001, p. 331).

In the mid-1800s, Cesare Lombroso took Rush's research further, embedding it within the idea of *biological determinism*—that is, that immorality and criminal behaviour were biologically determined—which became the prevailing explanation of deviant behaviour during the nineteenth century (Conrad & Schneider, 1992, p. 262). Lombroso's theory posited that people did not commit violent acts because they wanted to, but rather, because they were compelled to do so. This biological explanation for deviant behaviour gave shape to the need to control and contain these people, as they were unable to control themselves and were not amenable to treatment (Conrad & Schneider, 1992, p. 262). Henry Maudsley shared Lombroso's sentiments, stating that such individuals suffered moral imbecility due to defective organisation of both their physical and mental faculties. He identified within this particular group of individuals a criminal class—namely, "chronic offenders of lower-class origin" (Arrigo & Shipley, 2001, p. 332). Krafft-Ebbing further asserted that these individuals "were without prospect for success" and that "these savages … must be kept in asylums for their own [good] and [for] the safety of society" (Arrigo & Shipley, 2001, p. 332).

The psychopath label originated with psychiatrist Julius Koch, who introduced the term 'psychopathic inferiority' in 1891 to describe people who, due to their genetic disposition, engaged in deviant behaviours but were not considered insane. Koch's work was one of the first that attempted to classify different personality disorders. While he believed that such individuals suffered from moral deficits, they were not considered to be depraved or malicious (Arrigo & Shipley, 2001, p. 331). In developing these personality categories, Koch strove to veer away from the idea of moral insanity, believing that those who engaged in 'abnormal' behaviour were not insane but were in fact suffering a congenital defect not necessarily associated with either behaving viciously or wickedly. While he sought to supersede the social condemnation that was associated with Pritchard's idea of moral insanity, Koch was largely unsuccessful (Arrigo & Shipley, 2001, p. 332). In his effort to remove judgement from the term moral insanity, Koch's use of 'inferiority' inadvertently evolved to mean something entirely different from what he had intended—

that is, inferiority came to be understood as a derogatory term. He was further undermined when the term was changed to 'sociopathy', indicating a shift from a congenital origin to a social one (Milton et al., 1998, p. 8).

Moving into the twentieth century, Emil Kraepelin expanded on Koch's idea of psychopathic inferiority and, in 1915, described criminals as a general threat to society, possessing a dulled moral sense and lacking the ability to experience deep emotion or sympathy (Arrigo & Shipley, 2001, p. 334). Kraepelin described four types of psychopathic personality, using criteria he believed others in the field of psychiatry would easily recognise. These personality types were: morbid liars and swindlers, characterised as being charming, glib and apathetic to others; criminals by impulse, characterised by their urge to commit crime such as rape or arson, crimes that had no obvious rationale; professional criminals, characterised by crimes of calculated self-interest; and morbid vagabonds, characterised by a life lacking responsibility or purpose (Arrigo & Shipley, 2001, p. 333). Arrigo and Shipley (2001, p. 333) note that these descriptors closely resemble the contemporary diagnosis of ASPD.

The idea of the 'psychopathic personality' was later popularised by David Henderson and Harvey Cleckley (Arrigo & Shipley, 2001, p. 334; National Collaborating Centre for Mental Health, 2010). Henderson argued in 1939 that people who engaged in antisocial behaviour despite the absence of an intellectual impairment should be understood as experiencing 'psychopathic states'. Meanwhile, Cleckley furthered the idea of the psychopathic personality as a clinical diagnosis, establishing a set of criteria that was centred on antisocial behaviours, particularly acts of aggression and violence (National Collaborating Centre for Mental Health, 2010). The ideas of Henderson and Cleckley were later incorporated into the first edition of the DSM (Black, 2013, p. 26).

