Antisocial Personality Disorder, Psychopathy, and Aggression in Forensic Populations: A Continuing Education Manual for Psychologists

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Antisocial Personality Disorder, Psychopathy, and Aggression in Forensic Populations: Impulsive and Premeditated Violence, Psychopathological Profiles, and Clinical Implications

A Continuing Education Reading Manual for Licensed Psychologists and Graduate-Level Clinicians

Prepared for professional continuing education in forensic psychology, clinical psychology, and correctional mental health practice.

Abstract

Antisocial Personality Disorder (ASPD) represents one of the most clinically challenging and forensically consequential diagnoses encountered in correctional and psychiatric settings. Individuals with ASPD account for a disproportionate share of violent offending, recidivism, and treatment-resistant clinical presentations, and the disorder is deeply intertwined with psychopathic personality traits, substance use disorders (SUDs), trauma histories, and diverse forms of aggression. This continuing education manual synthesizes contemporary empirical evidence on the phenomenology of aggression in ASPD, drawing on integrated findings from studies of male incarcerated offenders that examined impulsive and premeditated aggression (Azevedo et al., 2020) and comparative psychopathological profiles of violent and sexual offenders (Özcanl■ et al., 2026). The manual traces the historical and conceptual development of ASPD and psychopathy; examines the mechanisms by which impulsivity, psychopathic traits, cognitive distortions, and comorbid disorders shape

aggressive behavior; and considers the clinical, forensic, and systemic implications for psychologists. Emphasis is placed on the differentiation of impulsive and premeditated aggression, the role of interpersonal and affective psychopathic facets as predictors of premeditated violence, and the differential psychopathological profiles associated with violent versus sexual offending within ASPD. The manuscript closes with a critical appraisal of methodological limitations, future research directions, and translational applications for risk assessment, treatment planning, and violence prevention.

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1. Introduction

Aggression is among the most clinically consequential and socially disruptive behaviors encountered in psychological and psychiatric practice. Although aggression can occur transiently in the context of acute distress or provocation in otherwise healthy individuals, its persistent and pervasive expression is a hallmark of several psychiatric conditions, most notably Antisocial Personality Disorder (ASPD). As defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), ASPD is characterized by a pervasive and persistent pattern of disregard for and violation of the rights of others, coupled with deceitfulness, impulsivity, egocentricity, callous disregard for others, manipulativeness, and elevated levels of risk-taking (Azevedo et al., 2020; Özcanl■ et al., 2026). The disorder requires evidence of conduct disorder before age 15 and is diagnosed only in individuals aged 18 years or older.

The prevalence of ASPD in the general population is estimated at approximately 3%, but this figure rises dramatically in incarcerated populations, where prevalence may approach 50% (Azevedo et al., 2020). Within forensic samples, individuals with ASPD are responsible for a disproportionate share of violent crimes and recidivism (Özcanl■ et al., 2026), rendering the disorder a central concern for correctional mental health services, forensic evaluators, and clinical psychologists working in high-security environments. Aggression in ASPD is not a monolithic construct; rather, it manifests along a spectrum ranging from impulsive, reactive outbursts driven by emotional dysregulation and perceived provocation, to premeditated, instrumental acts aimed at achieving specific goals such as material gain, dominance, or interpersonal control (Azevedo et al., 2020). The differentiation between these two forms of aggression carries substantial implications for prognosis, pharmacological responsiveness,

psychological treatment, and forensic risk assessment.

The construct of psychopathy overlaps conceptually with ASPD but is regarded as a distinct clinical entity emphasizing affective and interpersonal deficits—superficial charm, grandiosity, callousness, pathological lying, and emotional detachment—rather than the predominantly behavioral criteria that define ASPD (Özcanl■ et al., 2026). The Psychopathy Checklist–Revised (PCL-R; Hare, 2003) has become the gold standard for the assessment of psychopathy and provides a dimensional measure across four facets: interpersonal, affective, lifestyle, and antisocial. Psychopathy is a robust predictor of both criminal recidivism and premeditated aggression, and it represents a particularly malignant subtype within the broader ASPD population.

This continuing education manual synthesizes empirical findings and conceptual models concerning aggression, psychopathy, and comorbidity in offenders with ASPD, integrating cross-sectional evidence from forensic samples in Portugal and Türkiye. Two central bodies of work anchor the discussion. Azevedo et al. (2020) examined 134 male inmates in a Portuguese high-security penitentiary to characterize the prevalence and predictors of impulsive and premeditated aggression in ASPD. Özcanl■ et al. (2026) compared psychopathological, cognitive, and sociodemographic profiles of violent versus sexual offenders with ASPD evaluated at the Turkish Council of Forensic Medicine over a ten-year window. Together, these studies illuminate the heterogeneity of ASPD, the primacy of psychopathic interpersonal-affective traits in shaping premeditated violence, and the distinct clinical presentations that differentiate violent from sexual offending trajectories.

The purpose of this manual is to provide licensed psychologists and graduate-level clinicians with a scholarly, integrated understanding of these findings, situated within the broader theoretical and empirical literature on aggression, psychopathy, and forensic mental health. The manual is organized to first orient the reader to the historical and theoretical foundations of ASPD and psychopathy; then to develop conceptual models linking impulsivity, emotional dysregulation, and psychopathic traits to specific forms of aggression; and finally to translate this evidence into clinical practice recommendations for assessment, intervention, and risk management.

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2. Historical and Theoretical Foundations

The clinical recognition of individuals who consistently violate social norms, exhibit callous disregard for others, and appear resistant to moral or rehabilitative influence predates modern psychiatric nosology by more than two centuries. The evolution of the constructs now termed ASPD and psychopathy reflects a longstanding tension between behavioral and personality-based conceptualizations of chronic antisociality. Early psychiatric writers, including Pinel and Prichard, described syndromes of "manie sans délire" and "moral insanity" characterized by preserved intellect combined with disturbed conduct and affect. Cleckley's mid-twentieth-century clinical portrait of the psychopath, and the subsequent operationalization of psychopathy by Hare (2003) through the PCL-R, crystallized a construct emphasizing emotional and interpersonal deficits alongside behavioral deviance.

