

SAMPLE CHAPTER FROM:

# **Antisocial Personality Disorder**

The NICE Guideline on Treatment, Management  
and Prevention

By the National Collaborating Centre for Mental Health (NCCMH)

ISBN: 978-1-854334-78-7

Year: 2010

(one of a series of full guidelines on mental health from NICE)

Co-published by the Royal College of Psychiatrists  
and the British Psychological Society

Distributed by RCPsych Publications (via Turpin Distribution for the trade)

**[www.rcpsych.ac.uk/nice](http://www.rcpsych.ac.uk/nice)**



## 2 ANTISOCIAL PERSONALITY DISORDER

### 2.1 INTRODUCTION

This guideline is concerned with the treatment and management of people with antisocial personality disorder in primary, secondary and tertiary care. Various terms have been used to describe those who consistently exploit others and infringe society's rules for personal gain as a consequence of their personality traits, including antisocial personality disorder, sociopathy and psychopathy. Both the current editions of the major classificatory systems—the *International Classification of Diseases*, 10th revision (ICD-10; World Health Organization [WHO], 1992) and the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV; American Psychiatric Association [APA], 1994)—include antisocial personality disorder as a diagnosis, although ICD-10 describes it as dissocial personality disorder (WHO, 1992).

Modern concepts of antisocial personality disorder can be traced back to the early 19th century, and, arguably, have always been tightly linked with contemporary societal attitudes towards criminal justice and civil liberties (Ferguson & Tyrer, 2000). In the early 1800s clinicians attempted to understand criminals whose offences were so abhorrent that they were thought to be insane, yet their clinical presentations were not consistent with recognised mental syndromes. In describing such individuals, Prichard (1835) coined the term 'moral insanity', which was a form of 'mental derangement' in which the intellectual faculties are unimpaired, but the moral principles of the mind are 'depraved or perverted', and the individual is incapable of 'conducting himself with decency and propriety in the business of life.'

While the strength of the association between antisocial personality disorder and offending has never been in doubt, there has long been debate about its implications. In 1874 Maudsley argued that moral insanity was 'a form of mental alienation which has so much the look of vice or crime that many people regard it as an unfounded medical invention'. The crux of the problem was that it was not possible to draw a meaningful line between two forms of deviance from the norm: criminality on the one hand and antisocial personality on the other.

Throughout much of the 19th century, the diagnosis of 'moral insanity' gained acceptance across European and American courts of law (which were largely sympathetic to such a defence), until it was replaced by 'psychopathic inferiority', described in a series of influential works by Koch (1891). He believed these abnormal behaviour states to be the result of 'a congenital or acquired inferiority of brain constitution'. After Kraepelin (1905), who created the classification 'personality disorder', Schneider (1923) developed the characterisation of psychopathy as a fundamental disorder of personality, and he regarded individuals with 'psychopathic personalities' as those who 'suffer through their abnormalities, or through whom society suffers'. This may be seen as a precursor for modern diagnostic concepts in psychiatry, which place emphasis on the distress or impairment resulting from disorders (for example, in DSM and ICD).

It was Henderson (1939), however, who laid firm foundations for the modern delineations of antisocial personality disorder, in defining individuals with ‘psychopathic states’ as those ‘who conform to a certain intellectual standard but who throughout their lives exhibit disorders of conduct of an antisocial or a social nature’. In the US, Cleckley (1941) and McCord and McCord (1956) further pushed the notion of the psychopathic personality as a distinct clinical entity, and established its core criteria around antisocial behaviours (in particular, aggressive acts). These views have been extremely influential in shaping later classifications of sociopathy (DSM-I [APA, 1952]), antisocial personality disorder (DSM-II [APA, 1968] onwards), dissocial personality disorder (ICD) and psychopathy (Hare, 1980).

In 1959, the term psychopathic disorder was incorporated into the Mental Health Act in the UK, which made it possible for patients to be admitted to hospital compulsorily. Psychopathic disorder was defined as ‘a persistent disorder of mind (whether or not accompanied by subnormal levels of intelligence) which resulted in abnormally aggressive or seriously irresponsible conduct on the part of the patients, and require or are susceptible to medical treatment’. This legal definition has been criticised as poorly defined (for example, it is unclear what constitutes ‘abnormally aggressive’ or ‘seriously irresponsible’ conduct), removed as it is from validated psychiatric classifications of psychopathy (Lee, 1999).

The latter clause of the definition has also been seen as problematic (or at best optimistic) as it implied that treatment was beneficial or desirable, for which neither had an evidence base at the time (Ferguson & Tyrer, 2000). While this ‘treatability criterion’ was introduced to protect the personality disordered individual against wrongful detention, the definition of ‘treatability’ became so expanded in practice over the years as to render the term meaningless (Baker & Crichton, 1995). Hence, in the revised Mental Health Act (HMSO, 2007) a generic term ‘mental disorder’ replaces the various subtypes previously used (that is, mental illness, psychopathic disorder, mental impairment and severe mental impairment) and, as a consequence, the treatability test has been replaced with the practitioner needing to be satisfied that ‘appropriate medical treatment is available’ to justify detention for any mental disorder.

Alongside the ambiguity contained in the UK legislation, there is considerable ambivalence among mental health professionals towards those with personality disorder in general but particularly towards those with antisocial personality disorder. Some see this label as sanctioning self-indulgent and destructive behaviour, encouraging individuals to assume an ‘invalid role’ thereby further reducing whatever inclination they might have to take responsibility for their behaviour. Others believe that those with the disorder are better and more appropriately managed by the criminal justice system. The alternative view is that individuals with antisocial personality disorder are not only likely to infringe societal norms but also to have complex health needs that ought to be identified and addressed, either within or alongside the criminal justice system.

These tensions are evident across all aspects of the disorder, but especially regarding diagnosis. The criteria for antisocial personality disorder as specified in DSM-IV have been criticised because of the focus on antisocial behaviour rather than on the underlying personality structure (Widiger & Corbitt, 1993). This has led to the belief

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that antisocial personality disorder and its variants may be over-diagnosed in certain settings, such as prison, and under-diagnosed in the community (Lilienfeld, 1998; Ogloff, 2006). Moreover, a unique feature of antisocial personality disorder in DSM-IV is that it requires the individual to meet diagnostic criteria, not only as an adult, but also as a child or adolescent. This has led to concern that some children might be labelled as having a personality disorder before their personality has properly developed.

The DSM-IV definition has other major limitations including problems of overlap between the differing personality disorder diagnoses, heterogeneity among individuals with the same diagnosis, inadequate capture of personality psychopathology and growing evidence in favour of a dimensional rather than a categorical system of classification (Westen & Arkowitz-Westen, 1998; Clark *et al.*, 1997; Clark, 2007; Tyrer *et al.*, 2007; Livesley, 2007). Perhaps, most importantly, the individual personality disorder diagnoses in DSM-IV do not help practitioners to make treatment decisions; as a result practitioners have to focus on the specific components of personality disorder (such as impulsivity or affective instability) rather than on the global diagnosis when deciding on which intervention to use (Livesley, 2007).

Despite these difficulties, there is growing evidence from prospective longitudinal follow-up studies that identify a number of children whose conduct disorder with aggressive behaviour persists into adulthood, thereby justifying the approach of DSM to antisocial personality disorder (Robins *et al.*, 1991; Moffit *et al.*, 2001; Loeber *et al.*, 2002; Simonoff *et al.*, 2004; De Brito & Hodgins, in press). While the conversion rate from childhood conduct disorder to adult antisocial personality disorder varies from 40 to 70% depending on the study, the explicit continuity from conduct disorder in childhood/early adolescence and antisocial behaviour in adulthood has potential therapeutic implications regarding prevention that are discussed in Chapter 5. (However, it should be noted that some of this continuity is potentially artefactual, that is, it is a product of the fact that individuals need a diagnosis of conduct disorder before they can have one of antisocial personality disorder.) Nevertheless, this suggests that early intervention in children and adolescents may be effective in preventing the later development of antisocial personality disorder in adulthood.

