10

Personality Disorders

THEODORE ROBERT "TED" BUNDY

Theodore Robert "Ted" Bundy was born in Burlington, Vermont, on November 24, 1946. Bundy was an American serial killer who committed acts of murder, rape, kidnapping, and necrophilia against numerous young women and girls during (and possibly before) the 1970s. Known for his chameleon-like ability to blend in and his talent for belonging, he confessed to 30 homicides committed in seven states between 1974 and 1978—though the true total remains unknown.

Fatherless, Bundy spent his early childhood living in the home of his maternal grandparents, believing that his biological mother was actually his sister (a family ruse designed to avoid the social stigma of his illegitimate birth). At an early age, he exhibited disturbing behavior, on one occasion (at age three) reportedly surrounding his napping aunt with butcher knives and standing by the bed, smiling, as she awoke.

In his late teens, he had an explosive temper, was a compulsive masturbator, and a night-prowling peeping tom. Initially a college dropout, he eventually adopted a more civic-minded façade; he was commended by police for chasing down a purse-snatcher, became a well-regarded honors student and psychology major, and worked on a suicide hotline. After college, he even appeared to be headed for a successful career in law and politics.

Bundy's first series of known murders occurred in Washington and Oregon—while he worked at the government agency searching for the victims. Eluding capture, he later killed in Idaho, Utah, and Colorado. He exploited his good looks and charisma to win the trust of his young female victims, typically feigning disability or impersonating authority figures before overpowering them.

Arrested in Utah for a traffic violation, he was eventually convicted there for kidnapping as a consequence of evidence from his notorious Volkswagen Beetle. Extradition to Colorado to face murder charges followed. After two escapes and a series of violent and lethal assaults in Florida, he was finally apprehended. During his trial, Bundy insisted upon acting as his own defense counsel. Later, in prison, he offered his "expertise" on serial killers to assist investigators working on the famous Green River Killer case. Psychiatric examinations indicated a diagnosis of antisocial personality disorder though he is also considered by some to be the prototypical psychopath—charming, narcissistic, manipulative, and completely devoid of remorse. Florida executed Bundy in the electric chair on January 24, 1989.

Ted Bundy's lifelong pattern of disturbing and violent behavior, as incomprehensible as it may seem to others, was likely not experienced as unusual by him. It was instead a normative mode of functioning—predictable and familiar—due to its roots deep within the foundational recesses of his personality. What is personality? The question is easily asked but difficult to answer. Historically, the word itself is derived from

"*persona*," the Greek term originally representing the theatrical mask used by actors on the stage. Today, personality is viewed as a complex pattern of deeply embedded psychological characteristics—intrinsic, pervasive, largely unconscious, and resistant to change—that are automatically expressed in just about every area of functioning. It is thought that personality traits emerge from a complicated mixture of biology and experience to form a pattern of perceiving, feeling, thinking, coping, and behaving that is unique to each and every individual (Millon & Davis, 1996).

The personality has been compared to an impressionistic painting: from afar a cohesive image but up close a complex array of moods, cognitions, and motives. From an ecological and evolutionary point of view, **personality disorders** are not human perversities but problematic styles of human adaptation. Individuals with these disorders are intriguing and unique, but their biological makeup and early life experiences combined to misdirect development, so their sense of self, the expression of their thoughts and feelings, and their ways of behaving are constructed as unsatisfying, problematic, and troublesome (Millon & Davis, 1996). The disorder represents, in a sense, the way the individual has found to "get through life." Symptoms of the disorder are ego-syntonic—embodying the only "normal" the individual has ever known or experienced.

Personality traits are defined in the DSM-IV-TR and DSM-5 as enduring patterns of perceiving, relating to, and thinking about the environment and self that are present across a wide range of contexts and situations. However, these traits do not represent disorders *per se* until they become inflexible and maladaptive, causing significant functional impairment or subjective distress (APA, 2000, 2013). In fact, several authors have emphasized that personality disorders may be better understood as dimensions of general personality functioning rather than as discrete illness categories (Millon & Davis, 1996; Vachon et al., 2013). Interestingly, the characteristic impairment associated with many of the disorders in the DSM-IV-TR and DSM-5 is often *not* experienced subjectively by the individual with a personality disorder; instead, it is the people around him or her that are chronically subjected to the difficult and frustrating nature of the illness. Furthermore, while the DSM-IV-TR and DSM-5 both outline ten personality disorders, Millon and Davis (1996) assert that this list of personality constructs is *not* exhaustive and that many more likely exist.

Personality disorders, which are categorized as Axis II disorders in the DSM-IV-TR, may coexist with other mental disorders, for example, Axis I disorders in the DSM-IV-TR (see Chapter 2 about the multiaxial diagnostic nature of the DSM-IV-TR). And some have speculated as to how these two types of disorders may be related. For example, the **vulnerability model** considers personality as the equivalent of an immune system (or "force field"), with personality disorders predisposing an individual, because of his or her limited or impoverished coping responses, to the development of an Axis I disorder such as anxiety or depression. Interestingly, it is thought that personality disorders themselves may evoke the very stressors that will promote the development of an Axis I disorder, so the process becomes, in a sense, a vicious circle that continues to perpetuate stressful conditions, which further weaken the "immune system" and lead to more severe clinical conditions. According to the **complication model**, this vulnerability relationship is reversed; the Axis I disorder, however it began, creates a predisposition for personality change. For example, a man may experience a schizophrenic episode and become greatly depressed afterwards as he realizes the significance of this disorder for his life. He may then become pessimistic and hopeless (i.e., his personality traits change) as a result of a change in his self-concept and self-efficacy. Under the **pathoplasty model**, personality influences the course of the Axis I disorder without itself disposing toward the development of the disorder. Finally the **spectrum model** proposes a continuum of increasing trait or symptom severity (from normal personality to subclinical traits to full-blown Axis I disorders), wherein the entire personality is organized around subclinical traits (Millon & Davis, 1996).

Although the ten different personality disorders listed in the DSM-IV-TR and DSM-5 differ in varying degrees from each other in terms of symptom expression, all must first meet the DSM-IV-TR general diagnostic criteria for a personality disorder or the DSM-5 diagnostic criteria for a general personality disorder. DSM-5 diagnostic criteria for a general personality disorder are listed in Table 10.1.

Furthermore, the DSM-IV-TR and DSM-5 outline a clustering system for personality disorders, based on descriptive similarities, which has proven useful in some research and educational situations. **Cluster A** includes the paranoid, schizoid, and schizotypal personality disorders (individuals described as odd or eccentric); **Cluster B** includes the antisocial, borderline, histrionic, and narcissistic personality disorders (individuals often appearing dramatic, emotional, or erratic); and **Cluster C** includes the avoidant, dependent, and obsessive-compulsive personality disorders (individuals often appearing anxious or fearful). It must be noted that this

Table 10.1 DSM-5 Diagnostic Criteria for a General Personality Disorder

General Personality Disorder*

A. An enduring pattern of inner experience and behavior that deviated markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
   3. Interpersonal functioning
   4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition* (e.g., head trauma).

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Note: *In the DSM-IV-TR, the title was just "Personality Disorder" and the wording "another medical condition" was "a general medical condition" (APA, 2000, p. 689).

clustering system has serious limitations and has not been consistently validated. Also, individuals may often present with coexisting personality disorders from different clusters (APA, 2000, 2013).

Finally, the DSM-5 has proposed an alternative model for conceptualizing personality disorders, which focuses on both *personality functioning* and pathological *personality traits*. Rather than being based on the traditional categorical approach, this alternative model uses a *dimensional perspective* in which personality disorders are maladaptive variations of personality traits that gradually merge into normality and into each other. Under this model, level of personality functioning is evaluated on a continuum for self (identity and self-direction) and for interpersonal elements (empathy and intimacy), with disturbances in these areas forming the core of personality disorders. Pathological personality traits for each disorder are represented by a taxonomy of 25 specific trait facets (a catalogue of sorts of pathological personality trait descriptors), which are subsumed under five domains—negative affectivity, detachment, antagonism, disinhibition, and psychoticism.[1] According to the DSM-5, this model is useful in categorizing only the antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders (APA, 2013). While this alternative model is an exciting addition to the DSM-5, the traditional model will be used in this chapter as the framework for the presentation of the personality disorders, and for our discussion of their relationships with crime and violence.

Theoretical Conceptualizations

The various personality disorders outlined in the DSM have been conceptualized according to numerous theoretical perspectives. Personality theorist Theodore Millon (see Box 10.1) proposed a unique theory-driven

1. As an example, for avoidant personality disorder, theDSM-5 proposed diagnostic criteria include four possible pathological personality traits: anxiousness (an aspect of negative affectivity), withdrawal (an aspect of detachment), anhedonia (an aspect of detachment), and intimacy avoidance (an aspect of detachment).

framework that draws heavily from biosocial learning and evolutionary principles (Millon & Davis, 1996). The foundation of Millon's personality theory is comprised of three polarities of behavior and motivation: active-passive, pleasure-pain, and self-other. These can be used to derive personality coping patterns that correspond rather well with the official DSM personality disorders. Rather than articulating specific diagnostic criteria, Millon identifies *personality prototypes* representing each pattern and discusses each within clinical diagnostic domains at the behavioral (expressive behavior, interpersonal conduct), phenomenological (cognitive style, self-image, object representation), intrapsychic (regulatory mechanisms, morphological organization), and biophysical levels (mood or temperament).[2] Because Millon's model is an integrated approach involving biological, psychological, and social perspectives, it will be used in this chapter as the primary basis for the theoretical conceptualizations of personality disorders.

BOX 10.1 THEODORE MILLON'S BIOSOCIAL LEARNING (EVOLUTIONARY) THEORY OF PERSONALITY

Personality theorist Theodore Millon was one of the first appointees in 1974 to the APA's Task Force responsible for developing the DSM-III, and he served as a full member of the DSM-IV Axis II Work Group. He has been editor in chief of the *Journal of Personality Disorders* and has authored numerous personality assessment inventories.

Millon proposed a biosocial learning theory (subsequently identified as an evolutionary model), identifying personality patterns based on a threefold framework of behavioral and motivational polarities: *active-passive, pleasure-pain,* and *self-other.*

The Relationship Between Personality Disorders and Crime

The prevalence rates of personality disorders in studies of criminal populations tend to be reported in the literature in one of two ways. First, they are often listed in aggregate, using more generic terms such as "personality disorder" (e.g., Medlicott, 1976), "any personality disorder" (e.g., Grella et al., 2008; Pham & Saloppé, 2010), or "other character disorder" (e.g., Kahn, 1971). Sometimes, the aforementioned clustering system is used (e.g., McElroy et al., 1999; Catanesi et al., 2011). In fact, 17 of the studies of personality disorders in criminal populations listed in Table 10.2 utilize the aggregate approach while 5 use the clustering system. Although prevalence rates of general personality disorders in populations of criminal and violent individuals are helpful to some extent in understanding the relationship between these disorders and crime, the differential rates of presentation of these disorders suggests that a better understanding may be gained by examining them separately.

The prevalence rates of specific personality disorders are indeed reported in studies of criminal populations. Sometimes, a study will focus solely on one given personality disorder (e.g., Schuckit et al., 1977), and sometimes one will examine various personality disorders together but differentiate between them and list the prevalence rates of each disorder separately (e.g., DeJong et al., 1992).

Although two prevalence rate studies of criminal and violent behavior in populations with personality disorders are identified in Table 10.3 (Asnis et al., 1994; Tardiff & Koenigsberg, 1985), these studies appeared to examine personality disorders in the general sense without reporting rates for specific personality disorders individually. As can be seen by examining the "A Closer Look" boxes that follow in this chapter, studies reporting rates of criminal behavior among populations with specific personality disorders are exceedingly rare.

2. Note the incorporation of a domain approach into the alternative model for personality disorders proposed in the DSM-5.

Table 10.2 Prevalence of Personality Disorders in Criminal Populations

Antisocial Personality Disorder								
Source	**N**	**Gender**	**Age**	**Study Type**[al]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Schuckit et al. (1977)	199	M	Adult[b]	JD	Structured personal interviews of newly arrested prisoners at a San Diego, California jail	Antisocial personality	Brief screen for psychiatric illness (Woodruff et al., 1974)	16.0%
Langevin et al. (1982)	(1) 109 (2) 38	?	Adult?	PI	File record review of minimum-security forensic ward psychiatric hospital cases, 1969–1979 (Clarke Institute in Toronto, Ontario, Canada) (1) Killers (2) Nonviolent offenders	Antisocial personality	Feighner et al. (1972) psychiatric research diagnostic criteria	(1) 8.0% (2) 8.0%
Seltzer & Langford (1984)	85	M, F	15–25 (Median = 18)	PI	Interviews of individuals referred by courts or legal counsel to psychiatry department of large regional hospital in Northwest Territories, calendar year 1981	Antisocial personality	DSM-III, MMPI	12.9% (n = 11)
Reich & Wells (1985)	390	325 M, 65 F	M = 30.9	JD	Record review of defendants evaluated for competency to stand trial by the Yale–New Haven Psychiatric Court Clinic, 1980–1982	Antisocial personality disorder	DSM-III	1.0% (n = 4)[bh]
Wilcox (1985, 1987)	71	62 M, 9 F	Adult, juvenile (six < 18, five > 50)	HO	Record review of all individuals convicted for homicides committed in Contra Costa County, California, 1978–1980	Antisocial personality	?	35.2% (n = 25)[o]

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Antisocial Personality Disorder								
Source	**N**	**Gender**	**Age**	**Study Type**[al]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Bland et al. (1990)	180	M	18–44	JD	Diagnostic interviews with inmates from two correctional centers, Alberta, Canada	Antisocial personality	DSM-III (DIS)	56.7% (n = 102)[au*]
Coté & Hodgins (1990)	495	M	19–67 (M = 31.1)	JD	Diagnostic interviews with Quebec penitentiary inmates	Antisocial personality disorder	DSM-III (DIS)	61.5% (n = 303)
Yarvis (1990)	100	88 M, 12 F	33% < 25, 85% < 40	HO	Diagnostic interviews and record reviews of a series of murderers referred for psychiatric evaluation in California, 1980–1988	Antisocial disorder	DSM-III	38.0% (n = 38)[m]
Abram & Teplin (1991)	728	M	16–68 (M = 26.3)	JD	Diagnostic interviews with jail detainees at Cook County Department of Corrections, Chicago, November 1983–November 1984	Antisocial personality	DSM-III-R (DIS)	Lifetime: 50.1% (n = 371) Current: 49.9% (n = 363)
Côté & Hodgins (1992)	(1) 87 (2) 373	M	(1) M = 35.6, SD = 8.9 (2) M = 30.3, SD = 8.3	JD, HO	Diagnostic interviews and file reviews of penitentiary inmates, Quebec (1) Homicide offenders (2) Nonhomicide offenders	Antisocial personality disorder	DSM-III (DIS)	(1) 35.6% (n = 31) (2) 47.7% (n = 178)
DeJong, Virkkunen, & Linnoila (1992)	(1) 248 (2) 100	M	16–68 (M = 31.2, SD =11.9)	JD	Criminals ordered for forensic psychiatric examination at initial incarceration in Finland (1) Murders and attempted murderers (2) Arsonists	Antisocial personality disorder	DSM-III	(1) 32.0% (2) 16.0%
Marshall et al. (1998)	103	M	18–56	JD	Diagnostic interviews and questionnaires administered to recently sentenced inmates (August–December 1997) at Yatala Labour Prison, South Australia	Antisocial personality	DSM-III-R (PDI-R)	47.1%

Antisocial Personality Disorder								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Aromäki et al. (1999)	(1) 15 (2) 13 (3) 15 (4) 16	M	(1) $M = 33.8$, $SD = 7.3$ (2) $M = 38.0$, $SD = 5.8$ (3) $M = 39.5$, $SD = 7.7$ (4) $M = 31.7$, $SD = 6.9$	JD, CS	Blood samples, questionnaires, and interviews with volunteers, consisting of (1) Imprisoned violent men (2) Nonimprisoned violent men (3) Nonviolent alcoholics (4) Community controls	Antisocial personality disorder	DSM-III-R	(1) 92%* (2) 73%* (3) 0.0% (4) 0.0%
Gibson et al. (1999)	213	M	$M = 32$	JD	Structured interviews with randomly selected state prison and regional jail inmates from a rural New England state	Antisocial personality	DSM-III-R (DIS-III-R)	Lifetime: 54.5% ($n = 116$) Current: NA
McElroy et al. (1999)	36	M	18–47 ($M = 33$, $SD = 8$)	PI	Interviews with convicted sex offenders consecutively admitted to the New Life Program, Cincinnati, Ohio, November 1996–June 1998	Antisocial personality disorder	DSM-IV (SCID)	72% ($n = 26$)
						Total Cluster B personality disorders		92% ($n = 33$)
Langevin (2003)	(1) 33 (2) 80 (3) 23 (4) 611	M	(1) $M = 32.06$ (2) $M = 27.58$ (3) $M = 27.57$ (4) $M = 31.42$	PI	Interviews with convicted sex offenders ($n = 747$) belonging to one of four groups: (1) sex killers, (2) nonhomicidal sexually aggressives, (3) nonhomicidal sadists, and (4) general sex offenders. Participants were chosen from a database of more than 2,800 minimum-security forensic ward psychiatric hospital cases (Clarke Institute in Toronto, Ontario, Canada) seen since 1973.	Antisocial personality disorder	?	51.2% 41.3% 39.1% 10.6%
Rosler et al. (2004)	(1) 129 (2) 54	M	$M = 19.2$	PI	Diagnostic interviews with (1) prisoners and (2) controls in a German offender facility	Definite antisocial personality disorder	DSM-IV	9.3% 0%

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Antisocial Personality Disorder								
Source	**N**	**Gender**	**Age**	**Study Type[a]**	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Stuart et al. (2006)	103	F	*M* = 31.5, *SD* = 9.6	CS	Questionnaire administered to women arrested for violence and court referred to batterer intervention programs, Rhode Island	Antisocial personality disorder	DSM-IV (PDSQ)	7%
Huchzermeier et al. (2007)	(1) 141 (2) 111 (3) 47	M	Adult, youth	JD, PI	Diagnostic interviews with three different samples of incarcerated male violent offenders in Germany (1) Adult prison inmates, years 2000–2004 (2) Youth custody, 2001–2003 (3) Adults in a psychiatric hospital	Antisocial personality disorder	DSM-IV(SCID)	50.8%
Trestman et al. (2007)	(1) 218 (2) 177 (3) 110	307 M, 201 F	*M* = 31.6	JD	Diagnostic interviews with both male and female offenders categorized by race: (1) white, (2) black, and (3) Hispanic, in three male jails and one female jail (Connecticut)	ASPD	DSM-IV (SCID)	34.6%
Grella et al. (2008)	280	65% M	*M* = 34.8	JD	Diagnostic interviews with offenders consecutively admitted to prison-based substance abuse treatment programs at one of four research centers (Colorado, Rhode Island, Texas, California)	Antisocial personality disorder	DSM-IV (SCID)	42.1% (*n* = 118)
						Any personality disorder		45.4% (*n* = 127)
Pham & Saloppé (2010)	84	M	Adult	PI	Psychological evaluations of forensic patients at high-security psychiatric hospital in Tomai, Belgium (Etablissement de Défense Sociale)	Antisocial personality disorder	DSM-IV (SCID II)	48% (*n* = 40)

Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[al]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Pfeiffer, Eisenstein, & Dabbs (1967)	85	2/3 M, 1/3 F	17–63	JD	Federal prisoners referred for mental competency evaluations, at the USPHS Hospital in Lexington, Kentucky, 1960–1965	Schizoid personality	?	3.5% (n =3)
						Paranoid personality		1.2% (n = 1)
						Emotionally unstable personality		15.3% (n = 13)
						Inadequate personality		4.7% (n = 4)
						Passive-aggressive personality		7.1% (n = 6)
						Passive-dependent personality		3.5% (n = 3)
						Hysterical personality		2.4% (n = 2)
Kahn (1971)	43	41 M, 2 F	11–74	HO	Interviews and psychiatric examinations of individuals who made pleas of insanity to charges of first- or second-degree murder	Other character disorder	?	18.6% (n =8)
Medlicott (1976)	38	29 M, 9 F	14–62	HO	Individuals charged with murder (n = 28) and attempted murder (n = 10) who were hospitalized or referred for psychiatric opinion, New Zealand	Personality disorder	?	34.2% (n = 13)
Pétursson & Gudjónsson (1981)	47	44 M, 3 F	Adult[ai]	HO	File review of cases of intentional and unintentional homicide in Iceland, 1900–1979	Personality disorder	?	21.3% (n = 10)
Langevin et al. (1982)	(1) 109 (2) 38	?	Adult?	PI	File record review of minimum-security forensic ward psychiatric hospital cases, 1969–1979 (Clarke Institute in Toronto, Ontario, Canada) (1) Killers (2) Nonviolent offenders	Schizoid personality	Feighner et al. (1972) psychiatric research diagnostic criteria	(1) 5.0% (2) 3.0%