The DSM tradition, in contrast, has emphasized observable behavioral criteria, formalized in the ASPD diagnosis (Azevedo et al., 2020; Özcanl■ et al., 2026). This behavioral emphasis has enhanced diagnostic reliability but has been criticized for capturing a heterogeneous population, including individuals whose antisociality reflects environmental adversity or substance-related disinhibition rather than the core affective-interpersonal pathology that Cleckley and Hare regarded as definitive of psychopathy. Consequently, ASPD as defined in DSM-5 is a broader category than psychopathy; most psychopathic individuals meet criteria for ASPD, but many individuals with ASPD do not exhibit the full psychopathic personality structure.

This distinction is more than academic. Empirical research indicates that individuals with ASPD tend to focus on antisocial behavior, whereas psychopathy centers on emotional dysregulation and interpersonal-affective deficits (Azevedo et al., 2020). Some scholars have proposed that psychopathy represents a subset of ASPD marked by severe emotional dysregulation and affective deficits, and that these individuals constitute a biologically, physiologically, and psychologically distinct group (Azevedo et al., 2020). The characteristics of psychopathy—egocentrism, pathological lying, manipulation, irresponsibility, impulsivity, novelty seeking, limited behavioral control, insensitive affection, lack of empathy, guilt, or remorse, and antisocial but not necessarily criminal behaviors—manifest early in childhood and remain relatively stable through adolescence and adulthood (Azevedo et al., 2020).

The clinical importance of separating these constructs is reinforced by their differential prognostic implications. Psychopathy is a strong predictor of both criminal recidivism and

premeditated aggression (Azevedo et al., 2020), and its identification carries substantial weight in forensic risk assessment. Moreover, high-psychopathy offenders tend to respond poorly to conventional psychological and pharmacological interventions, whereas non-psychopathic ASPD offenders with predominantly impulsive aggression may benefit from currently available pharmacological treatments (Azevedo et al., 2020; Özcanl■ et al., 2026).

Aggression itself has been the subject of substantial theoretical elaboration. Contemporary frameworks distinguish impulsive (also called reactive) aggression from premeditated (also called instrumental or proactive) aggression (Azevedo et al., 2020). Impulsive aggression is characterized by uncontrolled and exaggerated responses to provoking stimuli. Individuals who exhibit this pattern tend to show high levels of physiological arousal associated with stress, neurocognitive difficulties, and impulsive personality traits (Azevedo et al., 2020). Premeditated aggression, by contrast, corresponds to acts that materialize a previously defined plan aimed at a specific gain. This form of aggression is associated with individuals who exhibit low physiological activation in response to stress and who present psychopathic personality traits (Azevedo et al., 2020). Non-dichotomous classifications also acknowledge forms of aggression linked to psychotic psychopathology, though this represents a less common category in ASPD populations.

The categorization of aggressive acts as impulsive or premeditated allows the characterization of individuals across sociodemographic, criminal, neurophysiological, and clinical variables (Azevedo et al., 2020). Importantly, the same individual may present acts of premeditated or impulsive aggression across their life; the distinction refers to the character of a given act rather than a fixed trait of the person. This has significant implications for clinical formulation and for the design of interventions targeting the specific pathway to violence in a given case.

The theoretical development of these constructs has been paralleled by advances in neurobiological models of aggression. Neurocognitive models propose that deficits in amygdala-mediated emotional learning and prefrontal inhibitory control may underpin the aggressive and antisocial behaviors observed in ASPD and psychopathy (Özcanl■ et al., 2026). Functional neuroimaging and electrophysiological studies have documented altered activation in the prefrontal cortex, amygdala, and orbitofrontal regions among individuals with psychopathic and antisocial traits (Özcanl■ et al., 2026). These findings support the view that aggression in ASPD cannot be fully understood without accounting for the underlying psychopathic characteristics that modulate emotional regulation and moral reasoning.

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3. Conceptual Models and Mechanisms

A comprehensive understanding of aggression in ASPD requires the integration of multiple conceptual layers: the phenomenology of aggressive acts, the personality architecture that shapes them, the neurocognitive mechanisms that translate provocation into behavior, and the contextual factors that either facilitate or inhibit violent expression. This section elaborates the conceptual models that undergird contemporary research and clinical practice, drawing on the integrated evidence base.

The Impulsive–Premeditated Dichotomy

The impulsive–premeditated distinction is best understood as a dimensional framework rather than a rigid dichotomy. The Impulsive/Premeditated Aggression Scale (IPAS; Stanford et al.) operationalizes this distinction through 30 self-report items rating aggressive acts over the previous six months (Azevedo et al., 2020). Discrete categorization is achieved by calculating the percentage of positive endorsements on items loading onto each dimension, yielding a classification of an individual's most recent aggressive acts as predominantly impulsive or predominantly premeditated. Sensitivity and specificity values for the IPAS have been reported at 0.97 and 0.50 for impulsive aggression, and 0.70 and 0.97 for premeditated aggression, respectively (Azevedo et al., 2020). Internal consistency coefficients across validation studies vary between 0.80 and 0.93 for impulsive aggression and between 0.66 and 0.90 for premeditated aggression (Azevedo et al., 2020).

Conceptually, impulsive aggression maps onto a phenomenology of rapid, emotionally charged, poorly modulated responses to perceived threat or provocation. Individuals engaging in impulsive aggression often exhibit heightened autonomic arousal, difficulty tolerating frustration, and cognitive narrowing under stress. Premeditated aggression, by contrast, is executed with cognitive planning, reduced emotional arousal, and instrumental intent. The two forms are not mutually exclusive within an individual's lifetime history, but they typically differ in their proximal triggers, physiological correlates, and prognostic implications (Azevedo et al., 2020).

Impulsivity as a Trait Versus Impulsive Aggression as an Act

It is essential to distinguish the trait of impulsivity from the specific act of impulsive aggression. Impulsivity, as conceptualized in DSM-5, implies behavioral and cognitive disinhibition, immediate reaction to stimuli, unplanned action on the spur of the moment, and reaction without regard for consequences (Azevedo et al., 2020). The Barratt Impulsiveness Scale, Version 11 (BIS-11), remains the most widely used psychometric instrument for the assessment of trait impulsivity (Azevedo et al., 2020). Impulsivity, measured by the BIS-11, has been positively correlated with both impulsive and premeditated dimensions of aggression as measured by the IPAS, as well as with proactive and reactive aggression dimensions on the Reactive-Proactive Aggression Questionnaire (Azevedo et al., 2020).