A criticism of mental health work in general has been the neglect of examining personality when assessing Axis I disorders or major mental illnesses (APA, 1980); hence DSM-III and its successors adopted a bi-axial approach to the diagnosis of mental disorders, thereby separating mental illnesses on Axis I from personality disorders on Axis II so that 'consideration is given to the possible presence of disorders that are frequently overlooked when attention is directed to the usually more florid Axis I disorder' (APA, 1980). One consequence of this approach has been the recognition that Axis I and Axis II conditions often co-occur and that this co-occurrence usually has a negative effect on the treatment of the Axis I condition (Reich & Vasile, 1993; Cohen *et al.*, 2005; Skodol *et al.*, 2005; Newton-Howes *et al.*, 2006). As described below, antisocial personality disorder is frequently found to be comorbid with a number of other mental disorders. Hence, an important aspect of this guideline is recognising how antisocial personality disorder might negatively moderate the response to conventional interventions offered for frequently co-occurring conditions such as substance misuse, depression and other Axis I conditions (Woody *et al.*, 1985;

Mather, 1987). It does not, however, offer guidance on the separate management of these co-occurring conditions.

## **2.2 THE DISORDER**

### **2.2.1 Symptoms, presentation and pattern of disorder**

The diagnostic system DSM-IV, the preferred diagnostic system for this guideline (see Section 2.2.2), characterises antisocial personality disorder as a pervasive pattern of disregard for and violation of the rights of others that has been occurring in the person since the age of 15 years, as indicated by three (or more) of seven criteria, namely: a failure to conform to social norms; irresponsibility; deceitfulness; indifference to the welfare of others; recklessness; a failure to plan ahead; and irritability and aggressiveness (APA, 1994).

Because those with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality and low conscientiousness, the condition is associated with a wide range of interpersonal and social disturbance. While many of these traits may well be inherited, people with antisocial personality disorder also frequently grow up in fractured families where parental conflict is the norm and where parenting is often harsh and inconsistent. As a result of parental inadequacies and/or the child's own difficult behaviour (or both), the care of the child is often interrupted and transferred to agencies outside the family. This in turn often leads to school truancy, delinquent associates and substance misuse. Antisocial personality disorder is often associated with low educational attainment. These disadvantages frequently result in increased rates of unemployment, poor and unstable housing and inconsistency in relationships in adulthood. Many are imprisoned or die prematurely as a result of reckless behaviour (Swanson *et al.*, 1994). This catalogue of continuing and multiple disabilities over time is not so much a description of 'symptoms', rather a description of a broad range of diverse problem areas that are likely to lead to an adverse long-term outcome.

Consequently, while criminal behaviour is central to the definition of antisocial personality disorder, this is often the culmination of previous and long-standing difficulties. Clearly, therefore, there is more to antisocial personality disorder than criminal behaviour, otherwise all of those convicted of a criminal offence would meet criteria for antisocial personality disorder and a diagnosis of antisocial personality disorder would be rare in those without a criminal history. However, this is not the case. The prevalence of antisocial personality disorder among prisoners is slightly less than 50% (Fazel & Danesh, 2002; Hart & Hare, 1989; Singleton *et al.*, 1998). Similarly, epidemiological studies in the community estimate that only 47% of people meeting criteria for antisocial personality disorder had significant arrest records; a history of aggression, unemployment and promiscuity were more common than serious crimes among people with antisocial personality disorder (Robins, 1987; Robins *et al.*, 1991). These data therefore show that the relationship between antisocial personality disorder and offending is not straightforward.

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This position is further strengthened when data on people with personality disorder (including those in the community) are examined by factor analysis. This approach consistently produces three or four higher order factors, the most prominent of which is an ‘antisocial factor’ (Mulder & Joyce, 1997; Blackburn & Coid, 1999; Livesley, 2007; Howard *et al.*, 2008). However, this higher order antisocial factor is more broadly described than in DSM and includes narcissistic, paranoid and histrionic traits as well as the more traditionally described antisocial personality disorder items such as conduct disorder and criminality.

For many clinicians, this broader description of antisocial personality disorder carries greater conviction than the more behaviourally-based criteria in DSM. Rather than focusing on criminality, mental health professionals are more interested in such features as unstable interpersonal relationships, disregard for the consequences of one’s behaviour, a failure to learn from experience, egocentricity, disregard for the feelings of others and persistent rule breaking (Livesley *et al.*, 1987; Tennant *et al.*, 1990; Livesley, 2007).

Despite disagreements and confusion regarding the diagnosis of antisocial personality disorder, there is a commonly held view that the strict personality component is characterised by a set of common traits including irresponsible and exploitative behaviour, recklessness, impulsivity and deceitfulness (Livesley, 2007). Benjamin (1996) has expanded on these features and delineates a characterisation that seeks to provide a description of the internal mental mechanisms at play in the disorder. She describes the core features of those with antisocial personality disorder as consisting of:

*‘a pattern of inappropriate and unmodulated desire to control others, implemented in a detached manner. There is a strong need to be independent, to resist being controlled by others, who are usually held in contempt. There is a willingness to use untamed aggression to back up the need for control or independence. The [antisocial personality] usually presents in a friendly, sociable manner, but that friendliness is always accompanied by a baseline position of detachment. He or she doesn’t care what happens to self or others’. (Benjamin, 1996, p. 197; emphasis added by GDG)*

At the present time, DSM is undergoing major revision (as DSM-V), and it is hoped that there will be a reduced emphasis on criminal behaviour and an increased emphasis on the interpersonal deficits to characterise antisocial personality disorder.

### **2.2.2 Diagnosis**

#### *DSM-IV*

Taking account of criticisms of DSM-III (APA, 1980) and DSM-III-R (APA, 1987) that the criteria were too behaviourally focused, some effort was made in the DSM-IV revision to produce a more trait-based description. Specifically, there was a field trial comparing Robins’ emphasis on the continuity of conduct disorder in childhood with adult antisocial personality disorder with the more trait-based personality criteria of the Psychopathy Checklist-Revised (PCL-R; Robins, 1987). Despite this work

and its implications, the changes introduced for DSM-IV were modest (Millon & Davis, 1996; Hare *et al.*, 1991). Hence, as described above, the principal criteria for antisocial personality disorder in DSM-IV are:

*'a pervasive pattern of disregard for and violation of the rights of others occurring since 15 years, as indicated by three (or more) of the seven criteria that include four in the interpersonal realm (including a failure to conform to social norms, irresponsibility, deceitfulness and indifference to the welfare of others); one in the behavioural realm (recklessness); one in both the behavioural and cognitive domain (a failure to plan ahead), and finally, one in the mood domain (irritability and aggressiveness)'. (Millon & Davis, 1996)*

One of the concerns of many authors (for example, Kernberg, 1992) is the degree to which antisocial personality disorder, with its interpersonal exploitativeness, can be usefully distinguished from narcissistic personality disorder; indeed, they are often found to co-occur. Millon and Davis (1996) offer useful guidance:

*'the antisocial is driven, first, to benefit himself and, second, to take vigorous action to see that these benefits do accrue to himself. This pattern is similar to, yet different, than seen in narcissists, where an unjustified self-confidence assumes that all that is desired will come to them with minimal effort on their part. The antisocial assumes the contrary. Recognising by virtue of past experience that little will be achieved without considerable effort, cunning and deception, the antisocial knows that desired ends must be achieved from one's own actions. Moreover, these actions serve to fend off the malice that one anticipates from others, and undo the power possessed by those who wish to exploit the antisocial.'*

Not only does this usefully separate antisocial personality disorder from narcissistic personality disorder, but it also describes a core component of antisocial personality disorder, namely that one needs to actively look after oneself because it is believed that no one else will do so.