DSM and the medicalisation of criminal behaviour

The first edition of the DSM in 1952 (American Psychiatric Association, 1952) did not explicitly mention ASPD; rather, it listed 'sociopathic personality disturbance'. Individuals with this diagnosis were deemed to be suffering a disturbance or illness in regard to conforming to social norms, with these behaviours causing discomfort to both the individual and those around them (American Psychiatric Association, 1952, p. 38). The DSM-I (American Psychiatric Association, 1952, pp. 38–39) noted these individuals could be identified by any of the following: antisocial reaction, dyssocial reaction, sexual deviation and addiction, which was further identified as either alcoholism or drug addiction.

When the DSM-II was released in 1968, 'antisocial personality' was listed among ten personality disorders. The criteria were similar to those for sociopathic personality disturbance in the DSM-I and, according to the DSM-II, these were "individuals who were basically unsocialised" (American Psychiatric Association, 1968, p. 43). The DSM-II further stated that a history of antisocial or criminal behaviour was not sufficient on its own to substantiate a diagnosis (American Psychiatric Association, 1968, p. 43).

The official 'antisocial personality disorder' classification was first used in the DSM-III when it was released in 1980, and it is at this point that the medicalisation of criminal behaviour became more explicit. The DSM-III defined ASPD as a personality disorder in which the individual has an enduring history of antisocial behaviour beginning prior to age 15 in which they violate the rights of others (American Psychiatric Association, 1980, p. 321). Attempts were made to include aspects of the previously developed 'psychopathy checklist' into the diagnosis to ensure that ASPD was not overly inclusive; however, the DSM-III committee rejected this suggestion (Pickersgill, 2012, p. 550). What further set the DSM-III apart from its predecessors was the removal of the criminal behaviour exclusion. This allowed criminal behaviour on its own to constitute a diagnosis of ASPD, opening the floodgates for the label to fit anyone who committed a crime (Russell, 1985, p. 21). This led Russell (1985, p. 21) to observe that, following the DSM-III criteria, there was no clear distinction made between ASPD and acts of criminality, and Stevens

(1993, p. 3) to conclude that the diagnostic criteria were broad enough to encompass almost all types of crime.

When the DSM-IV was released in 1994, it shortened the criteria of behavioural manifestations required for a diagnosis, making the process less cumbersome (Houser, 2015, p. 20). Furthermore, for a diagnosis to be made, the individual only had to meet three criteria instead of the previous four (Gurley, 2009, p. 298). While the actual changes in diagnostic criteria were minor, there were significant changes to the associated features and disorders section. For example, while there was no mention of personality traits in the DSM-III, the DSM-IV listed many traits of ASPD including "lack of empathy" and "superficial charm" (American Psychiatric Association, 2000, p. 647). The similarities to psychopathy have been noted. The release of the DSM-5 in 2013 saw no need to change the diagnostic criteria, despite suggestions from some that change was very much required (Hesse, 2010). It has subsequently been noted by McCallum (2001, p. 145) that the criteria for ASPD is based on behaviours that are more easily observed in those individuals who are either in prison or a forensic setting. Further to this, Ellard (cited in McCallum, 2001, p. 145) notes a class difference in which a bad-tempered thief is likely to receive an ASPD diagnosis, while those who commit white-collar crimes will avoid such a label. There are no set definitions as to what constitutes antisocial behaviour beyond specific deviations from social norms, which has given psychiatry a wide scope within which to work and a much larger pool of potential candidates for an ASPD diagnosis. The expectation that those who receive a diagnosis of ASPD are dangerous criminals may stem from the research from which the diagnosis is derived. Widiger et al. (1996) conducted the field trials for the diagnosis of ASPD in the DSM-IV. This research was conducted predominantly within prison populations, and with individuals who were psychiatric in-patients, had substance abuse disorders, and were homeless (Widiger et al., 1996, p. 5). These are all groups of people who typically bring to mind clichéd images of dangerousness and criminality and for whom society may feel justified in calling for segregation in institutions.

