A 16- to 45-Year Follow-up of 71 Men With Antisocial Personality Disorder

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We examined the long-term outcome of 71 men with antisocial personality disorder (ASPD) admitted to the University of Iowa Psychiatric Hospital. The subjects all met DSM-III criteria for ASPD based on admission records. Patients had been admitted between 1945 and 1970 and were evaluated between 1986 and 1990, an average of 29 years following hospital discharge. We traced 68 (96%), and 26 (36.6%) received a full or partial interview; 17 (23.9%) had died. Based on personal interviews, interviews with informants, and medical and legal records, we were able to rate globally 45: 12 (26.6%) had remitted, 14 (31.1%) had improved but not remitted, and 19 (42.2%) were unimproved. A Diagnostic Interview Schedule (DIS) was administered to 21 subjects; tobacco dependence, alcohol dependence, generalized anxiety disorder, and major depression were frequent lifetime disorders. Remission was associated with lower symptom severity at intake and follow-up evaluation of more than 25 years and current sobriety. Based on the study results, we conclude that for many, ASPD is chronic and is associated with ongoing psychiatric, medical, and social problems.
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ANTISOCIAL PERSONALITY disorder (ASPD) is characterized by a pattern of socially irresponsible, exploitative, and guiltless behavior.[1-2] Characteristics include failure to conform to the law, failure to sustain consistent employment, manipulation of others for personal gain, frequent deception of others, and failure to develop stable interpersonal relationships. The lifetime prevalence for ASPD is reported to range from 2% to 4% in men and 0.5% to 1% in women.[3] The prevalence peaks in persons aged 24 to 44 years and drops off in persons 45 to 64 years. The male to female gender ratio is estimated at between 2 and 6 to 1.[1] The prevalence of ASPD varies with the setting, but may reach 80% in jails and prisons.[4]

ASPD is associated with substantial psychiatric and medical comorbidity,[5-14] including alcoholism and drug abuse, depression, anxiety, other personality disturbances, sexual deviance, and somatization disorder in women. Persons with ASPD experience frequent traumatic injuries, accidents, suicide attempts, and human immunodeficiency virus infections.[5,6,8,15] Mortality rates are reported to be excessive from both natural and unnatural causes.[16,17] Antisocial persons use a disproportionate share of medical and mental health services.[18] ASPD has also been identified as a predictor of poor treatment response in certain populations.[19,20]

Despite the significance of ASPD to individuals and to the community, there is surprisingly little known about its course or outcome. Most of what we know is based on Robins' pioneering study[16] of 524 children referred to a child guidance clinic; when interviewed an average of 30 years later, 25% of men and 12% of women were found to meet lifetime criteria for ASPD. Information on 82 of the 94 cases meeting criteria for ASPD allowed for a comparison at follow-up. At follow-up, 12% had remitted, 27% had improved but not remitted, and 61% were unimproved. Robins reported that the median age for improvement was 35 years, but noted that there was "no age beyond which improvement seemed impossible" (p. 222).

Apart from Robins' study, there is little agreement on when (and if) "burnout" actually occurs. Cleckley[21] held that the prognosis for ASPD was nearly hopeless. Maddocks[22] was less pessimistic: in a 5-year follow-up study of 59 antisocials seen in a psychiatric outpatient clinic, he reported that nearly one fifth had "settled down." The rest were still actively antisocial, had died, or could not be located.

There are data to suggest that antisocials have progressively fewer legal problems as they age[2]; arrests and convictions are less frequent in older antisocials, perhaps explaining the decrease in prevalence after age 44 years in the Epidemiologic Catchment Area study.[3] This finding was also suggested in a recent follow-up study of forensic psychiatric patients in Canada with ASPD.[23] Although convictions declined

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after age 27, a significant portion of the 39 patients studied remained criminally active.