The implication is that impulsivity is present, to varying degrees, in nearly all forms of aggressive behavior, and it does not by itself allow the differentiation between premeditated and impulsive aggressive acts. Referring to an individual as "impulsive" therefore conveys limited specificity about the character of that individual's aggressive expression. This conceptual precision is critical for clinical formulation and forensic assessment, as it prevents the conflation of a personality trait with an act-level phenomenon.

The Psychopathy Framework and the Four-Facet Structure

The PCL-R conceptualizes psychopathy as a four-facet construct: Facet 1 (Interpersonal), Facet 2 (Affective), Facet 3 (Lifestyle), and Facet 4 (Antisocial). Facets 1 and 2 jointly represent the second-order Factor 1, which is related to emotional dysfunction, while Facets 3 and 4 form the second-order Factor 2, which is related to antisocial behavior (Azevedo et al., 2020). A score of 30 out of a possible 40 is conventionally used as the cutoff value for a categorical diagnosis of psychopathy.

Facet 1 (Interpersonal) captures glibness, superficial charm, grandiose sense of self-worth, pathological lying, conning, and manipulative behavior. Facet 2 (Affective) reflects lack of remorse or guilt, shallow affect, callousness, lack of empathy, and failure to accept responsibility. Facet 3 (Lifestyle) encompasses stimulation seeking, impulsivity, irresponsibility, parasitic orientation, and lack of realistic long-term goals. Facet 4 (Antisocial) captures poor behavioral controls, early behavioral problems, juvenile delinquency, revocation of conditional release, and criminal versatility.

Empirically, the interpersonal and affective facets have emerged as the most robust predictors of premeditated aggression, whereas the lifestyle and antisocial facets are more closely linked to general criminality and impulsive violence (Azevedo et al., 2020). In the Portuguese forensic sample studied by Azevedo et al. (2020), the interpersonal facet (Facet 1) reliably distinguished between impulsive and premeditated aggression in individuals with ASPD, with an exponential beta value of 1.42 (95% CI [1.03, 1.95]) in logistic regression analysis, indicating that each one-unit increase on the interpersonal facet was associated with a 1.42-fold increase in the odds of committing premeditated rather than impulsive aggression.

The Role of Emotional Dysfunction

The centrality of emotional dysfunction in shaping the topography of aggression in ASPD emerges as a unifying theme across the empirical literature. Individuals with intact emotional functioning who exhibit ASPD-related antisocial behavior are more likely to express aggression in the impulsive form, driven by acute affective states and perceived provocation. In contrast, individuals with the emotional deficits characteristic of psychopathy—shallow affect, callousness, lack of empathy—are more likely to engage in premeditated aggression, as they lack the affective brakes that ordinarily inhibit calculated harm-doing (Azevedo et al., 2020).

This distinction has been supported by findings that individuals with ASPD and psychopathy exhibited a higher prevalence of premeditated aggression than impulsive aggression when considering the psychopathy diagnosis, whereas the prevalence of premeditated and impulsive acts was similar (roughly 1:1) among ASPD patients overall (Azevedo et al., 2020). The correlational structure further supports this interpretation: the impulsive aggression dimension of the IPAS did not correlate with the PCL-R total score or its facets, whereas the premeditated aggression dimension positively correlated with the PCL-R total score, Facet 1 (interpersonal), and Facet 3 (lifestyle) (Azevedo et al., 2020).

Cognitive Distortions and Maladaptive Schemas

Beyond psychopathic personality structure, cognitive-behavioral models emphasize the role of maladaptive schemas and cognitive distortions in mediating the pathway from personality pathology to aggressive behavior. Cognitive distortions—including hostility, mistrust, overgeneralization, self-blame, and externalization of blame—are hypothesized to shape the

interpretation of ambiguous social stimuli in ways that increase the probability of aggressive responding (Özcanl■ et al., 2026).

In the Turkish forensic sample examined by Özcanl■ et al. (2026), violent offenders exhibited significantly higher scores on the Interpersonal Cognitive Distortions Scale (ICDS) than sexual offenders (Mean = 34.64, SD = 7.13 versus Mean = 27.54, SD = 5.95; $p < 0.001$). While the association between cognitive distortions and violent offending reached only marginal statistical significance in multivariate logistic regression ($\beta = 0.31$, $p = 0.069$), the pattern suggests that cognitive restructuring may be a valuable therapeutic target in violent ASPD offenders.

Comorbidity and Contextual Modulators

Substance use disorders represent a highly prevalent and clinically consequential comorbidity in ASPD populations. Approximately 56.7% of the Portuguese ASPD sample studied by Azevedo et al. (2020) exhibited SUDs, and the frequency of SUDs was significantly higher in individuals with ASPD than in those without (OR = 2.68, 95% CI [1.24, 5.78]). Substance use may amplify aggression through multiple mechanisms: acute intoxication reduces prefrontal inhibitory control and heightens impulsivity; withdrawal states produce dysphoria and irritability; and the pursuit of substances often generates interpersonal conflict and criminal opportunity. Some theorists have proposed that impulsive aggression and drug use may represent components of the same externalizing behavior spectrum (Azevedo et al., 2020).

Depressive and anxiety disorders are also prevalent in ASPD samples, though their contribution to aggression is more variable. Depressive disorders have been associated with impaired impulse control and aggressive behavior, and patients with major depression have shown higher impulsivity and more severe aggression than controls, along with greater likelihood of committing violent crimes (Azevedo et al., 2020). The prevalence of comorbidity between ASPD and anxiety disorders reported in the literature reaches approximately 50%, though lower rates are observed in some samples (Azevedo et al., 2020).

Trauma history—including physical, emotional, and sexual abuse—represents a further contextual modulator of aggressive expression. Early traumatic experiences shape attachment representations, emotional regulation capacities, and cognitive schemas, and they have been implicated in both violent and sexual offending trajectories. In the Turkish sample,

violent offenders predominantly reported physical abuse histories (88.2%), whereas sexual offenders more frequently reported sexual abuse histories (52.6%; $p < 0.001$) (Özcanl■ et al., 2026), reflecting the possibility of trauma-specific pathways to distinct offending outcomes.