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Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
						Immature or other personality		(1) 8.0% (2) 15.0%
Dell & Smith (1983)	253	M	15 and under–70+[d]	HO	File review of men convicted of manslaughter on the grounds of diminished responsibility, 1966–1977	Personality disorder	?	26.9% (n = 68)
Seltzer & Langford (1984)	85	M, F	15 and under–25 (Median = 18)	PI	Interviews of individuals referred by courts or legal counsel to psychiatry department of large regional hospital in Northwest Territories, calendar year 1981	Personality disorder	DSM-III, MMPI	28.2% (n = 24)
Taylor & Gunn (1984)	2,743	M	Adult	JD	File review of men remanded to Brixton Prison, South London (June, September, and December 1979 and March 1980)	Personality disorder	ICD	13.8% (n = 379)
Reich & Wells (1985)	390	325 M, 65 F	M = 30.9	JD	Record review of defendants evaluated for competency to stand trial by the Yale–New Haven Psychiatric Court Clinic, 1980–1982	Personality disorders (other than antisocial)	DSM-III	1.3% (n = 5)[bh]
Wilcox (1985, 1987)	71	62 M, 9 F	Adult, juvenile (six < 18, five > 50)	HO	Record review of all individuals convicted for homicides committed in Contra Costa County, California, 1978–1980	Passive-dependent personality	?	1.4% (n = 1)
Taylor (1986)	183	175 M, 8 F	18–73	JD	Record review of life-sentenced men and women, supervised by the Inner London Probation Service (inside prison and on license in the community)	Personality disorder	ICD-9	33% (n = 61)
Phillips et al. (1988)	1,816	1,569 M, 247 F	11–78 (M = 28)	PI, CS	Record review of psychiatric referrals from the criminal justice system of Alaska, 1977–1981	Personality disorders	DSM-II, DSM-III	15.2% (n = 276)

Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Yarvis (1990)	100	88 M, 12 F	33% < 25, 85% < 40	HO	Diagnostic interviews and record reviews of a series of murderers referred for psychiatric evaluation in California, 1980–1988	Borderline disorder	DSM-III	18.0% (n = 18)[j]
						Histrionic, narcissistic		2.0% (n = 2)[j]
						Paranoid, schizoid, schizotypal		5.0% (n = 5)[j]
						Avoidant or dependent, compulsive, or passive-aggressive		10.0% (n = 10)[j]
DeJong, Virkkunen, & Linnoila (1992)	(1) 248 (2) 100	M	16–68, (M = 31.2, SD = 11.9)	JD	Criminals ordered for forensic psychiatric examination at initial incarceration in Finland (1) Murders and attempted murderers (2) Arsonists	Borderline	DSM-III	(1) 58.0% (2) 65.0%
						Narcissistic		(1) 2.0% (2) 3.0%
						Paranoid		(1) 13.0% (2) 6.0%
						Passive-aggressive		(1) 10.0% (2) 6.0%
						Schizoid		(1) 1.0% (2) 4.0%
						Schizotypal		(1) 0.4% (2) 0.0%

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Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Wallace et al. (1998)	(1) 3,838 (2) 1,998 (3) 152 (4) 1,137 (5) 876	M	Adult	AR	Case linkage study of higher court records and psychiatric case register databases, Victoria, Australia, 1993–1995 (men) (1) Total convictions (2) Violent offenses (3) Homicide offenses (4) Property offenses (5) Sexual offending	Personality disorders	ICD-9	(1) 1.7% (n = 67) (2) 2.6% (n = 51) (3) 3.9% (n = 6) (4) 1.4% (n = 16) (5) 2.1% (n = 18)
	(1) 315 (2) 152 (3) 116	F	Adult		(women) (1) Total convictions (2) Violent offenses (3) Property offenses	Personality disorders	ICD-9	(1) 2.9% (n = 9) (2) 4.6% (n = 7) (3) 2.6% (n = 3)
McElroy et al. (1999)	36	M	18–47 (M = 33, SD =8)	PI	Interviews with convicted sex offenders consecutively admitted to the New Life Program, Cincinnati, Ohio, November 1996–June 1998	Paranoid	DSM-IV (SCID)	28% (n = 10)
						Schizoid		0% (n = 0)
						Schizotypal		0% (n = 0)
						Total Cluster A personality disorders		28% (n = 10)
						Borderline		42% (n = 15)
						Histrionic		6% (n = 2)
						Narcissistic		17% (n = 6)

Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
						Total Cluster B personality disorders		92% (n = 33)
						Avoidant		22% (n = 8)
						Dependent		8% (n = 3)
						Obsessive-compulsive		25% (n = 9)
						Total Cluster C personality disorders		36% (n = 13)
Baxter et al. (2001)	257	240 M, 17 F	M = 30.6, SD = 31.4[bi]	HO	File review of consecutive series of patients with index offenses of parricide or stranger killing admitted to 1 of 3 high-security hospitals in England and Wales, 1972–1996	Personality disorder	?	35.4% (n = 91)
Siponmaa et al. (2001)	126	123 M, 3 F	15–22 (Median = 20)	JD	Interviews with young offenders consecutively referred for presentencing psychiatric investigation, Stockholm, Sweden, 1990–1995	Personality disorder	ICD-9	53% (n = 67)
Rösler et al. (2004)	(1) 129 (2) 54	M	M = 19.2	PI	Diagnostic interviews with (1) prisoners and (2) controls in a German offender facility	Definite personality disorder	DSM-IV	(1) 21.1% (2) 0%
						Definite impulsive personality disorder		(1) 10.1% (2) 0%
						Other definite personality disorder		(1) 14.7% (2) 0%
Stuart et al. (2006)	103	F	M = 31.5, SD = 9.6	CS	Questionnaire administered to women arrested for violence and court referred to batterer intervention programs, Rhode Island	Borderline personality disorder	DSM-IV (PDSQ)	27%

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(Continued)

Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Huchzermeier et al. (2007)	(1) 141 (2) 111 (3) 47	M	Adult, youth	JD, PI	Diagnostic interviews with three different samples of incarcerated male violent offenders in Germany (1) Adult prison inmates, years 2000–2004 (2) Youth custody, 2001–2003 (3) Adults in a psychiatric hospital	Paranoid	DSM-IV (SCID)	9.0%
						Schizotypal		1.3%
						Schizoid		1.7%
						Cluster A		11.4%
						Histrionic		1.3%
						Narcissistic		11.6%
						Borderline		15.2%
						Cluster B		57.2%
						Avoidant		5.1%
						Dependent		2.0%
						Obsessive-compulsive		4.0%
						Cluster C		9.0%
						Negativistic		7.4%
						Depressive		3.7%
Trestman et al. (2007)	(1) 218 (2) 177 (3) 110	307 M, 201 F	$M = 31.6$	JD	Diagnostic interviews with both male and female offenders categorized by race: (1) white, (2) black, and (3) Hispanic, in three male jails and one female jail (Connecticut)	Cluster A	DSM-IV (SCID)	11.4%
						Cluster B		40.7%

Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
						Cluster C		14.1%
						Borderline PD		16.9%
Grella et al. (2008)	280	65% M	*M* = 34.8	JD	Diagnostic interviews with offenders consecutively admitted to prison-based substance-abuse treatment programs at one of four research centers (Colorado, Rhode Island, Texas, California)	Borderline personality disorder	DSM-IV (SCID)	13.2% (*n* = 37)
						Any personality disorder		45.4% (*n* = 127)
Hanlon et al. (2010)	77	69 M, 8 F	*M*= 31.92	HO	Indigent murder defendants and death row inmates clinically interviewed while in custody in jails and maximum-security prisons (Illinois and Missouri)	Personality disorder	?	54.5% (*n* = 42)
Pham & Saloppé (2010)	84	M	Adult	PI	Psychological evaluations of forensic patients at high-security psychiatric hospital in Tomai, Belgium (Etablissement de Défense Sociale)	Cluster A	DSM-IV (SCID II)	29% (*n* = 24)
						Paranoid PD		24% (*n* = 20)
						Schizoid PD		6% (*n* = 5)
						Schizotypal PD		5% (*n* = 4)
						Cluster B		62% (*n* = 52)
						Borderline PD		25% (*n* = 21)
						Narcissistic PD		18% (*n* = 15)
						Histrionic PD		2% (*n* = 2)

(Continued)

(Continued)

Other/General Personality Disorders								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
						Cluster C		23% (n = 19)
						Avoidant PD		4% (n = 3)
						Dependent PD		2% (n = 2)
						Obsessive-compulsive PD		19% (n = 16)
						Any PD		71% (n = 60)
Catanesi et al. (2011)	103	85.44% M	53.41% 25–54, 22.73% 45–65, 13.64% 18–24, 5.68% <18	HO	Psychiatric and psychological evaluations on perpetrators of homicide and attempted homicide, Italy	Personality disorder Cluster A	DSM-IV-TR	6.8%%
						Personality disorder Cluster B		16.5%

Notes: *Significant difference in comparison to control group.

[a1]AR = arrest rates of patients discharged from psychiatric facilities, JD = jailed detainees and incarcerated prisoners, HO = homicide offenders, BC = birth cohort study, PI = psychiatric inpatient sample, CS = community sample (i.e., epidemiological catchment area survey studies and outpatient psychiatric patients).

[b]Reported group mean ages: Antisocial personality (M = 21.9), drug (M = 19.6), alcohol (M = 32.5), no diagnosis (M = 22.0).

[d]Group mean ages: 1966–1969 (M = 36.1, SD = 15.8), 1970–1973 (M = 36.2, SD = 14.9), 1974–1977 (M = 37.1, SD = 16.9).

[j]Community sample comparative data (six-month prevalence rates from NIMH Community Survey Data): data not reported.

[m]Community sample comparative data (six-month prevalence rates from NIMH Community Survey data): 0.6–2.1%.

[o]Reported as n = 23 in Wilcox (1985).

[ai]Group means and standard deviations: Psychotic illness (35.7, 8.8), personality disorder and alcohol use disorders (24.4, 8.2), no psychiatric abnormality (34.0, 12.4).

[au]Lifetime prevalence rate. For community comparison sample, standardized prevalence ratio (SPR) = 6.6 (an SPR greater than 1 indicates the prevalence rate in the prison sample was greater than that in the general population).

[bh]Rates of personality disorders in comparison outpatient and inpatient samples from same catchment area: 4.3% (n = 401) and 2.3% (n = 21).

[bi]The former value represents parricidal offenders, the latter, stranger killers.

Table 10.3 Prevalence of Crime in Personality Disordered Populations

Source	N	Gender	Age	Study Type[a1]	Sample Description	Disorder	Crime Definition	Prevalence/ Incidence
Tardiff & Koenigsberg (1985)	(1) 2,106 (2) 810	(1) 842 M, 1,256 F (2) 354 M, 453 F	(1) ≤20 – 65+[aa] (2) ≤20 – 65+[aa]	CS	Psychiatric outpatients evaluated during 1.5 years at two New York hospitals, diagnosed using DSM II and DSM II criteria (1) Payne Whitney Clinic (2) Westchester Division of NY Hospital	Personality disorder (1) *n* = 372 (2) *n* = 130	Presence of assaultive behavior toward others in hospital records	(1) 1.3% (*n* = 5) (2) 6.9% (*n* = 9)
Asnis et al. (1994)	517	204 M, 313 F	13–87, *M* = 38.7	CS	Psychiatric outpatients, Montefiore Medical Center, Bronx, New York, diagnosed using DSM-III criteria	Personality disorder (*n* = 14)	Self-reported homicidal ideation and attempts	Ideation: 14% (*n* =2) Attempts: 7% (*n* = 1)

Note: [a1]AR = arrest rates of patients discharged from psychiatric facilities, JD = jailed detainees and incarcerated prisoners, HO = homicide offenders, BC = birth cohort study, PI = psychiatric inpatient sample, CS = community sample (i.e., epidemiological catchment area survey studies and outpatient psychiatric patients).

[aa](1) 12.4% (*n* = 261) 20 years and younger, 30.7% (*n* = 647) 21–30, 23.6% (*n* = 496) 31–40, 24.3% (*n* = 511) 41–64, 7.5% (*n* = 158) 65 years and older, 1.6% (*n* = 33) unknown; (2) 18.0% (*n* = 146) 20 years and younger, 31.4% (*n* = 254) 21–30, 18.0% (*n* = 146) 31–40, 27.0% (*n* = 219) 41–64, 5.0% (*n* = 41) 65 years and older, 0.5% (*n* = 4) unknown.

Cluster A Personality Disorders

Paranoid Personality Disorder

Paranoid personality disorder is a pervasive, inflexible, and enduring pattern of distrust and suspiciousness of others (APA, 2000, 2013). DSM-5 diagnostic criteria for paranoid personality disorder (PPD) are listed in Table 10.4. Except when noted, the language outlining the diagnostic criteria for PPD (and the other personality disorders in the DSM-5) remains unchanged from the DSM-IV-TR.

Prevalence and Incidence Rates of Paranoid Personality Disorder. Prevalence rates for PPD have been reported in the general population at 0.5%–2.5% (APA, 2000) and at 10%–30% in inpatient psychiatric settings and 2%–10% in outpatient mental health clinics (APA, 2000). More recent national survey data suggests rates between 2.3% and 4.4% (APA, 2013).

Theodore Millon refers to paranoid personality disorder (PPD) as the "suspicious pattern." Individuals having this disorder are characterized by defensive expressive behaviors, provocative interpersonal conduct, and a suspicious cognitive style. The primary regulatory (defense) mechanisms involved in the development and maintenance of this disorder are projection and fantasy—wherein the individual actively disowns undesirable aspects of himself or herself (i.e., personal traits and motives) and attributes them to other people, consequently remaining blind to these undesirable characteristics while being overly alert to and hypercritical of them in others (Millon & Davis, 1996).

Table 10.4 DSM-5 Diagnostic Criteria for Paranoid Personality Disorder

301.0 (F60.0) Paranoid Personality Disorder

A. A pervasive mistrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3. is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4. reads hidden demeaning or threatening meanings into benign remarks or events
5. persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
6. perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7. has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.*

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "paranoid personality disorder (premorbid)."

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Note: *In the DSM-IV-TR, this section reads "Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition" (APA, 2000, p. 694).

The Relationship Between Paranoid Personality Disorder and Crime and Violence

Though symptoms of extreme paranoia have shown empirical associations with violent behavior (see Chapter 5), systematic studies examining the relationship between PPD and crime and violence are rare; and what is known about this relationship appears largely based on clinical lore or information obtained from published biographical works and case studies. According to Tardiff (2007), individuals with PPD, particularly men, may be members of militaristic organizations or preoccupied with military themes. These individuals tend to be preoccupied with guns and often possess firearms. A history of violent episodes is usually rare; however, a history of violent threats against others is common (e.g., threatening human resources personnel after being fired from a job). Most PPD patients will not become physically violent, although, when they do, violence is often lethal and targeted against multiple individuals, such as in the work environment. Stone (1998) echoes these thoughts in his discussion of the relationship of PPD to homicide, suggesting that it may operate down any one of a number of pathways as a predisposing factor to the crime of murder. These include paranoid political and religious fanaticism, pathological jealousy of estranged spouses or lovers, or smoldering rage and resentment combined with a sense of righteous indignation. (Individuals with this disposition who are fired from their jobs feel unjustly picked on or mistreated and subsequently kill coworkers and bosses in acts of extreme retaliatory workplace violence.)

One rare example of a more systematic study in this area is a recent large-scale national survey of male prisoners in England and Wales conducted by Roberts and Coid (2010). They used multiple regression analyses to examine the independent associations between lifetime criminal offending and personality disorders in

A Closer Look: Paranoid Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	0	–
Jailed detainees and prisoners	3*	1.2–13.0%
Psychiatric inpatients	3*	9.0–28.0%
Total Number of Studies	**5†**	

Sample Characteristics	
Size	36–348
Gender	Male only (4 studies); male and female (1 study)
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Finland, Germany, and the United States)
Diagnostic Systems	DSM-III, DSM-IV, not reported in one study

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study (Yarvis, 1990) listed paranoid personality disorder but included it with other Cluster A personality disorders.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

391 of 3,563 prisoners who completed both of two surveys. Results indicated PPD was positively correlated with robbery and blackmail but negatively associated with driving offenses (differential associations between offense types and other personality disorders are listed in their respective sections in this chapter). Clearly, more work is needed to substantiate and qualify a putative relationship between PPD and various forms of criminal and violent behavior.

Schizoid Personality Disorder

Schizoid personality disorder is a pervasive, inflexible, and enduring pattern of social detachment and limited range of emotional expression (APA, 2000, 2013). DSM-5 diagnostic criteria for schizoid personality disorder are listed in Table 10.5.

Table 10.5 DSM-5 Diagnostic Criteria for Schizoid Personality Disorder

301.20 (F60.1) Schizoid Personality Disorder

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Neither desires nor enjoys close relationships, including being part of a family.
2. Almost always chooses solitary activities.
3. Has little, if any, interest in having sexual experiences with another person.
4. Takes pleasure in few, if any, activities.
5. Lacks close friends or confidants other than first-degree relatives.
6. Appears indifferent to the praise or criticism of others.
7. Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.*

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizoid personality disorder (premorbid)."

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Note: *In the DSM-IV-TR, the wording is "Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition" (APA, 2000, p. 697).

Prevalence and Incidence Rates of Schizoid Personality Disorder

Regarding prevalence rates for schizoid personality disorder, the DSM-IV-TR and DSM-5 simply state that this disorder is "uncommon in clinical settings" (APA, 2000, p. 696; APA, 2013, p. 654). More recent national survey data suggests rates between 3.1% and 4.9% (APA, 2013).

Theoretical Conceptualizations

Millon refers to schizoid personality disorder as the asocial pattern, with individuals having this disorder being characterized by impassive expressive behaviors (they are unsusceptible to pain or emotion), unengaged interpersonal conduct, and an impoverished cognitive style. The primary regulatory (defense) mechanism involved in the development and maintenance of this disorder is intellectualization—describing interpersonal and emotional experiences in a matter-of-fact, impersonal, or mechanical manner and focusing on the formal and objective aspects of these experiences (Millon & Davis, 1996).

The Relationship Between Schizoid Personality Disorder and Crime

Of the three Cluster A personality disorders, schizoid personality disorder appears to have received the most clinical and empirical interest in terms of its relationship with criminal and violent behavior, perhaps due to its earlier proposed (but unsubstantiated) conceptual overlap with psychopathy (Raine, 1986). References to the schizoid criminal can be found in the writings of earlier criminological theorists (e.g., Kretschmer, 1945); and Wolff found relationships between schizoid personality disorder and both antisocial conduct in childhood and criminality in adulthood, though this author appeared to use the term "schizoid personality disorder" interchangeably with

A Closer Look: Schizoid Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	0	–
Jailed detainees and prisoners	3*	1.0–4.0%
Psychiatric inpatients	4*	0.0–6.0%
Total Number of Studies	**6†**	

Sample Characteristics	
Size	36–348
Gender	Male only (4 studies); male and female (1 study); not reported (1 study)
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Canada, Finland, Germany, and the United States)
Diagnostic Systems	DSM (various editions), other psychiatric research diagnostic criteria, not reported in one study

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study (Yarvis, 1990) listed paranoid personality disorder but included it with other Cluster A personality disorders.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

"Asperger's disorder" (i.e., in Wolff & Cull, 1986, but not in Wolff, 1992—see Chapter 3). Additionally, Stone (1998) proposes that, although most individuals with schizoid personality disorder are not criminal and instead live in the margins of society working at certain reclusive occupations, some become capable of crimes and even extreme acts of violence due to their extreme detachment from human emotions. Stone notes, however, that paranoid traits are important factors in murders committed by schizoid individuals.

Other studies have compared the relationship between crime and schizoid personality disorder to that between crime and other personality disorders. In a longitudinal study of 168 Swedish offenders referred for presentencing forensic psychiatric evaluation, Hiscoke and colleagues (2003) found self-reported personality disorder symptoms to be related to subsequent violent criminal reoffending only for antisocial and schizoid personality traits. Roberts and Coid (2010), in their recent large-scale national survey of male prisoners in England and Wales (see above), found schizoid personality disorder to be positively correlated with kidnapping, burglary, and theft. Interestingly, the lion's share of the empirical work on the relationship between schizoid

personality disorder and crime and violence appears to have been conducted in neurobiological studies. For example, reduced skin conductance (SC) amplitudes to orienting stimuli have been found in secondary schizoid psychopaths relative to primary psychopaths (Blackburn, 1979) and in schizoid antisocial 15-year-old males relative to their nonschizoid antisocial counterparts (Raine & Venables, 1984—see Chapter 5). In fact, Fowles (1993) speculated that there might be a detached schizoid subgroup of antisocial individuals characterized by electrodermal hyporeactivity. Furthermore, in a sample of 32 prison inmates, Raine and Venables (1990) tested a stimulation-seeking theory of psychopathy and found schizoid criminals (defined by poor eye tracking), but not psychopaths, to be characterized by event-related potential (ERP) nonaugmenting/reducing (a psychophysiological profile characteristic of schizophrenia in which ERP amplitudes show no increase or actually decrease in response to visual stimuli of increasing intensity, in this case, brief flashes of white light). This finding suggests that the etiological mechanisms underlying schizoid criminality are different from those underlying other forms of criminality. Though the collective body of work in this area is comparatively larger than that on the other Cluster A personality disorders, more investigative efforts are needed to clarify the nature of the relationship between schizoid personality disorder and crime.

Schizotypal Personality Disorder

Schizotypal personality disorder is a pervasive, inflexible, and enduring pattern of intense discomfort in close relationships, distorted thinking and perceptions, and eccentric behavior (APA, 2000, 2013). DSM-5 diagnostic criteria for schizotypal personality disorder are listed in Table 10.6.

Table 10.6 DSM-5 Diagnostic Criteria for Schizotypal Personality Disorder

301.22 (F21) Schizotypal Personality Disorder

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Ideas of reference (excluding delusions of reference)
2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
3. Unusual perceptual experiences, including bodily illusions.
4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
5. Suspiciousness or paranoid ideation.
6. Inappropriate or constricted affect.
7. Behavior or appearance that is odd, eccentric, or peculiar.
8. Lack of close friends or confidants other than first-degree relatives.
9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.*

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizotypal personality disorder (premorbid)."

