ASK THE DOCTOR

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Antisocial Personality Disorder and Psychopathic Personality

Q. Dr. Hurley, I have noted that patients with mental retardation and developmental disabilities (MR/DD) and a significant history of antisocial behavior rarely are diagnosed with Antisocial Personality Disorder (ASPD). It often seems that it is not even considered in the differential diagnostic process. Do you agree?

A. Yes. While the condition is rare, of the many individuals I have treated or consulted on in the last three decades, only a very few were considered to have this diagnosis. There are serious implications attached to such a diagnosis, and state agencies and support providers in the MR/DD field are generally quite unreceptive to such a diagnosis. Some feel that individuals with MR/DD are stigmatized already and such a label is uncalled for. This is often based on a misconception and misunderstanding about the significance of the diagnosis.

It is not clear, however, why well trained psychiatric clinicians give this diagnosis infrequently to individuals with MR/DD who have a significant history of antisocial behavior.

Because of lack of training and knowledge about developmental disabilities, many clinicians are unlikely to make any psychiatric diagnosis for this population. Historically, either the presenting problem was seen as a behavior, or just part of the developmental disability.[11] In other cases, symptoms and problems were seen as "psychotic," and rarely did clinicians use diagnoses that they might with intellectually normal patients, such as depression or anxiety disorders. Even among seasoned clinicians who are quite familiar with MR/DD, particularly ASPD, there still is a reluctance to consider any of the personality disorders where the diagnosis might be called for.

Personality disorders are difficult to understand and define, even for intellectually normal patients. A personality disorder is a maladaptive characterological organization involving several areas of psychological functioning, most often associated with considerable personal and social disruption. The disorder arises by late adolescence, and it is then life long and part of the person's "psychological constitution." When applying the concepts of personality disorder to patients with MR/DD, it is even more difficult to make such global judgments due to developmental delay and behavioral aberrations that are common to developmental delay. Further, unless the clinician has had experience with forensic populations resulting in a clear understanding of ASPD, he or she would be reticent to diagnose this condition.

Q. What are the salient features of ASPD?

A. We must discuss the present criteria for ASPD and the concept of Psychopathic Personality. We are most concerned with actually understanding and identifying the "true psychopath."[3,5] In 1980, in an effort to make diagnosis more accurate, the DSM-III significantly changed diagnostic criteria and used the term ASPD. Within this framework, antisocial "acts" were emphasized, such as lying, stealing, poor work history, fights, assaults, unlawful behavior, and failure to honor work obligations; this has continued through to DSM-IV.[1] The World Health Organization ICD-10 diagnostic criteria includes useful descriptive constructs: callous unconcern for feelings of others; gross and persistent attitude of irresponsibility; lack of ability to maintain long term relationships, which is in contrast to the glib and superficial ability to establish relationships initially.[12]

Many individuals with criminal histories meet the criteria for ASPD, but are not "psychopaths." Instead, they are people who have suffered extreme economic and social deprivation, lived in poverty with little education, and may have become involved in social networks, drugs or gangs leading to forensic histories through

committing crimes and being convicted. Because most people with ASPD, and certainly psychopathic personality, do not seek treatment, those studied are the ones arrested and convicted, leading to a disproportion of unsuccessful psychopaths and individuals from lower socioeconomic circumstances in the known population. Thus, ASPD is a condition that is related to but not quite as serious and pervasive as the concept of the "psychopath."

Hare, an international leader in research on psychopathy, eloquently describes the psychopath as a remorseless predator who uses charm, intimidation, and any means necessary including cold blooded violence to attain his or her goals. Psychopaths have no remorse, and lack human empathy. They hone their skills by manipulation of others and they see no difficulty with this; people are to be used and are expendable. Psychopaths' skills at manipulation lead to them being described by others as "charming" and ingratiating. While many may ultimately be arrested, it is unknown how many go through life fairly successfully in many areas of business or other walks of life. Hare's landmark book, "**Without Conscience**," provides probably the clearest and most eloquent description of the psychopath; it is fascinating, compelling, and an excellent book for even the general public due to his sharp and incisive writing style.[5]

Q. How do the diagnostic frameworks affect individuals with MR/DD who have either ASPD or psychopathic personality?

A. In MR/DD populations, the diagnosis of either is extremely difficult. The majority of individuals with MR/DD have social adjustment problems; they have difficulty developing fully mature empathy and taking the others' point of view. They experience interpersonal difficulties, and often need specific instruction in many interpersonal areas, including dating and social relationships. Thus, within this context, clinicians are reticent to diagnose a personality disorder, and have difficulty separating skills affected by developmental delay from problems fitting a pathological framework. Indeed, this is a serious concern, and if the clinician is not totally confident, a diagnosis of any personality disorder should not be given.