Other follow-up studies are not directly comparable, since they concern juvenile-delinquent or criminal populations. Glueck and Glueck[24] concluded from a follow-up study of juvenile delinquents that nearly one third had fully remitted, although one fourth to one third had developed alcoholism. Reporting on criminal samples, Gibbens et al.[25] found that only 24% had no reconvictions during a follow-up evaluation. Similarly, Tong[26] reported high recidivism rates, except among elderly criminals. Guze,[4] in a study of male criminals, and Martin et al.,[27] in a study of female criminals, found that a clinical diagnosis of ASPD was a robust predictor of recidivism. Like studies of juvenile delinquents, studies of criminals add to our understanding of the natural history of ASPD, since many criminals have the disorder.[4] However, not all criminals have ASPD, and criminals with ASPD are probably more severely affected. These studies show high rearrest and reconviction rates, but little is reported on the adjustment of those not rearrested or reconvicted, and the former criminals may have disturbed and disruptive behavior that is not reflected in arrest and conviction data.

Several conclusions can be drawn from the literature: (1) ASPD appears to be a chronic disorder in many if not most persons, and is associated with substantial psychiatric and medical comorbidity; (2) although criminal behavior as reflected in arrest and conviction data tends to decline with age, other antisocial symptoms (e.g., poor job performance, family and marital problems) and comorbid psychiatric disorders may continue; (3) improvement may occur at any age, but most likely starts between the mid-thirties and early forties; and (4) antisocials suffer excessive mortality from both natural and unnatural causes.

Because these conclusions are based on limited data, we wished to replicate and extend these findings. Were these conclusions true in a more recent cohort? What were the rates of improvement and remission in adult antisocials, most of whom had not been seen in child guidance or mental health clinics as children? What was their psychosocial adjustment in late life? How does their long-term outcome compare with that of other psychiatric patients and controls? Did they still have elevated death rates? What factors were associated with outcome over the long term?

We had an opportunity to study these questions in 71 antisocial men evaluated between 16 and 45 years after hospital discharge. This report describes the conduct of the study and the overall findings. Other aspects of the study will be reported in the future.

METHOD

Sample Selection

The sample included 71 patients discharged between 1945 and 1970 who were evaluated at the University of Iowa Psychiatric Hospital and met DSM-III criteria[28] for ASPD. Since these criteria were not introduced until 1980, we screened the charts of about 250 persons who had received diagnoses of psychopathic personality, sociopathic personality disturbance, antisocial reaction, or other diagnoses suggesting ASPD (e.g., explosive personality). DSM-III criteria were applied to the case notes, which were carefully reviewed for signs and symptoms typical of ASPD. We limited our study to men to make the sample more homogeneous and to facilitate follow-up. Subjects with an IQ of less than 70 or who had an organic mental disorder, schizophrenia, or mania were excluded.

We limited our sample to those admitted between 1945 and 1970 for several reasons. First, hospital records during these years were of an unusually high quality. Generally, both resident and staff psychiatrists interviewed the patient and recorded his or her observations in detail, usually covering several single-spaced typewritten pages. Under separate headings, social workers obtained and recorded detailed descriptions of premorbid personality, occupational history, sexual history, recreational interests, early home environment, and situational factors possibly relevant to the presenting illness. In almost all cases, both the physician and social worker interviewed informants from the patient's immediate family.

Next, limiting our sample to antisocial persons hospitalized between 1945 and 1970 would, at a minimum, allow a follow-up evaluation of 16 years and a follow-up evaluation of 45 years at a maximum, since our evaluation took place between 1986 and 1990. This would provide a sufficient follow-up period to determine the course and outcome of ASPD and yet still allow us to trace most subjects. Finally, had we opted for an earlier cohort, we believe that too many would have died for the sample to be of value.

After the 71 subjects were identified, their case notes were abstracted by a trained researcher (S.E.B.) for sociodemographic, diagnostic, clinical, treatment, and outcome data using an instrument developed for that purpose. We were interested in gathering information on age at admission, referral source, marital history, family of origin, early childhood events, neurologic problems, history of adoption, foster home placement, incarceration, personal medical and psychiatric history, family psychiatric history, IQ, electroen-

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