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Psychopathy and Antisocial Personality Disorder: A Case of Diagnostic Confusion

By Robert D. Hare, Ph.D. | 1996-02-01 00:00:00.0
Dr. Hare, who has researched psychopathy for more than 25 years, is a professor of psychology at the University of British Columbia, and was scientific director of a 1995 NATO Advanced Study Institute on Psychopathic Behavior.

A Secret Service agent recently asked if I was familiar with a 1992 FBI report that almost half of the killers of law enforcement officers met the criteria for *antisocial personality*. I replied that I had not seen the report but that the finding did not seem surprising or noteworthy to me. My comment was based on the assumption that the report had used *antisocial personality* as a synonym for antisocial personality disorder (ASPD), a category listed in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* and applicable to the majority of criminals.

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However, the agent explained that the description of the killers in question indicated to him that they matched the profile of the psychopath defined by the Psychopathy Checklist-Revised (Hare 1991). When I later saw a copy of the FBI report, I realized that he was correct in his assessment and that the report's findings were indeed noteworthy and chilling, particularly for law enforcement officers.

The killers' characteristics referred to as antisocial personality in the FBI report were as follows: sense of entitlement, unremorseful, apathetic to others, unconscionable, blameful of others, manipulative and conning, affectively cold, disparate understanding of behavior and socially acceptable behavior, disregardful of social obligations, nonconforming to social norms, irresponsible. These killers were not simply persistently antisocial individuals who met *DSM-IV* criteria for ASPD; they were psychopaths-remorseless predators who use charm, intimidation and, if necessary, impulsive and cold-blooded violence to attain their ends.

The distinction between psychopathy and ASPD is of considerable significance to the mental health and criminal justice systems. Unfortunately, it is a distinction that is often blurred, not only in the minds of many clinicians but in the latest edition of *DSM-IV*.

Source of the Problem

Traditionally, affective and interpersonal traits such as egocentricity, deceit, shallow affect, manipulativeness, selfishness, and lack of empathy, guilt or remorse, have played a central role in the

conceptualization and diagnosis of psychopathy (Cleckley; Hare 1993; in press); Widiger and Corbitt). In 1980 this tradition was broken with the publication of *DSM-III*. Psychopathy- renamed antisocial personality disorder- was now defined by persistent violations of social norms, including lying, stealing, truancy, inconsistent work behavior and traffic arrests.

Among the reasons given for this dramatic shift away from the use of clinical inferences were that personality traits are difficult to measure reliably, and that it is easier to agree on the behaviors that typify a disorder than on the reasons why they occur. The result was a diagnostic category with good reliability but dubious validity, a category that lacked congruence with other, well-established conceptions of psychopathy. This "construct drift" was not intentional but rather the unforeseen result of reliance on a fixed set of behavioral indicators that simply did not provide adequate coverage of the construct they were designed to measure.

The problems with *DSM-III* and its 1987 revision *(DSM-III-R)* were widely discussed in the clinical and research literature (Widiger and Corbitt). Much of the debate concerned the absence of personality traits in the diagnosis of ASPD, an omission that allowed antisocial individuals with completely different personalities, attitudes and motivations to share the same diagnosis. At the same time, there was mounting evidence that the criteria for ASPD defined a disorder that was more artifactual than "real" (Livesley and Schroeder).

Psychopathy Checklist

Coincident with the publication of *DSM-III* in 1980, I presented some preliminary findings on efforts to provide researchers with an operational definition of psychopathy in offender populations (Hare 1980). During the next decade those early efforts evolved into the Hare Psychopathy Checklist-Revised (PCL-R) (Hare 1991), a 20-item construct rating scale that uses a semi-structured interview, case-history information and specific diagnostic criteria for each item to provide a reliable and valid estimate of the degree to which an offender or forensic psychiatric patient matches the traditional (prototypical) conception of the psychopath (Fulero; Stone). Each item is scored on a 3-point scale (0, 1, 2) according to the extent to which it applies to the individual. The total score can range from 0 to 40, with between 15 percent and 20 percent of offenders receiving a score of at least 30, the cutoff for a research diagnosis of psychopathy. To put this into context, the mean scores for offenders in general and for noncriminals typically are around 22 and 5, respectively.