Q. Why do you think it is so difficult to diagnose ASPD or any Personality Disorder in persons with MR/DD?

A. In the case of ASPD, the diagnostic confusion between ASPD and psychopathic personality is a serious problem. Secondly, due to the confounding effects of many developmentally delayed behaviors, antisocial "acts" may occur that have little to do with ASPD. Many individuals with MR/DD have a deficit in the ability to feel guilt, and also to profit from experience. They may seem unaffected by punishment or threat of it. Lastly, many may not see their own responsibility in their behaviors or problems, may externalize and blame others, and never understand their own behavior as in conflict with society. These patterns may have little to do with ASPD but be related to the effects of developmental delay.

We must remember, it is quite rare, with few reports on the subject.[4,6,7] Because of the seriousness of the diagnosis or label, clinicians should be quite careful and err on the side of deferring such a diagnosis.

Q. Aggressive behavior is so common, relatively speaking, in the MR/DD population, that it may be excused, even if quite serious or seemingly predatory in nature. But with the difficulty of diagnosis and stigma of the label, do you think it is important to recognize ASPD?

A. Yes, absolutely, because individuals with ASPD psychopathy can be quite dangerous. I have only known a small number of individuals with MR/DD and ASPD, but those individuals inflicted severe damage on others. Because they spent most of their time with others who also had MR/DD, the potential for victimization was extremely serious. One man with a long history of many types of antisocial acts, terrorized dozens of individuals, threatening to kill them if they ever told about his demands for sexual favors; not one individual did "tell" on him and it was discovered only by accident.[6] Another man engaged in serious community violence including rapes, arson, and significant intentional assaults. Because of their ability to engage others and be manipulative, they easily fooled staff and became a danger to others. Support staff and agencies made excuses; the police would not press charges because the individuals had mental retardation. So, after arrests, the men quickly returned to

their respective residential programs, with no requirements for supervision or continued monitoring. Thus, the support network serving such individuals must understand their condition, otherwise, they will have easy access to victims.

Q. Do you have recommendations for diagnostic guidelines for ASPD in the MR/DD population?

A. Yes. The clinician must know the individual well and must obtain a full history. The failure to obtain a history occurs frequently in most clinic situations because it is difficult, time consuming, and is not part of typical mental health diagnosis, as general requirements are that the patient give only his or her own verbal history.

After making every effort to get all available records from childhood on, the clinician will have at least the best picture of historical development of the reported antisocial behavior. Then, the clinician must know the person and observe, but more importantly feel, the manipulativeness of the personality–always jousting to be liked to get his or her needs met. One must listen carefully with the "third ear" to feel oneself being manipulated, being persuaded to like and feel sorry for the person, etc. Also, one must listen for a pattern of the person consistently blaming others and seeing him or herself as not responsible. Lastly, the antisocial acts must be sufficiently serious to warrant such a diagnosis, i.e., including serious and intentional assaults, arson and/or sexual predatory behavior.

Q. When does pedophilia overlap with ASPD?

A. Pedophilia is antisocial, but most individuals who are pedophiles are not psychopaths. The pedophilic assaults may be the only antisocial activity for an otherwise considerate and law-abiding individual. We know that most pedophiles were abused themselves in childhood, and many are remorseful and want help. We also believe that there is a higher victimization rate in the MR/DD population because of their vulnerability.

Q. Do you have any recommendations for clinicians?

A. First, clinicians should be familiar with ASPD and psychopathy. Second, if a person with MR/DD is identified, the clinician must make every effort to educate the support network and

Q. What causes ASPD or psychopathic personality?

A. We do not know, but many researchers believe that ASPD may be the result of social and economic circumstances. True psychopaths may also have a biological predisposition accounting for the lack of human empathy.[5,8,9,10]

Q. Is there any effective treatment?

A. There has been progress in treating other personality disorders, particularly Borderline Personality Disorder.[2] For the true psychopath, most believe that there is little to work with therapeutically.

For those with ASPD, the treating clinician should address any other co-morbid psychiatric conditions and advise regarding the appropriate care and supervision. Behavioral treatment includes progression in privileges with accepting of responsibility, discussing feelings, developing constructive relationships, and the development of coping skills for anger management and delaying of impulsive behavior.[2] Generally, antisocial behaviors tend to decline in intensity and severity after age 40 in most individuals. For true psychopaths, the prognosis is guarded. If it is thought that a person with MR/DD may have psychopathy, the entire support network must aim their efforts vigilantly at protecting others.

Families, and sometimes care providers, may need a form of treatment support. Families of individuals with ASPD and psychopathy suffer greatly. They are confused by the patients' superficially normal appearance in contrast to their behavior, and frequently feel guilt and frustration. They are often victimized by the patient to make restitution for the patient's acts. Professional staff and families are often direct victims. For example, one female with MR/DD and ASPD lied about a sexual relationship with a staff person, causing him serious legal and personal problems. This was part of a complex strategy she developed to change residential programs.

work to provide optimum strategies to protect others. If the criminal justice network is involved, if possible, they also must be included in the support strategies When an individual has a diagnosis of ASPD, it is not uncommon for the criminal justice system to react in a more harsh manner. Those supporting the individual must be alert to this reaction, and also work to protect the individual. As we know, any individual with MR/DD is extremely vulnerable to be repeatedly victimized in a prison or jail population. Specialized criminal justice facilities and arrangements are necessary to protect all involved.

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