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4. Empirical Findings Across Studies

The integration of empirical findings across the two anchor studies yields a rich, multidimensional picture of aggression in ASPD. This section synthesizes those findings, organized by domain, and highlights areas of convergence and divergence.

Sample Characteristics and Sociodemographic Findings

Azevedo et al. (2020) recruited 134 male inmates from a medium-high security penitentiary in northern Portugal between January and March 2015. All participants were serving sentences longer than 10 years, and the institution held 810 inmates at the time of the study. The mean age of the sample was 37.8 (SD = 9.2) years, mean educational attainment was 7.1 (SD = 2.9) years, and the mean length of imprisonment at the time of assessment was 112.9 (SD = 70.6) months. A total of 74.2% of participants had been convicted of violent crimes (physical assault, murder, or attempted murder), 71.6% met criteria for ASPD, 56.7% had SUDs, and 28.4% exhibited psychopathy on the PCL-R (Azevedo et al., 2020).

Özcanl■ et al. (2026) examined 89 incarcerated offenders diagnosed with ASPD at the Council of Forensic Medicine in Türkiye between 2014 and 2024, comparing 51 violent offenders with 38 sexual offenders. Notably, the Turkish study found significant sociodemographic differences between violent and sexual offenders: violent offenders were more frequently unemployed (58.8% versus 31.6%; $p = 0.009$) and divorced (45.1% versus 18.4%; $p = 0.022$), whereas sexual offenders were more often single (65.8% versus 39.2%). No significant group differences emerged in education level, economic status, family relationships, parental marital status, place of residence, or migration history, suggesting that basic demographic variables alone are insufficient to distinguish violent from sexual offenders (Özcanl■ et al., 2026).

Prevalence of Aggression Types

Among ASPD patients in the Portuguese sample, impulsive aggression was detected in 71.8% (n = 79) and premeditated aggression in 28.2% (n = 27), indicating that impulsive aggression is the predominant form in ASPD populations (Azevedo et al., 2020). ASPD patients had a lower frequency of impulsive aggressive acts compared to individuals without ASPD (OR = 0.22, 95% CI [0.06, 0.77]) but a higher frequency of premeditated aggressive acts (OR = 3.87, 95% CI [1.04, 14.47]). ASPD patients also had a higher mean score on the IPAS premeditated aggression dimension than non-ASPD individuals ($p < 0.05$) (Azevedo et al., 2020).

Psychopathy and Aggression Type

Within the ASPD subsample, the interpersonal facet of the PCL-R emerged as a significant predictor of aggression type. Individuals with ASPD who exhibited impulsive aggression had significantly lower total PCL-R scores ($p < 0.001$; 95% CI [4.38, 9.49]), lower Factor 1 scores, and lower Facet 1 (interpersonal) scores ($p < 0.05$) than ASPD individuals with premeditated aggression (Azevedo et al., 2020). ASPD individuals with impulsive aggression had a lower probability of exhibiting psychopathy (OR = 0.19, $p < 0.001$, 95% CI [0.07, 0.50]) than those with premeditated aggression, whereas ASPD individuals with premeditated aggression had a higher probability of showing psychopathy (OR = 5.26, $p < 0.001$, 95% CI [2.02, 13.70]). Among ASPD individuals with psychopathy, 51.4% exhibited impulsive aggression, indicating that psychopathy does not exclusively predict premeditated forms.

The Turkish sample yielded even more dramatic differentials in psychopathy between offender subtypes. PCL-R scores were markedly higher among violent offenders (Mean = 28.01, SD = 5.83) compared to sexual offenders (Mean = 11.94, SD = 3.70; $p < 0.001$, $t = 14.878$), indicating substantially stronger psychopathic traits in the violent crime group (Özcanl■ et al., 2026). Logistic regression identified psychopathy as the strongest independent predictor of violent offending ($\beta = 0.60$, $p < 0.001$, OR = 1.82, 95% CI [1.31, 2.54]), with each one-point increase in PCL-R score associated with an approximately 82% increase in the odds of violent offending. The overall model, which included psychopathy, cognitive distortions, substance use, and anxiety, achieved a Nagelkerke R^2 of 0.83, indicating that approximately 83% of the variance in offense type was explained by these predictors.

Impulsivity Findings

Impulsivity, as measured by the BIS-11, was comparable in individuals with and without ASPD in the Portuguese sample, and did not differ significantly between ASPD individuals with impulsive versus premeditated aggression (Azevedo et al., 2020). However, the IPAS dimensions of impulsive and premeditated aggression both showed positive correlations with the BIS-11 total score and all first- and second-order factors, indicating that impulsivity is present across aggressive expressions but does not by itself differentiate their type.

ASPD individuals with SUDs had higher mean scores on the self-control first-order factor and non-planning second-order factor of the BIS-11 than ASPD individuals without SUDs ($p < 0.05$), suggesting that substance use interacts with impulsivity dimensions in a manner that may exacerbate risk (Azevedo et al., 2020).

Substance Use Findings

The prevalence of SUD comorbidity with ASPD was 61.4% in the Portuguese sample, consistent with rates reported in prior international studies ranging from 40.7% to 90% (Azevedo et al., 2020). SUDs were significantly more common in ASPD individuals than in non-ASPD individuals (OR = 2.68, 95% CI [1.24, 5.78]). Addiction severity, as measured by the European Addiction Severity Index (EuropASI), did not differ between groups, and neither impulsive nor premeditated aggression dimensions correlated with EuropASI severity scores.

In the Turkish sample, substance use was significantly more common in violent than sexual offenders (84.3% versus 44.7%; $p < 0.001$) (Özcanl■ et al., 2026). However, once psychopathy was controlled for in the multivariate logistic regression, substance use no longer independently predicted violent offending ($\beta = 1.97$, $p = 0.215$), suggesting that psychopathy operates as a central organizing construct that may account for the univariate association between substance use and violence.

Trauma and Self-Injury

Non-suicidal self-injury was strikingly more common in violent than sexual offenders in the Turkish sample (86.3% versus 28.9%; $p < 0.001$), as was history of physical abuse (88.2%

versus 44.7%; $p < 0.001$) (Özcanl■ et al., 2026). Sexual offenders more often reported histories of sexual abuse (52.6% versus 7.8%; $p < 0.001$), a finding that corroborates prior research indicating that early traumatic sexual experiences may distort sexual scripts and attachment representations, increasing risk for later deviant sexual behavior (Özcanl■ et al., 2026).

