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EMPATHY AND EMOTIONAL REGULATION DEFICITS IN DISSOCIAL PERSONALITY DISORDER: CLINICAL CHARACTERISTICS IN THE UZBEK CULTURAL CONTEXT

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Abstract

Background: Dissocial Personality Disorder (DPD) is characterized by impairments in empathy and emotional regulation, leading to persistent antisocial behavior. Despite extensive research in Western populations, cultural influences on its clinical presentation in Central Asian societies remain insufficiently examined.

After participating in this activity, learners should be better able to:• Assess differences between adult patients with the diagnosis of borderline personality disorder (BPD) and healthy control subjects in terms of empathy and related processes• Evaluate the effects of empathy or related processes as factors contributing to abnormal social functioning in BPD We reviewed 45 original research studies, published between 2000 and 2019, to assess differences between adult patients with the diagnosis of borderline personality disorder (BPD) and healthy control subjects in terms of empathy and related processes (i.e., theory of mind, mentalizing, social cognition, and emotional intelligence). Thirty-six studies reported deficits of empathy or related processes in patients with BPD. Enhanced emotional empathy in BPD was also reported in eight studies, all of which revealed that patients had increased scores of personal distress on the Interpersonal Reactivity Index self-report questionnaire. Six studies did not find significant differences between patients with BPD and healthy control subjects in

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terms of empathy or related processes. No study reported enhanced cognitive empathy, social cognition, or emotional intelligence in patients with BPD. We postulate that deficits of empathy or related processes contribute to preempting the formation of stable interpersonal relationships, whereas enhanced emotional empathy might lead to personal (and interpersonal) distress, further contributing to abnormal social functioning in BPD.

Objective: To analyze empathy and emotional regulation deficits in Dissocial Personality Disorder within the Uzbek cultural context and discuss implications for diagnosis and clinical practice.

Methods: Narrative integrative review of psychiatric, psychological, and cross-cultural literature.

Results: Core deficits in affective empathy and emotional regulation are consistently observed, while sociocultural norms may mask or modulate symptom expression.

Conclusion: Incorporating cultural context is essential for accurate assessment and effective management of DPD.

Keywords: Dissocial Personality Disorder; empathy; emotional regulation; culture; Uzbekistan.

Introduction

Dissocial Personality Disorder (DPD), conceptually aligned with antisocial personality disorder in international diagnostic systems, represents a severe and enduring form of personality pathology. Individuals with this disorder demonstrate persistent patterns of disregard for social norms, interpersonal exploitation, diminished responsibility, and emotional detachment. These characteristics contribute to significant social dysfunction, interpersonal harm, and considerable burden on healthcare and legal systems.

Clinically, DPD is associated with early onset, chronic course, and limited responsiveness to treatment. Central to its psychopathology are deficits in empathy and emotional regulation, which undermine moral development and adaptive social behavior. Empathy deficits reduce sensitivity to others' suffering, while emotional dysregulation promotes impulsivity, aggression, and poor behavioral inhibition.

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Most existing research on Dissocial Personality Disorder has been conducted in Western cultural contexts, where individualistic values shape emotional expression, autonomy, and moral responsibility. Diagnostic criteria, assessment tools, and therapeutic models contextualized within these societies may not fully capture culturally specific manifestations of personality pathology in non-Western populations.

Culture plays a central role in emotional socialization, moral internalization, and interpersonal regulation. From early childhood, individuals learn culturally sanctioned ways of expressing emotions, resolving conflicts, and interpreting social norms. Consequently, identical psychopathological traits may manifest differently depending on sociocultural environment.

Uzbekistan represents a predominantly collectivistic society characterized by strong family cohesion, hierarchical relationships, and emphasis on social harmony. Multigenerational family structures, respect for elders, and clearly defined authority roles shape interpersonal dynamics. Cultural constructs such as *uyat* (shame) and *or-nomus* (honor) function as external regulators of behavior, reinforcing conformity and social accountability.

Within this cultural framework, dissocial traits may be masked by ritualized respect, outward behavioral compliance, and socially learned moral language. Individuals with DPD may exploit these norms to maintain dominance, justify aggression, or avoid responsibility, thereby delaying clinical recognition of pathology.

