

# Antisocial Personality Disorder among Prison Inmates: The Mediating Role of Schema-Focused Therapy

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**ABSTRACT:** *This study investigated the mediating role of schema-focused therapy in the treatment of antisocial personality disorder among prison inmates. The participants of the study were three hundred (300) prison inmates of Agodi Prison in Ibadan, Oyo State, Nigeria. The instruments used for the study were Antisocial Personality Disorder Self- Test (APDSF), deployed for screening the participants, and Antisocial Personality Disorder Symptoms Questionnaire (APDSQ) developed by the researcher. Pre-test Post-Test, control group experimental design was adopted for this study. The data were analysed using ANCOVA. There was significant main effect of treatment on antisocial personality disorder of the prison inmates. There was significant interaction effect of treatment of participants based on gender. There was also significant interaction effect of treatment on prison inmates based on time of incarceration.*

**Key words:** *Agodi prison, Antisocial Personality Disorder Symptoms Questionnaire (APDSQ), Antisocial Personality Disorder Self- Test (APDSF), Dissocial personality disorder, psychopathy*

## INTRODUCTION

Antisocial personality disorder (ASPD) is described by the American Psychiatric Association's Diagnostic and Statistical Manual, fourth edition- (DSM-IV-TR 2000); as an Axis II personality disorder characterized by " ...a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood" (WHO, 2010).

The World Health Organization's International Statistical Classification of Diseases and Related Health Problems', tenth edition (ICD-10), defines a conceptually similar disorder to antisocial personality disorder called Dissocial Personality Disorder (Oscar 2009; Adrian, 2010). Though the diagnostic criteria for ASPD were based in part on Hervey Cleckley's pioneering work on psychopathy, ASPD is not synonymous with psychopathy and the diagnostic criteria are different (Kueper et al 2010). Antisocial personality disorder (ASPD) is a mental problem that involves using others, manipulating them, even to the extent of violating their rights. This long-term problem, which is more common in men than in women, often has criminal manifestations.

It is a regular and persistent behaviour of disregard or disrespect for, and abuse of, the freedom, rights and privileges of others. It starts right from childhood beginning of adolescence and prolongs to adulthood'. Usually, criminal manifestations as a child are often linked to the development of this disorder later on in life. Cruelty to animals or younger siblings and damage to property among others are signs of antisocial personality disorder, which prisoner's exhibits. Prisoners are from different economically and socially disadvantaged circumstance, characterise by substance abuse, family disruption, and other traumatic experiences (Moxon, 2010). The prisoners have experienced many more potentially damaging life experiences than their never-imprisoned counterparts. In addition to prevalent experiential hardships, prisoners also display high rates of psychological disorders. They show high rates of personality disorder, affective disorders, functional psychosis, depression and post-traumatic stress disorder (PTSD), among other psychological problems (Davison, Leese, & Taylor; 2001 Esere, 2007).

In an interview with Forty Eight (48) male and female prisoners on the tenth day of their incarceration, Agali (2004) found high level of psychological symptoms which correlated with worries and cognitive stress. Even after leaving prison, many inmates still engage in mastered antisocial and amoral behaviours. While in incarceration, many of them become pawns for social and political violence, robbery and assassination. This is why many return to the prison shortly after their release. Antisocial personality disorder is characterized by at least three of the following:

- Callous unconcern for the feelings of others;
- Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations;
- Incapacity to maintain enduring relationships, though having no difficulty in establishing them;
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
- Incapacity to experience guilt or to profit from experience, particularly punishment;
- Being markedly prone to blame others or to offer plausible rationalizations for the behaviour that has brought the person into conflict with society.
- Persistent irritability as an associated feature; reflecte amoral, antisocial, psychopathic, or sociopathic personality (disorder).

The criteria specifically rule out conduct disorders (Moeller, 2006). Dissocial personality disorder criteria differ from those of antisocial and sociopathic personality disorder (Rotgers, 2006).