A 12-item version of the PCL-R was developed for use in the MacArthur Foundation study on the prediction of violence in the mentally disordered (Hart and others 1994). Published in 1995 as the Hare Psychopathy Checklist: Screening Version (PCL:SV) by Hart and colleagues, it is highly correlated with the PCL-R and is used both to screen for psychopathy in forensic populations and as a stand-alone instrument for the assessment of psychopathy in noncriminal populations. The PCL:SV formed the basis for the psychopathic personality disorder items used in the DSM-IV field trial for ASPD.

The items fall into two clusters: One cluster, referred to as Factor 1, reflects core interpersonal and affective characteristics; the other cluster, Factor 2, consists of items that reflect a socially deviant and nomadic lifestyle. The similarity between these factors and the behaviors and characteristics described above in the FBI report are obvious.

Most psychopaths (with the exception of those who somehow manage to plow their way through life without coming into formal or prolonged contact with the criminal justice system) meet the criteria for ASPD, *but most individuals with ASPD are not psychopaths*. Further, ASPD is very common in criminal populations, and those with the disorder are heterogeneous with respect to personality, attitudes and motivations for engaging in criminal behavior.

As a result, a diagnosis of ASPD has limited utility for making differential predictions of institutional adjustment, response to treatment, and behavior following release from prison. In contrast, a high PCL-R score depends as much on inferred personality traits as on antisocial behaviors, andýwhen used alone or in conjunction with other variablesýhas considerable predictive validity with respect to treatment outcome, institutional adjustment, recidivism and violence (Hare 1991; Harris and others; Hart and Hare, in press).

For example, several studies have found that psychopathic offenders or forensic psychiatric patients (as defined by the PCL-R) are as much as three or four times more likely to violently reoffend following release from custody than are nonpsychopathic offenders or patients. ASPD, on the other hand, has relatively little predictive power, at least with forensic populations (Hart and Hare, in press).

It might be argued that a diagnosis of ASPD is useful in civil psychiatric settings, particularly as a general risk factor for substance abuse (Leal and others). Even here, however, psychopathy may be more important than ASPD in understanding substance abuse (Alterman and colleagues; Cacciola and others).

The differences between psychopathy and ASPD are further highlighted by recent laboratory research involving the processing and use of linguistic and emotional information. Psychopaths differ dramatically from nonpsychopaths in their performance of a variety of cognitive and affective tasks. Compared with normal individuals, for example, psychopaths are less able to process or use the deep semantic meanings of language and to appreciate the emotional significance of events or experiences (Larbig and others; Patrick; Williamson and others).

It is worth noting that it is the interpersonal and affective components of psychopathy (as measured by PCL-R, Factor 1) that are most discriminating in these experiments. In sharp contrast, those with a diagnosis of ASPD (in which interpersonal and affective traits play little role) differ little from those without ASPD in their processing of linguistic and emotional material.

DSM-IV

Widespread dissatisfaction with the conceptualization and criteria for ASPD led the American Psychiatric Association to initiate a field trial in preparation for *DSM-IV*. A stated goal of the trial (Widiger and others) was to improve coverage of the traditional symptoms of psychopathy. Included with the *DSM-III-R* criteria for ASPD was a 10-item version of the PCL-R, referred to in the trial as the *psychopathic personality disorder* criteria. Many researchers and clinicians hoped that the field trial would bring the diagnosis of ASPD back on track, but it did so in only a limited sense (Hare and Hart 1995).

The field trial clearly indicated that most of the personality traits that reflect the traditional symptoms of psychopathy were just as reliable as those of the more behaviorally specific *DSM-III-R* items (Widiger and colleagues). Thus, the original premise for excluding personality from the diagnosis of psychopathy/ASPD (in *DSM-III*) turned out to be untenable. There was now a firm empirical basis for increasing the content-related validity of ASPD in *DSM-IV*, without a reduction in reliability. Yet this did not happen, partly because, it was argued, the average clinician would not use the carefully structured approach to the assessment of personality traits used in the field trial.

It may come as a surprise to most clinicians that the criteria adopted for *DSM-IV* were not actually evaluated in the field trial. What was evaluated was the 10-item set of adult symptoms (Criterion C) for ASPD listed in *DSM-III-R*. The seven-item set listed in *DSM-IV* was derived from the 10-item set; this

derivation was logical rather than empirical. Further, the field trial did not include evaluations of Criterion B (conduct disorder before age 15), a criterion listed in *DSM-IV* as a necessary condition for a diagnosis of ASPD.