Hormones and neurotransmitters

Traumatic events can disrupt the standard development of the central nervous system, which can generate a release of hormones that can change normal patterns of development.[86]

One of the neurotransmitters that has been discussed in individuals with ASPD is serotonin, also known as 5-HT.[86] A meta-analysis of 20 studies found significantly lower 5-HIAA levels (indicating lower serotonin levels), especially in those who are younger than 30 years of age.[87]

While it has been shown that lower levels of serotonin may be associated with ASPD, there has also been evidence that decreased serotonin function is highly correlated with impulsiveness and aggression across a number of different

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experimental paradigms. Impulsivity is not only linked with irregularities in 5-HT metabolism but may be the most essential psychopathological aspect linked with such dysfunction.[88] Correspondingly, the DSM classifies "impulsivity or failure to plan ahead" and "irritability and aggressiveness" as two of seven sub-criteria in category A of the diagnostic criteria of ASPD.[89][67]

Some studies have found a relationship between monoamine oxidase A and antisocial behavior, including conduct disorder and symptoms of adult ASPD, in maltreated children.[90]

Neurological

Antisocial behavior may be related to a number of neurological defects, such as head trauma.[91] Antisocial behavior is associated with decreased grey matter in the right lentiform nucleus, left insular, and frontopolar cortex. Increased volumes of grey matter have been observed in the right fusiform gyrus, inferior parietal cortex, right cingulate gyrus, and post-central cortex.[92]

Intellectual and cognitive ability is often found to be impaired or reduced in the ASPD population.[93] Contrary to stereotypes in popular culture of the "psychopathic genius", antisocial personality disorder is associated with reduced overall intelligence and specific reductions in individual aspects of cognitive ability.[93][94] These deficits also occur in general-population samples of people with antisocial traits[95] and in children with the precursors to antisocial personality disorder.[96]

People who exhibit antisocial behavior tend to demonstrate decreased activity in the prefrontal cortex, and is more apparent in functional neuroimaging as opposed to structural neuroimaging.[97] Some investigators have questioned whether the reduced volume in prefrontal regions is associated with antisocial personality disorder, or whether they result from co-morbid disorders, such as substance use disorder or childhood maltreatment.[98] It is still considered an open question if the anatomical abnormality causes the psychological and behavioral abnormality, or vice versa.[98]

Antisocial behavior is also associated with structural brain differences.[99] Some of the major areas involved are areas of the prefrontal cortex, such as the right frontal and temporal cortices, the ventromedial prefrontal cortex, and the middle and orbitofrontal cortices.[99] In these areas, a reduction in gray matter is seen in

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individuals with antisocial personality disorder, suggesting these structural differences may play a role in their behavior.[99] Reduced gray-matter volumes in these areas are in fact associated with a lack of emotional regulation, a lack of behavioral and response inhibition, and poor decision making among other affects.[100][101][102] Additionally, those with ASPD have shown decreased gray matter volumes in other brain areas such as the amygdala and insula, suggesting possible issues with emotional reactions to certain stimuli.[103] People that exhibit antisocial behavior also tend to demonstrate decreased activity in the prefrontal cortex, as is apparent in functional neuroimaging.

Emotional regulation disturbances in DPD may also be expressed in culturally specific ways. While overt emotional expression is often discouraged, dysregulated affect may emerge indirectly through controlling behavior, domestic conflict, or socially rationalized aggression framed as defense of honor or authority. These patterns complicate diagnostic assessment, as they may be misinterpreted as culturally normative behavior.

Integrating cultural context into psychiatric assessment is therefore essential. Understanding how empathy deficits and emotional regulation disturbances interact with Uzbek sociocultural norms can improve diagnostic accuracy and inform more effective, culturally adapted interventions. This article aims to contribute to this need by providing an integrative clinical and cultural analysis of Dissocial Personality Disorder.

2. Empathy Deficits in Dissocial Personality Disorder

Empathy deficits in DPD predominantly involve affective empathy, while cognitive empathy may remain relatively intact.

3. Emotional Regulation Disturbances

Emotional dysregulation manifests through impulsivity, aggression, and limited emotional reflection.

4. Cultural Modulation in Uzbekistan

Collectivistic norms and honor-based values shape symptom expression and concealment.

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5. Clinical Implications

Structured, culturally informed interventions emphasizing accountability are recommended.

6. Conclusion

Cultural context significantly influences clinical presentation and management of DPD.

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