Given the high number of individuals who are diagnosed with ASPD and who have had contact with the CJS, Schnittker et al. (2020) examined the criteria in more detail. The researchers found that, when performance of acts that are grounds for arrest are removed, the prevalence of ASPD dropped significantly (from 24 per cent to 7 per cent), signifying that, in approximately 70 per cent of cases, there would have been insufficient 'symptoms' for a diagnosis of ASPD to have been made (Schnittker et al., 2020, p. 9). What this evidence suggests is that, rather than being a personality disorder, ASPD is label of social deviance used to mark those who live with adverse personal circumstances and do what they need to do to survive, involving behaviours that deviate from social norms and are often criminal by definition (Schnittker et al., 2020, p. 14). Therefore, it stands to reason that a large number of people who have come into contact with the CJS will be diagnosed with ASPD, given the focus on criminal behaviour in the criteria.

The evidence presented thus far in the article proposes that rather than being a legitimate mental disorder, ASPD can instead be conceptualised as the medicalisation of certain types of criminal behaviour. On these grounds, there have been calls from scholars such as Münch et al. (2020, p. 13) to remove ASPD from the DSM. They state that harmful behaviour to others is not enough to sustain a diagnostic classification of mental disorder (Münch et al., 2020, p. 13). In light of this evidence, we have to then ask why psychiatry perseveres with the ASPD classification.

Discussion: Psychiatric expansion in the CJS

Foucault (1988, p. 191, emphasis original) previously stated that "to be dangerous *is not an offence*. To be dangerous *is not an illness*. It is not a symptom." If Foucault's assertion is correct, if indeed dangerousness is not enough to be considered a mental illness, then how do we make sense of the ASPD diagnosis and why does it continue to persevere? Alluded to earlier in this article, the history of ASPD demonstrates that psychiatry has long shown an interest in those who have engaged in 'immoral' acts. What began as a genuine

interest in understanding the behaviour of certain individuals has escalated into something much larger. This diagnosis serves other purposes for psychiatry as a profession, especially for the continued legitimacy of the mental health system, as well as providing a robust means of controlling those society would rather forget (Foucault, 1967).

When the deinstitutionalisation movement began in the 1960s, the factors driving change included an increased disillusionment with psychiatric hospitals, changing attitudes among the public towards mental health issues, as well as reduced state interest in funding such institutions (Fakhoury & Priebe, 2007, p. 313). Consequently, there was a pressing need for the profession to expand its focus beyond the hospital and the clinic into other institutions, with the CJS being one such area in which psychiatric expertise and practice could grow (Cohen, 2021, p. 293). Cocozza and Steadman (1978), for example, remark how psychiatry took the construct of 'the dangerous class' in the 1960s and 1970s and used it to further engage with the CJS. The prediction of dangerousness is common within many facets of the CJS such as when determining if an offender should be granted bail or parole (Cocozza & Steadman, 1978, p 265). The authors state that psychiatry shaped and promoted the idea of the dangerous individual so they could claim authority over it, thus entrenching themselves further within the CJS (Cocozza & Steadman, 1978). During this period, psychiatry was also facing a "crisis of legitimacy" (Mayes & Horwitz, 2005, p. 249). The anti-psychiatry movement, along with social constructionist and labelling theorists, had raised serious doubts over psychiatry's knowledge base, accusing the profession of being pseudoscientific, using the veneer of medicine to label society's misfits and social deviants as mad (Cooper 1967; Goffman 1963; Scheff 1966; Szasz 2010). More specifically, personality disorders were criticised for being too vague, with descriptors of only a sentence or two for each disorder, and poor levels of reliability and validity (Coolidge & Segal, 1998, p. 591).

As previously discussed, with subsequent DSM editions broadening the diagnostic criteria of ASPD since the DSM-III, it has allowed for other behaviours not traditionally seen as social problems by the standard of 'dangerousness' to be enveloped within the classification. As Conrad and Schneider (1992) have previously noted, such an expansion of medicalisation can have serious consequences: a psychiatric diagnosis transforms a social judgement into a clinical one, the focus then falls on the individual rather than the wider environment, and it is subsequently a convenient way of avoiding the consideration of political, systemic and structural issues (Conrad & Schneider, 1992, pp. 249–250).

