*Robert Weinstock,* [1] *M.D. and Mohan Nair,* [1] *M.D.*

# Antisocial Personality—Diagnosis or Moral Judgment?

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**ABSTRACT:** Antisocial personality is a problem-filled diagnosis. Even when diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) II manual, it was replete with value laden terminology. DSM III makes repeated criminal behavior central and includes a list of other behaviors that do not always truly imply an antisocial personality. In order to test the possibility that factors other than those listed in the manual may often influence the diagnosis, the prevalence of required characteristics in patients diagnosed antisocial personality was compared with the prevalence of required characteristics in another personality disorder, schizoid personality. The study involved a hospitalized Veteran's Administration (VA) population, employing DSM II criteria, which was used by the VA at that time. The difference was statistically highly significant. Examination of the case histories suggests that dislike of the patients or negative moral judgments about their actions frequently were involved in making a diagnosis of antisocial personality. It is therefore crucial that moral judgments not be disguised as scientific ones, and the meaning of an antisocial personality diagnosis as utilized by clinicians needs to be seriously questioned.

**KEYWORDS:** psychiatry, mental illness, human behavior

Antisocial personality is a problem-filled diagnosis. The term has evolved from psychopathic personality and was eventually changed to sociopathic personality in *Diagnostic and Statistical Manual of Mental Disorders* (DSM) I. The name was changed to antisocial personality when introduced in DSM II. Later it was revised in DSM III in an effort to correct some of the continuing difficulties. However, serious problems still remain with the diagnosis of antisocial personality.

To illustrate the continuing difficulties, how would most forensic psychiatrists label a patient who had the following history? Before age fifteen he missed five days of school a year for two years, ran away from home twice, and had grades markedly below his I.Q. level. Since age fifteen he was late to work three times in a month, showed failure to plan ahead as indicated by traveling from place to place without a clear idea of when the travel would terminate, recklessness as indicated by recurrent speeding, and also has had either two divorces or alternatively has had ten sexual partners in one year. Such a person would be labeled an antisocial personality if, in addition, he had a history of repeatedly violating the rights of others, which would usually be indicated by a history of committing crimes. Since we can arrive at the diagnosis with the criteria listed above, which I am sure, in and of themselves, would impress few clinicians, the commission of crimes seems to really be the essential element of this

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[1] Associate clinical professor of psychiatry and former resident in psychiatry, respectively, University of California, Irvine, Orange, CA.

diagnosis in DSM III. We are certain that most psychiatrists would not otherwise label such a patient an antisocial personality.

Of course, some other criteria in DSM III might be more relevant, but the example we gave above shows that these criteria are not necessarily essential to the diagnosis and that the history of committing crimes is really the crucial element in DSM III. The other characteristics described above may be correlated with the presence of an antisocial personality, but the decision-making process in DSM III allows for a diagnosis with a potentially unimpressive list. It is therefore possible that there are many additional factors that may contribute to a psychiatric diagnosis of an antisocial personality in a patient. One might, in fact, sometimes arrive at a diagnosis through criteria not listed in the diagnostic manual and then either ignore the manual or stretch the criteria to fit. Dislike of a patient or negative moral judgments may, in fact, be involved in having a patient receive the antisocial personality diagnosis. If so, the diagnosis may present a pseudo-scientific facade for value judgments. In our present era of strong law and order concerns, it can also place a psychiatrist in the very questionable ethical role of being the agent of punishment and in extreme instances even execution, because of his own unstated, unintentionally disguised moral judgments.

Moreover, the diagnosis of antisocial personality can often obscure more than it clarifies. A mere history of antisocial behavior can, in practice, lead to such a diagnosis in a patient who might otherwise be labeled as borderline. All further attempts to look for underlying psychopathology may consequently be terminated. DSM III does not allow the use of antisocial personality along with schizophrenia or mania, but does allow it along with personality disorder diagnoses, including borderline and schizotypal personality, or even schizophreniform disorders. Such a distinction seems very artificial to us, since it implies, for example, that the exact same behavior has one meaning in the schizophrenic patient, but an entirely different meaning with a schizophreniform patient. Geller [*1*] has written about sociopathic adaptations in even psychotic patients. If what was intended in DSM III was the use of the antisocial personality diagnosis only in the absence of other mental illnesses we should specifically say just that.

