Working With Patients Who Have Antisocial Personality Disorder

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Outline

What is ASPD?
What are the causes of Antisocial Behavior?
Personality Development & Nature Vs. Nurture
Brain Growth and Language Development
Psychopaths and Sociopaths
Working with Antisocial Patients
Malingering and Manipulation
Mental Illness and ASPD
Discussion

Are there evil people?

ASPD as a Construct

- The mental health community, legal system, and the public assume the term ASPD is
  - Valid
  - Precise
  - Heuristic
- ASPD makes your client sound evil

"Personality"

What is Personality?

- the complex of characteristics that distinguishes an individual or a nation or group; *especially* **:** the totality of an individual's behavioral and emotional characteristics
- those relatively stable and enduring aspects of an individual

"Antisocial"

Antisocial Personality Disorder

- Label describing a group of individuals with common values and behaviors in social situations
- The prevalence in the general population is approximately 2%
- Male: female ratio approximately 8:1

Coid, 2003; Torgersen, Kringlen & Cramer, 2001

Diagnostic Criteria (DSM-IV-TR)

- Pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more) of the following:
  - failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  - deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - impulsivity or failure to plan ahead
  - irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - reckless disregard for safety of self or others
  - consistent irresponsibility, as indicated by repeated failure to sustain steady work or honor financial obligations
  - lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Diagnostic Criteria (DSM-IV-TR)

- The manual lists the following additional necessary criteria:
  - The individual is at least age 18 years
  - There is evidence of conduct disorder with onset before age 15 years
  - The occurrence of antisocial behavior is not exclusively during the course of a Schizophrenia or a Manic Episode

Conduct Disorder 1

- A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria ….
  - Aggression to people and animals
    - 1. often bullies people, threatens, or intimidates others
    - 2. often initiates physical fights
    - 3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
    - 4. has been physically cruel to people
    - 5. has been physically cruel to animals
    - 6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
    - 7. has forced someone into sexual activity

Conduct Disorder 2

  - Destruction of property
    - 8. has deliberately engaged in fire setting with the intention of causing serious damage.
    - 9. has deliberately destroyed others' property (other than by fire).
  - Deceitfulness or theft
    - 10. has broken into someone else's house, building, or car
    - 11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
    - 12. has stolen items of nontrivial value without confronting a victim
  - Serious violations of rules
    - 13. often stays out at night despite parental prohibitions, beginning before age 13 years
    - 14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
    - 15. is often truant from school, beginning before age 13 years
- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

"Disorder"

The "Fallacy of *Misplaced Concreteness"**

…involves thinking something is a 'concrete' reality when in fact it is merely a belief, opinion or concept about the way things are.

*(originally coined by philosopher A. N. Whitehead)

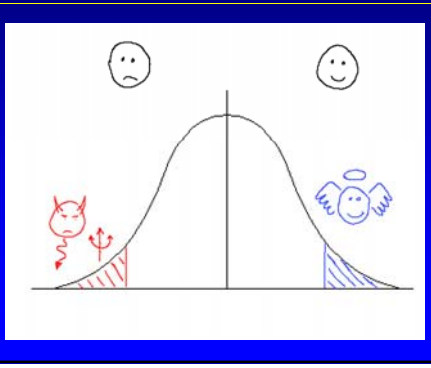
Semantics

- ***"Disorder"*** may refer to
  - a medical disease
  - randomness, a lack of determined order in information theory, mathematics, and computer programming
  - chaos
  - lawlessness
  - what entropy measures
  - Disorder = a British hardcore punk band from 1981
- Not all disorders are diseases
- ASPD is not a disease

ASPD - A Label

- Personality is something we all have – it is normal
- ASPD is a label for a group of traits displayed by people who fit arbitrary criteria picked by the DSM committee
  - The DSM committee change the criteria each edition!
- Personality is analogous to blood pressure, or IQ, or height
  - We all fall somewhere along the continuum (dimension)
- Diseases are not the same kind of a thing
  - We do not all have a little bit cancer
  - We are not all a little demented

ASPD - A Label



Analogy:

Intelligence and Mental Retardation

1913 Mental Deficiency Act

- Defined **four grades of "Mental Defective"**. In each case the condition had to be present "from birth or from an early age".
  - **Idiots** were people "so deeply defective in mind as to be unable to guard against common physical dangers"
  - **Imbeciles** were not idiots, but were "incapable of managing themselves or their affairs, or, in the case of children, of being taught to do so."

