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Comprehensive Psychiatry 46 (2005) 111 – 116
Comprehensive PSYCHIATRY
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The childhood-onset neuropsychiatric background to adulthood psychopathic traits and personality disorders

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Abstract

Childhood conduct disorder (CD) and adult psychopathic traits according to the Psychopathy Checklist Revised (PCL-R) were the closest psychiatric covariates to repeated violent crimes and aggression among offenders under forensic psychiatric investigation in Sweden. As psychopathy is not included in the present psychiatric diagnostic systems, we compared total and factor PCL-R scores to Axis I disorders, including childhood-onset neuropsychiatric disorders, and to Axis II personality disorders, to establish the convergence of psychopathic traits with other psychiatric diagnoses, and to identify possible unique features. Psychopathic traits were positively correlated with bipolar mood disorder and negatively with unipolar depression. The total PCL-R scores as well as the Factor 2 (unemotionality) and Factor 3 (behavioral dyscontrol) scores were significantly correlated with attention-deficit/hyperactivity disorder, Asperger's syndrome/high-functioning autistic traits, CD, substance abuse, and the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* Cluster B personality disorders. The interpersonal Factor 1 showed none of these correlations and may capture features that are specific to psychopathy, distinguishing core psychopathy from other diagnostic definitions.
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1. Introduction

In a recent study of violent offenders, conduct disorder (CD) and psychopathic traits according to the Psychopathy Checklist Revised (PCL-R) [1], independently, were the closest psychiatric covariates to repeated violent crimes and high aggression scores [2]. The relevance of childhood-onset CD for adult social maladaptation has long been well known [3] as reflected by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) definition of antisocial personality disorder [4]. Psychopathy assessed by the 20-item PCL-R instrument has attracted interest mainly in the area of risk prediction, but studies addressing its neuropsychologic [5], neurologic [6-8], and neurophysiologic [9-13] basis indicate that psychopathy may be a specific childhood-onset disorder of empathy and social functioning [14]. Personality disorders are not diagnosed in child and adolescent psychiatry. Aberrations in empathy, communicative skills, and executive control are instead captured by diagnostic definitions for the autism spectrum disorders, attention-deficit/hyperactivity disorder (AD/HD), learning disabilities, and tic disorders (including Tourette's syndrome) [15,16]. In analogy with adult personality disorders having childhood precedents, these disorders have been found to carry an increased risk of adjustment problems and aggression in adulthood [2,17-20].

Common to personality disorders, AD/HD, autistic traits, and learning disabilities is that they may be regarded as categorical disorders or as extreme constellations of normally distributed traits [15,21-23]. In the *DSM-IV*, personality disorders are defined as maladaptive patterns of cognitions, affects, interpersonal functioning, and impulse control that have caused psychosocial problems since adolescence. As indicated by the common features of these definitions, childhood-onset neuropsychiatric disorders and adult personality disorders may form a continuum describing the same underlying mechanisms in different terminologies. The erratic Cluster A personality disorders (paranoid, schizoid, and schizotypal) are thought to be related to psychotic disorders [24] or autism spectrum disorders [25,26] and the phobic Cluster C disorders

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0010-440X/$ – see front matter © 2005 Elsevier Inc. All rights reserved.
doi:10.1016/j.comppsych.2004.07.030

(avoidant, dependent, and obsessive-compulsive) to anxiety disorders [27], whereas the dramatic Cluster B disorders (histrionic, narcissistic, borderline, and antisocial personality disorders) clearly share core features with AD/HD [28]. The *DSM-IV* definition of antisocial personality disorder is mainly based on behavioral characteristics noted before the age of 15 years (CD) and continued into adulthood, whereas psychopathy, as first defined by Cleckley [29], describes a specific constellation of personality traits, including dominance-seeking (through the instrumental use of manipulation, cruelty, and fear) and deficits in emotional reactivity, attachment, purposefulness, and consistency.

To study the extent to which the features and problems assessed by the PCL-R correlate with *DSM-IV* diagnostic definitions of mental and personality disorders aiming at identifying possible unique features for psychopathy, we compared PCL-R ratings to independent ratings of childhood-onset neuropsychiatric disorders and adult psychiatric and personality disorders in perpetrators of severe crimes against other persons.