Travin [*2*] has described a tendency to misdiagnose schizophrenia as antisocial personality when there is accompanying antisocial behavior. Just because a schizophrenic is manipulative does not make him an antisocial personality. We believe that such a confusion can deprive the patient of necessary treatment and that it tends to obscure other relevant factors, such as the interaction between examiner and examinee. Many people more over, still use sociopathic as a diagnosis, even though it was eliminated, in our opinion, for good reason in DSM II, and we must actually go back to DSM I to find it. The fact that someone comes in conflict with society does not necessarily imply mental illness. If it did, American revolutionary leaders would have been sociopaths.

Antisocial personality is often used as a diagnosis with a scientific basis when antisocial behavior might be the more appropriate label. Alternately, merely a statement that no mental disorder is present might be more accurate. Often the diagnosis a person receives might depend more on the feelings of the examining psychiatrist towards the patient, and on how carefully one looks for underlying psychopathology. DSM II clearly used value laden terms, such as selfish, callous, and irresponsible, which were possibly more a reflection of the therapist's moral values than an appropriate diagnosis.

Lewis and Balla [*3*] found significant instances of underlying psychopathology, including psychosis and organic problems in people coming into conflict with the criminal justice system. Cleckley [*4*] was impressed by the similarities between schizophrenics and the antisocial personalities, even though he was pessimistic regarding treatability. Bender [*5*] described boys whose psychoses were manifested by behavior that was seen initially as purely criminal, such as fire-setting and stealing, but were really schizophrenic. Guttmacher [*6*] coined the term pseudo-psychopathic schizophrenia. Hoch [*7*] describes such patients as having a life history of getting into trouble, much like sociopaths, but with patterns of behavior that were bizarre

and would seem to come from internal stimuli. Ideas of reference, persecutory ideas, suspicion, grandiosity, hypochondriasis, as well as schizophrenic concretization and paralogical thinking can be found. Blacker and Tupin [8] have reported a pattern of behavior in some men, in which their behavior is a caricature of the male stereotype and which they have labeled hysterical personality. Such a person can commit antisocial acts as part of a need to prove himself a man and they call such patients pseudosociopathic hysterics. Such patients can provoke antagonistic responses from diagnosticians in contrast to women hysterics who generate more positive feelings, especially from male evaluators. It is also of interest that most patients diagnosed as antisocial personality are men.

Because of the problems with the antisocial personality diagnosis, and the possibility that patients with antisocial personality as a diagnosis may often be diagnosed on the basis of factors other than those in the diagnostic manual, we conducted a study in which we examined the records of patients diagnosed as antisocial personality and compared them with another personality disorder, schizoid personality, which was used as a control, to determine how often patients with each diagnosis met the required criteria.

## Method

The study was conducted at a Veteran's Administration (VA) Hospital, which is a major university training center. A retrospective examination was made of in-patient charts for a three-year period preceding the study until April 1981. All charts of individuals admitted to the VA who were primarily diagnosed as antisocial personality or sociopathic personality were examined, and 35 such cases were found. The use of sociopathic personality as a diagnosis, since it no longer existed in DSM II was interpreted to be a synonym for antisocial personality. Another personality disorder, namely schizoid personality, was chosen as a comparison group, and 19 such cases were found. In both groups, the specific criteria, as documented in DSM II were searched for in records that were evaluated retrospectively. DSM II was used since that was the diagnostic manual and criteria in use at that time at the VA. An attempt was made to remain blind, although in practice, this often proved to be difficult.