Suicide attempt history was reported in 30.3% of the Portuguese ASPD sample (Azevedo et al., 2020) and did not significantly differ by aggression type. In the Turkish sample, suicide attempt rates were also comparable across offender groups (64.7% in violent versus 55.3% in sexual offenders; $p = 0.367$) (Özcanl■ et al., 2026).

Depression, Anxiety, and Internalizing Symptoms

Depression and anxiety comorbidity did not significantly influence aggression type in the Portuguese sample. Depressive disorders were present in 31.5% of the total sample and anxiety disorders in 28.1%, with no significant differences between ASPD and non-ASPD subgroups (Azevedo et al., 2020).

In striking contrast, the Turkish sample revealed substantially higher depressive symptoms in sexual offenders (Mean = 35.15, SD = 8.06) than violent offenders (Mean = 13.64, SD = 5.28; $p < 0.001$, $t = -15.183$) as measured by the Beck Depression Inventory, and higher anxiety scores in sexual offenders as well ($p = 0.01$, $t = -2.617$) (Özcanl■ et al., 2026). This divergence points to a robust internalizing dimension in sexual offending within ASPD, distinct from the externalizing profile characteristic of violent offending.

MMPI Findings

The Minnesota Multiphasic Personality Inventory profiles further differentiated the Turkish offender groups (Özcanl■ et al., 2026). Violent offenders scored significantly higher on Hypochondriasis ($p = 0.02$), Psychopathic Deviate ($p = 0.014$), and Schizophrenia ($p < 0.001$) scales, indicating greater behavioral dysregulation, emotional blunting, and psychotic-like thought patterns. Sexual offenders scored higher on Hysteria ($p = 0.002$), Masculinity–Femininity ($p < 0.001$), Paranoia ($p = 0.002$), Psychasthenia ($p = 0.009$), Hypomania ($p = 0.03$), and Social Introversion ($p = 0.004$) scales, reflecting heightened emotional sensitivity, social withdrawal, and possible identity-related conflicts. No significant

difference was found on the MMPI Depression subscale (p = 0.268).

Summary Table

The following table synthesizes key comparative findings across the two anchor studies:

Domain	Portuguese Sample (Azevedo et al., 2020)	Turkish Sample (Özcanl■ et al., 2026)
Sample	134 male inmates; 71.6% ASPD	89 ASPD offenders; 51 violent, 38 sexual
Primary comparison	ASPD vs. non-ASPD; impulsive vs. premeditated aggression	Violent vs. sexual offenders within ASPD
Aggression type distribution	71.8% impulsive; 28.2% premeditated in ASPD	Not directly reported
Psychopathy prevalence	28.4% overall	Continuous PCL-R; Mean 28.0 (violent) vs. 11.9 (sexual)
Strongest predictor of aggression type/violence	PCL-R Facet 1 (Interpersonal); OR = 1.42	PCL-R total score; OR = 1.82
SUD prevalence	56.7% overall; 61.4% in ASPD	84.3% violent vs. 44.7% sexual
Depression	31.5% overall; no association with aggression type	Significantly higher in sexual offenders
Trauma type	Not directly compared	Physical abuse in violent; sexual abuse in sexual offenders

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5. Psychological Pathways and Stress Responses

Understanding the psychological pathways that translate personality vulnerability into aggressive behavior requires attention to the interplay of arousal, cognitive appraisal, emotional regulation, and behavioral execution. This section elaborates the psychological mechanisms that link ASPD, psychopathy, and stress responses to distinct forms of aggression.

Arousal and Autonomic Regulation

Impulsive aggression is characteristically associated with heightened autonomic arousal in response to perceived provocation or threat. Individuals engaging in impulsive aggression tend to exhibit high physiological reactivity, difficulty modulating stress responses, and cognitive narrowing under emotional load (Azevedo et al., 2020). This pattern is consistent with a hyperresponsive threat-detection system coupled with insufficient top-down regulatory control from prefrontal structures.

Premeditated aggression, by contrast, is associated with low autonomic arousal, reduced fear conditioning, and blunted physiological responses to stress cues. This hypoarousal is characteristic of the psychopathic profile and is thought to reflect underactivity in amygdala and related limbic circuits (Özcanl■ et al., 2026). The hypoaroused psychopath is capable of executing planned aggression without the physiological brakes—elevated heart rate, sweating, anticipatory anxiety—that would deter most individuals from calculated harm-doing.

Emotional Learning and Moral Reasoning

Neurocognitive models emphasize the role of amygdala-mediated emotional learning in the development of prosocial behavior and moral reasoning (Özcanl■ et al., 2026). The normal developmental pathway involves the pairing of another's distress with aversive emotional responses in the observer, generating empathic concern and inhibiting aggressive impulses. In psychopathy, this pairing is impaired: distress cues in others fail to elicit the aversive responses that ordinarily support prosocial behavior, and consequently, the affective brakes on harm-doing are weakened.

This impaired emotional learning is accompanied by deficits in the recognition and processing of specific emotional expressions, particularly fear and sadness. The consequence is a cascade of downstream effects: reduced empathy, blunted guilt and remorse, impaired moral socialization, and increased tolerance for aggressive behavior as an instrumental strategy (Azevedo et al., 2020).

Cognitive Appraisal and Attributional Bias

Individuals with elevated psychopathic and antisocial traits often exhibit hostile attributional biases—a tendency to interpret ambiguous social cues as hostile or threatening. This bias contributes to reactive aggression by lowering the threshold for perceiving provocation. In the Turkish sample, violent offenders scored significantly higher on cognitive distortion measures than sexual offenders, suggesting greater maladaptive cognitive processing in the violent group (Özcanl■ et al., 2026).

Cognitive-behavioral theorists have argued that these distortions—hostility, mistrust, overgeneralization, self-blame—mediate the relationship between personality pathology and violent behavior (Özcanl■ et al., 2026). The clinical implication is that cognitive restructuring may serve as a therapeutic entry point for reducing violent behavior, particularly in individuals whose aggression is driven by maladaptive appraisal patterns rather than by the core affective deficits of psychopathy.