#### *ICD-10*

In ICD-10 (WHO, 1992), the term used is dissocial personality disorder, rather than antisocial personality disorder. In summary, its criteria focus more than DSM-IV on interpersonal deficits (for example, incapacity to experience guilt, a very low tolerance of frustration, proneness to blame others, and so on) and less on antisocial behaviour *per se*. It does not require symptoms of conduct disorder in childhood. This definition of dissocial personality disorder has been criticised for including features of aggressive/sadistic personality disorder that cannot be accommodated elsewhere in ICD-10 (Millon & Davis, 1996).

#### *Psychopathy*

Cleckley (1941), in his influential book *The Mask of Sanity*, attempted to identify the underlying traits of those who behaved in an exploitative manner and thereby

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provided a description of psychopathy. Building on Cleckley's work, Hare and colleagues (2000) produced two separate factors to describe antisocial behaviour in their development of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991). The first of these related to the more narcissistic variant of personality abnormality, emphasising traits such as selfishness, egocentricity and callousness. The second referred to a more antisocial lifestyle with frequent criminal behaviour, early and persistent delinquency, a low tolerance for frustration, and so on. More recent work has expanded the description of psychopathy as comprising three or four factors. The four factor model (Neumann *et al.*, 2007) consists of:

- a) an interpersonal factor that includes superficial charm, grandiosity, pathological lying and manipulation
- b) an affective factor that includes callousness, lack of remorse, shallowness and failure to accept responsibility
- c) an impulsive lifestyle factor that comprises impulsivity, sensation seeking and irresponsibility
- d) an antisocial factor that involves general rule breaking.

The alternative three-factor model of Cooke and Michie (2001) differs in that it does not include an antisocial factor because this is seen as a concomitant, rather than a core feature, of psychopathy (Blackburn, 2007). This disagreement about whether criminal behaviour is a core or concomitant feature of psychopathy was echoed in the GDG's discussion of the concept of antisocial personality disorder.

The disorder of psychopathy, while associated with antisocial personality disorder, is distinct in that while most of those who score highly on the PCL-R (Hare *et al.*, 2000) will also meet criteria for antisocial personality disorder, only about 10% of those with antisocial personality disorder meet criteria for psychopathy as measured by the PCL-R. In this guideline, psychopathy is referred to only briefly and with reference to practice in tertiary care. The practical implications of this are that those who score highly on the PCL-R and who present to services, or are coerced into doing so, will do so largely to tertiary services.

Although there is disagreement on the diagnostic criteria for antisocial personality disorder, the criteria used in DSM-IV (APA, 1994) have been adopted in this guideline in order to provide a primary diagnostic anchor point. In addition, nearly all of the evidence examining the efficacy of the interventions focuses on those with a DSM diagnosis. However, evidence from other classificatory systems, that is, dis-social personality disorder in ICD-10 (WHO, 1992) and 'psychopathy' (Hare, 1991), is used where relevant.

### **2.2.3 Course and prognosis**

Gender affects both the prevalence of antisocial personality disorder (see Section 2.2.4) and its course: it is more common in men who are also more likely to persist with their antisocial behaviour when compared with women. For instance, Guze (1976) found that most incarcerated male felons were still antisocial by interview at follow-up (87% at 3 years, 72% at 9 years) while Martin and colleagues (1982) found

that among women, only 33% were engaging in criminal behaviour at 3 years and only 18% at 6 years. Nonetheless, follow-up studies also demonstrate a reduction in the rates of re-offending in men over time (Grilo *et al.*, 1998; Weissman, 1993). However, Black and colleagues (1995), in one of the few long-term follow-up studies of men with antisocial personality disorder showed that while the men had reduced their impulsive behaviour (and hence their criminality) with the passage of time, they continued to have significant interpersonal problems throughout their lives (Paris, 2003).

Antisocial personality disorder is associated with an increase in mortality. Martin and colleagues' (1985) follow-up of 500 psychiatric outpatients in St Louis in the US found that those with antisocial personality disorder had a greatly increased standardised mortality rate (SMR) compared with other psychiatric conditions (SMR = 8.57,  $p = 0.01$ ). An even more striking finding was provided by Black and colleagues (1996) in their follow-up of men with antisocial personality disorder. They found that young men with antisocial personality disorder had a high rate of premature death, with those under the age of 40 having an SMR of 33 with the SMR diminishing with increasing age. This increased mortality was due to not only an increased rate of suicide, but to reckless behaviour such as drug misuse and aggression.

One of the most striking findings from the literature is that a relatively small number of offenders commit the majority of crimes. For instance, it is known that 5 to 6% of offenders are responsible for 50% of recorded crimes (Farrington *et al.*, 1986). Furthermore, those who commit the majority of crimes, continue to do so throughout most of their life. This is in contrast to the large number of offenders who desist from criminal activity after adolescence. This observation has led to the concept of 'life-course-persistent offenders' as opposed to 'adolescence-limited offenders' (Moffitt, 1993). From the longitudinal Dunedin study, Moffitt was able to characterise life-course-persistent offenders as having inherited or constitutional neuropsychological difficulties that later interact with a criminological environment to produce a phenotype of persistent offending (Moffitt, 1993).

#### **2.2.4 Prevalence of antisocial personality disorder and related conditions**

The prevalence of antisocial personality disorder in the general population varies depending on the methodology used, and the countries studied, but all show that the condition is much more prevalent among men. The lifetime prevalence in two North American studies was 4.5% among men and 0.8% among women (Robins *et al.*, 1991) and 6.8% among men and 0.8% in women (Swanson *et al.*, 1994). Two European studies found a prevalence of 1.3% in men and 0% in women (Torgensen *et al.*, 2001) and 1% in men and 0.2% in women (Coid *et al.*, 2006). Despite these relative differences between North American and European studies, the rates of antisocial personality disorder reported indicate that even with the most conservative estimates antisocial personality disorder has the same prevalence in men as schizophrenia, which is the condition that receives the greatest attention from mental health

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professionals. While the incidence of antisocial personality disorder in women may be lower and the threshold for entry to services such as forensic services or the criminal justice system higher, there is some evidence to suggest that women with antisocial personality disorder (Yang & Coid, 2007) have greater severity of problems characterised by more complex comorbidities for both Axis I and Axis II disorders and corresponding poor outcomes (for example, Galen *et al.*, 2000).

Antisocial personality disorder is common in prison settings. Surveys of prisoners worldwide indicate a prevalence of antisocial personality disorder of 47% for men and 21% for women (Fazel & Danesh, 2002). In the UK prison population, the prevalence of people with antisocial personality disorder has been identified as 63% male remand prisoners, 49% male sentenced prisoners, and 31% female prisoners (Singleton *et al.*, 1998). By contrast, the prevalence of psychopathy in UK prisoners is only 4.5% using a PCL-R score of  $\geq 30$ , and 13% using a score of  $\geq 25$  (Hare *et al.*, 2000).

Significant comorbidity exists between antisocial personality disorder and many Axis I conditions. For instance, Swanson and colleagues' (1994) community study showed an increased prevalence of 'nearly every other psychiatric disorder ... with 90.4% having at least one other psychiatric disorder.' Substance misuse is the most important disorder co-occurring with antisocial personality disorder. In the Epidemiological Catchment Area (ECA) study, when men with and without antisocial personality disorder were compared, those with antisocial personality disorder were three and five times more likely to misuse alcohol and illicit drugs (Robins *et al.*, 1991). It is also important to note that while women have a significantly lower prevalence of antisocial personality disorder than men, those women with antisocial personality disorder have an even higher prevalence of substance misuse when compared with men (Robins *et al.*, 1991; Compton *et al.*, 2005).