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Note: *In the DSM-IV-TR, this wording was "Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder, or a Pervasive Developmental Disorder " (APA, 2000, p. 701).

Prevalence and Incidence Rates of Schizotypal Personality Disorder

Prevalence rates for schizoid personality disorder have been reported to be 3% in the general population (APA, 2000); more recently reported community rates for Norway and the United States are 0.6% and 4.6%, respectively (APA, 2013).

Theoretical Conceptualizations

Millon refers to schizotypal personality disorder as the eccentric pattern, with individuals having this disorder being characterized by eccentric expressive behaviors, secretive interpersonal conduct, and a disorganized cognitive style. The primary regulatory (defense) mechanism involved in the development and maintenance of this disorder is undoing; the individual uses bizarre mannerisms and idiosyncratic thoughts to retract or reverse previous acts or ideas that cause that individual feelings of anxiety, conflict, or guilt, and he or she uses ritualistic or magical behaviors to repent for or nullify misdeeds or thoughts assumed to be "evil" (Millon & Davis, 1996). Schizotypal personality disorder has been classified under the schizophrenia spectrum and other psychotic disorders in the DSM-5 (APA, 2013).

A Closer Look: Schizotypal Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	0	–
Jailed detainees and prisoners	2*	0.0–1.3%
Psychiatric inpatients	3*	0.0–5.0%
Total Number of Studies	**4†**	

Sample Characteristics	
Size	36–348
Gender	Male only
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Finland, Germany, and the United States)
Diagnostic Systems	DSM-III and DSM-IV

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study (Yarvis, 1990) listed paranoid personality disorder but included it with other Cluster A personality disorders.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

The Relationship Between Schizotypal Personality Disorder and Crime

Much of the work concerning the association between schizotypal personality disorder and criminal and violent behavior has focused on schizophrenia and crime (see Chapter 5). In fact, the relationship between schizotypal personality disorder (schizotypy) and aggression in children has been considered by researchers to be a nonclinical "downward extension" of the schizophrenia-crime relationship (Raine et al., 2011). Nonetheless, some studies have examined how this personality disorder may relate to crime and violence in its own unique way. For example, Roberts and Coid (2010), in their recent large-scale national survey of male prisoners in England and Wales (see above), found schizotypal personality disorder to be strongly associated with arson but negatively associated with robbery and blackmail. Additionally, neuroscience research studies have identified neurobiological deficits characterizing the schizotypal criminal. For example, recall from Chapter 5 Raine's (1987) finding of reduced skin conductance (SC) in high-schizotypy compared to low-schizotypy individuals in his study of 37 adult male prisoners in top-security English prisons; and consider the later findings from the prospective longitudinal Danish birth-cohort study that showed SC-orienting deficits in schizotypal criminals relative to schizotypal individuals who were not criminals, as well as this group's increased alcoholism relative to criminals, schizotypal individuals who were not criminals, and normal controls (Raine et al. 1999). Furthermore, Raine and colleagues (2011) found schizotypy to be related to certain types of aggression (i.e., total and reactive but not proactive aggression) in a sample of 3,804 Hong Kong schoolchildren (ages 8–16) and that peer victimization accounted for nearly 60% of this relationship. Finally, Wilkinson and colleagues (2011) found qualitative differences in reasoning about criminal behavior in high-schizotypal individuals compared to those with low schizotypy. Overall, though schizotypy research has proven helpful in understanding the relationship between schizophrenia and crime, this disorder's own relationship with criminal, violent, and aggressive behavior continues to be an important area of study.

Moreover, other researchers have examined the relationship between crime or violence and Cluster A personality disorders in aggregate. For example, Warren and colleagues (2002), in a sample of 261 incarcerated women, found Cluster A personality disorders to be significantly associated with prostitution. Furthermore, recall from Chapter 5 that Schug and colleagues (2007) examined schizophrenia-spectrum personality disorders (SSPDs—paranoid, schizoid, and schizotypal) and comorbidity with antisocial personality disorder in relation to self-reported criminal behaviors and psychophysiological functioning in an adult community sample. They found increased criminality in the comorbid group relative to each group having been diagnosed with one disorder alone and relative to controls, as well as significantly reduced SC orienting to neutral tones in the comorbid group relative to all other groups. These initial findings lend support for an association between schizotypal personality disorder—either alone or together with other SSPDs—and various forms of criminal, violent, and antisocial behavior; and research efforts should continue in this area of study.

Cluster B Personality Disorders

Antisocial Personality Disorder

Antisocial personality disorder is a pervasive, inflexible, and enduring pattern of disregarding and violating the rights of others (APA, 2000, 2013). DSM-5 diagnostic criteria for antisocial personality disorder (ASPD) are listed in Table 10.7.

Prevalence and Incidence Rates of Antisocial Personality Disorder

According to the DSM-IV-TR, prevalence rates for ASPD in community samples are 3% for males and 1% for females (APA, 2000), and more recent data indicate 12-month prevalence rates of 0.2–3.3% (APA, 2013). Within clinical settings, rates have been estimated between 3% and 30%, depending upon the type of population being studied. Substance-abuse treatment settings, prisons, and forensic settings are associated with even higher prevalence rates of ASPD (APA, 2000)—i.e., greater than 70% in some of these samples (APA, 2013).

Table 10.7 DSM-5 Diagnostic Criteria for Antisocial Personality Disorder

307.1 (F60.2) Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder [see Chapter 3] with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.*

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Note: *In the DSM-IV-TR, this wording is "Does not occur exclusively during the course of Schizophrenia or a Manic Episode" (APA, 2000, p. 706).

Theoretical Conceptualizations

Historically, the theoretical and diagnostic roots of ASPD run deep, and this disorder shares a rich ancestry with another psychiatric illness—psychopathy—which will be covered extensively later in this chapter. Also worth noting is that some authors (e.g., Lykken, 1995) have proposed a group or spectrum of *antisocial personalities* rather than representing this particular constellation of traits and behaviors as a singular disease entity. Millon refers to ASPD as the aggrandizing pattern: individuals having this disorder are characterized by impulsive expressive behaviors, irresponsible interpersonal conduct, and a deviant cognitive style. The primary regulatory (defense) mechanisms involved in the development and maintenance of this disorder are acting out and projection; the individual rarely constrains inner tensions that might build up by postponing expressions of offensive thoughts and malevolent action, and she or he directly and precipitously discharges—usually without guilt or remorse—socially repugnant impulses instead of refashioning them into socially acceptable forms (Millon & Davis, 1996).

The Relationship Between Antisocial Personality Disorder and Crime or Violence

Given the current diagnostic conceptualization of ASPD in the DSM-IV and DSM-5, with its emphasis on criminal, violent, aggressive, impulsive, and remorseless behavior, a relationship between this disorder and crime and violence seems unsurprising, if not intuitive. Indeed, some personality theorists such as Millon (Millon & Davis, 1996) have criticized the current DSM-IV criteria for ASPD (which have been retained in the DSM-5) as being merely a laundry list of undesirable, unlawful behaviors. In fact, the examination of an ASPD-crime relationship immediately gives rise to an inherent conceptual dilemma—a "chicken and egg" enigma of sorts: Is ASPD *related to* or *defined by* criminal behavior? Millon's criticisms suggests the latter view, which appears to predominate in the justice system as the overwhelming number of U.S. states specifically exclude

A Closer Look: Antisocial Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	1	7.0%
Homicide offenders	3*	35.2–38.0%
Jailed detainees and prisoners	13*	1.0–61.5%
Psychiatric inpatients	7*	8.0–72.0%
Total Number of Studies	**22**	

Sample Characteristics

Size	36–747
Gender	Male only (14 studies); female only (1 study); male and female (6 studies); not reported (1 study)
Age	Adult, youth
Location	North American and European countries (e.g., Australia, Belgium, Canada, Finland, Germany, and the United States)
Diagnostic Systems	DSM (various editions), other psychiatric research diagnostic criteria, not reported in two studies

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients, and another study involved both jailed detainees or prisoners and homicide offenders.

†ASPD is the most "popular" among the personality disorders in studies of this type.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **5 studies (22.7%)‡**

Note: ‡Rates of ASPD appear markedly (if not significantly) elevated relative to comparison group rates when rates are provided.

ASPD as a qualifying "mental disease or defect" for insanity and diminished capacity purposes (see Chapter 11). However, if ASPD is thought of as a suitable and accommodating "psychological terrain" for the progression toward crime and violence, a more complex relationship is not difficult to fathom.

Conceptual dilemmas notwithstanding, studies have attempted to go beyond establishing the mere presence of an ASPD-crime relationship and have made efforts toward a qualitative understanding of the nature of criminality in those with ASPD. For example, Roberts and Coid (2010) found conduct disorder and ASPD to be associated with a wide range of criminal offenses, including firearm possession, robbery and blackmail, escape and breach of parole, arson, kidnapping, fraud, burglary, and violence. Additionally, in a sample of 261

incarcerated women, Warren and colleagues (2002) found ASPD to be significantly associated with institutional violence.

The association between ASPD and homicidal violence appears well supported in the literature; according to Stone (1998), ASPD (including its "semantic close cousin," dissocial personality) is significantly overrepresented among samples of homicide offenders. For example, in an extensive review of serial killers, the editors of Time-Life Books (1992, in Ferreira, 2000) reported that 90% were deemed to be suffering from personality disorders, namely ASPD. In a study of serial sexual homicide, Geberth and Turco (1997) found all 68 (100%) of the serial murderers with sufficient data to complete research protocols met DSM-IV diagnostic criteria for ASPD. In a study of 693 homicide offenders in Finland (Eronen, Hakola, & Tiihonen, 1996), antisocial personality disorder was found to increase the odds ratio of homicidal violence over 10-fold in men and over 50-fold in women (odds ratios are calculated using prevalence rates of mental disorders). In sum, a further understanding of the qualitative nature of crime and violence in ASPD (i.e., the crucial next step beyond merely establishing the existence of a relationship based on prevalence rate studies) continues to be gained by empirical efforts in this area.

The Origins of Crime and Violence in Those With Antisocial Personality Disorder

Neurobiological Factors. Evidence from studies employing various neuroscience methods indicates structural and functional deficits in the brains of individuals with ASPD. In one of the earlier of these imaging studies, Raine and colleagues (2000) found individuals with ASPD (n = 21) had a 11.0% reduction in prefrontal gray matter volume compared to healthy controls (n = 34) and a 13.9% reduction compared to individuals with substance dependence (n = 26). Individuals with ASPD also demonstrated reduced autonomic reactivity during a stressor task, and results provided the first evidence for the structural brain deficits in ASPD that might underlie the characteristic low arousal, poor fear conditioning, lack of conscience, and decision-making impairments of this disorder.

Regarding psychophysiological findings, Lindberg and colleagues (2005) found quantitative EEG abnormalities (i.e., reduced overall alpha power and bilaterally increased occipital delta and theta power) in the waking EEG of 16 detoxified male homicidal offenders with ASPD when comparing these to the EEG's of 15 healthy controls. This result indicates that the ASPD group has difficulties in maintaining normal daytime arousal. Also, Lijffijt and colleagues (2009) found impaired P50 gating in ASPD individuals (n = 9) compared both to those with adult-onset antisocial behavior (n = 7) and to controls (n = 15), suggesting abnormal pre-attentive filtering in ASPD-related impulsive behavior. Finally, regarding hormone evidence, Aromäki and colleagues (1999) found significantly elevated rates of ASPD in men convicted of violent crimes (both in and out of prison—see Table 10.2) compared to controls and that unweighted ASPD symptom count was significantly and positively correlated with testosterone levels in these violent men. Overall, neurobiological studies continue to be among the more promising inquires regarding the etiological mechanisms underlying ASPD.

Psychological Factors: Comorbidity. Although ASPD may be criminogenic in and of itself, studies have demonstrated how its co-occurrence with other psychiatric conditions can contribute to crime and violence over and above what might normally be seen in those with this disorder alone. Evidence to date indicates that ASPD commonly presents with other personality disorders (see review in Blackburn, 2000), but its comorbidity with Axis I disorders such as schizophrenia has been observed to increase criminality. For example, in a multisite study of 232 men with schizophrenia and other psychotic disorders, Moran and Hodgins (2004) found those with a comorbid diagnosis of ASPD were characterized by early attention and concentration problems, below-average performance in school, and a greater likelihood of institutionalization before the age of 18. These individuals also committed more nonviolent crimes relative to those without ASPD. Furthermore, ASPD has demonstrated significant comorbidity with anxiety disorders among community adults (Goodwin & Hamilton, 2003); and, in a subsequent study of 279 male penitentiary inmates with ASPD, Hodgins and colleagues (2010) found two-thirds to have comorbid anxiety disorders, half of which with an onset before age 16 years. Most prisoners with anxiety disorders had been convicted of serious (interpersonal) violent crimes, and these authors suggest comorbidity with anxiety disorders may represent a distinct subgroup of ASPD offenders characterized by unique mechanisms underlying violent behavior.

Comorbid substance use disorders may also play a role in the etiology of crime and violence in those with ASPD. For example, in a longitudinal record-linkage study of 1,052 drug abusers recruited from a Swedish detoxification and short-term rehabilitation unit, Fridell and colleagues (2008) found those diagnosed with ASPD were 2.16 times more likely to be charged with theft and 2.44 times more likely to be charged with multiple types of crime (including violent and drug offenses) during a given year of observation. Of those with ASPD, 38% were readmitted to the facility within one year after their first admission. In a study of 41 mid-sentence female felons diagnosed with ASPD, Lewis (2011) found significant comorbidity with alcohol, opiate, and cocaine dependence, as well as an association between symptom severity and violent behavior among women with comorbid substance dependence. Finally, McCabe and colleagues (2012), in a sample of 1,530 individuals with psychotic disorders from a large-state cohort of adults receiving psychiatric services, found comorbid ASPD and substance use disorders to be associated with the greatest increase in risk for arrest. Overall, findings here suggest that the comorbidity of other psychological illnesses, including Axis I psychotic, anxiety, and substance use disorders, may contribute to an increased expression of criminal and violent behavior in individuals with ASPD.

Psychosocial Factors. Empirical evidence to date has also implicated environmental and family influences in the etiology of crime and violence in those diagnosed with ASPD. In a study of 54 men serving prison sentences for violent crimes, Hill and Nathan (2008) found a predictive pathway involving childhood conduct disorder (CD) and adulthood ASPD associated with interparental discord, as well as a separate predictive pathway associated with witnessing interparental violence in childhood. However, the CD-ASPD pathway was associated with social but not interpersonal violence, suggesting differential pathways to later serious violence depending upon the social context in which the violence occurs. More work is needed to further understand how these psychosocial factors may play a role in the relationship between ASPD and crime.

Applied Issues: Criminal Responsibility

Although the historical antecedents of ASPD have been discussed in theoretical relation to guilt or innocence in criminal legal matters, recent decades have demonstrated how the criminal justice system has attempted to incorporate ASPD into the determination of criminal responsibility (see Chapter 11). Even within the past decade, more and more authors have referred to how various judicial entities from around the world appear increasingly open to absolving individuals with ASPD from criminal guilt. For example, Palermo (2007) discusses the current willingness among forensic psychiatrists, psychologists, criminologists, and jurists in Europe to consider some personality disordered offenders (including those with ASPD) mentally and emotionally ill enough to be deemed not guilty by reason of insanity (NGRI). In fact, in a Dutch file-review study of 1,209 defendant pretrial reports, Spaans and colleagues (2011) found that a diagnosis of ASPD was associated with diminished criminal responsibility and a recommendation for forensic treatment. It will be interesting indeed to see in the coming years how criminal justice systems around the world, including in the United States, view individuals with this disorder in terms of guilt or innocence and how ASPD may factor into other criminal justice decisions, such as sentencing and conditional release.

Borderline Personality Disorder

Borderline personality disorder is a pervasive, inflexible, and enduring pattern of instability in relationships with others, self-image, and emotions, along with significant impulsivity (APA, 2000, 2013). DSM-5 diagnostic criteria for borderline personality disorder (BPD) are listed in Table 10.8.

Prevalence and Incidence Rates of Borderline Personality Disorder

Prevalence rates for BPD have been estimated at approximately 2% of the general population (APA, 2000), with more recent estimates of 1.6% to as high as 5.9% for median population prevalence (APA, 2013). Increased rates have been reported in other sample populations, such as in outpatients in mental health clinics or primary care settings (10%), in psychiatric inpatients (20%), and among clinical populations with personality disorders (30–60%; APA, 2000, 2013).

Table 10.8 DSM-5 Diagnostic Criteria for Borderline Personality Disorder

301.83 (F60.3) Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (*Note:* Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (i.e., spending, sex, substance abuse, reckless driving, binge eating). (*Note:* Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.
6. Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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Theoretical Conceptualizations

Writers from the earliest literary and medical history (including Homer, Hippocrates, and Aretaeus) have identified within single individuals intense and divergent moods, such as euphoria, irritability, and depression, that coexist (Millon & Davis, 1996). The concept of a "borderline" personality has evolved significantly from its early modern formulations by psychoanalytic theorists, who called this behavioral pattern "pseudoneurotic schizophrenia," "as-if personality," and "borderline state." The term "borderline" itself originally meant an individual who appeared to have a level of disturbance somewhere between the neurotic and psychotic. Kernberg (1967, in Bradley et al., 2007) later conceptualized "borderline personality organization" and subsequently identified three criteria for its structural diagnosis: (1) identity diffusion, i.e., the lack of a self or having an ego not performing its function; (2) lack of defensive operations, i.e., having more primitive defenses centering on the mechanism of splitting—of viewing others as all good or all bad; and (3) capacity for reality testing, i.e., having perceptions that are problematic but not psychotic and mostly intact (Kernberg et al., 1989). Research studies have since identified several mechanisms potentially at work in the etiology of BPD, including biological and genetic factors, separation and loss, childhood abuse, family environment, and attachment issues (Bradley et al., 2007).

Millon refers to BPD as the unstable pattern; individuals having this disorder are characterized by spasmodic expressive behaviors, paradoxical interpersonal conduct, and a capricious cognitive style. The primary regulatory (defense) mechanism involved in the development and maintenance of this disorder is regression—the individual retreats to earlier developmental states of anxiety tolerance, impulse control, and social adaptation (often evidencing immature if not increasingly infantile behaviors) during times of stress (Millon & Davis, 1996).

Borderline Personality Disorder and Crime, Violence, and Stalking

Until the end of the twentieth century, the relationship between BPD and crime and violence had gone largely unexplored. One of the initial empirical investigations of this relationship was a study by Raine (1993), who was

A Closer Look: Borderline Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	1	27.0%
Homicide offenders	1	18.0%
Jailed detainees and prisoners	4*	13.2–65.0%
Psychiatric inpatients	3*	15.2–42.0%
Total Number of Studies	**8**	

Sample Characteristics	
Size	36–505
Gender	Male only (4 studies); female only (1 study); male and female (3 studies)
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Finland, Germany, and the United States)
Diagnostic Systems	DSM-III and DSM-IV

Note: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

among the first to propose that the unique personality constellation of BPD, which includes unstable and intense interpersonal relationships, impulsivity, intense anger, and emotional instability, made an individual with this disorder particularly susceptible to violent behavior. In this study of 37 prisoners in an English top-security facility, a study that included 13 murderers, 5 violent offenders, and 19 nonviolent offenders, Raine found significantly increased borderline personality scores in murderers relative to nonviolent offenders. Specifically, affective instability and unstable, intense relationships represented the specific borderline traits elevated in the murderer group. According to Tardiff (2007), individuals with BPD engage in frequent displays of anger and violence towards others and, in between violent episodes, engage in a wide range of impulsive behaviors putting them at risk for crime and more violence. These include suicidal or self-mutilating behaviors, excessive spending, indiscreet sexual behavior, drug abuse, shoplifting, and reckless driving. Typically violence in these individuals is accompanied by intense displays of emotion and affective instability and is in response to feelings of abandonment or rejection from another—usually from someone from whom the individual wants love, care, or attention. In fact, in a small sample of personality disordered patients, Martins de Barros and de Pádua Serafim (2008) found those with

ASPD ($n = 11$) to be characterized as cold and to involve themselves more in crimes requiring detailed planning and those with BPD ($n = 19$) to be impulsive and to engage in explosive episodes of physical violence. Interestingly, however, Roberts and Coid (2010) found no associations between any offense types and BPD.

In a review of fairly recent research, Sansone and Sansone (2009) concluded that, aside from the increased rates of BPD observed in prison samples (see above), rates of BPD in female offenders are consistently higher than those in male offenders in studies that have compared both. In fact, among inmates, factors associated with an increased likelihood of BPD include being female, childhood sexual abuse, violent offenses, comorbid ASPD, and domestic violence. According to this review, several studies of homicide offenders have reported individuals with BPD and borderline characteristics within their samples (see also Table 10.2), and a number of authors have speculated that subtypes of BPD may be associated with homicidal acts. For example, some have suggested that serial murderers may represent a highly manipulative form of BPD, whereas others have argued that rage-based murders are related to an overcontrolled form of BPD. Stone (1998) discusses several additional cases of murderers with BPD (see Table 10.9) and notes the 3:1 ratio of female-to-male murderers with BPD in his long-term follow-up study of 206 BPD patients. He also notes that more than half (i.e., 8 of 15) of the women with BPD in his biographical series of murderers were victims of incest.