Stress, Substance Use, and Aggression

The interaction of stress, substance use, and aggression represents a particularly potent pathway to violence. Acute intoxication with alcohol or other substances reduces prefrontal inhibitory control, amplifies impulsivity, and disinhibits aggressive responses. Withdrawal states generate dysphoria and irritability that further lower the threshold for aggression. The pursuit of substances often generates interpersonal conflict, financial strain, and criminal opportunity, all of which increase exposure to violent situations (Azevedo et al., 2020).

The finding that substance use was substantially more prevalent in violent than sexual offenders in the Turkish sample (84.3% versus 44.7%) is consistent with this framework (Özcanl■ et al., 2026). However, the observation that substance use no longer independently predicted violent offending after psychopathy was controlled for suggests that psychopathy may function as an upstream construct that drives both substance use and violence, with substance use serving as a proximal amplifier rather than an independent cause.

Trauma and Developmental Pathways

Adverse childhood experiences shape the neurodevelopment of stress-response systems, emotional regulation capacities, and social cognition. Chronic exposure to abuse, neglect, or family instability disrupts the normal maturation of prefrontal-limbic circuits and promotes the

consolidation of maladaptive schemas. In ASPD populations, trauma histories are highly prevalent, and specific trauma types appear to be differentially associated with offense trajectories.

The Turkish study documented that violent offenders predominantly reported physical abuse (88.2%), whereas sexual offenders more frequently reported sexual abuse (52.6%) (Özcanl■ et al., 2026). This trauma-specific patterning suggests distinct developmental pathways: physical victimization may shape aggressive behavioral scripts and normalize physical violence as a means of conflict resolution, while sexual victimization may distort sexual scripts and attachment representations in ways that increase risk for later sexual offending.

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6. Mental Health Outcomes and Severity Spectrum

Aggression in ASPD occurs within a broader context of psychiatric comorbidity and functional impairment. This section examines the mental health outcomes associated with ASPD-related aggression and the severity spectrum across which these outcomes vary.

Severity of Personality Pathology

Individuals with ASPD exhibit substantial variability in the severity of their personality pathology. The PCL-R provides a dimensional measure of psychopathic severity, and higher scores are associated with more severe personality dysfunction, higher recidivism risk, and greater resistance to treatment (Azevedo et al., 2020; Özcanl■ et al., 2026). Within the Portuguese sample, ASPD individuals scored significantly higher on all PCL-R factors and facets than non-ASPD individuals, and 39.2% of ASPD individuals met the PCL-R threshold for psychopathy (Azevedo et al., 2020).

The severity gradient has direct clinical implications. Low-severity ASPD individuals with predominantly impulsive aggression, preserved emotional functioning, and comorbid substance use may respond to targeted pharmacological and psychological interventions. High-severity psychopathic offenders with predominantly premeditated aggression, callous-unemotional traits, and low anxiety are considerably more difficult to treat and pose elevated risk for future violence.

Substance Use Disorders

SUDs are the most prevalent psychiatric comorbidity in ASPD samples. In the Portuguese sample, 61.4% of ASPD individuals had SUDs (Azevedo et al., 2020), while 84.3% of violent Turkish offenders reported substance use (Özcanl■ et al., 2026). SUDs contribute to functional impairment across multiple domains, including employment, family relationships, legal status, and physical health, and they substantially amplify the risk of aggressive behavior through the mechanisms outlined earlier.

The bidirectional relationship between SUDs and aggression is important to appreciate clinically. Substance use both increases the probability of aggressive expression in the acute state and, over time, shapes personality functioning and social embeddedness in ways that perpetuate antisocial trajectories. Effective treatment of ASPD-related aggression frequently requires integrated attention to substance use.

Depressive and Anxiety Disorders

Depressive and anxiety disorders are prevalent in ASPD populations but exhibit variable relationships to aggression. In the Portuguese sample, approximately one-third of participants met criteria for depressive disorders and approximately one-quarter for anxiety disorders, with no significant differences between ASPD and non-ASPD subgroups (Azevedo et al., 2020). The prevalence of comorbidity between ASPD and anxiety disorders reported in the literature reaches approximately 50% (Azevedo et al., 2020).

The Turkish sample revealed a striking dissociation, with substantially higher depression and anxiety scores in sexual than violent offenders (Özcanl■ et al., 2026). This pattern is consistent with prior research indicating that sexual offending is often accompanied by internalizing psychopathology, guilt, and shame, whereas violent offending is characterized by externalizing pathology.

Self-Harm and Suicidality

Non-suicidal self-injury and suicide attempts are common in ASPD populations. Suicide attempts were reported in 30.3% of the Portuguese ASPD sample (Azevedo et al., 2020), and

non-suicidal self-injury occurred in 86.3% of the Turkish violent offender sample (Özcanl■ et al., 2026). The high rate of self-injurious behavior in violent offenders may reflect dysregulated affect and impulsive coping mechanisms characteristic of severe ASPD phenotypes, and it underscores the need for suicide risk assessment as a routine component of forensic psychiatric evaluation.

Psychosocial Functioning

Functional impairment in ASPD extends across multiple life domains. Employment instability, marital dysfunction, interpersonal conflict, and legal involvement are pervasive. The Turkish study documented that 58.8% of violent offenders were unemployed and 45.1% were divorced (Özcanl■ et al., 2026), reflecting the cumulative impact of personality pathology on social embeddedness.

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7. System-Level and Contextual Psychological Effects

The clinical presentation of ASPD-related aggression is shaped substantially by the systems within which affected individuals are embedded, most notably the correctional system, forensic psychiatric services, and the legal apparatus.

The Prison Context

The prison environment exerts a powerful influence on the expression and management of aggression. Prison populations exhibit high prevalence of mental pathology, including ASPD, SUDs, depressive disorders, and anxiety disorders, and inmate-to-inmate victimization is common (Azevedo et al., 2020). The high prevalence of aggressive acts and comorbid psychiatric disorders in forensic settings requires a complex and integrated psychiatric assessment that should address the needs of organized forensic psychiatric services in prisons.

Contextual factors shape research findings as well. Inmates may believe that participation in research confers personal benefits (social desirability bias), and legal circumstances may

modify response patterns on self-report measures (Azevedo et al., 2020). These considerations inform the interpretation of psychometric data collected in correctional settings and highlight the value of multi-method assessment that incorporates collateral information, clinical observation, and file review.