## Symptoms

People suffering from antisocial disorder may not seem antisocial all the time. In fact, they may display characteristics that are quite the opposite Listed below are some of the symptoms of antisocial personality disorder;

- Displaying charming personalities
- Flattering people
- Understanding what makes other people tick and uses them

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- Substance abuse problems
- Lying
- Stealing
- Getting into fights
- Breaking the law, showing disregard for rules in general
- Having no care for their own safety
- Showing no respect for the safety of others
- Being indifferent to the feeling of others
- Being prone to anger
- Displaying extreme arrogance
- Showing no sense of remorse

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder should also satisfy a set of general personality disorder criteria. The following are the basic ones.

- i) The individual is at least aged 18 years.
- ii) There is evidence of conduct disorder with onset before age 15 years.
- iii) The occurrence of antisocial behaviour is not exclusively during the course of schizophrenia or a manic episode.

Those diagnosed with ASPD as adults were commonly diagnosed with conduct disorder as children. The prevalence of this disorder is 3% in males and 1% in females, as stated in the DSM IV-TR.

### Further Diagnostic Considerations

Theodore Millon identified five subtypes of antisocial personality disorder (Moeller, 2006; Kueper, 2010) exhibiting all of the following:

- i. covetous antisocial – variant of the pure pattern where individuals feel that life has not given them their due.
- ii. reputation-defending antisocial – including narcissistic features
- iii. risk-taking antisocial – including histrionic features
- iv. nomadic antisocial – including schizoid, avoidant features
- v. malevolent antisocial – including sadistic, paranoid features.

### Comorbidity

Adrian (2010) notes that the following conditions commonly coexist with antisocial personality disorder (Adrian 2010)

- Anxiety disorders
- Depressive disorder
- Impulse control disorders
- Substance-related disorders
- Somatization disorder
- Attention deficit hyperactivity disorder
- Borderline personality disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Sadistic personality disorder

When these conditions are combined with alcoholism, people may show frontal function deficits on neuropsychological tests greater than those associated with each condition (Brown, 1994).

## Causes and Pathophysiology

Antisocial personality disorder is said to be genetically based but typically has environmental factors, such as family relations, that trigger its onset. Traumatic events can lead to a disruption of the standard development of the central nervous system, which can generate a release of hormones that can change normal patterns of development (Black, 2011). One of the neurotransmitters that have been discussed in individuals with ASPD is serotonin.

A recent meta-analysis of 20 studies showed a correlation between ASPD and serotonin metabolic 5-hydroxyindoleacetic acid (5-HIAA). The study found that a reasonable effect size (5-HIAA levels in antisocial groups were 0.45 standard deviation lower than in non-antisocial groups (Adrian, 2010). There is also a continuous debate as to the extent to which the legal system should be involved in the identification and admittance of patients with preliminary symptoms of ASPD.

### Prognosis

According to Emily Simonoff, Institute of Psychiatry, "childhood hyperactivity and conduct disorder also displays strong prediction of ASPD and criminality in early and mid-adult life. Lower IQ and reading problems were most prominent in their relationships with childhood and adolescent antisocial behaviour (Black, 2011).

### Epidemiology

Antisocial personality disorder is seen in 3% to 30% of psychiatric outpatients (Alterman et al; 1998). The prevalence of the disorder is even higher in peculiar populations, like prisons, where there is a preponderance of violent offenders (Darke et al; 1996). A 2002 literature review of studies on mental disorders in prisoners stated that 47% of male prisoners and 21% of female prisoners had antisocial personality disorder (Patric & Christopher, 2005). Similarly, the prevalence of ASPD is higher among patients in alcohol or other drug (AOD) abuse treatment programmes than in the general population (Hare, 1983). This suggests a link between ASPD and AOD abuse and dependence.