The behaviours captured under the current medical classification are no longer restricted to violent crime alone but can now be seen under the umbrella of criminality in a broader sense. Cohen (2016, p. 196), for instance, describes ASPD as the "perfect catch-all label" in that the criteria are so broad, they can be potentially applied to anyone who violates the law. Given the current prevalence figures for ASPD, this appears to be what has transpired. For example, Singleton et al. (1998, p. 23) report that, among prisoners who are diagnosed with ASPD in the United Kingdom, the population is more likely to have committed crimes such as theft, robbery or burglary rather than crimes of violence or sexual assault. The fact that an individual is far more likely to receive the ASPD label once they are involved in the CJS illustrates the way in which psychiatric professionals have been able to spread the diagnosis through their work in courts, jails and correctional facilities, and thereby justify their presence there. With the number of people in prison now receiving a mental illness diagnosis at much higher levels than the general population, this is essentially psychiatric institutionalisation under a different name (Cohen, 2021, p. 289). As a result, there is an increased number of psy-professionals required to provide 'care' to offenders (Cohen, 2021, p. 293). A disorder such as ASPD, which by design increases the rate of mental illness within prisons, serves as a convenient way for psychiatry to expand its involvement within the CJS.

There is much research demonstrating that this is a diagnosis reserved almost solely for those in the CJS. Fazel et al. (2016, p. 3) report that ASPD was the most commonly diagnosed personality disorder in their review of prison mental health reports, spanning multiple jurisdictions, over 12 years. Likewise,

Schnittker et al. (2020) report that ASPD is the most common psychiatric disorder diagnosed among prisoners. Further to this, while the prevalence rates in the general population would indicate there is a gendered nature to this diagnosis, Black et al. (2010) found no statistically significant difference in the number of men and women diagnosed with ASPD in correctional settings—indicating that ASPD is a diagnosis almost unabashedly reserved for those individuals who have contact with the CJS. From this standpoint, the ASPD label is effectively segregation and eugenics under a different name—the lower-class criminal population being locked away and, in certain jurisdictions, subject to the death penalty due to a convenient label. (For further discussion on eugenics theory and criminality, see, for example, Appleman, (2018) and Oleson (2016).)

By labelling offenders with a mental disorder, psychiatry is able to continue to grow and flourish in prisons (Cohen 2021, p. 293). As noted earlier in this article, there is no firm evidence to support a biological origin for ASPD; rather, ASPD would appear to be a socially constructed diagnosis, a diagnosis with a designated purpose. As was demonstrated through an analysis of the official history, the geneses of ASPD are rooted in moral judgement and the contravention of dominant social norms. While the disorder has changed over time to the current iteration we have today, what has not changed is the fundamental alignment of criminality with the ideas of insanity, a lack of reason and mental pathology. ASPD is a diagnosis committed to the medicalisation of criminal behaviour. Criminal or not, we should take heed of Rashed and Bingham (2014, p. 254), who remind us that "the end of social tolerance—the limit of what society may be willing to accommodate—does not mark the beginning of an illness."

Conclusion

This article has discussed and analysed ASPD from a social constructionist perspective, exploring the official history of the disorder, its development through each subsequent iteration of the DSM, and how ASPD has proliferated in the CJS. It has provided evidence as to why this classification is not a genuine diagnosis with empirical backing and has explored potential rationales as to why the diagnosis continues to persevere. My discussion and analysis have demonstrated the way in which behaviours associated with criminality have been medicalised under the ASPD classification and used as a form of social control. It was found that psychiatry, in looking to both expand and legitimise itself, has been able to uphold the ASPD diagnosis despite the criticisms levelled at it. By creating diagnostic criteria that included aspects of criminality, psychiatry expedited its power within the CJS and made itself an authority on all aspects of mental health for offenders.

While this article has explored the intersection between psychiatry and the CJS to explain the ASPD diagnosis through a sociological lens, future research could focus on the purpose of the diagnosis from a criminological perspective. Briefly mentioned in this article, eugenics and the prison industrial complex would be fruitful avenues to further explore. Future research might also investigate other repercussions of an ASPD diagnosis, such as the legal outcomes of people who receive the diagnosis in the courts system.