For other conditions, half of those with antisocial personality disorder will have co-occurring anxiety disorders (Goodwin & Hamilton, 2003) and a quarter will have a depressive disorder (Lenzenweger *et al.*, 2007). These co-occurring Axis I conditions are important because the presence of antisocial personality disorder is likely to be a negative moderator of treatment response when these conditions are treated by conventional approaches.

## **2.3 AETIOLOGY**

### **2.3.1 Gene-environment interactions**

As with most psychiatric conditions, antisocial personality disorder is construed as having both a biological and psychosocial aetiology. While it has long been recognised that genes contribute to antisocial behaviour, this field has advanced significantly within the past decade with more sophisticated designs and larger twin and adoptive samples. Two developments are especially noteworthy.

First, there is evidence that there is heterogeneity in the antisocial behaviour exhibited by young children. For instance, Viding and colleagues (2005) have shown

that by subtyping the antisocial behaviour in 7-year-old twins into those children with and without callous and unemotional traits (that is, AB/CU+ and AB/CU– respectively), that there was a much stronger heritability in the former (of 0.81 versus 0.30 respectively). Moreover, there is evidence that children who offend early and do so with greater aggression have an increased heritability for this behaviour (see a review by Viding *et al.*, 2008). Hence, there is some evidence that this aggressive antisocial behaviour is ‘hardwired’ in the brain from an early age.

Second, despite evidence for this deterministic ‘hardwired’ process, current thinking recognises that differing gene/environmental mechanisms are at play in such children. Hence, children who are genetically vulnerable to behaving in an antisocial manner are likely to also suffer from harsh and inconsistent parenting that, in turn, they may exacerbate by provoking negative responses with their behaviour. Adoption studies show an interactive effect of genetic vulnerability with an adverse environment so that there is more pathology than one would expect from either acting alone or in combination (Cadoret *et al.*, 1995).

This interactive effect of genes and environment suggests that the genetic risk might be moderated by intervening to reduce negative responses from the parent (for example, parent-training programmes, multisystemic therapy, and so on). Knowledge of the genetic vulnerability may inform programme content and delivery and so increase its effectiveness. For instance, children with callous and unemotional traits respond badly to being punished but positively to rewards and therefore require programmes tailored to their specific needs (see Chapter 5).

### **2.3.2 Biological markers for aggressive behaviour**

Cross-sectional studies comparing those with and without aggressive behaviour have demonstrated robust differences in physiological responses and in brain structure and function in these groups (see a review by Patrick, 2008). For instance, individuals prone to aggression have enhanced autonomic reactivity to stress, enhanced EEG slow wave activity, reduced levels of brain serotonin (Coccaro *et al.*, 1996a; Dolan *et al.*, 2001) and dysfunction in the frontocortical and limbic regions that mediate emotional processing (Intrator *et al.*, 1997; Raine *et al.*, 2000, Blair *et al.*, 2006).

While this increase in understanding in the biology of antisocial behaviour is to be welcomed, it is subject to the following limitations. Most of the studies carried out focus on those with aggressive behaviour and psychopathy rather than on antisocial personality disorder. For instance, children and adolescents who are aggressive have lower levels of autonomic arousal but an enhanced autonomic reactivity to stress (Lorber, 2004); whereas adults who score high on the Psychopathy Checklist have reduced autonomic activity in relation to stress. The studies suffer, furthermore, from failing to control for confounding factors, such as comorbidity and substance misuse and from a concentration on simple neuropsychological processes such as motor impulsivity or recognition of basic emotions, rather than on more complex behaviour and moral decision making. Finally, they appear to be disconnected from routine clinical work and hence are unlikely to influence current clinical decision making (Duggan, 2008).

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In addition to these biological factors, there are numerous adverse environmental influences that are important, including harsh and inconsistent parenting, social adversity, poverty and associating with criminal peers.

This consequence of the interaction between the various biological vulnerabilities and being brought up in an adverse environment has been articulated by Dodge (2000) who describes a 'child [who] never acquires the social skills and regulatory mechanisms necessary to navigate the world of adolescence. The child consistently fails to attend to relevant social cues, readily makes hostile attributions about peers and adults, accesses aggressive responses in social situations, and either impulsively performs these responses without thinking about their consequences or evaluates their likely outcomes as acceptable and selects them' (p. 458).

### **2.4 PRESENTATION IN HEALTHCARE AND OTHER SETTINGS**

Because people with antisocial personality disorder externalise their difficulties, it is not surprising that they rarely present in healthcare settings requiring help to deal directly with problems arising from their personality disorder. In general, therefore, they can be described as 'treatment rejecting' rather than 'treatment seeking' (Tyrer *et al.*, 2003). This is in contrast to people with borderline personality disorder, many of whom do seek treatment, albeit in a dysfunctional manner (Benjamin, 1993). This is important in that it underscores Coid's (2003) advice that those who provide mental health services ought not to assume that the frequency of help-seeking behaviour is necessarily an accurate indication of either the prevalence of the condition or its therapeutic need.

When people with antisocial personality disorder do present for treatment, this is usually either for a comorbid condition and/or they have been coerced into treatment by a relative or some external authority in a crisis. Given that those with antisocial personality disorder actively resist having to accept help, and that coercion into treatment directly challenges their core personality structure, it is clear that therapeutic interventions are also likely to be under threat in such circumstances. Hence, one might expect a high drop-out rate from treatment and indeed that is what has been found (Huband *et al.*, 2007). Nonetheless, people with antisocial personality disorder do present to healthcare services (either willingly or otherwise), so it is important that such services have an understanding of the core personality issues so that they can respond appropriately.

#### **2.4.1 Treatment attrition**

Dropping out of treatment is a particular problem in the treatment of personality disorder (Skodol *et al.*, 1983; Gunderson *et al.*, 1989) and those with antisocial personality disorder have several characteristics (including a hostile attributional style, low educational attainment and impulsivity) that place them at high risk of doing so. Dropping out of treatment is not only a waste of an expensive resource for

the service provider but also for the patients because their outcome is often worse than if they had never been treated (McMurran & Theodosi, 2007). This suggests that especial care needs to be taken in the management of those with antisocial personality disorder to identify indicators of drop out and actively address them.

*Patient preference, information and consent*

In a population that is largely 'treatment rejecting', issues concerning patient preference and information can be challenging. However, given the propensity of people with antisocial personality disorder not only to reject treatment but also to drop out of treatment, additional efforts to engage people may be required. These issues are dealt with more fully in Chapter 4 while ethical issues are covered further in Section 2.10.

## **2.5 USE OF HEALTH SERVICE RESOURCES AND OTHER COSTS**

It is important to recognise that while antisocial personality disorder is associated with considerable harm to the individual with the condition, this harm extends more broadly to have an impact not only on immediate family members, but on society at large. Extended harm leads not only to high levels of personal injury and financial damage for victims but also to increased costs of policing, security, and so on (Welsh *et al.*, 2008). Recognition of these extended costs is important in making a case for what appear to be, on occasion, expensive interventions.

The evidence on the health service costs of antisocial personality disorder is limited. In addition to the paucity of research there are problems in interpreting the current evidence base. There are a number of reasons for this. Health service use specific to antisocial personality disorder is often difficult to estimate because of the significant comorbidity between Axis I and Axis II disorders. In addition, many individuals with the condition do not present for treatment except under duress (for example, if they require drug detoxification in prison) and, even in cases where the person presents, the condition is often not recognised (for example, because people presenting require emergency treatment for an alcohol-related physical health problem or treatment for another comorbid condition). However, this apparent treatment avoidance can be construed more positively in that many with antisocial personality disorder do not seek help because they are not aware of the interventions available, or, when they do present for help, their presentation is so coloured by the nature of their personality disorder that services are reluctant to respond positively to their demands. This guideline recognises that those with antisocial personality disorder have many unmet needs and that current service provision may need to be reconfigured in order to meet their expectations.