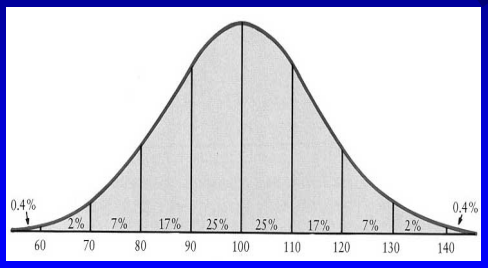
Roberts, A. 1981

1913 Mental Deficiency Act

- **Feeble-minded** people were neither idiots nor imbeciles, but
  - If adults, their condition was "so pronounced that they require care, supervision, and control for their own protection or the protection of others"
  - If children of school age, their condition was "so pronounced that they by reason of such defectiveness appear to be personally incapable of receiving proper benefit from instruction in ordinary schools"
- **Moral Defectives** were people who, from an early age, displayed "some permanent mental defect coupled with strong vicious or criminal propensities on which punishment had little or no effect"

Roberts, A. 1981

The New Intelligence Measure - IQ



Mental Retardation - A Label

Label	IQ
Borderline MR	70 - 79
Mild MR	50 - 69
Moderate MR	35 - 49
Severe MR	20 - 34
Profound MR	Below 20

MR = Mental Retardation

Why care about how we label intelligence – it is an abstract issue for the Psychologists?

Atkins v. Virginia

"Our independent evaluation of the issue reveals no reason to disagree with the judgment of the legislatures that have recently addressed the matter" and "concluded that death is not a suitable punishment for a mentally retarded criminal."

ATKINS V. VIRGINIA 536 U.S. 304 (2002)
260 Va. 375, 534 S. E. 2d 312

Atkins v. Virginia

… might have concluded that death is not a suitable punishment for an imbecile.

… but it is OK for idiots!

Antisocial Personality Disorder

Another label currently in vogue with the mental community, the courts, and the public, that sounds like it means something concrete

– but does not

Legal Implications of ASPD

… be careful about writing the diagnosis in the chart – it can get your patient killed …

Dr. Death

"Prosecutors regularly invoke diagnoses of psychopathy or antisocial personality disorder in capital sentencing … Courts have specifically permitted both diagnoses to be introduced as evidence of future dangerousness at the sentencing phase of capital trials."

"In over 140 cases, Dr. Grigson (often without ever having examined the defendant) testified to the effect that - the defendant has a severe antisocial personality disorder and is extremely dangerous and will commit future acts of violence."

http://ssrn.com/abstract=965837

Dr. Death - James Grigson

If an individual as a child growing up did have the first three: Bed wetting, fire setting, cruelty to animals, but also had difficulty in school getting along with peers and authority figures, this was an indication of possibility of future acts of dangerousness as an adult.

Dr. James Grigson, in an interview with Danish TV

After a defendant, during the guilt phase, has been found guilty of a capital offense, the next goal for the prosecutor (especially if he is politically elected and needs to prove his "toughness on crime") is to have him sentenced to death during the penalty phase.

But for many years, the prosecutors in Texas made good use of Dr. Death, AKA James Grigson, a Dallas forensic psychiatrist, who was more than willing to certify that the defendant was "absolutely" and "most certainly" a danger in the future, and thereby urge the jury to impose death. So in 98% of the 140 cases where Dr. Death was being used as an expert witness, the result was the death penalty.

http://www.fdp.dk/uk/grig.htm

Spot the Bad Guy?