Table 10.9 Cases of Murderers With Borderline Personality Disorder

Source	Age	Gender	Details/Description
Long-term follow-up study of 206 BPD patients (Stone, 1990)	Adult	M	In a lifelong battle with parents who humiliated him constantly; killed his mother when he was 40 after she had refused him his favorite meal at Thanksgiving.
Long-term follow-up study of 206 BPD patients (Stone, 1990)	15	M	Burned down the house of a family whose son, the patient assumed, had sexually molested his sister.
Kaplan et al. (1990)	Adult	F	Laurie Wasserman Dann: bizarre descent after divorce with husband, whom she stabbed with an icepick while he slept; consulted with famous psychiatrist in Chicago area, whose recommendations she ignored; sent him container of fruit juice laced with poison; barged into kindergarten of a school in Winnetka, Illinois, killing one child and wounded several others; killed herself when police later closed in.
Biographical series (Stone, 1998)	Adult	F	Velma Barfield, North Carolinian farm girl: father had intercourse with her from age 13 until age 17, when she married; became addicted to psychotropic drugs after her husband died a few years later; at first, falsified checks or stole small amounts to support her drug habit; eventually, faked her mother's signature on a loan against her mother's house and then poisoned her mother to prevent her from learning of the forgery; not antisocial until she became addicted after the death of her husband.
Hughes (1992)	Adult	F	Darci Pierce, Oregon adoptee: early rage outbursts at home; developed pseudologia fantastica, cunningly manipulative, and carried on sexual relationships with several relatives from age 6 on; in adolescence, mutilated herself and made up stories of living in mansions and taking fantastic trips; obsessed with having a baby and proving herself a better mother than either of hers, so fooled her boyfriend into marrying her because she was "pregnant"; grew desperate and killed a woman who was nine months pregnant, upon whom she did a cesarean section off a deserted highway using a car key as a scalpel, and then drove to the hospital, as though the hastily delivered baby was hers.

Source: Adapted from Stone (1998, pp. 41–42).

In a later review, Sansone and Sansone (2010) discuss the relationship between BPD and stalking behaviors. These authors pay brief homage to a well-known cinematic stalker with BPD, Alex Forrest (played by actress Glenn Close), who stalked and ultimately violently assaulted her married, one-night-stand lover, Dan Gallagher (played by actor Michael Douglas) in the movie *Fatal Attraction*. Sansone and Sansone review five studies reporting the prevalence rates of BPD among stalkers: a small minority (i.e., 4–15%) is characterized by this disorder. However, these authors note a significantly increased rate of BPD in a less forensically focused sample of stalkers (i.e., > 45%), and suggest that, overall, the unusual and intense attachment dynamics of BPD lend themselves particularly to the crime of stalking. Ultimately, although the relationship between BPD and crime and violence has received a modest amount or empirical attention, more research is needed to understand the mechanisms underlying this association.

Histrionic Personality Disorder

Histrionic personality disorder is a pervasive, inflexible, and enduring pattern of excessive emotionality and seeking of attention (APA, 2000, 2013). DSM-5 diagnostic criteria for histrionic personality disorder are listed in Table 10.10.

Prevalence and Incidence Rates of Histrionic Personality Disorder

Prevalence rates for histrionic personality disorder have been estimated at approximately 2–3%, with increased rates (i.e., 10–15%) reported in inpatient and outpatient mental health settings (APA, 2000). More recent national survey data indicate rates of 1.84% (APA, 2013).

Theoretical Conceptualizations

Millon refers to histrionic personality disorder as the gregarious pattern: individuals having this disorder are characterized by dramatic expressive behaviors, attention-seeking interpersonal conduct, and a flighty cognitive style. The primary regulatory (defense) mechanisms involved in the development and maintenance of this disorder are dissociation and repression—the individual regularly changes self-presentations to create a series of socially desirable but altering facades and engages in activities that distract them from reflection on and the integration of unpleasant thoughts and emotions (Millon & Davis, 1996).

Table 10.10 DSM-5 Diagnostic Criteria for Histrionic Personality Disorder

301.50 (F60.4) Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
7. Is suggestible, i.e., easily influenced by others or circumstances.
8. Considers relationships to be more intimate than they actually are.

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A Closer Look: Histrionic Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	0	–
Jailed detainees and prisoners	1*	1.3%
Psychiatric inpatients	3*	1.3–6.0%
Total Number of Studies	**3†**	

Sample Characteristics	
Size	36–299
Gender	Male only (3 studies); male and female (1 study)
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Germany and the United States)
Diagnostic Systems	DSM-III and DSM-IV

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study of homicide offenders (Yarvis, 1990) listed histrionic personality disorder but included it with narcissistic personality disorder.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

The Relationship Between Histrionic Personality Disorder and Crime

To date, the relationship between histrionic personality disorder and crime and violence has gone largely unexamined with the exception of Roberts and Coid (2010) who found no associations between histrionic personality disorder and any offense types. What is known about this relationship can be gleaned only from limited reports concerning the prevalence rates of histrionic personality disorder in criminal populations and vice versa.

Narcissistic Personality Disorder

Narcissistic personality disorder is a pervasive, inflexible, and enduring pattern of grandiosity, need for admiration, and lack of empathy for others (APA, 2000, 2013). DSM-5 diagnostic criteria for narcissistic personality disorder (NPD) are listed in Table 10.11.

Table 10.11 DSM-5 Diagnostic Criteria for Narcissistic Personality Disorder

301.81 (F60.81) Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations.
6. Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends.
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

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Prevalence and Incidence Rates of Narcissistic Personality Disorder

Prevalence rates for NPD have been estimated at less than 1% in the general population. Increased rates (i.e., 2–16%) have been reported in clinical populations (APA, 2000), but rates appear to vary according to the clinical setting and type of practice (Levy et al., 2007). More recent community estimates range from 0% to 6.2% (APA, 2013).

Theoretical Conceptualizations

The term "narcissism" is derived from the Greek myth of Narcissus, originally written as Homeric hymns in the seventh or eighth century BCE and made popular in Ovid's *Metamorphoses*. Narcissus mistook his own reflected image in a lake for that of another, fell in love with it, and died when the image failed to love him back (Levy et al., 2007). Pioneering English psychologist and sex researcher Havelock Ellis first applied this myth clinically in an 1898 case study of a man characterized by excessive masturbation (Levy et al., 2007), conceptualizing narcissism as autoeroticism or sexual gratification without stimulation by another person (Millon & Davis, 1996). Decades later Otto Kernberg, in his paper proposing borderline personality organization, described "narcissistic personality structure" and distinguished between normal and pathological narcissism (1967, 1970, in Levy et al., 2007). Around the same time Heinz Kohut introduced the term "narcissistic personality disorder" (one of the proposed primary disorders of the self—see Chapter 2), and these writings led to an increased interest in the topic (Levy et al., 2007). Millon refers to NPD as the egotistic pattern; individuals having this disorder are characterized by haughty expressive behaviors, exploitive interpersonal conduct, and an expansive cognitive style. The primary regulatory (defense) mechanisms involved in the development and maintenance of this disorder are rationalization and fantasy—the individual is self-deceptive and adept at concocting plausible reasons justifying behaviors that are self-centered and socially inconsiderate, and despite obvious shortcomings or failures, offers excuses to place himself or herself in the best possible light (Millon & Davis, 1996).

From a psychoanalytic perspective, self psychologists have made important contributions to the understanding of both normative and pathological narcissism. Kohut proposed the concept of the "selfobject": objects (i.e., people) that we experience early in our lives as part of ourselves (e.g., the mother to the three-month-old infant) and experience later in life in terms of the functions or services they originally performed (Kohut & Wolf, 1978). Two kinds of selfobjects are the *mirroring selfobject*, which responds to and confirms the child's innate sense of vigor, greatness, and perfection, and the *idealized parent imago*, which is perceived as a calm, infallible, and omnipotent person whom the child can admire and merge with when she or he needs soothing. In fact, Kohut proposed that a lack of mirroring and idealizing experiences from parents leads to the impairments and deficits in self-soothing and self-esteem that characterize the primary disorders of the self (including narcissistic personality disorder and narcissistic behavior disorder—see Chapter 2). Currently, though there is a broad theoretical and empirical literature on narcissism, some authors feel that it remains poorly calibrated across the disciplines of clinical psychology, psychiatry, and social or personality psychology (Pincus & Lukowitsky, 2010).

A Closer Look: Narcissistic Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	1	2.0%
Jailed detainees and prisoners	2*	2.0–11.6%
Psychiatric inpatients	3*	7.0–11.6%
Total Number of Studies	**4**	

Sample Characteristics

Size	36–348
Gender	Male only
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Finland, Germany, and the United States)
Diagnostic Systems	DSM-III and DSM-IV

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study of homicide offenders (Yarvis, 1990) listed histrionic personality disorder but included it with narcissistic personality disorder.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

The Relationship Between Narcissistic Personality Disorder and Crime and Violence

Aside from a few exceptions, the literature on the relationship between NPD and crime in general has not extended much beyond prevalence rate studies. One exception is Millon's discussion of a variant of the narcissistic personalities—the unprincipled narcissist—found more commonly as of late in drug rehabilitation programs, youth offender centers, and jails and prisons (Millon & Davis, 1996). Two other exceptions are Roberts and Coid's (2010) recent large-scale national survey of English and Welsh male prisoners (see above), which found NPD to be associated with drug offenses and fraud, and Warren and colleagues' (2002) finding of a significant association between NPD and incarceration for violent crime in a sample of 261 female prison inmates. Nonetheless, a fair amount of literature has been dedicated to examining the association between extreme forms of narcissism and violent behavior in particular. For example, numerous authors have presented theoretical and clinical formulations of narcissism and murder (see Table 10.12). Two concepts describing pathological forms or expressions of narcissism have been discussed in the literature, and these may be key in understanding the relationship between NPD and violent offending: narcissistic rage and malignant narcissism.

Narcissistic rage is one of two forms of aggression proposed by Kohut (1972, 1971, 1977, and 1984, in Kieffer, 2003). The first, *competitive (instrumental) aggression*, is directed at removing barriers to goals. **Narcissistic rage**, on balance, is directed toward the selfobjects that threaten or are perceived to threaten the self. It represents a need for avenging a previous *narcissistic injury*, a perceived harm or emotional insult that may seem ever so slight and almost imperceptible to others (e.g., when an acquaintance we like momentarily forgets our name) but that, nonetheless, exposes the vulnerable underbelly of the grandiose, primitively omnipotent and idealized self. Unlike competitive aggression, which dissipates immediately after the barrier is removed, narcissistic rage persists long after the threat is eliminated and may endure—smoldering and even increasing—with the passage of years. According to Kieffer (2003), patients with chronic narcissistic rage become preoccupied with malice and spite and may even "erupt in cold fury" and plan acts of revenge (p. 736; see also Harrang, 2012). Furthermore, some authors (e.g., Ornstein, 1998) have suggested that narcissistic rage may be expressed in behavior that is sadistic (i.e., direct behavior such as physical or verbal assault) or masochistic and paranoid (i.e., indirect behavior such as arrogant withdrawal, holding grudges, collecting injustices, self-mutilation or cutting, and suicidal threats). Fox (1974) even proposed a link between narcissistic rage and the forms of aggression observed in combat soldiers, aggression that is often the consequence of the death of a combat buddy—a circumstance that can be equated to the loss of a mirror relationship.

Malignant narcissism was originally described by Kernberg (1984, 1992, in Pollock, 1995), who proposed the term to represent an extreme variant of NPD and an intermediate or "hybrid" personality disorder between NPD and ASPD. Characteristics include typical NPD along with unrestrained "characterologically anchored" aggression (i.e., a "self-righteous aggression" that has "infiltrated" the pathologically grandiose self), unregulated antisocial behavior, "joyful cruelty" and ego-syntonic sadism, a lack of conscience, a need for power and significance, and paranoid interactions with others. According to Kernberg, malignant narcissism reflects a defense against feelings of inferiority, rejection, and insignificance. It develops through pathological self and object representations (i.e., through experiencing parental or other objects as omnipotent, cruel, attacking, and destructive originally), and it manifests as a ruthless desire to become superior and triumphant over life, death, fear, and pain through cruelty toward others or self-mutilation. Pollock (1995) indicates that the severe narcissistic and antisocial tendencies in this disorder may be expressed in extreme forms of sadism and violence and presents as an exemplar the case of a British spree serial killer whose behavior and history suggest the contributory role of malignant narcissism.

Interestingly, Stone (1998) alludes to the concept of malignant narcissism by discussing the trait overlap of NPD, ASPD, and psychopathy. Specifically, he notes egocentricity, or adhering only to one's own rules while being contemptuous of the rules or needs of others, as one of the core features of antisociality and psychopathy and states that, though many individuals with NPD are neither antisocial nor psychopathic, those who attempt or commit murder are more often narcissistic than antisocial personality disordered or psychopathic. He further notes that the blending of narcissistic and psychopathic traits form a personality configuration that is "almost ubiquitous among murderers of almost every type" (p. 36).

Table 10.12 Theoretical and Clinical Formulations of Narcissism and Murder

Fromm (1973)	Relationship between malignant aggression, narcissism, and symbiotic relationships and human destructiveness.
McCarthy (1978)	Homicidal behavior in young males due to narcissistic insults and anger.
Liebert (1985)	The use of borderline and narcissistic disorder in profiling of serial murderers.
Morohn (1987)	Narcissistic personality disorder in case of John Wesley Hardin and his murders.
Stone (1989)	Concept of malignant narcissism: Coexistence of narcissistic and antisocial traits in personalities of serial murderers.
Hickey (1991)	Highly developed narcissistic qualities present in personalities of serial murderers.
Gacono (1992)	Reported a Rorschach analysis of a sexual murderer indicating borderline personality, sadism, and narcissism.
Lowenstein (1992)	Borderline personality, pathological omnipotence, and antisocial behavior in personalities of serial murderers.
Palermo & Knudten (1994)	History of interpersonal sensitivity, feelings of inadequacy, and fear of rejection associated with fantasies of power and control over others in the case of Jeffrey Dahmer.

Source: Adapted from Pollock (1995, p. 259).

Other authors have proposed etiological mechanisms underlying associations between NPD and criminal offending. In a study of 51 male inpatients at two German maximum-security forensic hospitals, Dudeck and colleagues (2007) found significantly increased rates of NPD (but not other personality disorders) among sexual offenders compared to other offenders. The authors suggest an incapability to care for and exhibit empathy for others prevents these offenders from developing stable relationships. Because of their grandiose sense of importance combined with their lack of respect for the needs of others, those with NPD, it could be argued, are at greater risk of committing sexual crimes; they may respond to personal insults—real or imagined—with vindictive rage in the form of sexual violence, oblivious to the feelings or needs of their victims. Furthermore, Tardiff (2007) proposed that individuals with NPD feel as though they have the right to control others and demand their attention and admiration. Still, though this individual exploits others and has little or no remorse doing so, he or she exhibits little flagrant criminal behavior. When present, violence usually results from the individual's frustration and anger with others when they do not give the individual what he or she thinks is deserved. Ultimately, the understanding of the relationship between NPD and crime and violence to date remains largely theoretically based, and more work is needed to ground this relationship in empirical findings.

Cluster C Personality Disorders

Avoidant Personality Disorder

Avoidant personality disorder is a pervasive, inflexible, and enduring pattern of inhibited social interactions, feelings of inadequacy, and hypersensitivity to criticism or rejection (APA, 2000, 2013). DSM-5 diagnostic criteria for avoidant personality disorder are listed in Table 10.13.

Table 10.13 DSM-5 Diagnostic Criteria for Avoidant Personality Disorder

301.82 (F60.6) Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

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Prevalence and Incidence Rates of Avoidant Personality Disorder

Estimates of prevalence rates for avoidant personality disorder are between 0.5% and 1% for the general population and are approximately 10% among individuals in outpatient mental health clinics (APA, 2000). More recent national survey data suggests community rates of 2.4% (APA, 2013).

Theoretical Conceptualizations

Millon refers to avoidant personality disorder as the withdrawn pattern; individuals having this disorder are characterized by fretful expressive behaviors, aversive interpersonal conduct, and a distracted cognitive style. The primary regulatory (defense) mechanism involved in the development and maintenance of this disorder is fantasy—the individual achieves gratification of needs, confidence building, and conflict resolution primarily through the use of imagination and safely discharges frustrated affectionate and angry impulses by withdrawing into reveries (Millon & Davis, 1996).

The Relationship Between Avoidant Personality Disorder and Crime

To date, systematic empirical investigations of the relationship between avoidant personality disorder and crime and violence are scarce. One rare exception is the recent large-scale national survey of male prisoners in England and Wales conducted by Roberts and Coid (2010), which found avoidant personality disorder scores to be negatively correlated with firearm offenses but positively correlated with criminal damage. Unfortunately, the best source of information about the relationship between this personality disorder and crime remains that which can be gleaned from the limited reports of prevalence rates of avoidant personality disorder in criminal populations and of crime or violent behavior in those with this disorder.

Dependent Personality Disorder

Dependent personality disorder is a pervasive, inflexible, and enduring pattern of submissiveness, clinging behavior, and excessive need to be cared for (APA, 2000, 2013). DSM-5 diagnostic criteria for dependent personality disorder are listed in Table 10.14.

A Closer Look: Avoidant Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	0	–
Jailed detainees and prisoners	1*	5.1%
Psychiatric inpatients	3*	4.0–22.0%
Total Number of Studies	**3†**	

Sample Characteristics	
Size	36–299
Gender	Male only
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Germany, and the United States)
Diagnostic Systems	DSM-IV

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study of homicide offenders (Yarvis, 1990) listed avoidant personality disorder but included it with dependent, compulsive, and passive-aggressive personality disorders.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

Prevalence and Incidence Rates of Dependent Personality Disorder

The DSM-IV-TR reports that dependent personality disorder is one of the most frequently reported personality disorders among individuals in mental health clinics (APA, 2000). It does not, however, identify specific prevalence rates. More recent national survey data suggest rates between 0.49% and 0.6% (APA, 2013).

Theoretical Conceptualizations

Millon refers to dependent personality disorder as the submissive pattern; individuals having this disorder are characterized by incompetent expressive behaviors, submissive interpersonal conduct, and a naïve cognitive

Table 10.14 DSM-5 Diagnostic Criteria for Dependent Personality Disorder

301.6 (F60.7) Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. *Note:* Do not include realistic fears of retribution.
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself

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style. The primary regulatory (defense) mechanism involved in the development and maintenance of this disorder is introjection—the individual strengthens the belief that an inseparable bond exists between himself or herself and another through firm devotion to that person, forgoing independent views in favor of those of others to avoid conflicts and threats to this relationship (Millon & Davis, 1996).

A Closer Look: Dependent Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	1	1.4%
Jailed detainees and prisoners	2*	2.0–3.5%
Psychiatric inpatients	3*	2.0–8.0%
Total Number of Studies	**5†**	

Sample Characteristics	
Size	36–299
Gender	Male only (3 studies); male and female (2 studies)
Age	Adult, youth

Location	North American and European countries (e.g., Belgium, Germany, the United States)
Diagnostic Systems	DSM-IV, not reported in earlier studies‡

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study of homicide offenders (Yarvis, 1990) listed dependent personality disorder but included it with avoidant, compulsive, and passive-aggressive personality disorders.

‡Earlier studies (Pfieffer et al., 1967; Wilcox, 1985, 1987) utilize the term "passive dependent personality."

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

The Relationship Between Dependent Personality Disorder and Crime

To date, the relationship between dependent personality disorder and crime and violence remains largely unexamined. One rare exception is, again, the recent large-scale national survey of male prisoners in England and Wales conducted by Roberts and Coid (2010). This study found dependent personality disorder scores to be significantly and positively correlated with firearm and violent offenses but negatively associated with criminal damage. Unfortunately, as is the case for avoidant personality disorder, the best source of information about the relationship between dependent personality disorder and crime remains the limited studies examining the prevalence rates of this disorder in criminal populations and of crime or violence in those with this disorder.

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder is a pervasive, inflexible, and enduring pattern of concern for orderliness, perfectionism, and control (APA, 2000, 2013). DSM-5 diagnostic criteria for obsessive-compulsive personality disorder (OCPD) are listed in Table 10.15.

Prevalence and Incidence Rates of Obsessive-Compulsive Personality Disorder

Prevalence rates for OCPD have been estimated at approximately 1% in the general population and 3–10% in mental health clinic samples (APA, 2000). More recent community estimates have been reported at 2.1% to 7.9% (APA, 2013).

Theoretical Conceptualizations

Millon refers to obsessive-compulsive personality disorder as the conforming pattern; individuals having this disorder are characterized by disciplined expressive behaviors, respectful interpersonal conduct, and a constricted cognitive style. The primary regulatory (defense) mechanisms involved in the development and maintenance of this disorder are reaction-formation and identification—the individual repeatedly presents thoughts and behaviors that are positive and socially commendable but also diametrically opposite to her or his deeper contrary and forbidden feelings. For example, a person may appear reasonable and mature when faced with circumstances that cause others to become angered or dismayed (Millon & Davis, 1996).

Table 10.15 DSM-5 Diagnostic Criteria for Obsessive-Compulsive Personality Disorder

301.4 (F60.5) Obsessive-Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met).
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
4. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
8. Shows rigidity and stubbornness.

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A Closer Look: Obsessive-Compulsive Personality Disorder and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	0	–
Jailed detainees and prisoners	1*	4.0%
Psychiatric inpatients	3*	4.0–25.0%
Total Number of Studies	**3†**	

Sample Characteristics	
Size	36–299
Gender	Male only
Age	Adult, youth
Location	North American and European countries (e.g., Belgium, Germany, and the United States)
Diagnostic Systems	DSM-IV

Notes: *One study involved both jailed detainees or prisoners and psychiatric inpatients.