### Treatment

Some research on the treatment of ASPD showed positive results for therapeutic interventions (Moeller, 2006). Some studies found that the presence of ASPD does not significantly interfere with treatment for other disorders, like substance abuse (WHO 2008), although others have reported contradictory findings (Kueper, 2010). Schema Therapy is being investigated as a treatment for antisocial personality disorder (Rotgers, 2006). A review by Charles Borduin noted the strong influence of Multi-systemic therapy (MST) that could potentially improve this imperative issue. However, this treatment requires complete cooperation and participation of all family members.

## SCHEMA-FOCUSED THERAPY

Schema therapy or schema-focused cognitive therapy is a type of psychotherapy or talk therapy that is related to cognitive behavioural therapy. It is often used to treat patients with personality disorders or multiple serious mental health problems, which have historically been difficult to treat. It is also use for patients for whom other types of therapy have been ineffective. This type of therapy is structured and directive, and has historically produced good results for many patients.

Schema-focused therapy (SFT) retains a cognitive theoretical framework, and suggests that PDs result from early maladaptive schemas that interfere with the individual's ability to meet his or her core needs. The individual develops patterns of avoidance

and compensation to avoid triggering the schema, but these patterns become over-generalized and rigid. In order to adjust early maladaptive schemas, SFT uses a broad range of techniques, prominent among them are behavioural, psychodynamic, experiential and interpersonal strategies. In comparison traditional cognitive approaches, SFT is more flexible, elaborate and emotion -focused (McGinn & Young 1996). The treatments of FST also tend to be longer, between one and four years (Young, Klosko, & Weishaar 2003).

The concept of schema particularly early maladaptive schemas is central to schema therapy. Schemas are deeply-held, pervasive patterns of thought and belief which can seriously disrupt a person's life if they are negative. They are very difficult to change or even recognize, as they feature in a patient's life in diverse areas and form part of the backbone of a patient's views on self and life. These are most commonly developed in childhood, thus and are called early maladaptive schemas. However, they can also be developed later in life (Derefinko, 2008).

In schema theory, these patterns of thought account for why some people persist in repetitive, destructive, and maladaptive patterns of behaviour towards themselves and in their relationships with other people. For instance, a patient with a schema about failure may believe that he or she will fail at work, and in many areas, viewing failure as inevitable and deserved. People deal with this in three ways: surrender to it and embrace situations that support it, avoid encountering situations which relate to it, or overcompensate for it, often with hostility.

The schema therapist and the patient work to identify and change the patient's maladaptive schemas. Three stages are involved in schema therapy: assessment, awareness, and behavioural change. Patients first discover their schemas through questionnaires and explorer conversation then learn how to recognize incidences in daily life and see how these issues have an impact upon them. Finally, they learn how to make changes that challenge the schema, and develop positive coping skills and attitudes.

This study, therefore, used schema-focused therapy in the management of antisocial personality disorder of prison inmates to assist them improve their psychological well-being and to restructure their cognitive domains towards social and moral personality development.

**OBJECTIVES OF THE STUDY**

The general objective of the study was to investigate the effectiveness of schema-focused therapy on antisocial personality disorder of prison inmates. The specific objectives included:

To investigate the significant difference of treatment on antisocial personality disorder of participants based on gender.

To assess the significant difference of treatment on antisocial personality disorder of participants based on time of incarceration.

**RESEARCH HYPOTHESES**

The following null hypotheses were formulated and tested at 0.05 level of significance.

**Ho<sub>1</sub>:** There will be no significant difference in the level of reduction of antisocial personality disorder of prison inmates exposed to Schema-Focused therapy and the control group.

**Ho<sub>2</sub>:** Male and Female participants will not differ significantly in their level of reduction of antisocial personality disorder after exposure to treatment.

**Ho<sub>3</sub>:** There will be no significant difference in the level of reduction of antisocial personality disorder of prison inmates' based on time of incarceration.