Antisocial Personality Disorder

Really means your client:

✓breaks rules and gets in trouble, sometimes doesn't tell the truth, acts impulsively and for personal gain, is grumpy and fights a lot, isn't very responsible and doesn't seem to care

✓is now a grown-up, but was the same as a child

✓(The Doctors think) isn't crazy

Causes of ASPD

Theories of ASPD

- People are "born bad"
  - The idea is that some people have different biology that makes them "evil" (c.f. "Moral Defective")
  - This places all the blame on the offender
- People *become* bad
  - ~~Acquire some disease or injury~~
  - They are adversely affected by environmental influences as they are growing up
  - This places some blame on society

Nature vs. Nurture

The Genome Problem

- The human being develops from a single fertilized egg cell
- There are approx 25,000 genes
  - 8,000 are expressed in the brain
- How does such a small number of genes allow for the richness of human personality and achievement?
- There is no evidence that memory, language, personality are specified in the genetic code

Human Brain Development

- The human brain is immature at birth
- Growth and development continues after birth
  - chimp brain at birth 350 cc, adult brain 450 cc
  - human brain at birth 300 cc, adult brain 1400 cc
- Human babies cannot perform many functions that animals can from birth

Human Brain Growth

- Neuro-Imaging demonstrates specific brain areas grow at different times
  - *"The main surprise is an extraordinary wave of growth, like a forest fire, proceeding from the front of the brain to the back, between the ages of 3 and 15 years. Another surprise is that some brain systems lose tissue very rapidly,"*

Paul Thompson, Laboratory of Neuro-Imaging, UCLA

Human Brain Growth

- pronounced growth spurt from ages 3 to 6 in frontal regions of the brain that specialize in organizing and planning new behaviors.
  - during this period, children learn an immense variety of new behaviors.
- brain systems specialized for learning language grow extremely rapidly from age 6 until puberty in both boys and girls, but then stop
  - coincides with the critical period during which children easily learn new languages
- ages 7 to 11 children lose tissue in deep brain nuclei that control motor skills

Language Development

The Information Problem

- Every newborn person will encounter novel situations that no one can predict
- There is a lot to learn about the world
- There are more than 100 languages
  - Children can learn any of them
- Brains have no software program or dictionary
  - We are born without information
  - We learn as we go

Language Development

- 6 months — Babbles
- 1 year — Single words
- 2 years — Say 10 words, knows 40
- 3 years — Group objects into categories food, clothes etc.
- 4 years — Say 200+ words, basic rules of grammar
- 5 years — Knows 2,000 words uses sentences, understand time sequences, early conversation

Language Development

- 6 years — Tell a story
- 7 years — Understands alike or different, uses analogies
- 8 years — well developed time and number concepts, carry on a conversation, social courtesies
- 10+ years — Internal reflection, self-criticism, guilt

"If we spoke a different language, we would perceive a somewhat different world."

"The limits of my language are the limits of my mind. All I know is what I have words for".

Ludwig Wittgenstein

Language and World-View

- We base our understanding of the world on language
  - We label things with words
  - We describe concepts, categories, and rules with words
  - We *think* with words
- As we learn labels for things we also absorb the culture, the ethics of those who use those words

The Plastic Brain

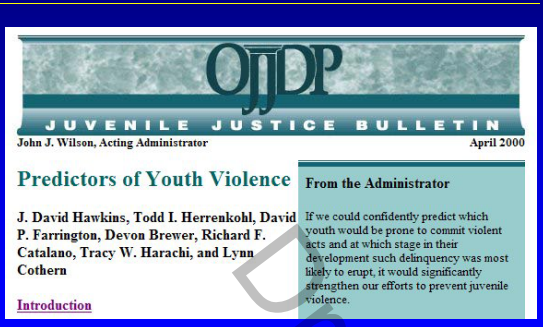
- Evolution produced an organ to deal with novel situations and learns from experience
  - A blank slate that learns fast
- Much learning occurs in the first 10 years
- The child's brain copies, or learns from, individuals in the environment
  - What language we learn
  - What ethics we adopt
  - What other people expect from us
  - What behaviors we copy