Charts where the diagnosis was not primary were excluded. Chance visits to the emergency room, either voluntary or enforced, by indigent or drunken veterans who were then diagnosed summarily by the emergency room intern or on medical and surgical wards, were not included. Only cases where the diagnosis was arrived after formal psychiatric workup were included.

Twelve criteria, diagnostic of antisocial personality as described by DSM II were looked for in the examination of the charts. The twelve criteria were the following:

(1) lack of loyalty to individuals,
(2) lack of loyalty to groups,
(3) lack of loyalty to society,
(4) selfish,
(5) callous,
(6) impulsive,
(7) unable to feel guilt,
(8) unable to learn from experience,
(9) poor frustration tolerance,
(10) tendency to blame others,
(11) repeated legal offenses, and
(12) irresponsible.

Criteria were noted as being present, absent, or that there was no evidence for either presence or absence.

Eight criteria described as being diagnostic of schizoid personality disorder, according to

DSM II were looked for in addition in all patients. However, the eight criteria are listed only for the patients who were primarily diagnosed as schizoid personality disorder. Nineteen such patients were found. These criteria were evaluated in a manner similar to that described above. The eight criteria listed in DSM II for schizoid personality were as follows:

(1) shy,
(2) oversensitive,
(3) seclusive,
(4) avoids competition,
(5) autistic,
(6) detached,
(7) unable to express anger, and
(8) suspicious.

The relative frequency with which individual criteria were present was noted for both groups, although only the criteria specific for the diagnosis used for that patient were tabulated.

## Results

The results for the proportion of possible characteristics present for both groups of patients are listed in Table 1. Separate variance estimates were made for both groups and $t$ tests were performed.

The $t$ value was found to be 11.02 with 26 degrees of freedom, which gives a $P < 0.001$. This table lists the proportion of possible characteristics present by rating the presence of possible characteristics as the numerator, and rating that either as the absence or missing data which could not be evaluated as the denominator. To test the possibility that the results would be different, we also did analyses that excluded missing data. This procedure was done because missing data could theoretically represent the presence of characteristics, which just happened not to be noted. Therefore we did the same tabulation involving the exclusion of all missing data and only rated patients in whom the characteristics were either present or absent. Very little difference was found. The $t$ value in this situation was 8.14 with 49 degrees of freedom, again using separate variance estimates, and the probability was still found to be $P < 0.001$.

Table 2 divides up the presence and absence of the required characteristics for antisocial personality by specific characteristics.

The criteria for schizoid personality were tabulated in a similar manner in Table 3.

The total number of cases were 35 for antisocial personality and 19 for schizoid personality. To look more specifically for some of the criteria, which might be influencing the diagnosis, we looked in both groups for certain other criteria in addition to those listed in DSM II. For these characteristics, please see Table 4.

The difference between the two groups for the criteria listed did not reach statistical significance. As can be seen from evaluation of the criteria, many of the characteristics that we

TABLE 1—*Proportion of possible characteristics present.*

| | Antisocial Personality | Schizoid Personality |
|---|---|---|
| No. of cases | 35 | 19 |
| Mean | 0.174 | 0.710 |
| Standard deviation | 0.125 | 0.191 |

TABLE 2—*Presence of antisocial personality.*

| | Criteria Absent | Criteria Present | Percent Present |
|---|---|---|---|
| Lack of loyalty to individuals | 15 | 0 | 0 |
| Lack of loyalty to groups | 10 | 2 | 5.7 |
| Lack of loyalty to society | 32 | 1 | 2.9 |
| Selfish | 0 | 0 | 0 |
| Callous | 0 | 0 | 0 |
| Impulsive | 0 | 27 | 77.1 |
| Unable to feel guilt | 0 | 1 | 2.9 |
| Unable to learn from experience | 0 | 1 | 2.9 |
| Poor frustration tolerance | 0 | 13 | 37.1 |
| Tendency to blame others | 5 | 3 | 8.6 |
| Repeated legal offenses | 8 | 10 | 28.6 |
| Irresponsible | 8 | 15 | 42.9 |