**Design**

This study employed a pre-test, post-test control group experimental design. There was treatment, which existed at one level (Schema-Focus Therapy). The covariate was the pre -test on prisoners' antisocial personality disorder. The experimental and control groups were pre-tested before the commencement of the training sessions. Afterwards, the treatment group was taken through a counselling therapeutic sessions (Schema-Focused Therapy). The control group was taken through a counselling therapeutic session that had no relationship with the intervention techniques this research measured.

**Sample and Sampling Technique**

The sample of this study consisted of three hundred (300) purposively selected participants from Agodi Prison in Ibadan. Antisocial Personality Disorder Self-Test (APDSF) was used to screen the prison inmates. Those with high level of Antisocial Personality Disorder were selected. Among of the participants, 216 (72%) were males, while 84 (28%) were females. Concerning their educational background, 132 (44%) possessed OND (Ordinary National Diploma) and above, while the other 168 (56%) possessed West Africa School Certificate Examination and below. Of these participants, 99 (33%) had been incarcerated for 10 years and above, while 201(67%) had been incarcerated for less than ten years.

**Instrument**

The instrument used for data collection was Antisocial Personality Disorder Symptoms Questionnaire (APDSQ) developed by the researcher. The Questionnaire had two sections with section A consisted of demographic information such as age, sex, educational background and year incarcerated. Section B consisted of 25 items measuring an individual's symptoms of antisocial personality disorder based on a 5 point Llikert rating scale, ranging from Strongly Disagree (1) to Strongly Agree (5). A pilot study was conducted using thirty (30) prison inmates from Lagbandoko Prison in Oyo town. The data obtained from the pilot study was subjected to Pearson Product Moment Correlation coefficient of 0.74 after test-retest reliability had been carried out with two weeks interval between the first and the second phases of administration of the test. This was done to verify the suitability of this scale for the participants.

**PROCEDURE**

This study was carried out in two phases. The first phase consisted of pre-session activities in which the participants were assigned to experimental and control group. As part of the pre-session activities, the researcher introduced herself to the Controller-General of Prison Services of Agodi Prison, Ibadan. A research assistant was employed by the researcher prior to the commencement of experimental treatment. No specific training skill was given to the control group, but the group was involved in a general discussion on topics which had nothing to do with the treatment package.

The second phase was the treatment phase. In this phase, the treatment was carried out over a period of twelve weeks of one hour per week. The experimental treatment package was executed through series of instructions, coaching, discussions, take-home assignments and behaviour rehearsals. The lecture was arranged in such a way that one lecture built on the next. Below is a summary of the activities undertaken during each session;-

**Session 1:** General orientation to the training programme which included the following;-

Introductory talk to create enabling psychological environment for the intervention.

Rationale for the programme and what the participants stand to benefit at the end of the programme.

Guiding principles on the expected conducts of the participants in the course of the programme.

Administration of the pre-test measure.

**Session 2:** Teaching on Realistic Thinking process. The following were the activities that took place in this session

Participants were taught to Think of a better ways of thinking and relating to others:

They were taught on how to restructure their thinking process.

They were taught to identify emotional responsiveness of their antisocial behaviours.

**Session 3:** Identification of repetitive, destructive and maladaptive patterns of behaviour towards themselves and in their relationships with other people. They were taught to understand and identify unrealistic beliefs

Negative self-statements and emotional abound relating to their antisocial behaviours

They were taught to change their mental pictures of their antisocial behaviours

**Session 4:** This session witnessed the discussion of recognition of habitual maladaptive thought related to antisocial behaviours. They were taught through explanatory conversation how to recognize incidences of these in daily living and see how these issues have an impact upon them.

**Session 5:** In this session, both the therapists and the participants discussed modification of low tolerance to frustration and low threshold for discharge of aggression including violence. The participants were taught to substitute these maladaptive behaviours with positive ones, such as high level of tolerance and high level of frustration, tolerance and aggression.

**Session 6:** Empathy was discussed here to replace callous and unconcern feelings for others. The participants were taught persistent positive attitude, responsibility and regard for social norms, rules and obligations.