Forensic Psychiatric Evaluation

Forensic psychiatric evaluation of individuals with ASPD requires the integration of clinical, psychometric, and judicial data. The evaluation typically encompasses standardized diagnostic assessment (e.g., MINI, SCID), personality assessment (e.g., PCL-R, MMPI), aggression assessment (e.g., IPAS, Buss-Perry Aggression Questionnaire), impulsivity assessment (e.g., BIS-11), and assessment of comorbid conditions (e.g., substance use severity via EuropASI, mood symptoms via Beck inventories) (Azevedo et al., 2020; Özcanl■ et al., 2026).

The Turkish forensic evaluation model exemplifies a comprehensive approach: diagnoses were established by multidisciplinary teams using DSM-5 criteria, combining clinical observation, collateral interviews, and criminal record review during a standardized 3-4 week observation period (Özcanl■ et al., 2026). All participants completed a standardized psychometric battery under the supervision of certified forensic psychologists, and each participant's official court file was examined to obtain judicial and contextual variables.

The Legal-Clinical Interface

The intersection of clinical assessment and legal decision-making creates unique challenges for forensic psychologists. The classification of aggression as impulsive or premeditated bears directly on questions of responsibility, culpability, and treatment mandate. Premeditated aggression, associated with planning and instrumental intent, generally connotes greater culpability and is more strongly linked to psychopathy, which in turn predicts poor treatment response and elevated recidivism risk (Azevedo et al., 2020; Özcanl■ et al., 2026).

The relationship between psychopathy and premeditated aggression should be carefully examined by clinicians and lawyers regarding individuals with ASPD (Azevedo et al., 2020). Psychopathy may exhibit both impulsive and premeditated aggressive behaviors, and the categorical distinction should not obscure the phenomenological complexity within individuals.

Risk Assessment and Management

Risk assessment for future violence in ASPD populations relies on the integration of static and dynamic risk factors. Static factors include criminal history, age at first offense, and psychopathy scores; dynamic factors include current substance use, treatment engagement, and social support. The identification of psychopathy as the strongest predictor of violent offending in the Turkish sample (Özcanl■ et al., 2026) reinforces the central role of PCL-R assessment in violence risk formulation.

The differentiation of impulsive from premeditated aggression carries specific risk-management implications. Impulsive aggression is often more responsive to environmental modification, pharmacological intervention targeting affective dysregulation, and skills-based psychological treatment. Premeditated aggression in the context of high psychopathy is less amenable to these interventions and may require containment strategies, careful monitoring, and structured supervision.

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8. Clinical Implications for Psychologists

The integrated evidence base yields several clinical implications for psychologists working with ASPD populations, whether in forensic, correctional, or general clinical settings.

Assessment Recommendations

Comprehensive assessment of ASPD should include structured diagnostic interviews (e.g., MINI, SCID), personality assessment (PCL-R, MMPI-2), aggression measurement (IPAS, Buss-Perry Aggression Questionnaire), impulsivity assessment (BIS-11), cognitive distortion assessment (ICDS), and evaluation of comorbid conditions (Beck Depression and Anxiety Inventories, EuropASI). The integration of self-report, clinician-rated, and collateral information sources reduces the impact of response bias and enhances diagnostic accuracy.

The categorical distinction between impulsive and premeditated aggression should be formally assessed and documented, as it carries direct implications for prognosis and

treatment planning. The IPAS provides a validated method for this categorization (Azevedo et al., 2020).

Psychopathy assessment via the PCL-R should be a routine component of forensic evaluation in ASPD, given the strong predictive value of psychopathy for premeditated aggression, violent recidivism, and treatment response (Azevedo et al., 2020; Özcanl■ et al., 2026). Particular attention should be paid to the interpersonal facet (Facet 1), which has emerged as the most robust predictor of premeditated aggression within ASPD.

Treatment Planning

Treatment planning should be individualized based on the specific profile of each ASPD patient. For patients with predominantly impulsive aggression, preserved emotional functioning, and comorbid SUDs, the treatment plan should emphasize integrated substance use treatment, emotion regulation skills training, and pharmacological intervention targeting affective dysregulation and impulsivity. Impulsive aggression tends to benefit from currently available pharmacological treatments (Azevedo et al., 2020).

For patients with predominantly premeditated aggression, high psychopathy scores, and callous-unemotional traits, the treatment approach must acknowledge the limited responsiveness of this population to conventional interventions. Structured cognitive-behavioral programs targeting cognitive distortions, behavioral contingency management, and containment-based strategies may be more appropriate than emotion-focused therapies.

For sexual offenders with ASPD, the elevated prevalence of internalizing symptoms and sexual trauma histories (Özcanl■ et al., 2026) suggests the importance of trauma-focused therapies alongside offense-specific interventions targeting deviant sexual arousal and cognitive distortions related to sexual behavior.

Risk Management

Risk management for ASPD-related aggression should be informed by the aggression type classification, psychopathy severity, and dynamic risk factors including substance use, treatment engagement, and social embeddedness. High-psychopathy premeditated offenders

require intensive monitoring, structured supervision, and containment-focused management. Impulsive aggressive offenders may respond to environmental modification, skills training, and pharmacological intervention.

The Role of Cognitive Restructuring

Cognitive restructuring emerged as a potentially valuable therapeutic target, particularly for violent offenders exhibiting elevated cognitive distortions (Özcanl■ et al., 2026). Interventions targeting maladaptive schemas—hostility, mistrust, externalization of blame—may reduce the frequency of aggressive appraisals and downstream aggressive behavior.

Working with Comorbidity

The high prevalence of SUD comorbidity requires integrated attention to substance use in nearly all treatment plans for ASPD. The bidirectional relationship between substance use and aggression, and the finding that substance use may function as a proximal amplifier of underlying psychopathy-driven violence risk, suggest that substance use treatment should be prioritized alongside personality-focused interventions.

Depressive and anxiety disorders, particularly in sexual offenders, may serve as therapeutic entry points and should be addressed through evidence-based interventions such as cognitive-behavioral therapy for depression and anxiety.

Ethical Considerations

Working with ASPD populations raises specific ethical considerations for psychologists. The tension between confidentiality and public safety, the assessment of malingering and response bias, the limits of predictive accuracy in violence risk assessment, and the potential for stigma and discrimination all require careful attention. Psychologists must maintain a clear-eyed appraisal of both the strengths and limits of available assessment tools and intervention strategies, and they must communicate this appraisal transparently to referring agencies, courts, and correctional systems.