†One additional study of homicide offenders (Yarvis, 1990) listed compulsive personality disorder but included it with avoidant, dependent, and passive-aggressive personality disorders.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Total Number of Studies	**0**		

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

The Relationship Between Obsessive-Compulsive Personality Disorder and Crime

To date, systematic empirical investigations of the relationship between OCPD and crime and violence have, for the most part, not been undertaken. In fact, this disorder is rarely mentioned within any criminological context, though Ferreira (2000) did state that there was no reported relationship between OCPD and serial murder. Once again, the rare exception is the recent large-scale national survey of male prisoners in England and Wales conducted by Roberts and Coid (2010), which found OCPD to be positively associated with firearm offenses. Unfortunately, like the other Cluster C personality disorders, the strongest argument to be made for a relationship between OCPD and crime remains that based on information gleaned from studies reporting on the prevalence rates of OCPD in criminal populations and of crime in disordered populations.

Multiple Personality Disorder and Dissociative Identity Disorder

Multiple personality disorder was first introduced in the DSM-III as "300.14 Multiple Personality," and it was classified under "Hysteria," one of the "Neurotic Disorders"(APA, 1980). Maintaining its original numerical code, it was renamed "Multiple Personality Disorder" in the DSM-III-R (APA, 1987) and then reconceptualized as a dissociative disorder and renamed in the DSM-IV (APA, 1994). **Dissociative identity disorder** is its current name in the DSM-5 at the time of this writing. According to the DSM-III-R, in classic cases of MPD, an individual has at least two fully developed personalities, with each having its own unique memories, behavior patterns, social relationships, styles of dress, and so on (APA, 1987; Carlisle, 1991). In adults, the number of personalities may range from 2 to over 100, but approximately half of the cases have 10 personalities or fewer. Transition from one personality to another—often triggered by psychosocial stress, environmental cues, or conflicts among personalities—usually happens within seconds or minutes but may occur gradually over hours or days. Studies demonstrated that different personalities might have different physiological characteristics (e.g., eyeglass prescriptions or medication responses) or responses to psychological tests. Also these personalities may or may not have an awareness of or be in communication with each other (APA, 1987). In terms of prevalence rates for MPD, the DSM-III-R merely states that "recent reports suggest that this disorder is not nearly so rare as it has commonly been thought to be" (p. 271). The DSM-IV-TR recognizes a recent "sharp rise" in the reported rates of dissociative identity disorder in the United States—attributable perhaps to a greater awareness of the diagnosis resulting in the identification of previously undiagnosed cases or to its being overdiagnosed in individuals that are highly suggestible. It does not mention any specific prevalence rates (APA, 2000). The DSM-5 mentions 12-month prevalence rates of 1.5% in a small U.S. community study (APA, 2013).

Diagnostic criteria multiple personality disorder, as outlined in the DSM-III-R, and for dissociative identity disorder, as outlined in the DSM-5, are listed in Tables 10.16 and 10.17, respectively.

Table 10.16 DMS III-R Diagnostic Criteria for Multiple Personality Disorder

300.14 Multiple Personality Disorder

A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

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Table 10.17 DSM-5 Diagnostic Criteria for Dissociative Identity Disorder

300.14 (F44.81) Dissociative Identity Disorder

A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, and other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. *Note:* In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

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Theoretical Conceptualizations

A DID process generally begins before the age of five and is the result of overwhelming trauma, which the mind of the child cannot tolerate. For emotional survival, the child dissociates self from the mental or physical pain. Depending upon the personality makeup of the child and the nature of the trauma, the event may be blocked from the awareness of the child. The structuring of this dissociated material leads to alter personalities or personality states (less fully developed personalities), which result in the DID process (see Carlisle, 1991, for a review). ***Dissociation***, the process of blocking out unwanted stimuli from awareness, occurs on a continuum from daydreaming to the more serious pathological form, dissociative identity disorder (Chu, 1988, in Carlisle, 1991).

The Relationship Between Dissociative Identity Disorder and Crime

It has been suggested that offender dissociation is common in violent crimes (Carlisle, 1991). The dissociative process is a protective psychological process that reduces depression, pain, and anxiety. Coons (1991) noted

that between 1977 and 1990, at least 18 accounts of murder defendants with alleged DID appeared in both the scientific literature and the lay press. Other cases, chronicled in local newspapers, undoubtedly exist. Of the cases reviewed by Coons, over two-thirds were thought by someone to be feigning DID, and only two were found NGRI. Most of the defendants showed a simplistic good/bad dichotomy or split between at least two personality states.

DID and Malingering. The possibility that the offender is feigning DID must always be considered. One of the most famous cases of malingering was that of American serial killer Kenneth Bianchi (the Los Angeles "Hillside Strangler"), who murdered—with his cousin Angelo Buono—10 young women (ages 12–28) and who appeared to manifest multiple personalities while under hypnosis. His claims of DID were eventually repudiated, and he was subsequently diagnosed as an antisocial personality (Watkins, 1984). Evidence of multiple personality symptomatology prior to the offense supports an argument for DID (see Lewis, Yeager, Swica, Pincus, & Lewis, 1997). Hall (1989) presents the case of John Jason Davis, a 46-year-old divorced male who murdered his live-in girlfriend. After Davis murdered the victim, he dismembered her body and scattered the body parts in plastic bags throughout the county. He was not arrested until 17 days later because his carefully calculated disposal of the remains made identification of the body nearly impossible. He had severed the fingertips from the hands, which eliminated fingerprint identification, and removed all the teeth so that dental records were useless (the victim was identified via the manufacturer's identification number on a steel plate that had been previously surgically implanted in her right forearm to mend a fracture). Davis had an extensive history of psychiatric hospitalizations and had been in outpatient therapy for eight months prior to the murder, to address his DID diagnosis.

In one interesting study of 12 murderers with DID, Lewis et al. (1997) demonstrated that DID can be differentiated from malingering by utilizing objective data (related to time periods before the offense) gathered from medical, psychiatric, social service, school, military, and prison records and from records of interviews with subjects' family members and others. In a novel approach, handwriting samples (e.g., old journals, letters) produced before the participants' psychiatric evaluations were also examined. Results indicated that symptoms and signs of DID in both childhood and adulthood were corroborated independently from multiple sources in all cases, and, in 10 cases, significant changes in writing style or signatures were documented. These authors conclude by asserting that it is possible to distinguish DID from malingering accurately, though this process requires great effort and ample amounts of objective evidence. Ultimately, more work is needed in this very under-researched area, which may further elucidate the nature of the relationship between MPD or DID, crime, and violence.

Psychopathy

Ted Bundy is often referred to as the prototypical psychopath. Unfortunately, though this assertion seems difficult to contest given the nature of his personality, history, and behavior, significant confusion related to the term "psychopathy" exists among both mental health professionals and the general public. This confusion is partly due to the fact that, literally translated, the term "psychopathy" means "mental illness" (from "*psyche*," or "mind," and "*pathos*," or "disease"). The news and popular media's use of the term as an equivalent for "insane" or "crazy" also confuses. How often do we hear "The police say a 'psycho' is on the loose," or "The guy that killed her must be a 'psycho'" Newton, 2000)? Furthermore, the term is often used to describe an individual who commits criminal acts that are unspeakable, horrific, or too difficult for most others to understand (Lykken, 1995). For example, murderers such as Ed Gein (see Chapter 2) may be thought of as psychopaths (Newton, 2000). Unfortunately, applying this label is a gross misrepresentation. Gein's behavior was admittedly bizarre—and he may have, in fact, possessed psychopathic traits to some degree—but, overall, he does not appear to meet the diagnostic criteria for psychopathy using today's standards (see below).

A Definition

One of the factors contributing to the confusion about psychopathy is the fact that a standardized definition has not yet permeated, in any official way, through the world of mental health clinicians or of the public at large.

However, Brinkley and colleagues (2004) provide a relatively comprehensive definition that has been cobbled together from other sources. **Psychopathy**, as it is currently defined, is a personality disorder that manifests early and persists throughout life (Hare, 1996). Psychopathic individuals have been traditionally described as lacking in empathy, loyalty, and guilt and engaging in persistent antisocial, impulsive, and irresponsible behavior (Cleckley, 1976). Such individuals typically do not evidence impaired intelligence but appear unable to make use of their intelligence to learn from mistakes (Hart & Hare, 1989). This discrepancy between ability and performance led Cleckley (1976) to conclude that psychopathic individuals suffer from a condition as debilitating as schizophrenia.

Historical Conceptions of Psychopathy

Psychopathy was the first personality disorder to be recognized in psychiatry (Millon et al., 1998, in Hare, 2003). It is important to note that the term "psychopathic" has been a generic label for all personality disorders until recent decades and was originally selected by German psychiatrist Julius Ludwig August Koch (1841–1908) in 1891 to indicate a physiological basis for these specific impairments in functioning (Millon & Davis, 1998). For centuries, psychopathy has shared a common lineage with antisocial personality disorder, which only recently (comparatively speaking) diverged when the DSM in 1980 moved away from focusing on the internal processes and personality traits of psychopathy and concentrated instead on the behavioral characteristics of this disorder—conceptualizing those characteristics as ASPD (see Figure 10.1).

The clinical and empirical discussion of psychopathy dates back many centuries and extends throughout many different cultures and societies. In fact, researchers have found references to psychopathic individuals in biblical, classical, and medieval texts (Arrigo & Shipley, 2001). For example, Theophrastus, Aristotle's student, describes the "Unscrupulous Man"—an individual who corresponds closely to modern conceptualizations of psychopathy:

> The Unscrupulous Man will go and borrow more money from a creditor he has never paid. . . . When marketing he reminds the butcher of some service he has rendered him and, standing near the scales, throws in some meat, if he can, and a soup-bone. If he succeeds, so much the better; if not, he will snatch a piece of tripe and go off laughing. (Millon & Davis, 1998, p. 430)

Numerous formal conceptualizations of psychopathy have been proposed over the past two centuries (see Figure 10.1). In 1801, Philippe Pinel (1745–1826) described *manie sans délire* or "insanity without delirium," noting that some patients engaged in impulsive acts and episodes of violence while still understanding the irrationality of their actions and having intact reasoning abilities. Though Pinel's *manie sans délire* label was intended as morally neutral, in 1812, American psychiatrist Benjamin Rush (1746–1813) reconceptualized Pinel's idea for this disorder—with its defects in "passion and affect"—as socially condemnable and pejorative. In 1835, James Cowles Prichard (1786–1848) introduced the term "moral insanity," an overly broad (as well as pejorative) term, which became a major source of contention and preoccupation in England and continental Europe for more than 70 years. Prichard even maintained that moral insanity reduced criminal culpability and should be employed as a legal defense. In 1874, another leading British psychiatrist of the period, Henry Maudsley (1835–1918), described the condition as a sort of moral "colorblindness": "As there are persons who cannot distinguish certain colours, having what is called colour blindness, so there are some who are congenitally deprived of moral sense" (Millon & Davis, 1998, p. 432).[3] Maudsley later described individuals with this disorder as "moral imbeciles" (Maudsley, 1895, in Saleh et al., 2010).

In the late nineteenth and early twentieth centuries, a move back toward moral neutrality can be observed in scholars' descriptions of the conceptual precursors of psychopathy. German psychiatrists turned attention

3. Johns and Quay (1962) coined a phrase that is often repeated in the literature on psychopathy: the psychopath, they said, "knows the words but not the music" (p. 217). In a sense, the idea is that psychopaths understand the lexical meaning of emotional words but do not experience their emotional value. It is interesting that both semantic "tone deafness" and moral "color blindness" have been used to describe deficits in those with psychopathy. These sensory analogues are elegantly understated yet eloquently capture the true essence of this disorder.

away from British value-laden theories and towards what they believed to be observational research. Koch (1891) introduced the term "psychopathic inferiority" (see above)—with *psychopathic* indicating a physical basis for these impairments and *inferiority* implying nothing more than a deviation from the norm. Unfortunately, Koch's efforts to obviate the pejorative label of Prichard's conceptions were slowly undermined, and, gradually, his term evolved to mean the opposite of what he had originally intended.

German psychiatrist Emil Kraepelin expanded on Koch's psychopathic inferiority terminology in 1915, moving it back toward moral judgment and social condemnation and including within it categories of criminal offenders of arguably the most vicious and wicked disordered sorts. These included "morbid swindlers and liars," who were manipulative, glib, charming, and unconcerned for others; "criminals by impulse," who were overcome by uncontrollable desires to commit offenses like arson or rape for purposes unrelated to material gain; "professional criminals," who acted out of cold, calculated self-interest rather than an uncontrollable impulse; and "morbid vagabonds," who wandered through life with neither self-confidence nor responsibility (Millon & Davis, 1998).

In the 1940s after World War I, an American psychiatrist named Hervey Cleckley published a hallmark book entitled *The Mask of Sanity* (1941), which marked the beginning of the modern clinical construct of psychopathy. Based on his own clinical observations, Cleckley proposed that psychopaths wear a "mask" of seeming emotional health, referring to them as "automatons" who appear outwardly normal but who are nonetheless internally devoid of the human emotional experience. Cleckley clearly stated his belief that criminal behavior was not inherent to the definition of psychopathy, but he noted that "when serious criminal tendencies do emerge in the psychopath, they gain ready expression" (1976, p. 262). In other words, the disinhibited nature of psychopathic individuals causes the behaviors toward which they might otherwise be inclined to become excessive (Brinkley et al., 2004). The diagnostic criteria for the "Cleckley psychopath" are listed in Table 10.18.

Table 10.18 Diagnostic Criteria for Psychopathy

The Mask of Sanity[1]	**PCL-R**[2]
"Cleckley's Psychopath"	**"Hare's Psychopath"**
Superficial charm and good intelligence	Item 1: Glibness/superficial charm
Absence of delusions and other signs of irrational thinking	Item 2: Grandiose sense of self-worth
Absence of nervousness or psychoneurotic manifestations	Item 3: Need for stimulation/proneness to boredom
Unreliability	Item 4: Pathological lying
Untruthfulness or insincerity	Item 5: Conning/manipulative
Lack of remorse or shame	Item 6: Lack of remorse or guilt
Inadequately motivated antisocial behavior	Item 7: Shallow affect
Poor judgment and failure to learn from experience	Item 8: Callous/lack of empathy
Pathologic egocentricity and incapacity for love	Item 9: Parasitic lifestyle
General poverty in major affective relations	Item 10: Poor behavioral controls
Specific loss of insight	Item 11: Promiscuous sexual behavior
Unresponsiveness in general interpersonal relations	Item 12: Early behavioral problems
Fantastic and uninviting behavior with drink and sometimes without	Item 13: Lack of realistic, long-term goals
Suicide rarely carried out	Item 14: Impulsivity
Impersonal, trivial, and poorly integrated sex life	Item 15: Irresponsibility
Failure to follow any life plan	Item 16: Failure to accept responsibility for own actions
	Item 17: Many short-term marital relationships
	Item 18: Juvenile delinquency
	Item 19: Revocation of conditional release
	Item 20: Criminal versatility

Sources: [1]Cleckley (1941); [2]Hare (2003)

Cleckley's work was a milestone in the understanding of psychopathy. His published clinical observations served as an anchor in the tumultuous seas of diagnostic confusion existing for clinicians encountering and working with psychopathic clients at that time. However, as much as *The Mask of Sanity* provided a standardized clinical view of psychopathy, an empirically validated measurement tool was still desperately needed for research studies. In 1980, Canadian psychologist Robert Hare developed the "Psychopathy Checklist" in an attempt to operationalize the construct of psychopathy based on Cleckley's clinical material and formulations. After years of refinement, the **Psychopathy Checklist—Revised** (PCL-R; Hare, 2003) is now considered the "gold standard" of psychopathy measures, and, although it was developed initially for use with Canadian offender populations, it has since demonstrated sound psychometric properties (i.e., good reliability and validity) in a multitude of sample types in locations around the world. The term "checklist" is actually somewhat of a misnomer, as the standard PCL-R assessment procedure consists of a semi-structured interview and a review of available file and collateral information. Unlike the polythetic diagnostic approach of the DSM, the PCL-R is based on a numerical scoring system in which each of its 20 items (see Table 10.18) is assigned a value of 0–2 based on the "goodness of fit" of that item to the individual being assessed. Scores for all items are summed, and a PCL-R total score 30 out of a possible of 40 points is considered the diagnostic threshold for psychopathy. Factor-analytic studies of these 20 items have since identified subcomponents of the higher-order construct of psychopathy; and individual PCL-R scores are now represented in either a two-factor structure, with interpersonal or affective elements comprising Factor 1 and social deviance, Factor 2, or, more recently, a four-facet structure, with Facet 1 being interpersonal, Facet 2 affective, Facet 3 lifestyle, and Facet 4 antisocial elements (Hare, 2003). Other researchers (Cooke & Michie, 2001) have also proposed a three-factor model, and, to date, a spirited debate continues in the literature regarding which model, the two-factor/four facet or the three-factor model, best captures the underlying structure of psychopathy (see Cooke et al., 2007; Hare, 2003).

Psychopathy Versus Antisocial Personality Disorder. Throughout the history of the DSM, nomenclature and the definitions of antisocial personality disorder, psychopathy, sociopathy, and the like have continued to evolve. In the first DSM (1952), this collection of personality characteristics was termed "Sociopathic Personality Disturbance," and, in the DSM-II (1968), it was termed "Antisocial Personality." The definitions for both included many of the personality characteristics set forth by Cleckley in his descriptions of the psychopath and were focused on internal processes and personality traits. However, as mentioned, a paradigm shift occurred in 1980 with the release of the DSM-III. In this and subsequent editions of the DSM, the term "Antisocial Personality Disorder" was adopted, and the focus was no longer on personality traits. The DSM-III task force felt that the clinical inferences necessary to determine the personality characteristics of the psychopath lowered the reliability of the diagnosis. Therefore, a diagnostic shift toward assessing the behavioral characteristics commonly associated with the disorder was made; and these diagnostic criteria were considered more reliable for identification purposes than were the personality factors explaining why the behaviors occurred. However, the new criteria were so broad they included almost every known criminal offense. In fact, Theodore Millon argued against the behavior-based conceptualization of ASPD, describing the diagnostic criteria as "merely a sequence of picayunish specifics (e.g., thefts, three or more traffic arrests, etc.)" (Millon & Davis, 1998, p. 430) and as a shift from the level of focus used to outline all of the other personality disorders.

Unfortunately, the DSM-IV (APA, 1994), DSM-IV-TR (APA, 2000), and DSM-5 (APA, 2013) have inadvertently compounded the confusion associated with this diagnostic terminology by adding, in the ASPD section, this note: "This pattern has also been referred to as psychopathy, sociopathy, or dissocial personality disorder" (APA, 2000, p. 702; APA, 2013, p. 659). Designations such as ASPD, sociopathy, and the like are erroneously used as synonyms for psychopathy, and each of these diagnostic constructs can represent a different constellation of personality traits and behaviors. For example, although approximately 90% of the criminals classified as psychopathic using the PCL-R are diagnosed with ASPD, only 30% of those with ASPD diagnoses meet criteria for psychopathy. In offender populations, the base rate for ASPD ranges from 50% to 80%, although the base rate for psychopathy is much lower at 15% to 25%. Most individuals with ASPD are not psychopaths; however, most psychopaths do engage in antisocial behaviors. More recent authors have proposed that ASPD

is on a continuum with psychopathy and that psychopathic ASPD is a more severe form—with a greater risk for violence—than ASPD alone (Coid & Ullrich, 2010). Others see these as overlapping constructs with differential patterns of criminal behavior, comorbidity with other personality disorders, victimization, and institutional adjustment (Warren & South, 2006). Furthermore, the designation of psychopathy is routinely equated with being untreatable (see below), and the consequences of diagnostic misidentification can be severe, substantial, and enduring. Regrettably, mental health professionals continue to remain perplexed when diagnosing, treating, or making recommendations to the court system about psychopathic individuals (Shipley & Arrigo, 2001).

