Law and Psychiatry

Antisocial Personality, Psychopathy, and Forensic Psychiatry

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In this column, I will discuss the diagnosis, assessment, forensic relevance, and treatment of antisocial personality disorder (APD) and its more severe subtype, psychopathy. In earlier work, I have generally equated the two terms. However, it is now more appropriate to separate them, referring to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV)[1] to define APD and reserving the term "psychopathy" to describe persons who meet more stringent criteria, often a high score on a version of Hare's Psychopathy Checklist (e.g., on the revised checklist PCL-R[2] or the screening version PCL-SV[3]).

This is broad topic. For more information, there are at least two excellent references that readers should consult. Cleckley's last edition of *The Mask of Sanity*[4] is a brilliant clinical and practical description of psychopathy. Then, for an excellent modern discussion of diagnosis and forensic applications of both APD and psychopathy, read the review article by Cunningham and Reidy.[5] Some of the key differences between the DSM-IV criteria for APD and the criteria for psychopathy, as defined by sources such as Hare and Cleckley, are outlined in Table 1.

Although DSM-IV criteria for APD are more reliable than those of previous editions of the DSM, their validity rests largely on the fact that the DSM-IV simply creates its own definition. The criteria largely neglect important interpersonal and affective issues, do not allow weighting of symptoms, create a great many combinations which can result in an APD diagnosis, and have been found to lack reliability in several studies.[5] DSM-IV's behavioral focus comes at the expense of understanding personality dynamics, which are widely viewed as the foundation of true psychopathy.

Overdiagnosis. Mislabeling people with chronic antisocial behavior is perhaps the most common diagnostic misunderstanding. The DSM and the *International Classification of Diseases* (ICD) clearly distinguish behavior from personality disorder. Overdiagnosis serves neither courts nor evaluees and hampers both treatment planning and fair legal outcome.

Children and Adolescents. Although childhood antisocial behavior and adult APD and psychopathy are correlated, not every conduct disorder becomes APD. Chronic antisocial behavior in children and adolescents should be taken seriously and sometimes can reasonably be predicted to continue into later life, but one should not diagnose APD or psychopathy without clear adult signs and history. Several studies have examined links between childhood attention-deficit/hyperactivity disorder (ADHD) and chronic adult antisocial behavior; however, specific predictability is poor, and a discussion of adult ADHD is beyond the purview of this column.

FORENSIC EVALUATION AND DIAGNOSIS

Since the evaluee often has an important interest in the outcome of the evaluation and is usually capable of misrepresenting his or her history and mental status, the examiner must give more time to forensic interviews than to most other assessments. This gives the examiner more than the usual opportunity to become familiar with the evaluee's style, develop whatever relationship is possible in an effort to see through the superficial presentation, and listen for inconsistencies. One should be careful to document that the evaluee understood the evaluation's purpose and the examiner's role.

The hallmarks of APD are more clearly found in the history than in the interview. Antisocial evaluees often diminish parts of their histories that tend to incriminate or inconvenience them, either with outright lies or with rationalization and a subtle choice of words. The history thus should not be limited to the evaluee's comments, but should also include as many other sources as feasible (e.g., family, friends, reports from victims and witnesses, law enforcement documents, court and institutional records, school and employment records). Corroboration is vital. Remember that a forensic evaluee's attitudes and motivations are not the same as those of purely clinical patients, even when the setting seems "clinical."

Diminishing the effects of their acts, blaming others, and using other ways of avoiding responsibility are common in individuals with APD. Sometimes the lies are as

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Table 1. Some differences between APD and psychopathy

Antisocial Personality Disorder*	Psychopathy**
• Broader, more inclusive	• Narrower, more severe, more likely to be reflected in criminality (especially Hare/PCL)
• Phenomenologic approach	• Personality deficit approach
• Largely based on visible consequences of unsocialized behavior ("conduct")	• Largely based on personality dynamics (and perhaps brain deficit), with a callous remorseless style of relating to others
• Focuses on antisocial issues and behaviors	• Includes many characteristics of DSM narcissistic, histrionic, paranoid, and borderline syndromes
**As defined in DSM-IV[1]*	*** As defined in sources such as Hare,[2,3] and Cleckley[4]*

obvious as a child's immature "whopper" (cf. "*pseudologia fantastica*"). The following comes from a defendant accused (later convicted) of robbery and of murder to avoid prosecution. The defendant has just learned that his victim was pregnant.