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9. Future Directions and Research Gaps

Despite substantial progress in the empirical understanding of aggression in ASPD, significant research gaps remain.

Sample Diversity and Generalizability

Both anchor studies were conducted in male, incarcerated populations, limiting generalizability to female offenders, community samples, and non-forensic clinical populations (Azevedo et al., 2020; Özcanl■ et al., 2026). Future research should include female ASPD samples to determine whether the aggression patterns and psychopathy correlates identified in male samples generalize across gender. Community-based studies of ASPD without criminal justice involvement would further clarify the relationship between personality pathology and aggression outside the incarcerated context.

Longitudinal Designs

The cross-sectional designs of the anchor studies preclude causal inference (Azevedo et al., 2020; Özcanl■ et al., 2026). Longitudinal research is needed to elucidate the developmental pathways from early childhood adversity through personality consolidation to specific offending trajectories. Prospective studies could clarify the temporal ordering of psychopathy, substance use, cognitive distortions, and aggressive behavior, and could inform preventive interventions.

Multimodal Assessment

Future research should integrate psychometric, neurocognitive, and neuroimaging data to further elucidate the mechanisms linking personality pathology to specific offending patterns (Özcanl■ et al., 2026). The incorporation of external, longitudinal quantification of aggressive acts through measures such as the Modified Overt Aggression Scale would complement self-report measures and reduce response bias (Azevedo et al., 2020).

Comorbidity Screening

Comprehensive psychiatric evaluation in ASPD should routinely include screening for conditions with high comorbidity, such as attention-deficit/hyperactivity disorder (Azevedo et al., 2020). Future research should systematically examine the contribution of ADHD, trauma-related disorders, and other frequently comorbid conditions to the aggression patterns observed in ASPD.

Statistical Considerations

The Nagelkerke R^2 of 0.83 observed in the Turkish logistic regression model indicates unusually high explanatory power for a clinical/forensic dataset and may partly reflect the very large between-group difference in psychopathy, which can yield near-complete separation and inflate apparent model fit in modest samples (Özcanl■ et al., 2026). Future work should evaluate model stability through internal validation (e.g., cross-validation, bootstrapping), report discrimination and calibration indices (AUC, calibration slope, Brier score), and consider penalized approaches (e.g., Firth logistic regression) to mitigate small-sample bias and separation effects.

Instrument Validation

The Interpersonal Cognitive Distortions Scale (ICDS) was originally developed and validated in a non-forensic sample of university students, and its psychometric properties in forensic populations may be limited (Özcanl■ et al., 2026). Further validation work on cognitive distortion measures in forensic samples is warranted.

Treatment Research

The paucity of controlled treatment research in ASPD populations represents a persistent gap. Very little research has investigated the treatments which might be useful in aggressive ASPD patients (Azevedo et al., 2020). Rigorous randomized controlled trials of pharmacological and psychological interventions targeting specific aggression subtypes are needed to advance evidence-based practice.

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10. Conclusion

Aggression in Antisocial Personality Disorder is a heterogeneous phenomenon shaped by the interplay of personality architecture, emotional dysfunction, cognitive processes, comorbid conditions, and contextual factors. The integrated evidence base examined in this manual supports several central conclusions with direct clinical relevance for psychologists.

First, aggression in ASPD is predominantly impulsive in nature, but a substantial minority of ASPD-related aggression is premeditated and is closely tied to psychopathic personality traits, particularly the interpersonal and affective facets captured by PCL-R Factor 1 (Azevedo et al., 2020). The categorical distinction between impulsive and premeditated aggression carries substantial prognostic and treatment implications and should be formally assessed in forensic evaluation.

Second, psychopathy represents a distinct and particularly malignant subtype within the broader ASPD population, characterized by emotional dysfunction and elevated risk for premeditated aggression, violent recidivism, and treatment resistance (Azevedo et al., 2020; Özcanl■ et al., 2026). The interpersonal facet of psychopathy has emerged as the strongest predictor of aggression type within ASPD, while the total PCL-R score has emerged as the strongest predictor of violent versus sexual offending among ASPD individuals.

Third, violent and sexual offenders with ASPD exhibit distinct clinical and psychological profiles. Violent offenders demonstrate higher levels of psychopathy, cognitive distortions, substance use, and externalizing behaviors, whereas sexual offenders exhibit greater internalizing symptoms, higher depression and anxiety scores, and more frequent histories of sexual trauma (Özcanl■ et al., 2026). These distinct profiles support the differentiation of intervention approaches based on offense trajectory and clinical presentation.

Fourth, impulsivity as a trait and SUDs as a comorbidity are ubiquitous in ASPD populations but do not by themselves differentiate aggression types (Azevedo et al., 2020). These variables serve as contextual amplifiers of aggressive expression rather than as fundamental determinants of aggression subtype.

Fifth, the clinical management of ASPD-related aggression requires individualized, mechanism-based interventions integrated with comprehensive assessment. High-psychopathy premeditated offenders require containment-focused management and

cognitive-behavioral approaches, while impulsive aggressive offenders may benefit from emotion regulation training, pharmacological intervention, and substance use treatment. Sexual offenders with elevated internalizing symptoms and trauma histories may benefit from trauma-focused therapies alongside offense-specific interventions.

The high prevalence of aggressive acts and comorbid psychiatric disorders in forensic settings underscores the need for organized forensic psychiatric services in correctional institutions and for continued investment in research, training, and evidence-based practice. Psychologists working with ASPD populations occupy a critical role at the interface of clinical care, public safety, and social justice, and the sophistication of their assessment and intervention practices bears directly on the wellbeing of patients, families, and communities.

The clinical translation of research findings on aggression in ASPD requires ongoing attention to the phenomenological complexity of aggressive behavior, the personality-based determinants of aggression subtype, and the contextual factors that shape aggressive expression. A clear definition of aggression type may benefit the design of clinical trials in ASPD patients (Azevedo et al., 2020) and may guide the development of increasingly targeted and effective interventions. As the field advances, the integration of neurobiological, psychometric, and clinical evidence will progressively refine our understanding of the mechanisms of aggression and expand the therapeutic options available to psychologists and their patients.

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11. References

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End of Continuing Education Reading Manual