Things become even more problematic when we consider that the *DSM-IV* text description of ASPD (which it says is also known as psychopathy) contains many references to traditional features of psychopathy. But in many respects the text account is incongruent with the formal diagnostic criteria. Further, the "Associated Features" section of the text contains this statement, and I paraphrase: Lack of empathy, inflated and arrogant self-appraisal, and glib, superficial charm are features of ASPD that may be particularly useful in prison or forensic settings wherein criminal, delinquent and aggressive acts will be less specific to the disorder.

The words used to describe these and related affective and interpersonal features are those typically associated with psychopathy and were based heavily on the 10-item psychopathic personality disorder set derived from the PCL-R. It is difficult not to conclude that DSM-IV contains two sets of diagnostic criteria for ASPD, one consisting of antisocial and criminal behaviors, and the other consisting of these behaviors plus clinical inferences about personality. The clinician is not provided with guidelines on how to make these inferences.

Some Problems

An unfortunate consequence of the ambiguity inherent in *DSM-IV* is likely to be a court case in which one clinician says the defendant meets the *DSM-IV* definition of ASPD, another clinician says he does not, and both are right! The first clinician uses only the formal diagnostic criteria whereas the second clinician agrees that the defendant meets the formal criteria but argues that he or she does not have the personality traits described in the "Associated Features" section of the *DSM-IV* text.

The failure to differentiate between psychopathy and ASPD can have serious consequences for clinicians and for society. For example, most jurisdictions consider psychopathy to be an aggravating rather than a mitigating factor in determining criminal responsibility. In some states an offender convicted of first-degree murder and diagnosed as a psychopath is likely to receive the death penalty on the grounds that psychopaths are cold-blooded, remorseless, untreatable and almost certain to reoffend. But many of the killers on death row were, and continue to be, mistakenly referred to as psychopaths on the basis of *DSM-III, DSM-III-R or DSM-IV* criteria for ASPD (Meloy). We donýt know how many of these inhabitants of death row actually exhibit the personality structure of the psychopath, or how many merely meet the criteria for ASPD, a disorder that applies to the majority of criminals and that has only tenuous implications for treatability and the likelihood of violent reoffending. If a diagnosis of psychopathy has consequences for the death penalty- or for any other severe disposition, such as an indeterminate sentence or a civil commitment- clinicians making the diagnosis should make certain they do not confuse ASPD with psychopathy.

Had *DSM-IV* accepted the results of its own trial, ASPD and psychopathy might now be more or less synonymous constructs. Instead, the failure to explicitly bring personality back into the diagnosis of ASPD means that the disorder is ambiguous and continues to lack congruence with traditional conceptions of psychopathy.

Perhaps this situation- an unfortunate and unnecessary one in my view- will be rectified in *DSM-V*. Meanwhile, it is worth noting that interpersonal and affective traits are more discriminating of the construct of psychopathy than are the socially deviant behaviors reflected in the *DSM-IV* criteria for ASPD (Cooke). Diagnostic confusion about the two disorders has the potential for harming psychiatric patients and society as well.

Camouflage Society

In my book, *Without Conscience*, I argued that we live in a "camouflage society," a society in which some psychopathic traits- egocentricity, lack of concern for others, superficiality, style over substance, being "cool," manipulativeness, and so forth- increasingly are tolerated and even valued. With respect to the topic of this article, it is easy to see how both psychopaths and those with ASPD could blend in readily with groups holding antisocial or criminal values. It is more difficult to envisage how those with ASPD could hide out among more prosocial segments of society. Yet psychopaths have little difficulty infiltrating the domains of business, politics, law enforcement, government, academia and other social structures (Babiak). It is the egocentric, cold-blooded and remorseless psychopaths who blend into all aspects of society and have such devastating impacts on people around them who send chills down the spines of law enforcement officers.

