



## Antisocial personality disorder and anxiety disorder: A diagnostic variant?

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### ABSTRACT

Antisocial personality disorder (ASPD) with co-morbid anxiety disorder may be a variant of ASPD with different etiology and treatment requirements. We investigated diagnostic co-morbidity, ASPD criteria, and anxiety/affective symptoms of ASPD/anxiety disorder. Weighted analyses were carried out using survey data from a representative British household sample. ASPD/anxiety disorder demonstrated differing patterns of antisocial criteria, co-morbidity with clinical syndromes, psychotic symptoms, and other personality disorders compared to ASPD alone. ASPD criteria demonstrated specific associations with CIS-R scores of anxiety and affective symptoms. Findings suggest ASPD/anxiety disorder is a variant of ASPD, determined by symptoms of anxiety. Although co-morbid anxiety and affective symptoms are the same as in anxiety disorder alone, associations with psychotic symptoms require further investigation.

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### 1. Introduction

It has been hypothesized that antisocial personality disorder (ASPD) with co-morbid anxiety disorder may constitute a distinct sub-category of ASPD with different etiology, requiring different treatment interventions (Hodgins, 2007). ASPD is highly disabling and a major public and mental health concern (Grant, Hasin, et al., 2004; Grant, Stinson, et al., 2004; Robins, Tipp, & Pryzbeck, 1991; Westermeyer & Thuras, 2005) affecting 1–4% of the population in Westernized countries (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Moran, 1999; Samuels et al., 2002; Torgersen, Kringlen, & Cramer, 2001). It responds poorly to treatment interventions (Dolan & Coid, 1993; Warren, McGauley, Norton, & Dolan, 2003) and persons with ASPD are sometimes excluded from mental health services (NIMHE, 2003) despite high levels of co-morbidity with other clinical syndromes (Compton, Conway, Stinson, Colliver, & Grant, 2005; Robins et al., 1991). North American community studies indicate that 34–54% of persons with ASPD have lifetime anxiety disorder (Goldstein et al., 2006; Goodwin & Hamilton, 2003; Lenzenweger, Lane, Loranger, & Kessler, 2007; Sareen, Stein, Cox, & Hassard, 2004). This combination is associated with increased risks of major depression, substance misuse, and suicide attempts. Persons with ASPD and co-morbid anxiety disorder are more likely to seek treatment from mental health professionals than those with ASPD alone

(Ullrich & Coid, 2009) and anxiety disorder is strongly associated with lifestyle instability in persons with ASPD (Ullrich & Coid, 2010). However, it is unclear whether these increased risks among persons with both ASPD and anxiety disorder (in contrast to ASPD alone) are explained by features inherent to ASPD, in the sense that they reflect two separate syndromes of ASPD. Alternatively, presence of a separate but co-morbid anxiety disorder could merely convey additional associated disadvantages of anxiety symptoms.

Research into the association between anxiety and psychopathy, which is on a continuum with ASPD (Coid & Ullrich, *in press*), has important implications for this field of research. A division between a “primary” and “secondary” origin to antisocial behavior has previously been applied in the case of psychopathy but not in describing variants of ASPD. While phenotypically similar, primary psychopathy is traditionally thought to be underpinned by an inherited affective deficit whereas secondary psychopathy reflects an environmentally acquired affective disturbance. Primary psychopaths are believed to have low levels of anxiety whereas secondary psychopaths have high levels (Karpman, 1941, 1948). Primary psychopaths are also interpersonally confident, dominant, and free from negative emotions, whereas secondary are withdrawn, hostile, and have multiple, serious emotional problems (Blackburn, 1998; Skeem, Johansson, Andershed, Kerr, & Loudon, 2007).

The aim of this study was to examine associations between ASPD and anxiety disorders in a representative household survey of adults carried out in Great Britain in 2000. If ASPD/anxiety disorder constitutes a discrete syndrome, and not merely two separate but co-morbid syndromes, it should firstly demonstrate distinct differences in terms of its antisocial criteria. Secondly, it should demonstrate differences in its co-morbid psychopathology. A final

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question is whether anxiety disorder in conjunction with ASPD is the same condition at both syndromal and symptom level as in persons with anxiety disorder alone.

## 2. Method

### 2.1. Sample

The British National Survey of Psychiatric Morbidity of adults aged 16–74 years and living in private households in England, Wales, or Scotland has previously been described (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001). This was a two-phase survey design. In phase I, participants completed computer-assisted interviews lasting approximately 1½ h. The Royal Mail's small users Postcode Address File was used as the sampling frame. Postal sectors were selected with probability proportional to size. The Kish grid method (Kish, 1965) was used to select systematically one person in each household.

A total of 8886 adults completed first-phase interviews, a response rate of 69.5%. Measurement of prevalence of Axis II personality disorders was carried out in both phases; in phase I using self-report and in phase II using structured clinical interview on a sub-sample. Details of the second phase have been described previously (Coid et al., 2006) and these measures are not used in this study.