Parents, Society, Environment and Childhood Development

The Origins of ASPD

- Nature v. Nurture? - personality is shaped by experiences during childhood development
- Personality traits are fixed by age 10
- Antisocial personality is evident early - violent children are the most likely to become violent adults
  - 2/3 of boys with high teacher-rated aggression scores at ages 10 and 13 had criminal records for violent offenses by age 26 (Stattin and Magnusson, 1989)

Predictors of Violence at Different Ages



OJJDP

JUVENILE JUSTICE BULLETIN

John J. Wilson, Acting Administrator — April 2000

Predictors of Youth Violence

J. David Hawkins, Todd I. Herrenkohl, David P. Farrington, Devon Brewer, Richard F. Catalano, Tracy W. Harachi, and Lynn Cothern

Introduction

From the Administrator

If we could confidently predict which youth would be prone to commit violent acts and at which stage in their development such delinquency was most likely to erupt, it would significantly strengthen our efforts to prevent juvenile violence.

www.ncjrs.gov

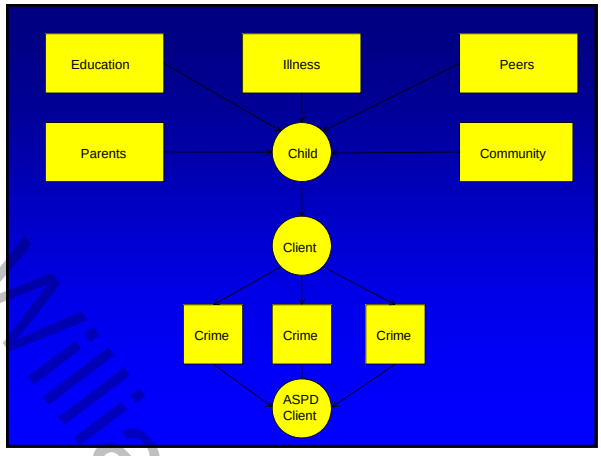
Predictors of Violence at Different Ages

Ages 6 - 11
- Criminality
- Substance Abuse
- Antisocial Parents
- Socioeconomic Status
- Aggression
- Social Ties
- School Attitude
- Abusive Parents
- Antisocial Peers

Ages 12 - 14
- Social Ties
- Antisocial Peers
- Criminality
- Aggression
- School Attitude
- Antisocial parents
- Socioeconomic Status
- Substance Abuse
- Abusive Parents

Lipsey and Derzon, 1998

Reframing ASPD



Multiple Factors Interact

- Socioeconomics
- Parenting Style (Aggression/hostility)
- Parental mental illness and substance abuse
- Lack of limit setting
- Lack of nurturing/absence of role models
- Peer influences
- Learning disability
- Hyperactivity
- Other mental disorders
- Medical factors
- Drugs

Patient Evaluation

Rules to Live By

- At the outset
  - All new patients sign a treatment contract
  - All new patients sign releases to allow you to talk to anybody and everybody
    - Family
    - Employer
    - Parole/probation officer
    - Other providers
  - All new patients have to be instructed in acceptable standards of behavior

Principles of Assessment

- It is never "just" ASPD
- Assume multiple diagnoses
- Antisocial patients don't present or make disclosures the same way regular patients do
- Evaluation should be especially thorough
  - Because it is harder to find the illness
- Failure to treat the illness may lead to criminal recidivism

Chronological Assessment

- ASPD in an adult implies strong risk that family have
  - mental illness
  - substance abuse
  - personality disorder
- Take a detailed family history
  - Identify genetic loading for mental illness
- Evaluation organized chronologically

Assessment

- Clinical interview
  - Family History
  - Pregnancy and Delivery
  - Developmental History (Milestones)
  - Living Situation and Parenting
  - Sexual History (including abuse)
  - Education
  - Employment
  - Legal History and baseline personality
  - Substance Abuse
  - Past Medical History
  - Past Psychiatric History
  - Present Complaints
  - Review of Symptoms \ Syndrome Screening
- Neuropsychiatric Exam
- Diagnostic Studies