Healthcare service costs incurred by people with dangerous and severe personality disorder have been estimated in a study conducted in Rampton, the high secure hospital in Nottinghamshire (Barrett *et al.*, 2005). The mean cost per person receiving care at the hospital over a 6-month period was £65,545 (2002/03 prices), but there was considerable variation among individuals, with the 6-month cost ranging from

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£59,000 to £83,000. No other evidence on health and social care costs directly associated with antisocial personality disorder was identified in the existing literature. However, more extensive research has been undertaken on the costs associated with conduct disorder. Romeo and colleagues (2006) estimated such costs in a sample of young children (aged from 3 to 8 years) with conduct disorder in the UK, adopting a broad societal perspective that included health services, education, social care and costs borne to the family. The mean annual cost per child reached £6,000 (2002/03 prices); the greatest component of this cost (about 78%) reflected non-service costs to the family, comprising mainly extra time spent on household tasks. Costs to education services and to the NHS approximated £1,300 and £550 per year, respectively.

Another study conducted in the UK compared the total costs incurred by children with conduct disorder, children with some conduct disorder traits and children without conduct disorder, from the age of 10 and up to the age of 28 years (Scott *et al.*, 2001a). A wide perspective was adopted in this study, which considered special educational, health, foster and residential care services, crime costs, state benefits received in adulthood and breakdown of relationships reflected in domestic violence and divorce. The total cost per person diagnosed with conduct disorder as a child reached £70,000 (1998 prices); the respective cost per person with conduct problems in childhood exceeded £24,000. In contrast, the cost per child in the control group was only £7,400 over 18 years (that is, from 10 to 28 years of age). The most significant cost element in the group that had been diagnosed with conduct disorder in childhood was the cost associated with criminal behaviour—this amounted to 64% of the total cost. Special education services incurred 18% of the total cost, foster and residential services 11%, state benefits 4%, while NHS costs constituted only 3% of the total cost incurred by this population. Similar findings were reported in a US study that compared the costs of children with conduct disorder, oppositional defiant disorder and elevated levels of problem behaviour, with a group of children without any of these disorders (Foster *et al.*, 2005): the 4-year health and criminal justice costs of children with conduct disorder were twice as much as the respective costs incurred by children with oppositional defiant disorder, 1.7 times higher than costs of children with problem behaviour, and more than 3 times the costs recorded for the control group. Comorbid conduct disorder has been shown to significantly increase costs in adults who were diagnosed with depression in childhood: Knapp and colleagues (2002) demonstrated that adults who had depression and comorbid conduct disorder as children incurred more than double the costs compared with those who were diagnosed with depression (but no conduct disorder) in childhood. Conversely, it has been suggested that comorbid depression increases costs incurred by young offenders in custody or in contact with youth offending teams (Barrett *et al.*, 2006). Besides depressed mood, younger age was also shown to result in an increase in total costs.

For those who engage in criminal behaviour there are the obvious costs of such behaviour, including emotional and physical damage to victims, damage to property, police time, involvement with the criminal justice system and prison services. Brand and Price (2000) estimated that the total cost of crime in England and Wales reached £60 billion in 1999/2000. This estimate included costs incurred in anticipation of crime, such as security expenditure and insurance administration, costs directly

resulting from crime, such as stolen or damaged property, lost output, emotional and physical impact on victims, health and victim services, as well as costs to the criminal justice system, including police services. Nevertheless, other important consequences of crime, such as the fear of crime and its impact on quality of life were not taken into account in the estimation of the above figure. Fear of crime and other intangible costs to crime victims, such as pain, grief and suffering, have been the subject of research of a growing literature aiming at estimating the wider cost implications of crime to the society (Dolan *et al.*, 2005; Dolan & Moore, 2007; Dolan & Peasgood, 2007; Dolan *et al.*, 2007; Loomes, 2007; Semmens, 2007; Shapland & Hall, 2007). Mental healthcare needs of victims of crime should not be ignored because these have been shown to substantially contribute to the costs associated with crime: a US study estimated that crime victims represented about 20 to 25% of people visiting mental healthcare professionals, incurring a cost to mental healthcare services of between \$5.8 and \$6.8 billion in the US in 1991 (Cohen & Miller, 1998).

Equally important to the above costs are the costs associated with lost employment opportunities, family disruption, relationship breakdown, gambling and problems related to alcohol and substance misuse (Myers *et al.*, 1998; National Research Council, 1999; Home Office & Department of Health, 2002). Therefore, the financial and psychological implications of antisocial personality disorder, offending behaviour and conduct disorder are likely to be wider than those indicated by the figures reported in the published literature. Efficient use of available healthcare resources is required to maximise the benefits for people with these conditions, their family and carers, and society in general.

## **2.6 TREATMENT AND MANAGEMENT IN THE NHS**

While the ‘therapeutic gloom’ surrounding the condition identified by Aubrey Lewis in 1974 has been lightened with many more initiatives available to enable staff to intervene in this group (Department of Health, 2003), nonetheless it remains the case that high-quality evidence of efficacy for these initiatives is lacking. For instance, 19 years after Lewis’s pessimistic assessment, Dolan and Coid (1993) in their review of the treatment of psychopathic and antisocial personality disorder concluded that the evidence base for such treatments was poor. They could identify only a small number of studies and these were limited by poor methodology and lack of long-term follow-up.

Ten years after the Dolan and Coid (1993) review, further work failed to uncover a more credible evidence base (Warren *et al.*, 2003). In 2007, the situation was similar: two systematic reviews of psychological and pharmacological treatments could locate only five trials in the treatment of antisocial personality disorder that met Cochrane criteria for an acceptable randomised controlled trial (RCT) (Duggan *et al.*, 2007a, Duggan *et al.*, 2007b). More significantly, all of these five trials examined the effect of the intervention to reduce substance misuse in those with antisocial personality disorder, rather than the characteristics of antisocial personality disorder *per se*. A failure to achieve a consensus on defining the trial population and on the outcomes that were relevant was identified as the main reasons for this lack of progress (Duggan *et al.*, 2007a, Duggan *et al.*, 2007b).

### **2.6.1 Pharmacological treatments**

Although there is no reliable estimate of the use of pharmacological treatments among those with antisocial personality disorder in the literature, a varied list of drugs are commonly prescribed. Dolan and Coid (1993) reviewed the use of numerous drug groups including antidepressants, hypnotics, anxiolytics, antiepileptics and central nervous system stimulants in people with antisocial personality disorder. The research evidence justifying the use of these interventions was found to be limited.

As a DSM diagnosis has limited uses for treatment planning (Livesley, 2007), Soloff (1998) recommended a symptom-orientated approach to guide the use of pharmacotherapy in personality disorder. Among his symptom domains, the following are potentially relevant for antisocial personality disorder: impulse-behavioural, affective and cognitive-perceptual (because of associated paranoid features). He found evidence favouring selective serotonin reuptake inhibitors (SSRIs) and antimanic drugs for impulsive dyscontrol; SSRIs and other antidepressants for emotional dysregulation and low dose antipsychotics for cognitive-perceptual abnormalities. Many of the trials in his review focused on borderline personality, and it remains to be evaluated as to whether effective reduction of anger or impulsiveness in that group might be extrapolated to people with antisocial personality disorder (Soloff, 1998).