TABLE 3—*Presence of schizoid personality characteristics.*

| | Criteria Absent | Criteria Present | Percent Present |
|---|---|---|---|
| Shy | 3 | 14 | 73.7 |
| Oversensitive | 1 | 15 | 78.9 |
| Seclusive | 1 | 17 | 89.5 |
| Avoids competition | 0 | 14 | 73.7 |
| Autistic | 4 | 8 | 42.1 |
| Detached | 6 | 11 | 57.9 |
| Unable to express anger | 0 | 10 | 52.6 |
| Suspicious | 0 | 19 | 100.0 |

expected to discriminate between the two groups, such as jail and violence, surprisingly were found to be present in both groups of patients. The only criteria that did seem to be markedly different insofar as they were present only in the antisocial personality group and not in the schizoid personality group, were the histories of medical problems and also having been a Vietnam veteran. Both the history of medical problems and having been a Vietnam veteran were present only in the antisocial personality group.

## Case Histories

Some individual case vignettes are included to give some idea of the type of patient who was diagnosed as "antisocial personality" in this group.

### *I.J.*

Deceased by suicide at age 27, he was 100% service connected for schizophrenia, and admitted repeatedly for psychotic decompensation.

### *P.R.*

He was age 47, married 17 years, with a degree in accounting. He had a good life, an onset of illness at age 38, and 4 hospitalizations since. He had overt psychotic symptoms and a good response to Mellaril®.

TABLE 4—*Presence of other characteristics.*

| | Antisocial Personality | | Schizoid Personality | |
|---|---|---|---|---|
| | Criteria | | Criteria | |
| | Present | Absent | Present | Absent |
| Manipulative | 10 | 5 | 3 | 4 |
| Argumentative | 20 | 4 | 8 | 3 |
| Disability issue | 9 | 3 | 2 | 4 |
| Hypochondriasis | 4 | 2 | 2 | 2 |
| Requesting anxiolytics | 7 | 2 | 3 | 1 |
| Discharge AMA | 19 | 16 | 11 | 8 |
| Poor work history | 20 | 8 | 9 | 3 |
| Past psychiatric hospitalization | 28 | 0 | 12 | 5 |
| Jail | 20 | 1 | 7 | 1 |
| Violence | 14 | 1 | 8 | 1 |
| Disturbed family | 10 | 3 | 7 | 1 |
| Three divorces | 4 | 6 | 2 | 6 |
| Street drug abuse | 17 | 2 | 6 | 3 |
| Alcohol abuse | 27 | 3 | 12 | 3 |
| Abnormal EEG | 2 | 2 | 1 | 1 |
| History of seizures | 8 | 5 | 3 | 3 |
| History of medical problems | 12 | 1 | 0 | 0 |
| Suicide history | 19 | 1 | 8 | 1 |
| Age below 30 | 18 | 17 | 7 | 12 |
| Vietnam veteran | 9 | 0 | 0 | 0 |
| Psychotic diagnosis | 14 | 21 | 8 | 11 |
| Other psychiatric diagnoses | 21 | 14 | 11 | 8 |

*R.F.*

Deceased at age 47 from alcoholic complications, he was a Vietnam veteran, was married and employed until 1978. He reported insomnia, paranoia, auditory hallucination, and progressive deterioration following Vietnam. His Minnesota Multiphasic Personality Inventory (MMPI) showed high scores on depression, schizophrenia, paranoia, and psychopathic deviance.

*P.A.*

Age 47, also diagnosed as schizophrenic in the past with pancreatitis, diabetes, Parkinson's disease, and with a history of head trauma sustained in the war. He had flattened affect and auditory and visual hallucinations. He had multiple hospitalizations, did not follow medical advice, and had one incident of shooting at a policeman. He had completed high school and college. He had an alcohol history from age 10.

