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Adult psychopathic personality with childhood-onset hyperactivity and conduct disorder: a central problem constellation in forensic psychiatry

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Abstract

To describe lifetime mental disorders among perpetrators of severe inter-personal crimes and to identify the problem domains most closely associated with aggression and a history of repeated violent criminality, we used structured interviews, clinical assessments, analyses of intellectual functioning, medical and social files, and collateral interviews in 100 consecutive subjects of pretrial forensic psychiatric investigations. Childhood-onset neuropsychiatric disorders [attention-deficit/hyperactivity disorder (AD/HD), learning disability, tics and autism spectrum disorders] affected 55% of the subjects and formed complex comorbidity patterns with adult personality disorders [including psychopathic traits according to the Psychopathy Checklist (PCL-R)], mood disorders and substance abuse. The closest psychiatric covariates to high Lifetime History of Aggression (LHA) scores and violent recidivism were the PCL-R scores and childhood conduct disorder (CD). Behavioral and affective PCL-R factors were closely associated with childhood AD/HD, CD, and autistic traits. The results support the notion that childhood-onset social and behavioral problems form the most relevant psychiatric symptom cluster in relation to pervasive adult violent behavior, while late-onset mental disorders are more often associated with single acts of violent or sexual aggression.

Keywords: Forensic psychiatry; Violent crime; Disruptive behavior disorders; Comorbidity; Risk factor

1. Introduction

Psychiatric problems are over-represented among violent offenders, but the nature of the association between psychiatric features and criminality is far from obvious. Although dependent on inclusion criteria, legislation and availability of mental health care, surveys of mental disorders in offender groups invariably find sharply increased prevalences of disorders and needs (Fazel and Danesh, 2002). Epidemiological research has shown that psychotic disorders and mental retardation carry an increased risk of violent offending (Lindqvist and Allebeck, 1990; Hodgins, 1992; Hodgins et al., 1996) even if the risk increase is not always identifiable in patient groups (Skeem

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and Mulvey, 2001). Childhood-onset disruptive behavior disorders [attention-deficit/hyperactivity disorder (AD/HD), oppositional defiant disorder (ODD), and conduct disorder (CD)] carry a high risk of persisting into adulthood as antisocial behaviors (Lahey and Loeber, 1997; Moffitt and Caspi, 2002). Aggressive behavior is also a clinical feature of tic disorders and autism spectrum disorders [referred to as 'pervasive developmental disorders' (PDDs) in DSM-IV (American Psychiatric Association, 1994; Siponmaa et al., 2001; Soderstrom, 2002)]. Several definitions of personality disorders (such as borderline personality disorder, antisocial personality disorder and psychopathy) contain aggressive behaviors as discriminative traits (American Psychiatric Association, 1994; Hare, 1980).

The aims of the present study were to (1) analyze the comorbidity between childhood and adulthood disorders among 100 perpetrators of violent crimes investigated by means of structured interviews, clinical assessments, neuropsychological tests and file reviews and (2) identify the lifetime psychiatric characteristics most closely associated with high levels of aggression and criminal recidivism.

2. Subjects

Subjects were consecutively recruited among perpetrators of severe violent or sexual index crimes, i.e. crimes where the life of another person had been threatened or taken (murder/manslaughter in 21 cases, attempted murder/manslaughter in 17, aggravated assault in 17, aggravated unlawful threat/robbery in 6, rape in 3, sexual child abuse in 22 and arson in 14). All were admitted to the study department by court order to undergo forensic psychiatric investigations for periods up to 4 weeks. Participation required a basic Swedish education to ascertain sufficient language comprehension for the diagnostic methods and to ensure access to school records. The study group was set to include 100 subjects, and data were consecutively collected from October 1998 until February 2001, when 92 men and eight women, aged 17–76 (median 30) years, had been included. Another 21 subjects, 18 men and three women, aged 17–62 (median 35) years, who met the inclusion criteria but declined participation differed from the study group by higher prevalences of psychotic disorders. After the study, the subjects were followed through trials, appeals to higher courts and sentencings. All were finally convicted of their index crimes, in some cases after a change in the legal definition. The final sanctions were prison in 51 cases, inpatient forensic psychiatric treatment in 42 and probation with community treatment in seven.

All subjects were detoxified during several weeks on remand before admission to the study. All but four remained on remand and shared standardized living conditions during the study period. Sixty-four subjects had psychopharmacological therapy (minor tranquillizers in 17, major tranquillizers in 9, benzodiazepines in 5, antidepressant medication in 19, mood stabilizers in 3, and more than one of these medications in 11), and three had medication for somatic problems. Pharmacological treatment was often initiated after admission to the study department, and both pretreatment state and therapeutic effect were considered in the diagnostic work-up and in the evaluation of test results.

3. Methods

3.1. Overall clinical diagnostic work-up

DSM-IV diagnoses on Axes I and II (American Psychiatric Association, 1994) were assigned by AF and HS in consensus on the basis of the diagnostic work-up (interviews, assessments and tests) described below and data from educational and social welfare registers (including child health care and school records), medical records (including child and adolescent psychiatric contacts), and the forensic psychiatric investigation reports. All concomitant diagnoses were recorded to provide as complete a picture of comorbidity as possible. In the diagnostic work-up, psychiatric, psychological, and psychosocial aspects were rated independently to enable comparisons between the different diagnostic schemes. To conform to the most widely used terminology, we use 'autism spectrum disorders (ASD)' instead of 'persistent developmental