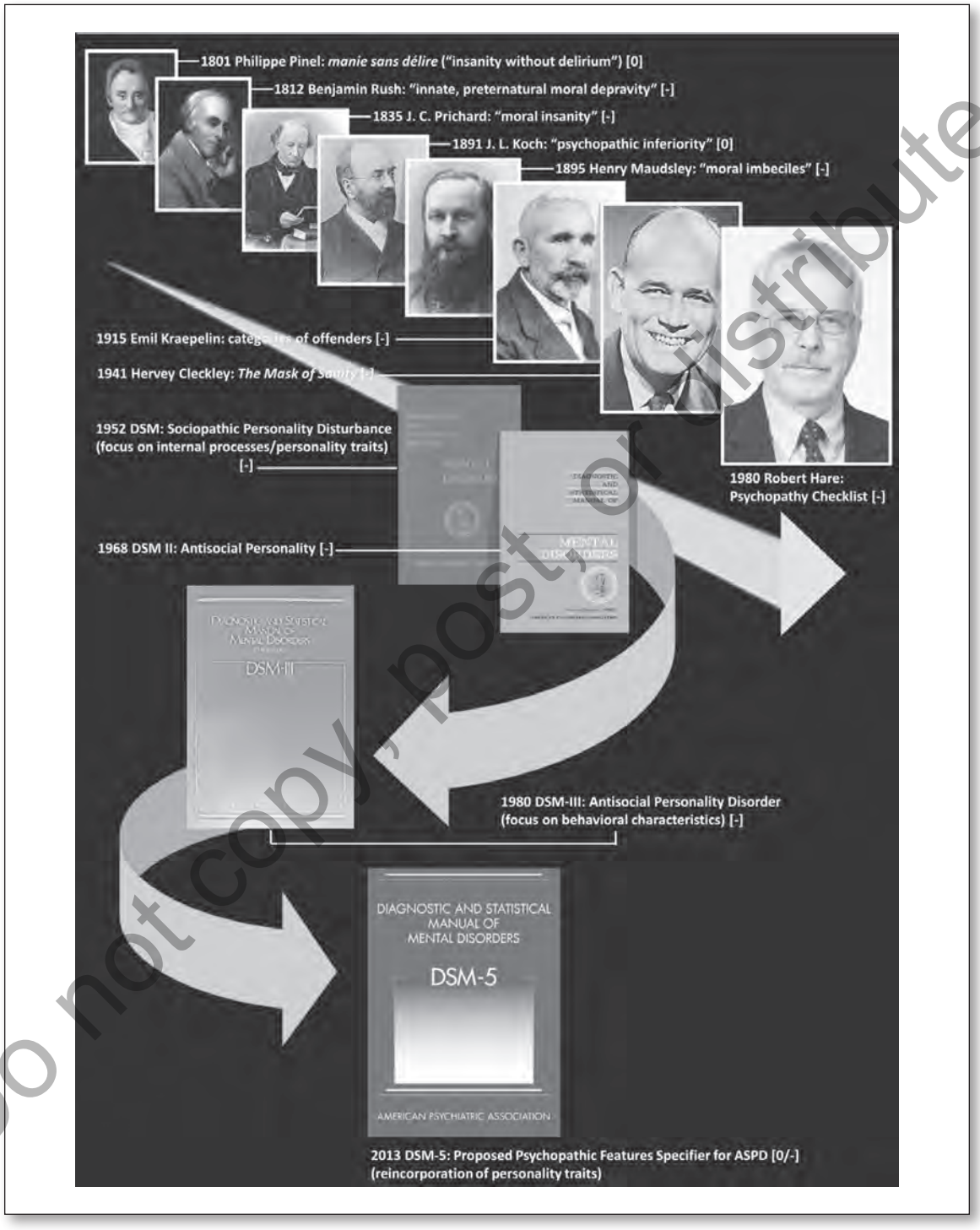
Interestingly, the DSM-5 has made a significant step toward the recognition of psychopathy by incorporating it into its alternative model for personality disorders (see above). Under this new proposed model, the designation "psychopathic features" has been added as a specifier for ASPD:

> A distinct variant often termed psychopathy (or "primary" psychopathy) is marked by a lack of anxiety or fear and by a bold interpersonal style that may mask maladaptive behaviors (e.g., fraudulence). This psychopathic variant is characterized by low levels of anxiousness (Negative Affectivity domain) and withdrawal (Detachment domain) and high levels of attention seeking (Antagonism domain). High attention seeking and low withdrawal capture the social potency (assertive/dominant) component of psychopathy, whereas low anxiousness captures the stress immunity (emotional stability/resilience) component. (APA, 2013, p. 765)

In essence, using this proposed model, a clinician can now diagnose an individual with ASPD as having psychopathic features or not. It will be interesting to see how researchers and mental health professionals apply this new model in research, clinical, and forensic arenas and if it contributes at all to reducing the conceptual and diagnostic confusion (and "healing" the rift—so to speak—among nomenclatures) related to psychopathy and ASPD.

Relationship Between Psychopathy and DSM-IV-TR Personality Disorders. Psychopathy is not included in recent editions of the DSM as a distinct disorder, though psychopathic features have been proposed as a specifier for ASPD in the DSM-5. This change does not mean that psychopathy is a completely different diagnostic phenomenon from the personality disorders currently outlined within the DSM-IV-TR and DSM-5. Rather, it is merely a different conceptualization, a different constellation or subset of the limited number of traits and behaviors that form the basis of the human experience and the foundations of the other DSM personality patterns and disorders. As such, a conceptual overlap between many of the PCL-R traits of psychopathy and the traits of personality disorders in the DSM-IV-TR and DSM-5 should not be surprising. In fact, recent research (Vachon et al., 2013) demonstrates how psychopathy and other personality disorders may be understood theoretically using basic traits such as impulsiveness, warmth, straightforwardness, modesty, and deliberation. From a theoretical standpoint, Lykken (1995) proposes a group of "psychopathies" and Millon (Millon & Davis, 1998) identifies 10 theoretical subtypes of psychopathy, which overlap, in different aspects, with the various personality disorders outlined in DSM-IV-TR and DSM-5. In order of severity, these subtypes are unprincipled, disingenuous, risk-taking, covetous, spineless, explosive, abrasive, malevolent, tyrannical, and malignant. For example, according to Millon, the "unprincipled psychopath" is seen most commonly in conjunction with narcissistic personality patterns and the "disingenuous psychopath" with a variant of histrionic personality disorder (the individual has a veneer of friendliness and sociability and pursues a strong need for attention and approval). The category "spineless psychopath" is a derivative of the "avoidant and dependent personality" diagnosis, and the "abrasive psychopath" has negativistic and paranoid personality patterns. The "malevolent psychopath" displays the patterns of sadistic or paranoid personalities, the "tyrannical psychopath" those of sadistic and negativistic personalities, and the "malignant psychopath" those of individuals diagnosed with paranoid personality disorder. Furthermore, some psychopathy researchers have advanced the notion that certain of the disorders that are diagnosed more commonly in women, including borderline personality disorder, histrionic personality disorder, and somatization disorder, may represent female expressions of psychopathy (Verona & Vitale, 2006).

Figure 10.1 History of Psychopathy



Notes: [0] = morally neutral; [-] = moral censorious or indicative of social depravity, pejorative (Arrigo & Shipley, 2001; Millon & Davis, 1998).

Researchers have also recently sought to extend former theoretical speculations and clarify this overlap using empirical rather than theoretical approaches. For example, in a sample of 299 German violent offenders, Huchzermeier and colleagues (2007) found significant associations between Factor 2 of PCL-R-measured psychopathy and antisocial and borderline personality disorders; they also found a significant correlation between narcissistic personality disorder and Factor 1 of the PCL-R. In a sample of 84 Belgian adult male forensic patients, Pham and Saloppé (2010) found significant positive relationships between ASPD and (a) PCL-R total scores, (b) Factor 1 and 2 scores, and (c) Facet 1, 3, and 4 scores. They also found a significant positive correlation between narcissistic personality disorder and PCL-R Factor 1 and Facet 1 scores.

Psychopathy and Sociopathy

The term **sociopathy** was first coined in 1914 by German psychiatrist Karl Birnbaum, who attributed the causes of this disorder to societal forces. This social conditioning thesis became prominent among psychiatrists later in the 1920s (Millon & Davis, 1998), and the label "sociopath" gained widespread popularity in the 1950s when social constructivism was the dominant paradigm (Fersch, 2006). In fact, the first DSM (APA, 1952) reflects this social constructivism zeitgeist in its use of the term "sociopathic personality disturbance." Some theorists have proposed a theoretical distinction between sociopathy and psychopathy. In perhaps one of most well known of these theoretical differentiations, Lykken (1995) discusses the "family of antisocial personalities," consisting of sociopathic personality, psychopathic personality, and character neurosis, a "wastebasket collection of persons who break the rules, usually in a rather minor way" and, incidentally, the group most likely to benefit from treatment (p. 39). Lykken relates inadequate socialization to both sociopathic and psychopathic personalities but proposes that, in those with sociopathic personalities—the largest group—this lack of socialization is due to neglectful or incompetent parenting while in those with psychopathy, it is overridden by innate biological (i.e., genetic) characteristics (see also Lykken, 2000). However, Lykken admits that his proposed taxonomy was not derived from empirical data but rather "concocted . . . from the armchair" (Lykken, 1995, p. 41). Other theorists have even proposed a conceptual continuum of psychopaths, sociopaths, normal criminal offenders (i.e., neither psychopaths nor sociopaths), and non-offenders—based on biological predispositions and parenting competency (Walsh & Wu, 2008).

Although a theoretical distinction between sociopathy and psychopathy may be helpful in terms of understanding the etiology of the behavior associated with these disorders, in practice, this distinction has gained little—if any—scientific traction. For example, to date there are no empirically validated methods for measuring sociopathy in research studies, and no one has articulated how the outward clinical presentation of sociopathy might be distinguishable from that of psychopathy. So, from a scientific standpoint, "sociopathy" is an antiquated term, lacking clear definition and remaining largely unsuitable for technical use.

Theoretical Conceptualizations

Meloy and Shiva (2007) discuss how several psychoanalytic theories may help us understand psychopathy. These authors quote Freud (1928/1961) to eloquently summarize the psychoanalytic conceptualization of the psychopathic mind:

> two traits are essential in a criminal: boundless egoism and a strong destructive urge. Common to both of these, and a necessary condition for their expression, is absence of love, lack of an emotional appreciation for (human) objects. (p. 178)

According to Meloy and Shiva (2007), the foundation on which the "house of psychopath" is constructed is comprised of three elements: no attachment, underarousal, and minimal anxiety. The psychopath's mind is characterized predominantly by a dismissive attachment style or a chronic emotional detachment from others (which includes elements such as apathy, self-absorption, preoccupation with nonhuman objects, and no displays of emotion). British psychoanalyst John Bowlby initially described this condition as "affectionless

psychopathy" in a study of 44 juvenile thieves (Bowlby, 1944). He believed it was caused by constant maternal rejection in infancy and early childhood. In fact, early skin contact with the mother may be the first means of affectional relatedness and the beginnings of secure attachment, which may be absent in the psychopath (Meloy & Shiva, 2007).

Other unconscious processes have been proposed to be at work in the etiology and maintenance of the psychopathic personality. For example, psychopaths may be characterized by failures of internalization—meaning failures in the transference of external means of biological and psychological regulation and functioning to their inner worlds. These failures begin with an organism's distrust of the environment and deficits in incorporation (e.g., the infant's developmentally primitive instinct and desire to "take in" everything—from the mother's nipple to a piece of lint on the floor—through its mouth). Two kinds of internalizations, *identifications* (ways of modifying the self or behavior to resemble the object) and *introjections* (internalized representations of objects that become part of the superego) thus become, in the psychopath, absent, unavailable when wanted, or harsh and unpleasant. Lacking internalized processes for self-soothing, the child anticipates hard, aggressive objects from the outside world and identifies with them for adaptation and defense. Anna Freud (1936/1966) called this phenomenon "identification with the aggressor," when abused children closely bond to their abusive parent; Meloy (2001, in Meloy & Shiva, 2007) termed it a "predator part-object" in psychopathy. According to Meloy and Shiva (2007), the central motivation of the psychopath is to dominate his objects (p. 339); thus, the psychopath operates from within a dominance-submission (prey-predator) paradigm, desiring neither affectional relating nor reciprocal altruism.

Furthermore, psychopaths are characterized by a grandiose self structure comprised of (1) a "real self," the actual specialness of the child; (2) the "ideal self," a fantasized image compensating for oral rage and envy; and (3) an "ideal object," a fantasized image of a parent who is completely loving and accepting—often contrasting with the behavior of the devalued actual parent. They also have primitive object relations, with a personality organized at the preoedipal or borderline level and no tripartite structure (id, ego, superego), and unintegrated good and bad part-objects maintained through primitive defenses. Finally, the psychopath is thought to be characterized by sadistic superego precursors, which are projected aspects of early persecutory objects; narcissistically defined affects, which create an emotional world similar to that of a presocialized young toddler—in fact, psychopathic men are said to modulate emotions like five- to seven-year-old boys (Meloy & Shiva, 2007, p. 342); and two ego-syntonic modes of aggression: affective and predatory.

From an evolutionary perspective, some theorists have proposed how the behavioral traits of psychopathy may be transmitted intergenerationally. For example, Dawkins (1989, in Raine, 1993) proposes the notion of the "selfish gene," wherein genes struggle selfishly and ruthlessly for their only goal—survival—and humans are merely containers to serve this purpose. Individuals may die, but genes are passed on from generation to generation. Furthermore, behaviors evolve if they increase the "reproductive fitness" (ability to have more offspring) of the individual. Resources (e.g., food and access to mates) are crucial to reproductive fitness, and, in humans, such fitness stems from power, money, and social class. Furthermore, although reciprocal altruism (e.g., sharing food with hungry neighbors) provides an evolutionary advantage, so, in fact, does antisocial behavior, in the form of a "cheating" strategy involving lying and property crime. In fact, sexual infidelity and rape can be seen as the "ultimate" reproductive cheating strategies; hence psychopaths (from an evolutionary perspective) become the "ultimate cheats" (Raine, 1993).

Some have proposed that psychopathic traits may develop at the "macro" level, necessitated by the location, ecological niche, and social climate of a given society. For example, Raine (1993) contrasts the characteristic psychopathic and nonpsychopathic qualities of two relatively geographically isolated groups of people in different parts of the world: the !Kung bushmen of the Kalahari desert and the Mundurucu of the Amazon basin (see Box 10.2). Another often-cited example is the Yanomamo Indians of southern Venezuela and northern Brazil. Chagnon (1988, in Raine, 1993) found the men of this tribe to be characterized by significant psychopathic features: they broke rules when doing so was in their interest, forcibly appropriated women, and were fearless and highly aggressive. Of all male deaths in this group, 30% are due to violence. In fact, the term "*unokais*" is bestowed upon any tribal member who has committed homicide, and Chagnon reported nearly half (44%) of all Yanomamo males over the age of 25 have killed (one *unokais* killed 16 times). Murders are motivated by fighting over women, and violence translates directly into reproductive fitness. Specifically, *unokais*—compared to men

BOX 10.2 PSYCHOPATHIC AND NONPSYCHOPATHIC SOCIETIES

	!Kung Bushmen	Mundurucu
Location	Kalahari desert	Amazon basin
Ecological Niche	Harsh	Rich
Social Climate	Cooperative	Competitive
Parental Investment	High	Low
Fertility	Low	High
Male Activities	Group hunting	Competition, raids
Favored Traits	Reciprocal altruism, careful mate selection, good parenting	Manipulative behavior, fearlessness, fighting

Source: Adapted from Raine (1993).

who have not killed—have more wives (1.63 vs. 0.63) and children (4.91 vs. 1.59), and villages containing *unokais* are attacked less frequently and have lower death rates.[4]

From a neurobiological perspective, imaging studies have identified abnormalities in brain structure and function that may point toward underlying neurobiological mechanisms in the development of psychopathy. More specifically, these abnormalities are in the cortical regions, such as the prefrontal regions, and the subcortical regions, such as the amygdala and other limbic structures (Glenn & Raine, 2009). For example, fMRI evidence indicates deficient fear conditioning in psychopathic individuals in the limbic-prefrontal circuit: the amygdala, orbitofrontal cortex, insula, and anterior cingulate (Birbaumer et al., 2005). Also abnormalities in emotion processing exist in the cortical and subcortical brain regions of criminal psychopaths (Müller et al., 2003). Structural imaging studies have identified corpus callosum abnormalities (e.g., in white matter volume, thickness, and length) in the brains of psychopathic antisocial individuals (Raine et al., 2003) and an exaggerated structural asymmetry between the right and left hippocampi, with the right hemisphere's volume greater than the left's, in unsuccessful psychopaths (Raine et al., 2004). Finally, Yang and colleagues (2005a) found white matter structural increases in the prefrontal region of the brains of pathological liars, which may explain why psychopathic individuals can become such adept and proficient (i.e., pathological) liars. Furthermore, researchers have examined genetic influences on psychopathy and antisocial behavior, particularly as they may relate to or interact with influences from the environment. Twin and adoption studies tend to define psychopathy via related personality traits rather than the PCL-R (Waldman & Rhee, 2006). A meta-analysis of 51 twin and adoption studies (Waldman & Rhee, 2006) indicates evidence for genetic and non-shared environmental influences (i.e., nearly 50% for each) but not for shared environmental influences. Overall, neurobiological research has become one of the most impassioned and promising areas of investigation in the study of psychopathy.

4. Similar cross-cultural examples of psychopathic individuals have been identified in cultures from around the world. For example, the Yoruba, a rural tribe from Nigeria, has a syndrome known as *arankan*—a person "who always goes his own way regardless of others, who is uncooperative, full of malice, and bullheaded." The Alaskan Inuit have a word, "*kunlangeta*," that refers to an individual whose "mind knows what to do but he does not do it." This individual may repeatedly lie, cheat, steal, and refuse to go hunting; and when the other men are away from the village, he takes sexual advantage of many women. He does not pay attention to reprimands, and is always being brought before the elders for punishment (Murphy, 1976, p. 1026).

Contributions from other theoretical perspectives have also aided in our current understanding of the etiological mechanisms underlying psychopathy. From a cognitive and information processing perspective, numerous studies have identified a broad array of deficits in attention, language, and behavioral inhibition among psychopathic individuals (Hiatt & Newman, 2006). Psychosocial theorists have emphasized the role of family background in the development of psychopathy. Early psychosocial research in psychopathy began with the pioneering work of Bowlby (1944) on the relationship between prolonged maternal deprivation and "affectionless psychopathy" and delinquency (see above). Also, McCord and McCord (1964) emphasized the influence of parental rejection, having an antisocial parent, erratic discipline, and poor parental supervision on the development of psychopathy. Subsequent researchers have linked the etiology of psychopathy to family factors such as childrearing problems (meaning the supervision and monitoring of children), with poor supervision being the strongest predictor of offending among all childrearing deficits; discipline or parental reinforcement, with harsh or punitive discipline, erratic or inconsistent discipline, and low parental reinforcement (i.e., not praising) predicting offending; the warmth or coldness of emotional relationships, with cold, rejecting parents tending to have delinquent children; parental involvement with children, with low parental involvement in the child's activities predicting offending; child abuse and neglect; parental conflict and disrupted families; and large family size. This last factor might need some explanation: as the number of children in a family increases, the amount of parental attention given to each child decreases; and as the number of children increases, the household tends to become more overcrowded, possibly leading to increases in frustration, irritation, and conflict. Other family factors associated with the development of psychopathy are having criminal or antisocial parents or siblings; other parental features such as mothers who bear children early or in their teens or who are unwed, high parental stress, parental anxiety or depression, or parental substance use; and socioeconomic factors.

The Relationship Between Psychopathy and Crime

The Prevalence of Psychopathy in Criminal Populations. Studies of prevalence rates of psychopathy in criminal populations are somewhat unique relative to those for the other personality disorders covered in this chapter in that they tend to appear in one of two forms: (1) with rates of psychopathy reported as present or absent or (2) with rates of psychopathy reported as actual PCL-R scores. Given the enormous number of studies of psychopathy in criminal populations published over the past several decades and the sheer numbers of prevalence rates that could be gleaned from each, we did not attempt to present a comprehensive or even a representative list of such studies here. Rather, a comparatively modest number of studies were identified to demonstrate how our general organizational framework for understanding the relationship between mental illness and crime (i.e., via the examination of reported prevalence rates) could be applied to the literature on psychopathy (see Tables 10.19 and 10.20).

The Relationship Between Sociopathy and Crime

For posterity's sake, examples of studies examining the prevalence rates of sociopathy and crime were also identified here (see Tables 10.19 and 10.20). Interesting (but not surprising) is their publication before the formal research operationalization of psychopathy in the PCL in the year 1980 (and before the move toward ASPD in the DSM-III). Also interesting is the fact that the specific method used to produce a diagnosis of sociopathy in these studies (with the exception of the study by Guze et al., 1974) is conspicuous in its absence (as it is in most of the pre-1980 studies of psychopathy discussed above).