*D.K.*

Divorced after eleven years of marriage, with a good work history as a trucker, until the onset of seizures. He described auditory hallucinations and a 9-kg (20-lb) weight loss before the last admission. He complained of depression, anxiety, and peptic ulcer disease. He stated that the onset of depression came since the presence of seizures, and was worsened by divorce, by having gone to jail, and by the death of his mother. He had a family history positive for

Huntington's chorea. The patient would not stay on the ward, and viewed the hospital as a place for rest. He threatened another patient with a knife, and used alcohol while on pass. He was uncooperative, with no goals, and did not participate in hospital activities.

*H.M.*

Age 44, 100% service connected veteran, diagnosed as paranoid schizophrenia in exacerbation in the past. He lived in a Board and Care home, and suffered from auditory hallucination, paranoia, and clothes smelling of urine. He had a history of an organic brain syndrome secondary to head trauma, with bilateral cortical atrophy. He was blind in one eye secondary to retinal detachment and he was described as manipulative. The staff felt that the patient was manipulating to stay in the hospital until he received eye surgery to avoid paying for Board and Care. He was described as irritating, demanding, and smoked in bed.

*H.N.*

Age 21, and had his left testicle removed at age ten. He had a record of alcohol and drug use since the age of 14, and bed-wetting since the age of 9. He had multiple hospitalizations, and a history of auditory hallucinations, suicide attempts, wrist slashing, overdoses, and car crashes. He also had a seizure history and was said to have staged a seizure in front of the nursing station. His suicide attempts were seen as attention seeking. He had been admitted for depression, got better while in the hospital, but decompensated again while in the hospital when his doctor left on vacation.

*K.A.*

Age 57, 100% service connected World War II veteran, a married ex-salesman. He was unable to work secondary to somatic complaints, anxiety, and depression. He was described as gambling with his income and his present crisis was precipitated by an arrest for shoplifting salami and a roast. He was seen as overdependent on the VA Hospital, and was also diagnosed as a masochistic personality. Medically, he was post-myocardial infarction, had diabetes mellitus, a history of a pulmonary embolus, and the presence of peptic ulcer disease.

## Discussion

The results of this study show a markedly statistically significant difference between the proportion of required diagnostic criteria present for the antisocial personality disorder patients, as opposed to the proportion present for the schizoid personality disorder patients. Many more necessary criteria were therefore present in schizoid personality patients as opposed to antisocial personality patients. The results indicate that either patients were correctly diagnosed as antisocial personality, even though the evidence was not documented in the charts, or more likely, in our opinion, that factors other than those listed in the DSM II manual, in fact, led to the patients receiving their diagnoses. The fact that even when missing characteristics were excluded, the difference between the two groups of patients was still very highly statistically significantly different, at the 0.001 level, would indicate that the most likely explanation for this difference is that other factors were involved in the diagnosis. Of course, it is possible that DSM III corrects all the problems, and we did, in fact, use DSM II in this study. However, the very specific nature of the required criteria in DSM III and the requirement that certain specific characteristics be present before age 15, make it likely that the results would have been even more striking if DSM III had been used. This is especially true since few charts nowadays include childhood history. In addition, this study was done at one VA hospital, and therefore, does not necessarily generalize to other settings, but our impression is that the problem re-

ported is widespread. Moreover, this study was not done in a forensic science setting and the diagnoses were not made by forensic psychiatrists, but it is unlikely that forensic psychiatrists would be immune from the problem described. Rater bias may also have been a problem, but an attempt was made to remain blind, even though the use of hospital records made true blindness not always possible.

It is, therefore, most likely that factors other than those listed in the diagnostic manual influenced the making of the diagnoses. Our attempt to delineate some of these factors was not successful. However, our subjective impression as shown by the case vignettes, was that dislike of the patient by the doctor or staff or both truly influenced the diagnosis, although such factors were usually not written into hospital records specifically. Although dislike of many such patients might be quite understandable, disguising such subjective reactions as an objective diagnosis can be misleading at best. It may say more about the evaluator than it does about the patient.