In conclusion, there are no set definitions as to what constitutes antisocial behaviour, beyond deviating from the social norms, which has given psychiatry a wide scope within which to work and a much larger pool of candidates for an ASPD diagnosis. Psychiatry, with its now expansive reach, can exercise governance over many 'problem groups', controlling not only how they are perceived by the general public by labelling them with ASPD, but also how they are treated. While ASPD is far from the most commonly diagnosed mental disorder within the general population, it is one of the most commonly diagnosed mental disorders within the CJS. In maintaining the diagnosis, psychiatry can not only maintain its foothold in the CJS, it can continue to extend its influence there, and this can be dangerous for any person who finds themselves on the wrong side of the law.

References

Abdallah-Filho, E., & Völlm, B. (2020). Does every psychopath have an antisocial personality disorder? *Brazilian Journal of Psychiatry, 42*(3), 241–242. https://doi.org/10.1590/1516-4446-2019-0762

Allsopp, K., Read, J., Corcoran, R., & Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry Research, 279,* 15–22. https://doi.org/10.1016/j.psychres.2019.07.005

American Psychiatric Association. (1952). *Diagnostic and statistical manual: Mental disorders.* American Psychiatric Association.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). American Psychiatric Association.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. revised). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Appleman, L. I. (2018). Deviancy, dependency, and disability: The forgotten history of eugenics and mass incarceration. *Duke Law Journal, 68*(3), 417–478. Available at: https://scholarship.law.duke.edu/dlj/vol68/iss3/1

Arrigo, B. A., & Shipley, S. (2001). The confusion over psychopathy (I): Historical considerations. *International Journal of Offender Therapy and Comparative Criminology, 45*(3), 325–344. https://doi.org/10.1177/0306624X01453005

Augstein, H. F. (1996). JC Prichard's concept of moral insanity: A medical theory of the corruption of human nature. *Medical History, 40*(3), 311–343. https://doi.org/10.1017/S0025727300061329

Beccaria, C. (1764). *An essay on crime and punishment*. International Pocket Library.

Becker, H. S. (1966). *Outsiders: Studies in the sociology of deviance.* Collier-Macmillan.

Beier, A. L. (2005). Identity, language, and resistance in the making of the Victorian "criminal class": Mayhew's convict revisited. *Journal of British Studies, 44*(3), 499–515. http://dx.doi.org/10.1086/429703

Black, D. W. (2013). *Bad boys, bad men: Confronting antisocial personality disorder.* Oxford University Press.

Black, D. W., Gunter, T., Loveless, P., Allen, J., & Sieleni, B. (2010). Antisocial personality disorder in incarcerated offenders: Psychiatric comorbidity and quality of life. *Annals of Clinical Psychiatry, 22*(2), 113–120. Available from: https://www.researchgate.net/publication/44576381_Antisocial_personality_disorder_in_incarcerated_offenders_Psychiatric_comorbidity_and_quality_of_life

Canino, G., & Alegría, M. (2008). Psychiatric diagnosis: Is it universal or relative to culture? *Journal of Child Psychology and Psychiatry*, *49*(3), 237–250. https://doi.org/10.1111/j.1469-7610.2007.01854.x

Cocozza, J. J., & Steadman, H. J. (1978). Prediction in psychiatry: An example of misplaced confidence in experts. *Social Problems, 25*(3), 265–276. https://doi.org/10.2307/800064

Cohen, B. M. Z. (2016). *Psychiatric hegemony: A Marxist theory of mental illness*. Palgrave MacMillan.

Cohen, B. M. Z. (2021). Mental health and crime: A critical review. In E. Stanley, T. Bradley & S. Monod de Froideville (Eds), *The Aotearoa handbook of criminology* (pp. 288–297). University of Auckland Press.

Conrad, P., & Schneider, J. W. (1992). *Deviance and medicalisation: From badness to sickness.* Temple University Press.

Coolidge, F. L., & Segal, D. L. (1998). Evolution of personality disorder diagnosis in the Diagnostic and Statistical Manual of Mental Disorders. *Clinical Psychology Review, 18*(5), 585–599. https://doi.org/10.1016/S0272-7358(98)00002-6

Cooper, D. (1967) *Psychiatry and anti-psychiatry*. Tavistock Publications.