Psychopathy and Risk for Recidivism

The area of psychopathy research that predominates the literature on the relationship between psychopathy and crime addresses how psychopathy might relate to criminal recidivism. This research has had and will continue to have significant practical implications, particularly given the criminal justice system's strong demand for predictions of criminal and violent behavior (e.g., by the parole boards, courts, and clinicians responsible for releasing clients). Dozens of studies utilizing an array of different methodological approaches have examined the utility of psychopathy in criminal recidivism prediction. These studies have varied in aspects such as research design (i.e., prospective designs versus postdictive analyses), psychopathy measurement (i.e., PCL-defined measures versus

Table 10.19 Prevalence of Psychopathy and Sociopathy in Criminal Populations

Psychopathy								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Cohen & Freeman (1945)	(1) 320 (2) 87	M, F	Adult?	AR	Police records of arrested patients from 1,676 patients paroled or discharged from Norwich State Hospital (Connecticut), 1940–1944 (1) Arrested before hospitalization (2) Arrested after hospitalization	Psychopathic personality	?	(1) 3.7% (n = 12) (2) 4.6% (n = 4)
West (1966)	148	88 M, 60 F	< 20 – 40+	HO	Homicide followed by suicide, subjects in England and Wales, 1954–1961	Aggressive psychopaths	?	2.7% (n = 4)
Okasha et al. (1975)	(1) 60 (2) 20	(1) 50 M, 10 F (2) ?M, ?F	25–35[a]	HO	"Socio-psychiatric study" of (1) Murderers in Abou-Zabel and Kanater prisons, Egypt (2) Murderers in Egyptian State Mental Hospital	Psychopathy	?	(1) 50.0% (n = 30) (2) 0.0% (n = 0)
Heilbrun 1979	76	?	M = 30.14	JD	Prisoners in Georgia state system (inclusion in study required at least grade 6 reading level)	Psychopathy	MMPI-Pd scale & CPI-So scale	50% scores of 32+
Grann et al. (1999)	401	M/F?	?	JD (and post-detainment follow up)	Individuals convicted of violent crime and court-ordered to evaluation	Psychopathy	PCL-R	43% scores of 22+ 32% scores of 26+ 10% scores of 32+

(Continued)

(Continued)

Psychopathy								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Långström & Lindblad (2000)	56	M = 54 F = 2	15–20	JD	Adolescents who committed a crime severe enough to receive detainment and be ordered to forensic psychiatric investigations	Psychopathy	PCL-R	16% (n = 9) Score of 26+
Langevin (2003)	(1) 33 (2) 80 (3) 23 (4) 611	M	(1) M = 32.06 (2) M = 27.58 (3) M = 27.57 (4) M = 31.42	PI	Interviews with convicted sex offenders (n = 747) belonging to one of four groups: (1) sex killers, (2) nonhomicidal sexually aggressives, (3) nonhomicidal sadists, and (4) general sex offenders. Participants were chosen from a database of more than 2,800 minimum-security forensic ward psychiatric hospital cases (Clarke Institute in Toronto, Ontario, Canada) seen since 1973	PCL-R > 30	PCL-R	15.2% 15.0% 17.4% 4.8%
Porter et al. (2003)	38	M	41.42	JD/HO	Sexual homicide offenders taken from a group of 125 homicide offenders, from a larger group of about 800 incarcerated offenders in Canadian federal prisons	Psychopathy	PCL-R	52.6 % (n = 20) scores of 30+
Hervé et al. (2004)	90	M	M = 30.6	JD	Archival study of incarcerated federal offenders who had committed acts of unlawful confinement (hostage takers), 1960s–1998, Pacific region of Canada	Psychopathy	PCL-R	48.9 % (n = 44) PCL-R ≥ 30
Vitacco et al. (2007)	168	M	M=16.40	PI	Offenders placed at the Medota Juvenile Treatment Center in Wisconsin	Psychopathy	PCL-YV	M = 19.10

Psychopathy								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Walsh & Kosson (2007)	199	M	17–40	JD	Offenders serving 1 or less years at a county jail	Psychopathy	PCL-R	33.2% (n = 66) scores of 30+
Fougere, Potter & Boutilier (2009)	40	M	13–19	JD, CS	File review of court-ordered assessments or of aggression risk assessments in Nova Scotia	Psychopathy	PCL-YV	Median score in violent group = 21 Median score of sexual offender group = 17.5
Sociopathy								
Source	**N**	**Gender**	**Age**	**Study Type**[a1]	**Sample Description**	**Disorder**	**Diagnostic System**	**Prevalence/Incidence**
Pfeiffer, Eisenstein, & Dabbs (1967)	85	2/3 M, 1/3 F	17–63	JD	Federal prisoners referred for mental competency evaluations, at the USPHS Hospital in Lexington, Kentucky, 1960–1965	Sociopathic personality	?	2.4% (n =2)
Kahn (1971)	43	41 M, 2 F	11–74	HO	Interviews and psychiatric examinations of individuals who made pleas of insanity to charges of first- or second-degree murder.	Sociopathic	?	32.6% (n =14)

Notes: [a1]AR = arrest rates of patients discharged from psychiatric facilities, JD = jailed detainees and incarcerated prisoners, HO = homicide offenders, BC = birth cohort study, PI = psychiatric inpatient sample, CS = community sample (i.e., epidemiological catchment area survey studies and outpatient psychiatric patients).

[a] Highest percentage of subjects in this age range.

Table 10.20 The Prevalence of Crime in Psychopathic Populations

Source	N	Gender	Age	Study Type	Sample Description	Disorder	Crime Definition	Prevalence/Incidence
Guze et al. (1974)	35	?M, ?F	Adult	CS	Community psychiatric clinic patients, diagnosed using Feighner's diagnostic criteria (Feighner et al., 1972)	Sociopathy	Felony conviction	37.0% (n = 13)
Ishikawa et al. (2001) and Yang et al. (2005b)	29	M	21–45	CS	Interviews and collateral file reviews of 91 adult males recruited from five temporary employment agencies in the greater Los Angeles area, diagnosed with the PCL-R (using a tertile split)	Psychopathy	Criminal convictions (court records and self-report)	"Unsuccessful psychopaths": 55.2% (n = 16)

A Closer Look: Psychopathy and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	1	3.4–4.6%
Birth cohorts	0	–
Community samples	1*	(see below)‡
Homicide offenders	2	0.0–50.0%
Jailed detainees and prisoners	7*	10.0–52.6%‡
Psychiatric inpatients	2	4.8–17.4%†
Total Number of Studies	**12**	

Sample Characteristics

Size	38–747
Gender	Male only (6 studies); male and female but generally more males than females (5 studies); not reported (1 study)
Age	Youth, adult

Location	North American and European countries (e.g., Canada, England, Egypt, the United States, and Wales)
Diagnostic Systems	PCL-R, PCL-YV, MMPI-Pd scale, and CPI-So scale, not reported in earlier studies

Notes: *One study (Fougere et al., 2009) involved both jailed detainees or prisoners and community individuals.

†Rates reported in Langevin (2003). In another psychiatric inpatient study (Vitacco et al., 2007), the mean PCL-YV score was 19.10.

‡Fougere et al. (2009) reported mean PCL-YV scores of 21.0 for violent offenders and 17.5 for sexual offenders.

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Arrest rates	0	–	–
Birth cohorts	0	–	–
Community samples	1	55.2%	"Unsuccessful psychopaths" (criminal convictions)
Homicide offenders	0	–	–
Jailed detainees and prisoners	0	–	–
Psychiatric inpatients	0	–	–
Total Number of Studies	**1**		

Sample Characteristics

Size	29
Gender	Male only
Age	Adult
Location	United States
Diagnostic Systems	PCL-R

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

self-reports), and settings (i.e., prison and correctional settings, forensic psychiatric settings with insanity acquittees as subjects, and civil psychiatric settings). Also, they have taken into account—to varying degrees—factors such as gender, ethnicity, country of study, and age (Douglas et al., 2006). Overall, results from a series of meta-analyses of these studies conducted within the past two decades have (with some caveats) generally supported an association between measures of psychopathy and criminal re-offending, across contexts and types of people (Gendreau et al., 2002; Hemphill et al., 1998; Salekin et al., 1996; and Walters, 2003, in Douglas et al., 2006). Efforts to further refine our understanding of this relationship continue (e.g., Walters, 2012). In fact, PCL measures of psychopathy continue to play a prominent role in contemporary risk assessment instruments (Douglas et al., 2006) and have demonstrated comparatively more predictive power than other recidivism-related variables, such as substance abuse, early behavioral problems, age, number of convictions, elementary school maladjustment, early separation from a parent, never having been married, and failure on prior conditional release (e.g., Grann et al., 1999; Harris et al, 1993).

A Closer Look: Sociopathy and Crime

Prevalence of the Disorder in Crime

Study Type	Number	Prevalence Rates
Arrest rates	0	–
Birth cohorts	0	–
Community samples	0	–
Homicide offenders	1	32.6%
Jailed detainees and prisoners	1	2.4%
Psychiatric inpatients	0	–
Total Number of Studies	**2**	

Sample Characteristics	
Size	43–85
Gender	Male and female (predominantly male)
Age	Youth, adult
Location	United States
Diagnostic Systems	Not specified

Prevalence of Crime in the Disorder

Study Type	Number	Prevalence Rates	Crime Definition
Arrest rates	0	–	–
Birth cohorts	0	–	–
Community samples	1*	37.0%	Felony convictions
Homicide offenders	0	–	–
Jailed detainees and prisoners	0	–	–
Psychiatric inpatients	0	–	–
Total Number of Studies	**1**		

Sample Characteristics	
Size	35
Gender	Male and female
Age	Adult
Location	Not specified
Diagnostic Systems	Feigner diagnostic criteria

Note: *Community psychiatric patients.

Nondisordered or community resident comparison group or general population baseline rates for either disorder or crime provided: **0 studies (0.0%)**

More recent work has focused on how different factors—such as socioeconomic status and ethnicity—may interact with psychopathy in the prediction of violence. For example, in a sample of county jail inmates in the United States, Walsh and Kosson (2007) found psychopaths to be nearly twice as likely to reoffend violently than those without a psychopathy diagnosis; also, although psychopathy predicted recidivism at lower but not higher levels of socioeconomic status (SES) for European American inmates, its predictive power was stable across SES levels for African American inmates. Furthermore, a recent meta-analysis by Hawes and colleagues (2013) has shown the effectiveness of a combination of psychopathy and measures of sexual deviance as predictors of sexual recidivism.

Psychopathy, Homicide, and Other Violent Crimes

A fair amount of empirical attention has been directed toward understanding the nature of violence and aggression in individuals with psychopathy, and evidence suggests that the violent crimes committed by psychopaths exhibit a more complex and distinctive form of violence than do those of other violent offenders (O'Toole, 2007).

Motivation: Instrumental Homicides. Studies of homicide offenders have demonstrated how psychopaths may have different motives for murder than do those who are not psychopaths. Specifically, distinctions have been made between instrumental and reactive homicides. According to Woodworth and Porter (2002), *instrumental homicides* are "cold blooded"—associated with premeditation, motivated by an external goal, and not preceded by a strong emotional reaction (e.g., an offender carefully plans, carries out, and conceals a homicide in order to steal from the victim). *Reactive homicides*, however, are "crimes of passion"—associated with high levels of impulsivity, reactivity, and emotions (e.g., a stranger verbally insults the perpetrator, who, in a rage, immediately starts a fight and proceeds to stab the victim to death with a weapon of "convenience," such as a broken bottle in a bar). It has been proposed that violence and aggression in psychopaths is motivated by primitive or weak rather than intense or emotional states and thus is more instrumental in nature (Hare, 2003). Others argue that, although psychopaths are certainly capable of both instrumental and reactive violence, they are prone to the former (Glenn & Raine, 2009).

In fact, many studies involving different sample types (i.e., incarcerated offenders and community individuals) and methodologies (e.g., the coding of offense histories, psychological tests, and computer tasks) have shown relationships between various forms of instrumental aggression and psychopathy (Cornell et al., 1997; Glenn & Raine, 2009; Hare, 2003; Serin, 1991). However, some of these (e.g., Glenn & Raine, 2009; Serin, 1991) are not based on criminal offending. Regarding homicide offenders, Woodworth and Porter (2002), for example, found nearly all (93.3%) of homicides committed by psychopaths in a sample of 125 Canadian offenders to be instrumental in nature, compared to approximately half (48.4%) of those committed by offenders who were not psychopaths. Williamson and colleagues (1987) found that, among offenders from five Canadian correctional institutions convicted of violent crimes (including murder, violent assaults, robbery, kidnapping, and sexual assault), psychopaths were significantly more likely motivated by material gain, while those not psychopathic were more often motivated by strong emotional arousal (i.e., jealousy, rage, or intense argument). In fact, most homicides committed by nonpsychopaths—but none of those committed by psychopaths—occurred during a domestic dispute or an intensely emotional event. Cornell and colleagues (1997) found that instrumental (and more psychopathic) violent offenders were significantly more often not provoked by the behavior of the victim and not acting in a state of anger compared to reactive violent offenders. Studies have also demonstrated that instrumental violence and homicide may be more related to the interpersonal and affective (i.e., Factor 1) features of psychopathy (Dempster et al., 1996, in Hare, 2003; Porter et al., 2001; Woodworth & Porter, 2002), though psychopathic murderers may be unwilling (or perhaps or unable) to recognize the instrumental nature of their own violence. For example, Porter and Woodworth (2007) compared the official accounts and self-reported descriptions of homicides committed by 50 incarcerated offenders and found that psychopaths exaggerated the reactivity of their homicides to a greater degree than nonpsychopaths (even though the homicides of psychopaths were primarily instrumental). Finally, although the aggression of psychopaths often appears to

be used for instrumental gain, recent evidence suggests that aggression by psychopaths may also have more self-gratifying aspects, as evidenced by thrill-seeking and sadistic motivations (Porter & Woodworth, 2006).

Victimology. Perhaps due to the interpersonal deficits associated with psychopathy (i.e., little familial contact, reduced relationship intensity, frequent changes in residence), some researchers have speculated that psychopaths would victimize known individuals such as family members or friends less often when committing acts of violence (Williamson et al., 1987). In fact, barring some rare exceptions (e.g., Laurell & Dåderman, 2005), one of most consistent findings across studies is that victims are generally not family members but rather are unknown to the psychopathic violent offender (e.g., Cornell et al., 1997; Weizman-Henelius et al., 2002). Some evidence suggests that victim gender may also be somehow related to psychopathy in violent offending. For example, Williamson and colleagues (1987) found that nonpsychopaths were more likely to victimize females that were known to them, but psychopaths more often victimized males who were not known to them. Interestingly, Hervé and colleagues (2004) found that violent Canadian hostage takers were more likely to have victimized female strangers. In the most comprehensive study to date of the relationship between crime scene behavioral characteristics and psychopathy, Häkkänen-Nyholm and Hare (2009), using retrospective file-based PCL-R assessments, national legal registry data, and computerized police crime report data in a sample of 546 Finnish homicide offenders, found that offenders with higher PCL-R scores were more likely to kill males as well as nonfamily members or ex-partners.[5] Other aspects of the victimology of psychopathic violent criminals have also been examined. For example, offenders whose victims include both children and adults are more likely than not to be psychopaths (O'Toole, 2007).

Offense Behavior. Other researchers have examined potential relationships between psychopathy and specific offense-related behaviors. Regarding offense planning, Williamson and colleagues (1987) suggest that psychopaths often engage in criminal behavior that lacks purpose and long-range planning, but Cornell and colleagues (1997) found instrumental violent offenders (who are, by and large, more psychopathic) had significantly higher proportions of offense planning and goals present than did reactive violent offenders. Studies have also shown that a psychopathic offender is more likely to commit a sexually motivated homicide and to engage in significantly more gratuitous or excessive violence, including sadistic violence, than is a nonpsychopathic offender (Porter et al., 2003). Juodis and colleagues (2009) found psychopathic murderers were more likely to act alone when perpetrating sexual homicides but tended to involve an accomplice in other types of homicides. Additionally, psychopaths were likely to commit gratuitous acts of violence against women, regardless of whether or not they were acting alone. Regarding other offense-related behaviors, homicidal offenders with increased levels of psychopathy have demonstrated a greater likelihood of being under the influence of alcohol while killing and of leaving their crime scenes without informing anyone (Häkkänen-Nyholm & Hare, 2009); and male psychopaths have been shown to be more geographically mobile than nonpsychopaths (O'Toole, 2007). Finally, psychopathic traits may be inferred from the crime scene behaviors of serial violent offenders. Impulsivity and sensation seeking may be evidenced by the variation among the crime scenes of one offender (e.g., in victim age, race, and physical appearance; in method of assault; in types of injuries to victims; and in weapon choice). There may be risky behavior over and beyond what is needed to commit the crime, and glibness or superficial charm and conning and manipulative behavior may be indicated by the killer's various approaches to accessing victims, which might include a con, ruse, or surprise or a blitz assault (O'Toole, 2007).

Psychopathy and Serial Murder. Ted Bundy's pattern of heinous violent behavior may be very difficult for some to understand. Many serial killers like Bundy perpetrate multiple acts of extreme violence against others, which—on their face—would seem to indicate that some form of severe personality pathology (such as psychopathy) is at work in these individuals. It seems tempting, then, if not intuitive, to assume a strong

5. The past decade (with the exception of rare examples such as Taylor et al., 2012) has, disappointingly, yielded a near dearth of systematic empirical studies into the effectiveness of criminal investigative psychological techniques such as criminal profiling. Schug thinks that studies such as this—linking measurable personality constructs to documented crime scene behaviors—are among the most promising lines of inquiry to date for advancing the current (and, arguably, floundering) scientific state of the practice of criminal profiling.

association between serial murder and psychopathy. In fact, frequent references are made in the serial murder literature to these killers being "psychopathic sexual sadists" (Geberth & Turco, 1997). Furthermore, criminal profiling methods developed by the FBI have relied heavily upon differentiating both crime scenes and offenders into psychopathic (organized) and psychotic (disorganized) types, especially in serial and sexual homicide cases (Turvey, 2008), and the presence of psychopathy has been noted in published case assessment reports of sexual murderers (e.g., Gacono, 1997). Moreover, one statistic that is commonly proffered in media and law enforcement circles is that over 90% of all serial killers are psychopaths. Though this figure is impressive and even sounds reasonable, one must be cautioned that the "science" behind it is actually somewhat dubious.

In fact, to date, very few empirical investigations into the relationship between psychopathy and serial murder have been undertaken. Geberth and Turco (1997), for example, used a case history evaluation protocol (including psychiatric and law enforcement data) on a sample of 248 identified serial sexual killers in the United States. They found that all of those with complete protocols ($n = 68$) met a rigorous DSM-IV criteria for ASPD and sexual sadism (psychopathy, however, was not assessed). The widely publicized "90%" figure mentioned above appears to be derived from a study by Stone (1998), who—in an admittedly novel approach—reviewed 279 "true crime" biographies of murderers. Results indicated that 74 out of 77 (or 96%) of the male serial killers in this sample met PCL-R criteria for psychopathy (using PCL-R scores of 25 or higher). Stone acknowledges some of the methodological weaknesses of this approach, admitting that his biographical series is not representative of murderers in the United States in general. (In fact, according to Stone, only about 1 murderer in 1,100 becomes the subject of a full-length book.) He also appears to acknowledge that detailed information obtained from direct clinical interviews would be more desirable than that derived from biographical novels.

Other studies, on balance, have demonstrated how individuals who commit horrific homicidal acts against others may not necessarily be psychopathic. For example, in a study of 14 juvenile offenders who had committed simultaneous sexual assault and homicide or attempted homicide, Myers and Blashfield (1997) found mean PCL-R scores to be 22.4 (range 7.1–30.6). In a later study of 25 nonfamily child abductors who murdered their victims, Beyer and Beasley (2004) reported mean PCL-R scores of 17.6 (range 5–37). In fact, only four of the offenders (19%) in this study exceeded the cutoff score that would classify them as psychopaths; this finding was consistent with the overall lack of glibness or superficiality or of conning or manipulation among this group and with the presence of appropriate affect and expressions of remorse and even of victim empathy observed in many of these participants.

In sum, what is known about the relationship between psychopathy and serial murder is actually very limited. Widely disseminated characterizations of this relationship are based on less-than-scientific data collection methods, systematic studies are few and far between, and studies of individuals who commit reprehensible acts of sexualized lethal violence demonstrate that these individuals often do not necessarily meet diagnostic criteria for psychopathy.

Psychopathy and "White-Collar" Crimes

In a casual response to a journalist's question at the end of a 2002 address to the Canadian Police Association meeting in St. John's, Newfoundland, Robert Hare astutely noted, "Not all psychopaths are in prison. Some are in the boardroom" (Babiak et al., 2010). In fact, recent decades have witnessed the growth of target-rich environments in which white-collar or corporate psychopaths are able to thrive: business, financial institutions, organized religion, politics, social organizations, and the Internet are now fertile and lucrative "kill zones," with Ponzi schemes, insider trading, and mortgage and Internet frauds their weapons of economic assault.

Lykken (1995) linked the concepts of psychopathy and white-collar criminality by first noting the importance of examining the white-collar criminal within the context of his proposed classification of criminal types, referring to them as "people with 'broadly normal temperaments and backgrounds [who] are sometimes lured into crime by environmental circumstances that constitute a kind of Devil's offer that they cannot (or do not choose) to refuse'" (p. 20). He subsequently stated that these are the politicians, police officers, businessmen, lawyers, company executives, or stock speculators who, on one hand, may feel normative shame and guilt if caught and, on the other, may be more likely to succumb to this "Devil's offer" if they possess a psychopathic personality. Hare (1993) discusses how psychopathic individuals may con or manipulate their way into desirable and profitable professional roles. Using their masterful skills as imposters, these individuals may forge and

brazenly use impressive credentials (often faked and unchecked, in professions with easy-to-learn jargon) to adopt or acquire positions that offer prestige and power, such as the professional position of financial consultant, minister, counselor, psychologist, medical doctor, and even surgeon.

Though it makes sense that many psychopaths would likely not possess a common work ethic, the corporate environment of large organizations can be a prime hunting ground for entrepreneurial psychopaths with the necessary skills and attributes to fool others; especially useful are psychopathic traits that equate to "talents" in the business world (Babiak & Hare, 2006). Other researchers have even suggested that there are specific behavioral manifestations of corporate psychopathy, including features such as the harsh treatment of employees, the sudden termination of employee contracts, unhealthy and environmentally damaging production practices, dangerous working conditions, the violation of human rights conventions and employment laws, and bullying (Boddy, 2011).

The fact remains, however, that there is little empirical data on the role of psychopathy in corporate crime (Babiak et al., 2010). One notable exception is a first-of-its-kind study of 203 U.S. corporate professionals, in which Babiak and colleagues (2010) used in-house "360°" assessments and performance ratings to determine the applicability of PCL measures of psychopathy in a corporate sample, as well as the prevalence of psychopathic traits. Results indicated that the performance of PCL measures was comparably to that observed in studies of offenders and community members: the prevalence rate of psychopathy in this sample was higher than reported rates in community samples (5.9% compared to 1.2% for "potential" or "possible" psychopathy and 3.0% compared to 0.2% for a PCL-R-comparable cut score of 30). Furthermore, psychopathy scores were associated with peer ratings of creativity and good strategic thinking and communication skills (charisma and good presentation style) but negatively associated with ratings of being a team player, management skills, and overall accomplishments (responsibility and performance). Further research (Mathieu et al., 2013) has demonstrated the utility and effectiveness of the B-Scan 360, a promising measure of psychopathy for use in corporate settings. Other methods of operationalizing corporate psychopathy have been proposed (e.g., Boddy, 2011), but these require empirical validation.