In the first phase, 8397 (94.5%) completed all questionnaire sections. Among non-respondents, 24% were refusals, and 6.5% non-contacts. However, weighting procedures took into account proportions of non-respondents according to age, sex, and region to ensure a representative sample, compensating for sampling design and non-respondents in the standard error of the prevalence and controlling for effects of selecting one individual per household.

Ethical approval was obtained from the London Multi-Centre Research Ethics Committee and all 149 local research ethics committees covering areas where addresses had been selected. Informed written consent was obtained from all participants.

### 2.2. Measurement of psychiatric morbidity

Personality disorder was measured according to DSM-IV, Axis II criteria, using the screening questionnaire for the structured clinical interview for Axis II (SCID-II; First, Spitzer, Gibbon, & Williams, 1997). Subjects gave "yes" or "no" responses to 116 questions on laptop computers. Ten categories of personality disorders derived from the instrument were created by applying algorithms developed using data obtained in a previous survey of prisoners (Singleton, Meltzer, Gatward, Coid, & Deasy, 1998; Ullrich et al., 2008). In analyses of that survey cut-off points were manipulated to increase levels of agreement, measured by the kappa coefficient, between both individual criteria and diagnoses measured in the initial screening questionnaire and the subsequent phase II clinical interview. This allowed diagnoses to be obtained from the self-completion instrument. Sensitivity and specificity of the SCID-II screen for personality disorders in this British household survey were: 0.79/0.93 for avoidant, 0.67/0.97 for dependent, 0.83/0.88 for obsessive-compulsive, 0.71/0.86 for paranoid, 1.00/0.93 for schizotypal, 1.00/0.83 for schizoid, –/1.00 for histrionic, –/1.00 for narcissistic, 0.62/0.94 for borderline, and 0.80/0.88 for antisocial personality disorder. Because prevalence of histrionic and narcissistic PD were very low, it was not possible to calculate their sensitivity.

The revised Clinical Interview Schedule (CIS-R; Lewis, Pelosi, Araya, & Dunn, 1992) was used to obtain prevalences of common mental disorders in the past week (affective and anxiety disorders), using the ICD-10 classification (WHO, 1993), includ-

ing generalized anxiety disorder, mixed anxiety and depression, depressive episodes, phobias, obsessive-compulsive disorder, and panic disorder. Apart from depressive episodes, remaining diagnoses were collapsed into one category of "any anxiety disorder". CIS-R dimensional scores were also used in subsequent analyses including: obsessions, compulsions, panic, phobias, anxiety, worry, depression, physical health problems, irritability, sleep problems, concentration/forgetfulness, fatigue, and somatic symptoms.

Participants screened positive for psychosis if any two of five criteria were currently present from the Psychosis Screening Questionnaire (PSQ; Bebbington & Nayani, 1994). However, the prevalence of categorical diagnosis of probable psychosis was low ( $n=40$ ) and dimensional scores of the PSQ were used in statistical analyses.

The Alcohol Use Disorders Identification Test (AUDIT; Babor, de la Fuente, Saunders, & Grant, 1992) assessed alcohol misuse over the past year. A cut-off of 20+ was an indicator of alcohol dependence (Babor, Higgins-Bridle, Saunders, & Monteiro, 2001).

Questions designed to measure drug use were included in phase I interviews. Positive responses regarding a series of different substances (cannabis, amphetamines, cocaine, crack cocaine, heroin/methadone) to any of five questions (for cannabis two questions had to be answered positively) measuring drug dependence over the past year (Singleton et al., 2001) were combined to produce a single category of "any" drug dependence.

### 2.3. Statistical analysis

To take into consideration DSM-IV requirement of a minimum age of 18 years for diagnosis of ASPD, younger participants were excluded from analyses. We also excluded those with conduct disorder only and those fulfilling only the adult ASPD criteria because they demonstrate strong similarities in terms of co-morbid psychopathology (Sareen et al., 2004). Inclusion could have biased the results. The remaining participants ( $N=7211$ ) were categorized into four groups according to criteria for (i) both ASPD and any anxiety disorder; (ii) single diagnosis of ASPD; (iii) single diagnosis of anxiety disorder; and (iv) they did not fulfill the criteria for either diagnosis.

Data on nominal level were analyzed using simple or multinomial logistic regression. For group comparisons, a reference category was defined and the other groups contrasted against this reference group. Analysis on the association between diagnostic groups (ASPD/anxiety, ASPD only, anxiety only, others) and co-morbid psychopathology were carried out using three logistic regression analyses with different reference groups. Data on interval- or ratio-scale level were analyzed by means of uni-/multivariate analysis of (co-)variance. Deviation from the reference group was used to calculate the contrasts.

To control for the potentially confounding effects of demography and co-morbidity with other disorders/substance abuse, all analyses were carried out unadjusted and adjusted. For adjusted analyses of demography, all variables were entered simultaneously in the model. For subsequent analyses, demographic differences and co-morbid psychopathology on Axis I and Axis II were controlled for.

All analyses were performed using SPSS (v14).

## 3. Results

### 3.1. Demography

Weighted data for 7211 male and female respondents included 160 (2.2%) with a diagnosis of ASPD, 75 (1.0%) with ASPD and co-morbid anxiety disorder, 968 (13.4%) anxiety disorder but not ASPD,

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