> *I didn't kill her. When I left the house, she was alive. I didn't hit her or nothin.' I put a sheet over her face so she couldn't identify me. Why would I need to kill her if she couldn't identify me? That doesn't make any sense, does it?*
>
> *I have a theory. Most murders are committed by victims* [sic] *who know the victim, right? I didn't know her, so that makes me a lot less likely than her boyfriend or somebody. He knew she'd got herself pregnant, not me. When you think about it, there's nothing they're accusing me of that he couldn't have done himself. And he had a* motive*, Doc. I didn't have* any *motive.*

Antisocial evaluees often have a friendly, even charming, demeanor that can disarm the interviewer and interfere with objectivity. They may gloss over important topics with vague or incomplete answers and a dismissive smile. They may make the evaluator feel silly about asking certain questions, as if they were so obvious or unimportant that a good interviewer shouldn't bother. Sometimes, on the other hand, evaluees are threatening or frightening, tempting examiners to gloss over important questions, skip details, and shorten interviews. Each of these styles tends to shift control of the interview from interviewer to evaluee and decreases the amount of information that is elicited.

Some examinations have an element of danger for the interviewer. One should be certain that criminal evaluations, particularly, take place in safe environments. All clinicians, not just female or inexperienced ones, should pay close attention to safety issues.

FORENSIC RELEVANCE OF APD AND PSYCHOPATHY

It is important to understand that the forensic relevance of any disorder or syndrome is related more to social function, statute, and legal rules than to diagnosis. The law is more interested in behavior than "status."

General Criminality

Some of the association between APD and criminality rests on the fact that many behaviors associated with the indiscriminate seeking of pleasure and stimulation are illegal. Those with APD are more likely than the general population to disregard legality when in the pursuit of pleasure or stimulation. There are other factors as well. The same qualities that often lead these individuals to brush aside the concept of illegality can also keep them from properly considering the consequences of their actions, including consequences that hurt others or increase the chances of getting caught. Finally, both mental health professionals and laypersons tend to use criminal behavior as a definition of APD.

Not all criminals, even chronic ones, have APD. Several studies indicate that 50%–80% of male prison inmates qualify for a diagnosis of APD.[6] Only about one-third meet PCL-R criteria for psychopathy. In a North Carolina study, only about 11% of female felons met APD criteria.[7] This group was demographically different from male inmates in the same prison system; only 11% of the women who met criteria for APD were incarcerated for a violent offense. It is difficult to ascertain the proportionate number of crimes committed by those with APD or psychopathy, compared to all crimes. It may be that persons with APD or psychopathy are caught less often, which would make the inmate percentage an underestimate of overall criminal impact.

For those who are caught and convicted, different crimes have differing proportions of APD/psychopathy involvement. Many kinds of murder, for example, rarely

involve these diagnoses, although others do. Several generally nonviolent crimes, such as forgery and confidence games, regularly involve APD, while other nonviolent crimes do not. Repo et al.[8] found that only 2% of first offender Finnish arsonists had APD; however, the number increased to 14% among some groups of repeat offenders.

The converse query—what portion of those with APD and psychopathy actually commit crimes?—is harder to answer but arguably more relevant. Many people with APD are not criminal; the NIMH Epidemiologic Catchment Area study found no significant arrest record for 53% of community residents who met DSM-III-R criteria for APD.[9] Nevertheless, there are few broad population studies (and apparently none of true psychopathy), since people with APD rarely come to mental health attention except in situations that involve criminal activity.

Sex Offenses

It is important to differentiate APD and psychopathy from the paraphilias, and specifically from sexual offenses. Some sex offenders (more violent than nonviolent ones) meet DSM criteria for APD, but there is little evidence that APD or psychopathy *per se* is routinely associated with sex offenses *per se*. The somewhat archaic term "sexual psychopath," now becoming associated with sexual predator laws, has little psychiatric meaning.

Prevalence studies vary greatly. Curtin and Niveay[10] found that only 17% of Swiss non-homicidal, serious sex offenders had APD. The subject group included very few incest offenders. On the other hand, McElroy et al.[11] found that 72% of serious but non-homicidal U.S. sex offenders, both paraphilic and non-paraphilic, met DSM criteria for APD. A Canadian study reported a 35% prevalence of APD among those who had committed sexual homicide, but 0% among incest perpetrators.[12] The association of adult rape with psychopathic perpetrators or APD is complex, but impulsive gratification, poor judgement, and lack of empathy for the victim (all characteristic of APD) are present in many cases.

The variety of sex offenders' disorders, criminal careers, behaviors, and responses to certain treatment modalities makes it important that clinicians not mistake their primary problem for APD. When APD and sex offenses are combined, the offenders' response to treatment or rehabilitation is generally poorer than in sex offenders without APD.

Violence and Sadism

For most people who meet criteria for APD (but not for psychopathy), harm to others arises primarily from self-serving behavior and disregard for others, not from specific pleasure in hurting them. Violence is still common, however. Although aggression and danger may be stimulating or an uncaring means to an end and the perpetrators do not consider others' feelings or (often) the consequences of their acts, their reasons for violence, sexual assault, or placing others at risk are different from those of individuals who are primarily physically predatory, paraphilic, sadistic, or explosive. When a forensic clinician must try to predict the future behavior of a patient, discuss potential treatment and treatment response, or assess a patient's ability to form intent or control his or her actions, it is important to remember that there are a number of conditions other than ASP and psychopathy that may be involved, such as intermittent explosive disorder, sexual sadism, and substance abuse.