Psychopathy and Sexual Crimes

Sex for the psychopath is characteristically impersonal, casual, and trivial (Hare, 2003)—a state of affairs that might seem to encourage sexual offending. However, much of the literature on the relationship between psychopathy and sexual crimes presents a somewhat mixed picture. For example, a review by Vitacco and Rogers (2009) indicates that, although sexual offending recidivists are characterized by increased PCL-R scores relative to sexual offenders who do not reoffend, in general, most sex offenders—including recidivists—are not psychopaths (see Table 10.21). According to Vitacco and Rogers (2009), this is because sex offenders often have multiple motivations for deviant behavior. However, in a small subset of sex offenders, psychopathic traits do appear to play a contributory role in sex offending.

Table 10.21 Psychopathy and Recidivism in Sex Offenders

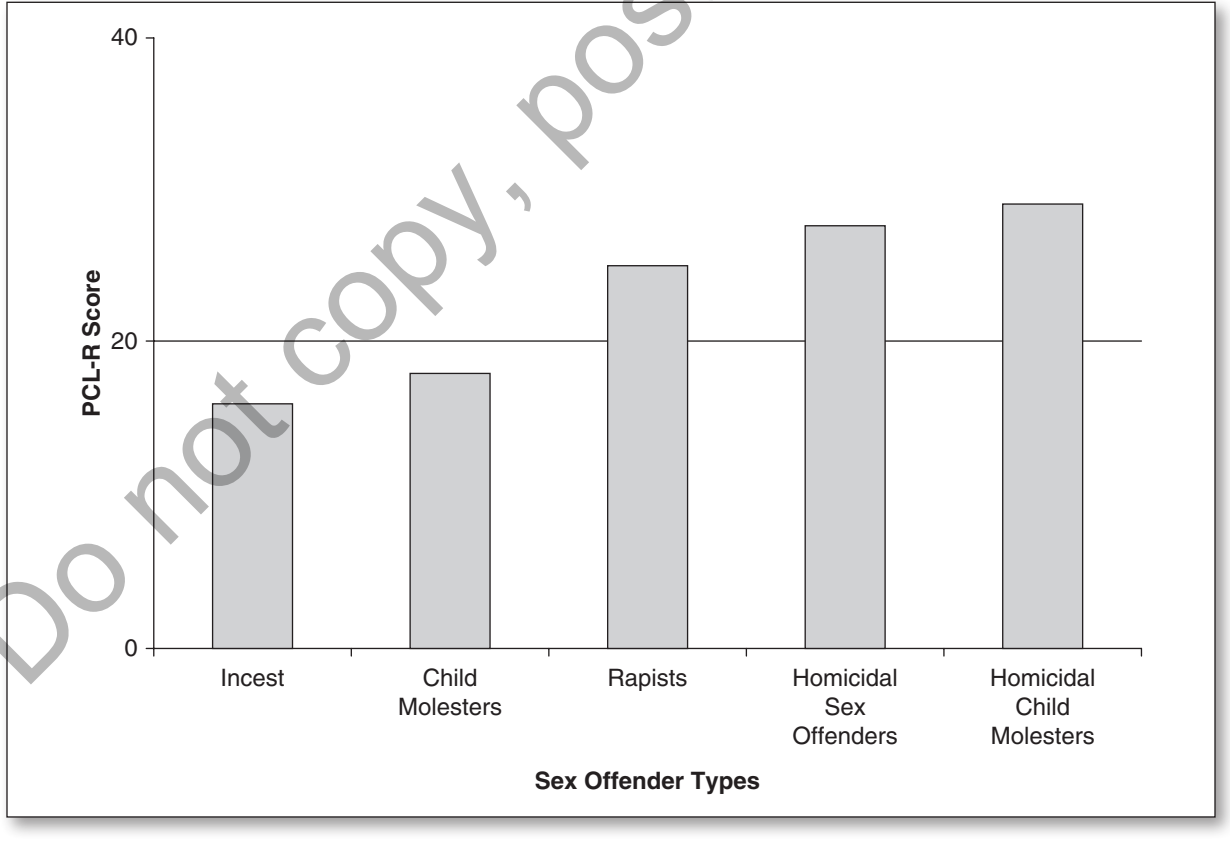
	PCL-R Total Scores	
Study	**Sex Offenders Who Reoffend**	**Sex Offenders Who Do Not Reoffend**
Langevin et al. (2004)	21.4	15.7
Hanson & Harris (2000)	23.4	16.7
Dempster (1998), Simourd & Malcomb (1998)	21.5, 23.2	13.3
Firestone et al. (1999)	21.7	16.3

Source: Vitacco & Rogers (2009).

Regarding recidivism studies in particular, Bradford and colleagues (2007) report that PCL-R studies of sex offenders have also shown mixed results. In fact, although the PCL-R has demonstrated strong correlations with general and violent criminal behavior (see above), it appears less strongly correlated with sexual offending behavior (Hare, 2003). However, the PCL-R appears important in differentiating recidivists from nonrecidivists across offender and paraphilia types (Bradford et al., 2007). In fact, the importance of considering the comorbidity of psychopathy and paraphilias in predicting the risk of recidivism has been emphasized in the literature, and psychopathy has historically been factored into various formulations of sexual predator laws (Saleh et al., 2010).

Interestingly, studies have also shown mixed results for the PCL-R's ability to distinguish among sex-offender subtypes. For example, a review by Bradford and colleagues (2007) indicates that PCL-R scores do not appear to differentiate significantly between sex offender and paraphilia types (i.e., between incest offenders, child molesters, rapists, homicidal sex offenders, and homicidal child molesters). In fact, the majority of child molesters are not psychopathic. Nonetheless, PCL-R scores do appear to be comparatively elevated in groups characterized by more violence (see Figure 10.2). In a subsequent study, however, Porter and colleagues (2009) found rapists, a mixed group of rapists and molesters, and offenders convicted of nonsexual crimes had significantly increased mean PCL-R total scores compared to child molesters (with PCL-R scores reported in the child molester and rapist groups similar to those reported by Bradford et al., 2007). But psychopathy was associated with an increased number of previous sex offenses within the child molester group. Clearly, more work is needed to ascertain if specific subtypes of sex offenders are, in fact, characterized by differential levels of psychopathy.

Figure 10.2 Mean PCL-R Scores in Different Sex Offender Types



Source: Adapted from Bradford et al. (2007, p. 288).

Other studies have examined how sexual offending may relate to violence in psychopathic individuals. For example, Porter and colleagues (2003) found that psychopaths committed sexual homicides more often than their nonpsychopathic counterparts and that most sexual murderers (84.7%) had moderate to high scores on the PCL-R. This finding is consistent with other data suggesting increased levels of psychopathy in offenders whose crimes are characterized by both sexual and violent components (see above), though more work is needed to understand the interplay of sex, violence, and psychopathy in the more extreme end of the offending spectrum.

Psychopathy may have important implications in clinical settings involving sexual offenders. For example, Oliver and Wong (2011) examined predictors of treatment dropout in a sample of 154 federally incarcerated sex offenders in a high-intensity sex-offender treatment program. Results from logistic regression and discriminant function analyses indicated that the emotional facet (Facet 1) of the PCL-R and having never being married were the most salient predictors of treatment dropout; this research correctly identified about 70% of the dropout cases. In terms of clinical recommendations, Vitacco and Rogers (2009) suggest that psychopathy should be considered only as a peripheral issue in sexually violent predator (SVP) determinations and that, beyond SVP determinations (e.g., institutional placement or treatment development), psychopathy should be evaluated selectively. These authors recommend considering the complex interplay of paraphilias, psychopathology, and facets of psychopathy in program development and emphasize the fact that measurements of psychopathy may not be precise. In terms of treatment considerations, the following guidelines for the treatment of psychopathic sex offenders have been offered: (1) target cognitive distortions frequently employed to minimize responsibility, (2) target affective deficits that impair ability to experience emotions of others (victims), (3) employ long term components aimed at improving psychopathic personality traits, and (4) target issues related to general recidivism (Vitacco & Rogers, 2009). Overall, the relationship between psychopathy and sexual offending appears to have captured the attention of researchers and clinicians alike, and understanding this relationship could have significant implications in the conceptualization, management, and treatment of this potentially more dangerous and psychopathic sex offender.

Subcriminal Psychopathy

Though psychopaths may be at high risk for engaging in criminal behavior, not all of them succumb to that risk. In fact, for some careers (e.g., bomb disposal technician, test pilot, race car driver), certain levels of psychopathic traits such as fearlessness would seem advantageous—if not necessary. Several authors have discussed the concept of the "successful" psychopath: individuals in the general population whose psychopathy appears in adaptive and subclinical manifestations (Hall & Benning, 2006). Examples from history include, according to some, Oskar Schindler (savior of hundreds of Krakow Jewish concentration camp victims and protagonist of Steven Spielberg's *Schindler's List*), President Lyndon Johnson, Prime Minister Winston Churchill, explorer Sir Richard Burton, and test pilot Chuck Yeager—the first man to break the sound barrier (Lykken, 1995). The term "successful psychopath" may have different connotations, however. For example, Ishikawa and colleagues (2001) utilize the term "successful" psychopath to represent a psychopathic individual who has avoided criminal conviction (but not criminal behavior *per se*). In all, a better understanding of the relationship between psychopathy and crime is achieved by understanding why some psychopaths may avoid committing crimes and, of course, how some are able to commit crimes without being caught.

Psychopathy and the Legal System

According to Lyon and Ogloff (2000), American case law is replete with examples of expert evidence about psychopathy, ASPD, and sociopathy being offered in both criminal and civil courts on a wide array of legal issues. In criminal settings, information about or evidence of psychopathy has been applied to areas such as witness credibility, competency to stand trial, insanity, capital sentencing, and sexual psychopath and habitual offender laws. Within the civil context, evidence of psychopathy has emerged in areas such as child custody disputes and civil commitment procedures. Viljoen and colleagues (2010) reviewed 111 American and Canadian adolescent offender cases, which included 143 separate evaluations involving psychopathy, and found the introduction of psychopathy evidence to be increasingly common in a sizeable number of cases. Results indicated that, although

judges did not make ultimate legal decisions based on psychopathy evidence, this evidence was influential in some cases. Evidence of psychopathy was also used to infer that the treatment of these youths would be difficult or impossible, and the absence of psychopathy was, at times, interpreted as a sign of amenability that supported more lenient sanctions. Juvenile psychopathy is itself a largely unexplored and controversial topic (Salekin, 2006), particularly given the implications of applying the psychopathy label to youth (Viljoen et al., 2010). In fact, some researchers have conceptualized milder forms of psychopathy and developed measures for these; for example, measuring "callous-unemotional (CU) traits" (Frick et al., 2003) might be more appropriate when dealing with youth offender populations. Overall, research indicates that the use of psychopathy in courtroom applications is limited but growing, and it will be interesting to see how psychopathy may factor into legal decision-making processes in the future.

Perhaps alarmingly, recent evidence also suggests that psychopathic individuals may be effective at "working the system"—manipulating decision makers in criminal justice and correctional settings to receive more favorable treatment. For example, Häkkänen-Nyholm and Hare (2009; see above) found psychopathic homicidal offenders to be more likely to deny criminal charges, to be convicted of lesser charges (i.e., involuntary manslaughter as opposed to manslaughter or murder), and to be granted permission from the Supreme Court to appeal their lower court sentence. In a study of 310 male Canadian offenders, Porter and colleagues (2009) found that high-psychopathy sexual and nonsexual offenders (despite significant criminal histories and high rates of recidivism) were two-and-a-half times more likely to be granted conditional release than nonpsychopathic offenders, suggesting their greater proficiency in convincing parole boards to release them into the community.

Origins of Crime and Violence in Psychopathy: Theoretical Explanations and Etiological Mechanisms

Although Cleckley (1941) emphasized that criminal behavior was not inherent to the definition of psychopathy, he admitted that the disorder provided fertile ground for manifestations of crime to occur. Consequently, psychopathy may be considered "criminogenic" in the sense that it allows for the easy expression of crime and violence because of its key characteristic personality traits (e.g., impulsivity and lack of remorse and empathy. In fact, the PCL-R incorporates elements of criminality (i.e., items 18–20) that need not be present to meet the diagnostic threshold for psychopathy but that suggest important relationships to the construct. Nonetheless, other factors should be taken into account, factors that may impact the origin, maintenance, and modes of expression of criminal and violent behavior within the psychopathic individual.

Gender. Newer research is beginning to elucidate gender differences in psychopathy, which may contribute to differential forms of antisocial and criminal behavior among psychopathic men and women. Cleckley (1988) originally presented the cases of two female psychopathic individuals ("Roberta" and "Anna") in *The Mask of Sanity*; and despite the fact that women who met the criteria for the "Cleckley psychopath" were appearing in clinical settings as early as the 1940s, few active attempts were made to study female psychopathy until the 1960s and 1970s, when the number of incarcerated females increased dramatically (Vitale & Newman, 2001). Though available evidence suggests slightly lower base rates of psychopathy in incarcerated women compared to men (Vitale & Newman, 2001; Vitale & Verona, 2006; Warren et al., 2003), prevalence rates in the general population might not necessarily be comparable. For example, female psychopathic behaviors may be less overt and less likely to result in incarceration compared to those of male psychopaths (e.g., a female psychopathic individual who neglects her children may do so without drawing the attention of authorities). The processes underlying the behavioral symptoms of psychopathy (e.g., of impulsivity and lack of inhibition) also appear to differ between women and men, and studies comparing male and female offenders have revealed salient differences in the expression of psychopathy in women—including less evidence of early behavioral problems, less disinhibition, and less overtly violent aggression. In fact, covert relational aggression involving social network manipulations, such as gossip, the refusal of friendship, and ostracism, is more common in females and contrasts to the overt physical aggression often seen in males. On balance, emotional reactivity and "mood-anxiety" may be more strongly associated with antisociality in women, and female psychopaths have been characterized by increased sexual misbehavior such as prostitution (Verona & Vitale, 2006). Furthermore, the lower reported base rates of

psychopathy in women may simply be due to the inability of the PCL-R to measure female manifestations of psychopathy adequately; for example, the rates of juvenile delinquency—assessed in item 18—are lower in females relative to males (Vitale & Newman, 2001).

Comorbidity, Culture, and Cognitive Ability. Other factors may contribute to crime and violence in psychopathy. For example, the comorbidity of psychopathy with childhood-onset disorders such as ADHD (Langevin & Curnoe, 2010), CD, autism spectrum disorders, mental retardation, and tic disorders—symptoms of which have been associated with increased levels of aggression in some sample groups (e.g., Anckarsäter, 2005)—may play a role in psychopathic criminality. Ethnic and cultural variations in psychopathy may also affect how and how often crime and violence occur within psychopathic individuals. Although the majority of the research to date on psychopathy has been conducted in North America on European American prisoners, a recent review (Sullivan & Kosson, 2006) indicates evidence for the reliability and partial-construct validity of psychopathy across ethnicity. However, numerous studies of offenders in incarcerated, psychiatric, and forensic settings from around the world suggest what may be cross-cultural variations in levels of psychopathy among these offenders. Finally, expressions of criminal behavior in psychopathy may be affected in some way by cognitive ability. For example, Heilbrun (1979) found psychopathic offenders with lower intelligence to be characterized by more violent criminal behaviors than those with higher intelligence. Ultimately, though it is tempting merely to assume that the psychopath will be criminal and violent due to the nature of his or her disorder, proposals from earlier authors (e.g., Cleckley) and evidence from recent studies indicates that factors not related to this disorder contribute to psychopathic crime and violence and must also be considered.

Treatment of Psychopathy

Much of the literature on clinical and applied issues related to psychopathy has been devoted to understanding what—if any—treatments may be effective for psychopathic populations. Cleckley (1988) originally suggested that psychopaths would neither benefit from nor be capable of forming the emotional bonds required for effective therapy; and subsequent clinical evidence and research findings in this area have left little room for optimism (Harris & Rice, 2006).

One of the more ubiquitous examples in this literature of an unsuccessful attempt to treat psychopathy is the therapeutic community method. Rice and colleagues (in Harris & Rice, 2006) evaluated an intensive therapeutic community for mentally disordered offenders thought to be especially suitable for psychopaths. It operated for over 10 years in a maximum-security psychiatric hospital during the latter part of the twentieth century, and it was known worldwide for its novel approach. Largely peer operated, this therapeutic community involved up to 80 hours of weekly intensive group therapy sessions, which had the goal of fostering empathy and responsibility for peers. Results, however, were shocking to investigators—the program *actually made psychopaths worse*. A follow-up evaluation (M = 10.5 years post-treatment) of 146 treated and 146 untreated offenders (matched on recidivism-related variables such as age, criminal history, and index offense) indicated that, compared to no program (in most cases, untreated offenders went to prison), treatment was associated with lower violent recidivism for nonpsychopaths but *higher recidivism for psychopaths*. Psychopaths, while in the program, also showed poorer adjustment in terms of behavioral problems, even though they were just as likely as nonpsychopaths to achieve positions of trust and early recommendations for release.

Harris and Rice suggest that this therapeutic community, in which participants learned more about the feelings of others and were tasked with taking others' perspectives, using emotional language, behaving in socially skilled ways, and delaying gratification, actually aided psychopaths in their criminal endeavors, emboldening them and equipping them with new skills for the manipulation and exploitation of others. Despite similar results being reported in other therapeutic community programs, their popularity in prisons, secure hospitals, and other institutions in Europe (in which some participants are likely to be psychopaths) has unfortunately not waned. Furthermore, other approaches have provided little to no evidence of treatment effect for psychopaths; these include cognitive-behavioral therapy (CBT) targeting criminogenic needs, e.g., antisocial attitudes and cognitions, pro-criminal associates, and personality factors such as impulsiveness and self-control (see Gendreau, Goggin, French, & Smith, 2006); behavioral modification using token economies; and multisystemic therapy (MST). These dismal results have led some to suggest that discussing the management

rather than the treatment of psychopathic offenders may be more warranted and that programs benefitting other offenders may actually increase the risk represented by psychopaths. Ultimately, psychopaths may be fundamentally different from other offenders in that they possess no deficit or impairment that is "fixable" by therapy—having instead an evolved and viable life strategy that incorporates lies, cheating, and the manipulation of others (Harris & Rice, 2006).

Conclusion

As a group, personality disorders are among the most studied psychiatric illnesses in terms of their relationships to violence, crime, aggression, and antisociality. Most of the work in this area has focused on psychopathy and the Cluster B personality disorders and on theoretical conceptualization, diagnostic clarification, etiological mechanisms, and clinical and applied issues. Additionally, a fair amount of work—particularly that using neuroscience approaches—has been conducted on the Cluster A (or schizophrenia spectrum) personality disorders and their relationships with criminal and violent behavior. Studies relating Cluster C personality disorders (avoidant, dependent, and obsessive-compulsive personality disorders) to crime and violence, however, are virtually nonexistent.

Because of their enduring and ubiquitous nature, personality disorders pose a unique and challenging problem with regard to crime and violence. These behaviors are likely to manifest as ingrained patterns and across situations and contexts—thus extending the scope and time frame in which they may occur. Moreover, as they are ego-syntonic and viable (yet maladaptive) strategies that individuals have adopted to "get through life," insight into these disorders may be rare—and the affected individual's willingness to change even rarer. For Ted Bundy, this strategy was a deadly combination of lying, manipulation, emotional coldness, and violence—it was perfectly suited to a multiple killer, but it ultimately led to his death and to the destruction of innocent lives around him.

KEY TERMS

antisocial personality disorder
avoidant personality disorder
borderline personality disorder
Cluster A [personality disorders]
Cluster B [personality disorders]
Cluster C [personality disorders]
complication model
dependent personality disorder
dissociative identity disorder
histrionic personality disorder
multiple personality disorder
narcissistic personality disorder
narcissistic rage
obsessive-compulsive personality disorder
paranoid personality disorder
pathoplasty model
personality disorders
personality traits
psychopathy
Psychopathy Checklist—Revised (PCL-R)
schizoid personality disorder
schizotypal personality disorder
sociopathy
spectrum model
vulnerability model

REVIEW QUESTIONS

1. Using the different theoretical perspectives discussed in the chapter, compare and contrast the conceptualizations of the personality disorders outlined in DSM-5. What are some of the similarities and differences in the way pathological patterns of inner experience and behavior are conceptualized across disorders?
2. Examine Tables 10.2, 10.3, 10.19, and 10.20 and the summaries of research studies in the "A Closer Look" sections for each personality disorder in this chapter. Discuss how prevalence rates of crime in those with personality

disorders and of these disorders in criminal populations differ among these specific disorders, if at all. Using the information in the tables, speculate as to how these differences in prevalence rates may have been caused by methodology (e.g., in terms of study types, sample characteristics, methodological issues, or other concerns).

3. Describe multiple personality disorder and dissociative identity disorder and critically evaluate the evidence for a relationship between these disorders and crime and violence.
4. Discuss the evolution of the term "psychopathy" in terms of its conceptualization and meaning relative to social condemnation. How are psychopathy, antisocial personality disorder, and sociopathy differentiated from one another? Explain the reasons for the differences in diagnostic nomenclature.
5. Hervey Cleckley argued that criminality is not necessarily a component of psychopathy, and, though a significant amount of research has been conducted using the PCL-R to understand criminal behavior, it is also technically possible to render a psychopathy diagnosis when no criminality is present using this measure. Should criminality be conceptually distinct from psychopathy? Why or why not?