### **2.6.2 Psychological treatments**

Unfortunately, the evidence base for psychological treatments for antisocial personality disorder is as limited as that for pharmacological treatments (Duggan *et al.*, 2007). Much more emphasis has been placed on the psychological treatment of other personality disorders, primarily borderline personality disorder (for example, Kernberg, 1984; Linehan & Dimeff, 1997). The earlier approaches to treating antisocial personality disorder and psychopathy took place largely in high secure hospitals (where 25% met criteria for legally defined psychopathic disorder). As with the treatment of personality disorder more generally, psychoanalytic approaches to treatment were most prevalent (Cordess & Cox, 1998).

Partially informed by developments in the 'what works' criminological literature, cognitive behavioural approaches have gained in prominence. For instance, in the Dangerous and Severe Personality Disorder (DSPD) service (see Section 2.7) that provides interventions for highly psychopathic men, a range of interventions are available including dialectical behaviour therapy, schema-focused therapy, cognitive analytic therapy, violence reduction programmes, and so on (Home Office, 2005a). These interventions await evaluation.

### **2.6.3 Psychosocial interventions**

In the development of treatments for personality disorders the therapeutic community and its various developments have played an important role. The Henderson Hospital

was a specialist inpatient unit specifically developed to treat personality disorder in the NHS (Rapoport, 1960). The therapeutic community movement had a significant impact on mental healthcare in the mid to late 20th century (Lees *et al.*, 2003) with parallel developments in the prison service (Grendon Underwood; Snell, 1962) and drug services. However, in the healthcare field there has been a recent move away from this area in part because of high costs in the absence of convincing evidence for efficacy.

### *Interventions for offenders*

Although the evidence of efficacy in intervening for those with antisocial personality disorder is slight, there is an important parallel criminological literature that is considered in this guideline. The literature on interventions to reduce offending behaviour is greater in volume and quality than that for antisocial personality disorder *per se* and so is potentially important to this guideline. However, this literature (reviewed in Chapter 7) has two limitations: it does not make an antisocial personality disorder diagnosis a necessary condition of entry to the studies and the outcome criteria are usually restricted to the presence or absence of re-offending. While these studies are clearly relevant to those with antisocial personality disorder (given that those in prison are likely to have this disorder), developing a guideline on the basis of this evidence is clearly not straightforward and is discussed further in succeeding sections.

## **2.7 THE DANGEROUS AND SEVERE PERSONALITY DISORDER INITIATIVE**

A recent and important national initiative is the Dangerous and Severe Personality Disorder (DSPD) Programme (Home Office & Department of Health, 2002). DSPD is an umbrella term, grouping together people with a severe personality disorder where there is a significant risk of serious harm to others. It is likely that many people with DSPD also fulfil criteria for antisocial personality disorder. For the purpose of DSPD assessments, the criteria for 'severe personality disorder' are defined as follows (Home Office, 2005a):

- a PCL-R score of 30 or above (or the Psychopathy Checklist-Screening Version [PCL-SV] equivalent); or
- a PCL-R score of 25-29 (or the PCL-SV equivalent) plus at least one DSM-IV personality disorder diagnosis other than antisocial personality disorder; or
- two or more DSM-IV personality disorder diagnoses.

The DSPD programme in England and Wales provides treatment for approximately 300 men in high security with about half in prisons and half in high secure hospitals. Treatment consists mainly of cognitive behavioural programmes delivered in group and individual settings and aimed at risk reduction. Anticipated length of stay is between 3 and 5 years. It is therefore too early for a definitive evaluation particularly because many individuals will be transferred to other secure facilities at the end of treatment rather than being discharged to the community. The programme

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incorporates extensive evaluation including a minimum dataset collated centrally for all men in the high secure prison and hospital places as well as independent evaluation of assessment, treatment outcome, and organisational and management arrangements.

While the extent of service planning and public funds committed to this group is significant, these services are restricted to a very small proportion of the population so they are likely to have only a minimal impact on the very large numbers of people with antisocial personality disorder, the majority of whom are in prison or in the community.

### **2.8 THE ORGANISATION AND COORDINATION OF TREATMENT AND CARE**

The organisation and coordination of care is the subject of a separate chapter (Chapter 4). The purpose of this section is to outline the key issues to be considered in that chapter and how they will be integrated through the guideline. Most people with antisocial personality disorder receive the majority of their care outside the health service. They make demands on educational, social care and housing services and, as result of their offending, on the criminal justice system. The effective delivery of a healthcare intervention for antisocial personality disorder will therefore require an acknowledgement and understanding of the wider system as a minimum, but for those individuals with complex needs it will also require effective coordination of care across multiple agencies. This can be very demanding work, especially when it is carried out in the community with the most troublesome offenders and those who provoke the most anxiety, and has led to the development of specific coordination systems such as the Multi-Agency Public Protection Arrangements (MAPPA) panels (Home Office, 2005c), which coordinate multi-agency care from mental health, social services and the criminal justice system. Whichever system of coordination is chosen it is likely that a number of agencies (in addition to mental health services) will need to play a part if the cycle of continuing adversity is to be broken. Successful interventions for those with antisocial personality disorder may require these interventions to be multimodal and across most of the life span.

However, such complex interventions are expensive and not widespread around the country, and it is therefore inevitable that some people who need treatment may not receive it. They may also not receive treatment because psychiatric teams still reject those who behave antisocially and because people with antisocial personality disorder are often reluctant to engage in treatment. Their callous and unemotional response to vulnerability may extend to themselves: they may see their own needs as signs of weakness and treat them with contempt, and by extension, treat caregivers with contempt.

One of the key conceptual issues that affects services for antisocial personality disorder and psychopathy is the persistent belief that these disorders exist in isolation,

especially in relation to Axis I disorders. Some of the homicides committed by the mentally ill that have been the subject of inquiries occurred because men with both antisocial personality disorder and a psychotic disorder were turned away on the grounds that they ‘only’ had a personality disorder and therefore were not mentally ill. Even in very experienced services, professionals find it hard to accept that severe personality disorders and severe mental illness not only coexist, but are very likely to coexist (Blackburn *et al.*, 2003). Thus if services are set up as either ‘personality disorder services’ or ‘mental illness services’, the most risky, treatment averse people will not be identified.

## **2.9 ASSESSMENT**

Much of the focus on the assessment of people with antisocial personality disorder has focused on the assessment of risk, in particular risk to others. (This is the specific focus of Chapter 6 and will not be discussed in detail here.) However, people with antisocial personality disorder often have complex needs, which in turn require complex assessment often from a multi-agency and multi-professional perspective and would include not only risk but mental state (because of the high level of comorbid mental disorders in people with antisocial personality disorder presenting to services), drug and alcohol misuse (the latter has a strong association with the risk of violent or offending behaviour), physical health needs, social and housing needs and also the needs of family members, in particular children. The Department of Health document, *Personality Disorder: No Longer a Diagnosis of Exclusion* (2003), is clear that personality disorder should no longer be a reason for being denied treatment; however without effective assessment an effective treatment plan is not likely to be put in place.

The issue of assessment raises questions about the structure and purpose of assessment of antisocial personality disorder at different levels of the healthcare system. In many mental disorders there is an increasing emphasis on a stepped care approach to treatment (NCCMH, 2005a) and although the evidence base is limited it is possible that this will be considered an appropriate way forward for antisocial personality disorder (this is discussed further in Chapter 4). However whichever model is chosen it is likely that the focus on assessment and intervention, at least in healthcare, will vary across the healthcare system. One approach that may be helpful is to consider people with antisocial personality disorder presenting to primary care as having ‘problems’; those presenting to secondary care as having ‘symptoms’; and those presenting to tertiary care to having either ‘complex problems’ or requiring a forensic assessment. For this approach to be effective within the stepped care model, practitioners at different levels would require guidance on: (a) recognition of the disorder and its implications regarding the presenting problem; (b) how to respond to this in an appropriate manner; and (c) under which circumstances a referral to another tier is indicated. (See Chapter 4 for further discussion.)