However, persons with many indices of *psychopathy* (such as high PCL scores) have a higher probability of violence. The violence is often purposeful ("instrumental") rather than reactive or emotional. Psychopathy is often present in those with sadistic characteristics and in violent or sadistic sexual offenders. The converse (e.g., the rate of sadism in psychopaths) is more difficult to estimate.

Substance Abuse

APD and substance abuse overlap significantly. However, they should not be assumed to be synonymous nor generally causally related, except insofar as antisocial traits are consistent with trying and using intoxicating substances and the acts of obtaining and using them may be illegal in themselves. Antisocial traits thus may have predictive value for substance abuse, but not for most forms of addiction. Similarly, the traits associated with substance abuse do not confer APD or psychopathy on substance abusers. Such an argument would imply that the personality disorder can be acquired through external influences in late adolescence or adulthood, which is not the case.

Impulsive Behavior

The association between APD and poor impulse control is sometimes used to explain, or justify, such things as impulsive substance abuse, gambling, or violence. However, behaviors such as compulsive gambling or so-called "sex addiction" should be viewed as separate from APD.

Insanity and Diminished Capacity Defenses

No U.S. jurisdiction accepts antisocial personality alone as a limiting factor in a defendant's ability to form intent or take responsibility for his or her actions; thus APD does not support an insanity defense (and it is often specifically excluded from insanity defense statutes). Although psychopaths and those with APD are indeed different from normal people, defense arguments that they cannot control their behavior are almost always futile. Cases in which heinous behaviors *are* eventually

mitigated by a defendant's mental state virtually always contain strong evidence of Axis I and/or general medical disorders (e.g., psychosis, morbid depression, dementia, intoxication).

There is rarely any question about an APD evaluee's legal capacity to perform ordinary social functions such as contracting, making financial or business decisions, or keeping promises, provided he or she chooses to do so. The forensic professional should help the attorney or court to separate *behavior* from personality disorder or mental illness (the latter usually as defined by the relevant jurisdiction, not by DSM-IV). In most cases, antisocial behavior in a person with APD should not be construed as stemming from a mental illness or incapacity. To view the evaluee otherwise is clinically and forensically inaccurate and serves neither the court nor the individual.

Criminal Sentencing, Recidivism, and the Death Penalty

APD and psychopathic offenders are associated with far more criminal recidivism (and in some groups violent recidivism) than other offender groups,[5] although studies of psychopathy and recidivism in females, children, and some ethnic minorities are limited. Psychopathy, as defined by PCL-R criteria, predicts even higher rates of recidivism, violent recidivism, and failure to complete parole. The increased rate of recidivism is in part simply due to including repeated illegal acts in the definition of APD. The reasoning is not entirely circular, however, since people with APD actually choose to commit their antisocial acts, seek the stimulation associated with them, do not delay the gratification presumed to occur with them, and lack some of the judgement and allowance for future consequences that prevents others from committing them.

The presence of studies indicating higher rates of criminal recidivism in those with APD and psychopathy suggests that courts should sentence these individuals accordingly. The diagnosis should be made carefully, however, and the role (or lack of role) of the personality disorder in the crime should be considered (i.e., whether or not some other, perhaps mitigating, factor was involved). Although research supports the validity of the PCL-R for assessing post-release criminal and violent recidivism in many populations, relying on only one test to demonstrate increased risk is unwise. It is more prudent to use a negative PCL-R result to mitigate against psychopathy (and its potential for violence and recidivism) than to use a positive one by itself to seal a defendant's fate, particularly in capital sentencing.

TREATMENT AND OUTCOME

First, let's consider the widespread impression that those with APD "burn out" in middle age. Although antisocial activity may change with age, it does so in complex ways and rarely ceases. Antisocial traits are persistent, and criminal behavior of some kind often continues into late life.

APD is very difficult to treat, and psychopathy even harder. The treatments that occasionally do work (such as highly specialized residential behavioral and psychotherapeutic programs that control every aspect of the patient's life for a long, indeterminate period) are so expensive and time-consuming that society rarely finds them cost effective.

Now the good news: most antisocial behavior is not due to APD. Those who are mentally ill and commit antisocial acts often respond to appropriate treatment. The range of disorders and treatments is beyond the purview of this column, but are well described in recent articles and texts.[13]

THE LAST WORD

Confusing antisocial *behavior*, antisocial *personality disorder*, and true *psychopathy* increases the frustration associated with each. Such confusion causes problems for courts and parole boards and may deprive both the individual and the community of opportunities for effective treatment or management.

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