DeLisi, M., Drury, A. J., & Elbert, M. J. (2019). The etiology of antisocial personality disorder: The differential roles of adverse childhood experiences and childhood psychopathology. *Comprehensive Psychiatry, 92*, 1–6. https://doi.org/10.1016/j.comppsych.2019.04.001

Fakhoury, W. & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry, 6*(8), 313–316. https://doi.org/10.1016/j.mppsy.2007.05.008

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: Prevalence, adverse outcomes, and interventions. *Lancet Psychiatry, 3*(9), 871–881. https://doi.org/10.1016/S2215-0366(16)30142-0

Fernando, S. (2018). Racialisation of the schizophrenia diagnosis. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 195–201). Routledge.

Foucault, M. (1967). *Madness and civilisation: A history of insanity in the age of reason*. Routledge.

Foucault, M. (1988) *Politics, philosophy, culture: Interviews and other writings, 1977–1984*. Routledge.

Georgaca, E. (2014). Discourse analytic research on mental distress: A critical overview. *Journal of Mental Health*, *23*(2), 55–61. https://doi.org/10.3109/09638237.2012.734648

Glenn, A. L., Johnson, A. K., & Raine, A. (2013). Antisocial personality disorder: A current review. *Current Psychiatry Reports, 15*(12), 1–8. http://dx.doi.org/10.1007/s11920-013-0427-7

Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Gurley, J.R. (2009). A history of changes to the criminal personality in the DSM. *History of Psychology, 12*(4), 285–304. https://doi.org/10.1037/a0018101

Hare, R. D. (1993). *Without conscience: The disturbing world of the psychopaths among us*. The Guilford Press.

Hesse, M. (2010). What should be done with antisocial personality disorder in the new edition of the diagnostic and statistical manual of mental disorders (DSM-V)? *BMC Medicine, 8*(1), 1–4. http://dx.doi.org/10.1186/1741-7015-8-66

Houser, M. C. (2015). *A history of antisocial personality disorder in the diagnostic and statistical manual of mental disorders and treatment from a rehabilitative perspective* [Master's thesis, Southern Illinois University]. OpenSIUC. https://opensiuc.lib.siu.edu/cgi/viewcontent.cgi?article=1795&context=gs_rp

Jones, D. W. (2017). Moral insanity and psychological disorder: The hybrid roots of psychiatry. *History of Psychiatry*, *28*(3), 263–279. https://doi.org/10.1177/0957154X17702316

Mayes, R., & Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences, 41*(3), 249–267. https://doi.org/10.1002/jhbs.20103

McBride, R. (2022). Carceral psychiatry. In M. Harbusch (Ed.), *Troubled persons industry: The expansion of psychiatric categories beyond psychiatry* (pp. 221–244). Palgrave MacMillan.

McCallum, D. (2001). *Personality and dangerousness: Genealogies of antisocial personality disorder*. Cambridge University Press.

McGann, P., & Conrad, P. (2007). Deviance and medicalization. In G. Ritzer (Ed.), *Blackwell encyclopedia of sociology* (pp. 1110–1114). Blackwell.

Measham, F., & Moore, K. (2008). The criminalisation of intoxication. In P. Squires (Ed.), *ASBO nation: The criminalisation of nuisance* (pp. 273–88). Policy Press.

Milton, T., Simonsen, E., & Birket-Smith, M. (1998). Historical conceptions of psychopathy in the United States and Europe. In T. Milton, E. Simonsen, M. Birket-Smith & R. D. David (Eds.), *Psychopathy: Antisocial, criminal, and violent behaviour* (pp. 3–31). The Guilford Press.

Münch, R., Walter, H., & Müller, S. (2020). Should behavior harmful to others be a sufficient criterion of mental disorders? Conceptual problems of the diagnoses of antisocial personality disorder and pedophilic disorder. *Frontiers in Psychiatry, 11*, 558655. https://doi.org/10.3389/fpsyt.2020.558655

National Collaborating Centre for Mental Health. (2010). *Antisocial personality disorder: Treatment, management, and prevention*. British Psychological Society.