## **2.10 ETHICAL CONSIDERATIONS IN ANTISOCIAL PERSONALITY DISORDER**

### **2.10.1 Introduction**

So far this chapter has focused on the professional or societal approach to personality disorder, but antisocial personality disorder also raises key ethical issues. In relation to antisocial personality disorder and psychopathy, a key conceptual question is whether they are disorders at all. The debate is complicated by the fact that philosophers have used the concept of the psychopath as a medical entity to explore issues of moral reasoning and responsibility (Murphy, 1972; Duff, 1977; Malatesti, 2006); while, at the same time, a debate has continued in psychology and psychiatry whether psychopaths (and indeed, people with antisocial personality disorder) are properly the subject of medical discourse at all, precisely because of the implications for criminal responsibility. Much of the current research has been used to address this debate: therefore, if there is a biological basis for antisocial personality disorder and psychopathy, then, it is argued, it is a disorder, which needs treatment, or at least intervention.

This debate is too large to review in any depth here, but there are three related aspects that may be useful to consider. First, debaters in this area need to beware of conceptual slippage: ‘antisocial behaviour’ is not the same as criminality or violence or antisocial personality disorder or psychopathy. Much more is known about the brains of those who behave in cruel and unusual ways than was known 10 years ago and those findings cannot explain why people in general choose to behave antisocially. Second, neural/genetic findings can only contribute to an understanding of the causes of any behaviour. All human behaviours are complex, and involve higher level thinking about motives, beliefs, attributions, both in the actor and those affected by him/her. It seems very probable that genetic vulnerability interacts with environment to produce a neural matrix that contributes causally to socially significant rule breaking: but it is only a contribution, and not a total explanation. Third, researchers and healthcare policy makers need to understand that because the problems posed by people with antisocial personality disorder and psychopathy are social ones, there will have to be a social/political dimension to the work that is undertaken. This often seems alien to many healthcare professionals and scientists who see biosciences as politically and morally neutral. But people who behave antisocially, for whatever reason, generate negative attitudes in the rest of their social group, and those attitudes will not fade away quickly. Even if it could be demonstrated that all social behaviour is caused by failure of inhibition to the amygdala, this is unlikely to change public attitudes to the perpetrators. Another problem is that most social groups accept some degree of antisocial rule breaking as normal and tolerable. Therefore researchers will only ever be able to work with highly selected samples of social rule breakers: ones identified by the fact that they have crossed a certain social threshold and invited what Strawson calls ‘participant reactive attitudes’ (Strawson, 1968). Therefore care needs to be taken about what extrapolations are made from the research, and the social attitudes that may be challenged by research findings.

These issues have influenced the position taken in this guideline: that not all criminal rule breaking is evidence of mental disorder, but that some of the most egregious types of criminality, such as extremes of violence towards the vulnerable, do reflect failures in the capacity to relate to others that amount to a disorder. A useful concept here is that of the eighth amendment to the US constitution: a state of mind that results in 'cruel and unusual' behaviour is, on the balance of probabilities, a disordered mind.

### **2.10.2 Treatability**

The notion of 'treatment' for antisocial personality disorder and psychopathy also raises a number of ethical issues, principally the assumption that it is a disorder that is amenable to intervention. As Adshead (2002) has pointed out, the 'treatability' of any disorder relies on a number of factors, not all of which are to do with the individual patient. A key issue in the treatment of antisocial personality disorder and psychopathy is the test of therapeutic outcome: how will the practitioner know if treatment has been successful? In the past, treatments have focused on either people feeling better or behaving better, and practitioners have sometimes assumed that one implies the other. Treatments also have within them an implied theoretical model about what is 'wrong' with the individual concerned: but if the model is wrong, then the treatment may be ineffective, even if it is well thought out and well delivered.

The conceptual problem referred to above dominates debates about treatment and treatment outcomes. However, many researchers and clinicians would argue that people with antisocial personality disorder are in states of mind in which other people are seen as either predator or prey, and that they are therefore justified in acting cruelly towards them. Interventions could then be geared to enabling individuals to examine their own states of mind more, understand the minds of others, and have an investment in behaving more pro-socially. Interventions could include psychological treatment, social and vocational rehabilitation, education and medication. They may also include long-term social support (not least because social isolation is a potent risk factor for violence in high-risk individuals).

There is evidence that some of these interventions can change behaviour, at least for some people, through developing a more pro-social state of mind. The ethical issues then turn on resource allocation. Most ethical arguments about healthcare resources are utilitarian in nature: what will bring about the most good for the greatest number? For example, in relation to the DSPD programme, the argument has been that the provision of services will prevent severe harm. Whether this is true is the subject of current research enquiry, ideally including a comparison with a treatment/intervention-as-usual group, although the ethical problems here may be insuperable (Farrington & Welsh, 2006).

### **2.10.3 Issues of coercion in relation to antisocial personality disorder**

It is a general principle of bioethics that respect for the autonomy of patients is paramount, and a general principle of law that everyone has control over his/her own body

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and any treatment interventions that are offered. Under the new Mental Capacity Act (HMSO, 2005), any person with capacity can refuse treatment, even if this is to his/her own detriment.

The only people with capacity who cannot refuse treatment, and can have treatment forced upon them, are those with mental disorders who pose a risk to themselves or others. The ‘or’ is crucial here; most libertarian philosophical arguments (Saks, 2003) would contend that forced medical treatment is only justified to improve a person’s own health and safety, and that the insult to dignity is outweighed by the prevention of serious harm.

It has long been a matter of debate about the extent to which societies should coerce people into treatment that is not of benefit to them directly, especially where the ‘treatment’ is aimed at reducing risk to others, regardless of what the individual wants. This is at least partly because when this is done, the person is treated merely as a means to an end, not as an end in themselves, and this type of insult to human dignity is morally unacceptable.

Mental health professionals often argue that they are not doing this in two ways. First, they will argue that the patients are benefiting, even if indirectly; at least they are benefiting from not being allowed to harm others. A problem with this argument is that it could be seen as discriminatory—generally competent citizens are allowed to choose whether they do harm or not, and take the consequences. It should be remembered that the current Mental Health Act (HMSO, 2007), even with its amendments, allows for the detention and forced treatment of people with full capacity.

Second, it is argued that people who are a risk to others have lost some of their claims to full exercise of autonomy. Given that they are likely to be deprived of their liberty if they harm others, there may be little insult to dignity in offering treatment while they are detained. This argument of course applies only to prisoners, and those who have harmed others already; it cannot apply to those who are detained on the chance that they may offend.

This presents significant challenges for mental health professionals. There may need to be a distinction made between legal coercion and therapeutic persuasion. It is very unlikely that all antisocial patients can be coerced into pro-social thinking or behaviour. This raises important issues of balance between the rights of individuals to have liberty restrained or treatment imposed against the rights of a community to be protected from potential harm.

### **2.10.4 Risk assessment**

Central to the issue of coerced treatment is the problem of identifying those who present a risk (this is discussed more fully in Chapter 6). The main concerns about justice arise from issues of *consent* and *accuracy*. To detain a person because they are a risk to others may be entirely justified if it is true. Those assessing risk therefore need to be certain that their methods of risk assessment are accurate and also fairly used. For example, risk assessment needs to look at both resilience and protective factors that might reduce risk, not just those factors that make risk more likely. It will not be just

to detain someone (especially if it is indefinite) if all positive factors have not been considered. It will be especially unjust if the main reason for detention is professional anxiety alone. Currently there is considerable controversy about the best methods of undertaking individual risk assessment with some arguing that actuarially-based methods such as the Violence Risk Appraisal Guide (VRAG) or PCL-R have reasonable properties to enable prediction of violence at the individual level (for example, Campbell *et al.*, 2007); while others argue that it is not appropriate to use such measures to routinely inform clinical decisions (for example, Cooke *et al.*, 2007; Hart *et al.*, 2007).