It is difficult to believe that negative feelings about a patient, or hidden moral judgments did not seriously influence the diagnosis of the so-called antisocial patients. The case histories suggest that many of these patients were probably truly ill, although they were manipulative and not especially likeable. It is often easier to have sympathy for a schizophrenic than for an exaggeratedly hypermasculine patient or "tough guy." If one dislikes a patient, any sign of his being manipulative could result in his being labeled antisocial. Even though many patients and even successful admired members of society can be manipulative, in forensic science settings, the commission of a crime often leads to a negative attitude towards a patient, and intolerance of any manipulative tendencies in the patient.

The problem is complex, but we believe that forensic psychiatrists should be alert for elements of narcissism, schizotypal features, borderline personality organization, impulsivity, hysteria, or even frank psychosis in such patients. The use of antisocial personality as a diagnosis can result in a cessation of all efforts to search for illness, and in an absence of understanding along with therapeutic nihilism, or even to a death penalty in our present climate. In the hospital setting, there would generally be no effort to treat a patient with a diagnosis of antisocial personality. In essence, such a diagnosis on record may bias all future doctors to stay away. In the forensic psychiatric setting, it leads to an abandonment of all efforts to look for mitigating psychopathology, or possibly treatable conditions. The diagnosis most likely often amounts to the very subjective judgment that a person should be punished and not treated, because the psychiatrist is too angry at the patient or his actions to want to treat him. This judgment, however, is more appropriately left to judges and juries, and should not be preempted by the psychiatrist. It may be popular in that it allows the courts to punish with a clear conscience and makes sure that other psychiatrists will not become involved, but it is certainly a very questionable role for the forensic psychiatrist.

The best approach for a psychiatrist to avoid hidden moral judgments that masquerade as scientific procedures would be to examine the patient thoroughly in a nonthreatening atmosphere and to try to present all the relevant facts to the courts. If we dislike or disapprove of a patient, we should say just that, rather than use a diagnosis inappropriately and claim we are making a medical evaluation, or that we are saying anything more than the obvious fact that he has a criminal record. If we find no psychopathology, we should say just that, rather than add a diagnosis of antisocial personality, merely because the person was found in the criminal justice system, or because we dislike him, or have a strong aversion to his acts. Otherwise, we encourage a system in which the patient receives a thorough evaluation only if he is fortunate enough to be evaluated by someone who likes him or empathizes with him to some extent. A diagnosis of antisocial personality, in reality, however, can be the equivalent of nothing more than calling someone an incorrigible nogood criminal, but disguised in a pseudo-scientific manner to appear as if we are saying something more. The diagnosis, even when used according to the appropriate criteria, can result in the termination of all attempts at evaluation and

possible treatment. When used inappropriately, the diagnosis can be downright misleading, unfair, and hazardous to the patient.

This study suggests that much forensic science use of and research on antisocial personality may be very questionable. At least in the hospital studied, the diagnosis of antisocial personality was not made according to the diagnostic manual, DSM II, in use at the time. Although DSM III may have increased rater reliability, it is not clear that it has increased validity, and the problem is intensified when the diagnostic manual is not even followed. Moreover, if the diagnostic manual continues to be frequently ignored when making an antisocial personality diagnosis, we are left with the potential for very questionable subjective moral judgments disguised as scientific clinical judgment. Such a practice makes a diagnosis of antisocial personality very questionable when used in this manner for forensic, clinical, or research purposes. Even when used according to DSM III, one can arrive at criteria which meet the requirements for the diagnosis, but are not themselves persuasive. Unless we can develop more appropriate criteria and use them in a consistent nonjudgmental manner, antisocial personality as a diagnosis may obscure more than it clarifies and may be most often a moral judgment masquerading as a scientific diagnosis.

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Address requests for reprints or additional information to
Robert Weinstock, M.D.
University of California, Irvine
101 City Drive South
Orange, CA 92668