**Session 7:** This session witnessed the discussion of capacity to maintain enduring relationships. The participants were taught regular and persistence behaviour of regard and respect for freedom, rights and privileges of others.

**Session 8:** In this session, the therapists and the participants discussed the evil effects of deception, repeated lying, use of aliases, conning others for personal profit or pleasure.

**Session 9:** Impulsiveness or failure to plan ahead and its negative effects were discussed in this session. Also reckless disregard for safety of self and others its implication were also discussed.

**Session 10:** The Therapists and the participants discussed humility as a sort of replacement for arrogance, taking of fruits to replace drug being abused and engaging in recreational activities instead of getting into fights.

**Session 11:** The participants were made to apply and practise the newly acquired skills.

**Session 12:** Overall review of previous sessions' activities, including rehearsal and role play; Administration of post-test measure and conclusion.

## DATA ANALYSIS

The data obtained in this study were analyzed using analysis of Covariance (ANCOVA). This was used because it has the ability to control errors, adjust treatment means and partition a total covariance estimate of missing data. It is capable of testing for the significance of the difference among means of the experimental and the control groups as well as test for the correlation between the pre-test and post-test measures.

## RESULTS

The results obtained, as shown in Table 1, revealed a significant main effect of treatment (Schema-Focused therapy) on antisocial personality disorder of prison inmates. Therefore, the first hypothesis, which states that there will be no significant main effect of treatment on antisocial personality disorder of prison inmates, was rejected, since a significant main effect ( $F=1,298$ ;  $P<0.05$ ) existed in the treatment of experimental group.

As shown in Table 2, the post-treatment outcome of participants based on gender indicated significant interaction effect of treatment on participants' antisocial personality disorder. With this finding, therefore the alternative hypothesis, which supports the existence of significant interaction effect, was accepted.

As shown in Table 3, the post-treatment outcome revealed that there was a significant interaction effect of treatment on prison inmates' antisocial personality disorder based of time incarcerated. Thus the finding failed to support the null hypothesis that was predicted.

## DISCUSSION

The results obtained from the first hypothesis indicated that there existed significant main effect of treatment on the participants' antisocial personality disorder. This is an indication that treatment (Schema-focused Therapy) was effective. This result corroborates that of Oscar-Berman et al. (2009) who noted that, through schema therapy, the therapist and the patient work to identify and change the patient's maladaptive schema. This was exactly what the researcher did. She split the treatment programmes into three phases. She started the treatment programme with participants through therapeutic assessment to know the level of their antisocial personality disorder. The second phase focused on creating awareness for the participants to recognize how repetitive, maladaptive and destructive pattern of behaviour could affect their lives negatively. The third phase was on the replacement of antisocial behaviour with socially acceptable social norms, rules and obligations. From the foregoing, it can be confirmed that this study lent credence to the findings of Rogers (2006), who opines that Schema Therapy is an effective treatment for antisocial personality disorder. This result also confirms the importance of independent variables in exerting influence on criterion variables.

Again, the fact that the treatment programmes was carried out for twelve weeks of intensive exposure to various positive skills to counter the antisocial behaviours is another evidence for the effectiveness of the therapy.

The results of hypothesis two indicated that there was significant interaction effect of treatment on gender of the participants. This finding is in contrast with that of Moeller et al (2006), who claim that antisocial personality disorder is more common in men than in women, and that men often have criminal manifestations. This result is not surprising considering the fact that violent, activities like cruelty to animals or younger siblings and damage to property, associated with ASPD are usually displayed by males more than females. Also the feminine nature of women paved way for capacity to maintain enduring relationships, high frustration tolerance, high threshold for discharge of aggression and pleasant and concern feelings for others.