More on Personality Disorders

- Neurobiology of Impulsive-Aggressive Personality-Disordered Patients
- Pharmacology of Personality Disorders
- Understanding the Usefulness of Psychosocial Interventions for Personality Disorders

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References

1. Alterman AI, Cacciola JS, Rutherford MJ. Reliability of the Revised Psychopathy Checklist in substance abuse patients. Psychological Assessment: J Consult Clin Psychol. 1993;5:442-448.
2. Babiak P. When psychopaths go to work. Int J Appl Psychol. 1995;44:171-188.
3. Cacciola JS, Rutherford MJ, Alterman AI, Snider EC. The examination of the diagnostic criteria for antisocial personality disorder in substance abusers. J Nerv Ment Dis. 1994;182(9):517-523.
4. Cleckley HM. The Mask of Sanity, 5th ed. St. Louis: Mosby; 1976.
5. Cooke D. An item response theory analysis of the Hare Psychopathy Checklist-Revised. Manuscript under review. 1995.
6. Federal Bureau of Investigation. Killed in the Line of Duty. Washington. U.S. Department of Justice; 1992.
7. Fulero SM. Review of the Hare Psychopathy Checklist-Revised. In: Conoley JC, Impara JC, eds. 12th Mental Measurements Yearbook. Lincoln, Neb.: Buros Institute; 1995.
8. Hare RD. A research scale for the assessment of psychopathy in criminal populations. Personality and Individual Differences. 1980;1:111-119.
9. Hare RD. The Hare Psychopathy Checklist-Revised. Toronto: Multi-Health Systems; 1991.
10. Hare RD. Without Conscience: The Disturbing World of the Psychopaths Among Us. New York: Pocket Books; 1993.
11. Hare RD. Psychopathy: A clinical construct whose time has come. Criminal Justice and Behavior. In press.
12. Hare RD, Hart SD. A commentary on the Antisocial Personality Disorder Field Trial. In: Livesley WJ, ed. The DSM-IV Personality Disorders. New York: Guilford; 1995.
13. Harris GT, Rice ME, Quinsey VL. Violent recidivism of mentally disordered offenders: the

development of a statistical prediction instrument. Criminal Justice and Behavior. 1993;20(4):315-335
14. Hart SD, Hare RD. Psychopathy: Assessment and criminal conduct. In: Stoff D, Maser J, Breiling J, eds. Handbook of Antisocial Behavior. New York: John Wiley & Sons. In press.
15. Hart SD, Cox DN, Hare RD. The Hare Psychopathy Checklist: Screening Version. Toronto: Multi-Health Systems; 1995.
16. Hart SD, Forth AE, Hare RD. Psychopathy as a risk marker for violence: development of a screening version of the Revised Psychopathy Checklist. In: Monahan J, Steadman HJ, eds. Violence and Mental Disorder: Developments in Risk Assessment. Chicago: University of Chicago Press; 1994.
17. Larbig W, Veit R, Rau H, et al. Cerebral and peripheral correlates of psychopaths during anticipation of aversive stimulation. Paper presented at the annual meeting of the Society for Psychophysiological Research. Oct. 1992; San Diego.
18. Leal J, Ziedonis D, Kosten T. Antisocial personality disorder as a prognostic factor for pharmacotherapy of cocaine dependence. Drug Alcohol Depend. 1994;35:31-35.
19. Livesley WJ, Schroeder M. Dimensions of personality disorder: The DSM-III-R Cluster B diagnoses. J Nerv Ment Dis. 1991:179(6);317-328.
20. Meloy JR. Symposium on the psychopath and the death penalty. American Academy of Psychiatry and the Law, 21st annual meeting. Oct. 27, 1990; San Diego.
21. Patrick CJ. Emotion and psychopathy: some startling new insights. Psychophysiology. 1994;31:319-330.
22. Stone GL. Review of the Hare Psychopathy Checklist-Revised. In: Conoley JC, Impara JC, eds. 12th Mental Measurements Yearbook. Lincoln, Neb.: Buros Institute; 1995.
23. Widiger TA, Cadoret R, Hare RD, et al. DSM-IV Antisocial Personality Disorder Field Trial. J Abnorm Psychol. In press.
24. Widiger TA, Corbitt E. The DSM-IV Antisocial Personality Disorder. In: Livesley WJ, ed. The DSM-IV Personality Disorders. New York: Guilford; 1995.
25. Williamson SE, Harpur TJ, Hare RD. Abnormal processing of affective words by psychopaths. Psychophysiology. 1991;28:260-273.