2. Subjects

With the approval of the Research Ethics Committee at Göteborg University, 100 consecutive informed and consenting subjects (92 men and 8 women, aged 17-76; median, 30 years) were recruited among all consecutive admissions to the Department of Forensic Psychiatry in Göteborg between 1998 and 2001. Participation required a basic Swedish education to ascertain sufficient language comprehension for diagnostic interviews and self-ratings. All were under prosecution for severe violent and/or sexual crimes and underwent forensic psychiatric investigation by court order. Detailed descriptions of the study group and basic clinical work-up are provided in previous publications [2,20].

3. Methods

Because subjects were free to determine the extent of their participation, the number of subjects varied somewhat between the different parts of the study. *DSM-IV* diagnoses were assigned in consensus by the first and senior author (HS and AF) on the basis of complete diagnostic work-up (described below), all records assembled for the investigation (school, welfare, and lifetime medical), and the forensic psychiatric investigation reports. The psychiatric, psychologic, and psychosocial assessments were performed independently from each other and are presented in greater detail in Ref. [2].

3.1. Psychiatric work-up (Axis I diagnoses)

The psychiatric work-up included the structured diagnostic instruments Structured Clinical Interview for *DSM-IV* Axis I Disorders [30], the Asperger's Syndrome Diagnostic Interview (ASDI) [31], and the *DSM-IV* criteria, currently and retrospectively, for AD/HD, tic disorders, impulse control disorders, and all other relevant Axis I disorders not covered by the Structured Clinical Interview for *DSM-IV* Axis I Disorders, administered by HS. The autism spectrum disorders are here referred to as autism, Asperger's syndrome, and atypical autism according to the most widespread clinical use, corresponding to the terms *autistic disorders*, *Asperger's disorder*, and *pervasive developmental disorder* used in the *DSM-IV*. For AD/HD, the criterion that excludes other comorbid neuropsychiatric disorders was disregarded to allow a complete record of the pattern of comorbidity. Conduct disorder before the age of 15 years was diagnosed on the basis of self-described Structured Clinical Interview for *DSM-IV* Axis II Personality Disorders items [32] for antisocial personality disorder (Criterion C) and reviews of data registered during adolescence. The diagnosis of developmental coordination disorder (DCD) was based on the Asperger's Syndrome Diagnostic Interview criterion of motor clumsiness and required a history of both gross and fine motor clumsiness. Childhood data such as the number of fulfilled Gillberg and Gillberg criteria for Asperger's syndrome and of *DSM-IV* criteria for AD/HD (statistically analyzed separately for AD and HD) met during childhood, tics (rated as no tics, childhood tics, chronic tics, or Tourette's syndrome), DCD (rated as no DCD, childhood DCD, and persistent DCD), and global IQ were used as dimensional ratings for the severity of each symptom cluster.

When possible ($n = 31$), a semistructured collateral interview was performed with a relative who had known the index subject as a child by 1 of the social workers involved in the forensic psychiatric investigations.

3.2. Psychologic work-up (Axis II diagnoses)

Structured Clinical Interview for *DSM-IV* Axis II Personality Disorders ($n = 74$, [32]) were made by clinical psychologists (TN, AC and their colleagues) with training for the instrument, who were blind to the Axis I diagnostic work-up, in all but 5 cases where the interview was made by HS. The numbers of fulfilled criteria were used as dimensional ratings of dysfunctional/maladaptive personality traits. Neuropsychologic functioning was assessed by the Wechsler Adult Intelligence Scale–Revised [33], administered by clinical psychologists and rated according to Swedish norm data. Mental retardation (IQ < 70) and borderline mental retardation (IQ 71-85) were diagnosed on the basis of test results and the clinical weight of problems attributable to the cognitive dysfunction.

3.3. Ratings of psychopathy according to the PCL-R

Psychopathy Checklist Revised ratings were made in all cases by one of the authors (AKS) with special training in the use of the instrument on the basis of ratings made by

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