Oleson, J. C. (2016). The new eugenics: Black hyper-incarceration and human abatement. *Social Sciences, 5*(4), 66. https://doi.org/10.3390/socsci5040066

O'Reilly, M., & Lester, J. (2017). *Examining mental health through social constructionism: The language of mental health*. Palgrave MacMillan.

Pickersgill, M. (2012). Standardising antisocial personality disorder: The social shaping of a psychiatric technology. *Sociology of Health & Illness,* 34(4), 544–559. https://doi.org/10.1111/j.1467-9566.2011.01404.x

Pitts, J. (1968). Social control: The concept. In D. Sills (Ed.), *International encyclopedia of the social sciences* (Vol. 14, pp. 381–396). The MacMillan Company & The Free Press.

Rafalovich, A. (2020). Conflict and complementarity: Medicalization, criminalization, and the question of agency. *Deviant Behavior, 41*(7), 868–881. https://doi.org/10.1080/01639625.2020.1734747

Rashed, M. A., & Bingham, R. (2014). Can psychiatry distinguish social deviance from mental disorder? *Philosophy, Psychiatry, & Psychology, 21*(3), 243–255. https://doi.org/10.1353/ppp.2014.0043

Russell, D. (1985). Psychiatry: Making criminals mad. *Australian Left Review*, *92*(Winter), 20–23. Available from: https://archivesonline.uow.edu.au/nodes/view/13214#idx99635

Scheff, T. (1966) *Being mentally ill: A sociological theory*. Aldine.
Schnittker, J., Larimore, S. H., & Lee, H. (2020). Neither mad nor bad? The classification of antisocial personality disorder among formerly incarcerated adults. *Social Science & Medicine*, *264*, 113288. https://doi.org/10.1016/j.socscimed.2020.113288
Scull, A. T. (1975). From madness to mental illness: Medical men as moral entrepreneurs. *European Journal of Sociology/Archives Européennes de Sociologie*, *16*(2), 218–261. https://doi.org/10.1017/S0003975600004938
Singleton, N., Meltzer, H., Gatward, R., Coid, J., & Deasy, D. (1998). *Psychiatric morbidity among prisoners: Summary report*. The Stationery Office.
Soares, M. H. (2010). Studies of personality disorders antisocial and borderline. *São Paulo School of Nursing, 23*(6), 852–858. https://doi.org/10.1590/S0103-21002010000600021
Stevens, G. F. (1993). Applying the diagnosis antisocial personality to imprisoned offenders. *Journal of Offender Rehabilitation, 19*(1/2), 1–26. https://doi.org/10.1300/J076v19n01_01
Szasz, T. S. (2010). *The myth of mental illness: Foundations of a theory of personal conduct*. Harper Perennial.
Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology, 14*(3), 208–215. https://doi.org/10.1016/j.ijchp.2014.03.004
University of Liverpool (2019, July 8). *Psychiatric diagnosis "scientifically meaningless"*. Science Daily. www.sciencedaily.com/releases/2019/07/190708131152.htm
Weare, S. (2013). "The mad", "the bad", "the victim": Gendered constructions of women who kill within the criminal justice system. *Laws*, *2*(3), 337–361. https://doi.org/10.3390/laws2030337
White, K. (2018). The social construction of mental illness. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 24–30). Routledge.
Whooley, O. (2018). The DSM and the spectre of ignorance: Psychiatric classification as a tool of professional power. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 179–185). Routledge.
Widiger, T. A., & Corbitt, E. M. (1993). Antisocial personality disorder: Proposals for DSM-IV. *Journal of Personality Disorders, 7*(1), 63–77. https://doi.org/10.1521/pedi.1993.7.1.63
Widiger, T. A., Hare, R., Rutherford, M., Alterman, A., Corbitt, E., Hart, S., Kultermann, J., Woody, G., & Frances, A. (1996). DSM-IV antisocial disorder field trial. *Journal of Abnormal Psychology, 105*(1), 3–16. https://doi.org/10.1037/0021-843X.105.1.3