There is also the problem that the most at-risk people are those who are not identified for risk assessment; that is, that in relation to mental illness at least, the thing that makes people risky is their unpredictability. As several authors have noted, one would have to detain a large number of individuals who had done nothing, to prevent one homicide (for example, Dolan & Doyle, 2000). What this means is that society accepts that some degree of violence will occur, but possibly not if it is committed by those with mental disorders.

There is another aspect to risk assessment that has not received much attention. If risk assessment is a healthcare intervention, and part of the overall medical management of forensic patients, then it could be argued that it needs the patient's consent. This is particularly so given that it is a medical intervention (like a lumbar puncture) that could have serious side effects for the patient. Under the Mental Capacity Act (HMSO, 2005), it may be possible for capacitous patients to refuse risk assessment, and it might then be argued that it would be unlawful to carry out a risk assessment without consent.

Healthcare professionals often resist the use of violence risk assessment on the grounds that it is stigmatising to the individual or conflicts with good clinical care. Yet assessment of risk also implies assessment of safety; for every individual identified as presenting a high risk, the same process will indicate that others present a low risk and should be managed accordingly. For every patient identified as having a high score on instruments such as the PCL-R, many others will be shown to have a low score. There is sometimes a genuine conflict of values between patient autonomy and the safety of others. The conflict should not be ignored but managed by the use of evidence-based diagnostic and risk assessments that are transparent and open to challenge. Traditional methods of assessment often meet neither standard.

### **2.10.5 The ethics of public protection**

A real ethical debate exists about the extent to which a range of healthcare professionals should be involved in public protection. On the one hand, there are those who take the view that their knowledge and expertise in assessing risk imposes a duty on them to act on that knowledge to assist in public protection from a small number of risky individuals with mental disorders (especially antisocial personality disorder and psychopathy). On the other hand, there are those who take the view that their primary ethical duty is to 'make the care of the patient their first concern' (General Medical

Council, 2006), and who argue that acting in ways that reduce risk but cause patients distress or anxiety violates their ethical duty and identity as doctors.

This debate has taken on an extra significance with the passing of the Criminal Justice Act (HMSO, 2003), which requires psychiatric expert testimony before passing sentences for public protection (that is, sentences that are longer than usual, or may lead to indefinite detention). In these circumstances, psychiatrists are providing testimony that, it might be argued, causes harm to the defendant, at least, from the defendant's viewpoint. In the UK, the psychiatrist treating the patient may also be the one who is invited to give an expert opinion about the patient's risk on the grounds that they know the patient best. If the treating psychiatrist takes the view that they have a duty to public safety, which overrides the duty to the patient's interests, then the patient may find that the doctor in whom they have confided is using those confidences against them in the wider interest of the public good.

The key ethical tension here is arguably about deceit, not a clash of duties. The anxiety is that in the pursuit of public protection, mental health professionals will mislead patients into thinking that the patient's interests are their first concern. If mental health professionals inform forensic patients that their first duty is to public safety, and that therefore they will disclose private medical information when necessary even if the patient refuses to give consent, then this is a transparent procedure, and the patient can decide how then to conduct themselves. In a medico-legal context, where the assessing doctor has no prior therapeutic relationship with the patient, then arguably the relationship between them is not a traditional medical one, and the transaction is straightforward and there is no clash of ethical duties (Appelbaum, 1997). The ethical concern is about honesty: that a healthcare professional will allow the patient or defendant to think that they will protect their interests against those of third parties, when they have no intention of doing so.

A possible ethical and legal solution to the tension is for the mental health professional to gain informed consent for both risk assessments and medico-legal interviews, in which they clearly advise patients/defendants of the purpose of the interview, the use to which the material will be put and who will be informed of the outcome. Given the potentially negative outcomes of these assessments for the patient/defendant, it could be argued that existing law on informed consent and refusal of treatment requires that patients/defendants be informed that they need not answer the doctor's questions. There remains an anxiety that even with this type of warning against self-incrimination, patients/defendants may not understand that the assessor is not in a traditional beneficent role. From a therapeutic point of view, complete transparency about the potential conflict of duties is likely to promote trust and a collaborative attitude in the patient/defendant.

The Royal College of Psychiatrists' Scoping Group on Expert Testimony has submitted a report (Royal College of Psychiatrists, 2008a) advising experts of the distinction between testimony given for therapeutic purposes and testimony given for public protection purposes. The American Academy of Psychiatry and the Law (2005) has issued ethical guidelines to its members, which state that no psychiatrist should give expert testimony on a patient they are treating. In the UK, there are particularly difficult conflicts around Mental Health Tribunal evidence, where the

responsible medical officer (RMO) gives professional evidence as to the clinical care of the patient, and expert forensic evidence about the nature of the risk they pose to others. This tension arises because the Mental Health Act (HMSO, 2007) assumes that patients with mental disorders lack capacity to make good quality decisions, and that psychiatrists are therefore justified in doing what they think best, including in relation to public safety. However, since most patients (especially those with antisocial personality disorder) have full legal capacity, and can exercise autonomy, the RMO's position may no longer be justified, and their role in public protection becomes primary. It is for this reason that some detained patients see their lawyers as being the only people who represent their interests in a trustworthy way (Sarkar & Adshead, 2005).

### **2.10.6 Ethical issues and children**

Children are considered in this guideline as the focus of preventative interventions (see Chapter 5).

#### *The prevention of antisocial personality disorder*

Here the aim is to alter the course of a childhood disorder such as conduct disorder and thereby potentially prevent the development of antisocial personality disorder in adult life. The work on preventative interventions is the focus of Chapter 5 and their efficacy will not be discussed in any further detail here. The ethical problem is that interventions that might prevent the development of antisocial personality disorder may contravene the ethical principles of beneficence and justice for all patients.

All ethical dilemmas involve a clash of values or ethical principles; some dilemmas are especially concerning because there is no painless outcome and even doing the right thing may lead to a moral loss (for example, the issue of coerced treatment). Interventions to prevent antisocial personality disorder will be justified in terms of beneficial consequences in the future: no (or reduced) antisocial personality disorder, and thus the prevention of harm to others, costs to society and antisocial individuals. There is no question that the outcomes look very attractive as benefits. The question is: at what cost to human dignity and justice will these benefits come? Will the ends justify the harms done in the process? And most importantly in ethical decision making: who gets to decide?

Given that genetic vulnerabilities may increase a child's chance of developing conduct disorder, especially if they are raised in an abusive environment, if nothing can be done to help the child, there may be little point in identifying them. Indeed, their chance of failure may be increased because the environment around them may be even more rejecting and suspicious of them.

The provision of services to an at-risk child, however identified, will depend on the resources allocated for this. It is easier to change a child's environment than it is to change their genes. For example, if we take the genetically vulnerable child identified above, one intervention might be to place them in a secure home where they will not be maltreated. This may mean: (a) taking the child away from the parents before

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there is any chance of maltreatment; and (b) investing funds to provide the secure base for the child's development. These measures could reduce the amount of conduct disorder (and therefore possibly antisocial personality disorder), but may be costly in terms of justice and resources. Again, resource allocation is a matter of values: there is no good reason not to do everything that can be done to prevent the maltreatment of children except that society may decide to spend the money in another way. The key ethical issue here is the resource allocation of funds for research and interventions with at-risk children. Identifying individuals at risk may be less useful in the long term than trying to reduce maltreatment of the child overall.