**Table 1.**

Post Treatment Comparison of Experimental and Control Group using ANCOVA

| Source of variation | DF  | SS       | MS       | F. Ratio Obs. | F. Ratio Crit. | Test Decision |
|---------------------|-----|----------|----------|---------------|----------------|---------------|
| Between Group       | 1   | 25217.91 | 25217.91 | 159.87        | 2.31           | Rejected Ho   |
| Within Group        | 298 | 52862.22 | 177.39   |               |                |               |
| Total               | 299 | 78080.13 | 25395.3  |               |                |               |

Critical value F (1, 298) = 159.87 P&lt;0.05

**Table 2.**

Post Treatment Comparison of Participants Based on Gender using ANCOVA

| Source of variation | DF  | SS        | MS       | F. Ratio Obs. | F. Ratio Crit. | Test Decision |
|---------------------|-----|-----------|----------|---------------|----------------|---------------|
| Between Group       | 1   | 27934.76  | 27934.76 | 113.53        | 2.31           | Rejected Ho   |
| Within Group        | 298 | 141105.98 | 473.51   |               |                |               |
| Total               | 299 | 169040.74 | 28408.27 |               |                |               |

Critical value F (1, 298) = 113.53 P&lt;0.05

**Table 3.**

Post Treatment Comparison of Participants Based on Time Incarcerated

| Source of variation | DF  | SS       | MS      | F. Ratio Obs. | F. Ratio Crit. | Test Decision |
|---------------------|-----|----------|---------|---------------|----------------|---------------|
| Between Group       | 1   | 987.15   | 987.63  | 21.57         | 2.43           | Rejected Ho   |
| Within Group        | 298 | 17551.8  | 59.7    |               |                |               |
| Total               | 299 | 17790.95 | 1047.33 |               |                |               |

Critical value F (1, 298) = 21.57 P&lt;0.05

The result of the third hypothesis showed that there was significant interaction effect of treatment on the participants' based on time incarcerated. The reason for this treatment effectiveness is not hard to find. The majority of prison inmates' engage in antisocial and amoral behaviours while in incarceration. Agali (2004) found that on the tenth day of their incarceration, the inmates he sampled exhibited high level of psychological symptoms. The result obtained from this hypothesis is valid considering the fact that the treatment measure dealt comprehensively with cognitive restructuring of the participants. Again, as opposed to short-term treatment which addresses a single behavioural issue, schema therapy is a kind of structure therapy in which the patient interacts and follows certain steps which demonstrate his/her progress towards overcoming negative patterns (Black, 2011).

### Implications for Social Reconstruction

The findings of this study have implications for counsellors, psychologists, social workers, parents and others in the business of rehabilitating persons with antisocial behaviours. The major ones are discussed below;

Schema-focus therapy, if adopted in the treatment of APD, will assist to bring participants into a more peaceful state of mind, or into an attitude which would be helpful to society, rather than being harmful to society. Thus, the inmates will return to the society as better human beings.

The mediating role of schema-focused therapy process acts as a change in lifelong socially acquired patterns of behaviours and values, which entail a much more complex and sometimes traumatic change on the individual's structure of character.

Schema-focused therapy, if adopted as intervention strategies, is likely to promote correction and rehabilitation. It works better than inflicting punishment on people who breach the law for maintenance of social order. This is also to prevent the prisoner from engaging in antisocial personality disorders upon their return to the community.

Corrections or rehabilitation is not the sole responsibility of the department of correctional services. Correction is a societal responsibility. It follows, therefore, that counselling psychologists and social workers should play a major role in reintegrating prison inmates into society by providing social assistance to them.

### CONCLUSION

Schema-Focused Therapy (SFT) retains cognitive theoretical framework, and suggests that personality disorder results from

early maladaptive schemas that interfere with the individual's ability to meet his/her core needs. The individual develops patterns of avoidance and compensation to avoid triggering the schema. However, these patterns become over-generalized and rigid. In addressing early maladaptive schemas, SFT uses a broad range of techniques including behavioural, experiential, psychodynamics, and interpersonal strategies. Consequently it is more flexible, elaborative, and emotion-focused than traditional cognitive approaches.

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