Violence Risk Screening

- Screening
  - Developmental risk factors for Sociopathy
  - Criminal Justice history
    - Juvenile criminal conduct
    - Number and length of adult incarcerations
    - Prison disciplinary actions (tickets) or VOP
  - Terminations/Military Disciplinary Actions
  - Screen for past violence in psychiatric programs
    - Seclusion/restraint episodes
    - Involuntary medication
    - Attacks on staff members
    - Triggers
- Patient Education
  - Institutional policy on violence
  - Possibility of criminal charges

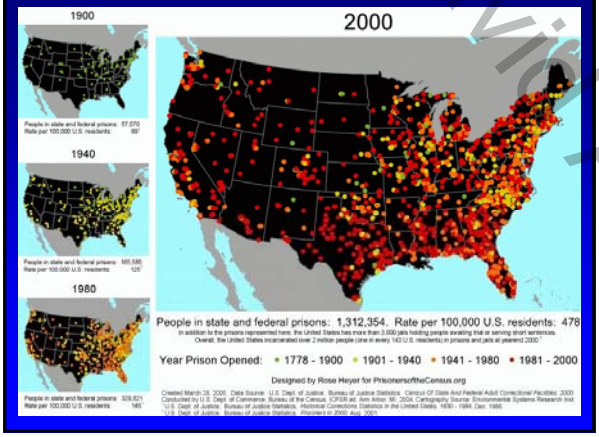
Questions about you as a child	Yes	No
Did a parent have drug or alcohol problems?	☐	☐
Did a parent have mental illness?	☐	☐
Has anybody in your family been in prison? Who? _____	☐	☐
Was there violence in your home growing up?	☐	☐
Were you ever in foster care or removed from your family?	☐	☐
Did you have counseling for childhood behavior problems?	☐	☐
Did you suffer childhood physical abuse?	☐	☐
Did you suffer childhood sexual abuse?	☐	☐
Did you ever start fires or harm animals?	☐	☐
Were you ever expelled from school?	☐	☐
Were you arrested as a juvenile?	☐	☐
Were you ever a gang member?	☐	☐

Questions about you as an adult	Yes	No
Have you ever been in jail? How many times? ____	☐	☐
Have you ever been in prison? How many times? ____	☐	☐
Have you ever violated probation or parole?	☐	☐
Have you been the subject of military disciplinary action?	☐	☐
Have you ever had a fight with a police or correctional officer?	☐	☐
Have you ever used a weapon in a fight?	☐	☐
Have you ever attacked a healthcare worker?	☐	☐
Have you ever been placed in restraints or seclusion?	☐	☐
Have you ever been medicated against your will?	☐	☐
Have you ever been knocked unconscious with a head injury?	☐	☐
Have you ever been fired? How many times? ___	☐	☐
Have you learned any martial arts or boxing?	☐	☐

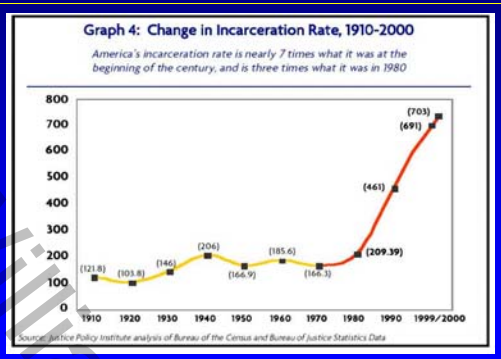
Is ASPD the Wrong Diagnosis?

- No Childhood Conduct Disorder
- Developmental Disability
- Learning Disability
- Brain Injury
- Mood Disorder (Depression, Bipolar)
- Pervasive Developmental Disorder
  - Asperger's Syndrome
  - Autism spectrum
- Culture
  - Latin America, Africa – different childhood experiences

Mental Illness and ASPD



Trends in Incarceration



Diagnosis Rates in Corrections

Disorder	Males	Females
Substance Abuse	61% Jail 70% Prison	70% Jail 80% Prison
Antisocial Personality Disorder	50%	12%
Schizophrenia/Mood Disorder	9%	18%
Major Depression (lifetime)	6%	17% Jail 13% Prison
PTSD	-	33%
Sexual Abuse	-	50%

Patient Challenges

- Multiple diagnoses is the rule
  - Personality disorders
  - Substance Abuse
  - Organic Disorders
  - Learning Disabilities
- Presence of substance abuse and personality disorder does not exclude psychiatric illness
- Two problems confront clinicians
  - False positives – treating malingerers
  - False negatives – failure to treat illness
- False negatives incur more liability
  - Untreated mood disorder carries risk of suicide and violence

Co-morbid Mental Illness

- 19 epidemiological studies of the association between antisocial behavior and depression show:
  - depression in antisocial children is more common than in non-antisocial children
  - in three of the studies the rate of depression was more than 40%
  - in the majority it exceeded 15%.
- children with hyperactivity are at increased risk of antisocial behavior and alcohol abuse in adult life
  - The prognosis is worse when the ADHD symptoms are associated with conduct problems or learning difficulties.
- at least 10% of antisocial children have anxiety disorders such as PTSD

Angold et al., 1999, Taylor, Chadwick, Heptinstall & Danckaerts, 1996, Farrington, 1995

Mood Disorder and ASPD

- Personality Disorder does not exclude mental illness
  - Does change the way it presents
  - Cluster B personality disorders look worse when mixed with mood disorder symptoms
  - Many ASPD or "Borderline" patients have an Affective Disorder
- Antisocial patients lack skills to seek empathy and disclose to others
- Mood disorders can cause violence

Sleep Disturbance

- Common complaint driving request for psychotropic medication
- Etiologies include
  - Malingering
  - Affective Disorders
  - Primary sleep disorders
- Screen for biological symptoms of mood disorder
- Normalizing sleep improves outcome in Affective Disorders
  - Capitalize on side effects e.g. sedative atypicals or antidepressants
- Seek collateral information
  - Correctional Officers
  - Hospital records

Malingering

Malingering

- Many patients report depression, insomnia, psychotic symptoms without support for real illness
  - ? Prior history of treatment (obtain records)
  - Family history of mental illness
- Treatment of malingerers is a significant economic burden
- Treatment of malingerers is bad practice

Assessment

- Have as much information as possible before interview
- Take time to do a thorough evaluation
- Maintain good rapport
- Do not treat based on symptoms alone
- Ask open ended questions
- Ask about invalid symptoms
  - Cognitive assessment (MMSE)
  - Malingerers' symptoms often do not conform to known illness presentations
- Note patients drawing attention to symptoms
  - Malingerers often try to control the interview and become intimidating

Assessment

- Observe patients when they are unaware
- Collateral History
  - Observations of team members and C.O.'s
  - Correlate current GAF with past year's function
  - Family psychiatric history and their observations of patient
  - Outpatient providers' records
- Ask about adverse consequences from symptoms
  - Termination of employment, hospitalization/self injury
- Check for evidence of behavioral disturbance due to illness
  - e.g. paranoia outside of clinical setting
- Consider observation without treatment

Intimidation by Patients

"Trouble is forbidden. Cause trouble and we call the police."

Final Reflections

Personality Disorder Treatment

- We treat manifestations of Personality Disorders that
  - Affect relations with others
  - Affect parenting
  - Affect marital stability
  - Jeopardize employment
- We don't treat criminal conduct

Conclusions

- ASPD is not a "thing"
  - It is a working construct in evolution
- ASPD patients are a product of childhood adversity
- Most patients have multiple diagnoses
- A clue to those diagnoses comes from the family history
  - You know something was wrong there
- Treat the treatable
- Set limits to restrict the antisocial behavior