Manifestations of Anxiety in Patients With Antisocial Personality Disorders : A Comparison of 524 Cases With Matched Controls

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ABSTRACT

The stereotypic absence of overt anxiety in psychopaths has been held to interfere with many programs of therapy or rehabilitation. Newer research indicates that symptoms and signs of anxiety may be found in persons suffering from this chronic disorder. The question is still moot and requires resolution in order to plan effective programs of prevention and treatment.

In the present study, all adult first admissions to public mental health facilities in the state of Missouri from 1972-1980 were examined. Of 25,321 such admissions, approximately four per cent received a "best" psychiatric diagnosis of antisocial personality. From the total group, 524 pairs of experimental subjects and matched controls were selected and compared on the basis of an automated index mental status examination. The antisocial subjects demonstrated significantly more often generalized antisocial traits, hostility, dangerousness, and poor insight and judgment. A substantial minority demonstrated anxiety and depression at a prevalence rate not significantly different from matched controls. A dysphoric syndrome among psychopaths, especially those being treated in mental health facilities, of anxiety, agitation, and depression without motor retardation, but with special emphasis on difficulties in intellectual functioning, neurotic sensitivity, somatic complaints, and irritability was delineated. Differences in treatment outcome currently are being investigated.

INTRODUCTION

Since 1891, when Koch first divised it, the term "psychopath" has been used to describe persons whose behavior patterns bring them

repeatedly into conflict with society. Through the years, that original term has developed some curious twists of meaning and has been replaced by others such as "sociopath" or "antisocial personality disorder." Evidence from natural history studies has accumulated to show that the behavior involved is categorical and repetitive, with an early onset and a duration of some years (Goodwin and Guze, 1979) and frequently with remission in early middle age (L. Robins, 1966; Weiss, 1973).

Certain syilogistic assumptions about the treatability of psychopaths, however defined, nevertheless have become stereotyped but are actually moot, as follows :

(1) Although mental health professionals emphasis the promise of treatment and rehabilitation for psychopaths (Weiss and Perry, 1977) and there is substantial evidence that at least some psychopaths respond to various kinds of treatment (Jones, 1954; Mark and Ervin, 1970; Morris and Hawkins, 1970, 1977; Lorion, 1975; Weiss, 1980), many psychiatrists echo Guze's contention that such treatment is not "consistently and predictably effective" (1976). This pessimistic view that the disorder is "generally... life-long" and not responsive to therapy, is stated in DSM-II (1968) and dates back at least to Morel (1839) and Koch (1891), being supported in this century by such leaders as Henderson (1939).

(2) If psychopaths are not treatable, why ? The reason most commonly given is "the patient's lack of motivation for change" (Goodwin and Guze, 1979). Since Aichhorn's description of his work with delinquents (1935), it has been suggested that psychopaths cannot be successfully motivated for treatment unless they first become anxious, and contemporary authorities such as Halleck (1967) agree that only if such persons are "troubled" are they likely to benefit from psychotherapy. The Freudian contention that a quantum of anxiety is prerequisite to successful psychotherapy is further exemplified in the writings of such later autors as Kubie (1960).

(3) Although Pinel (1801) had emphasized affective disturbance in psychopathy ("manie sans délire") and Magnan (1893) considered con-

comitant anxiety to be unexceptional, and although authors such as E. Robins (1967) have presented natural history evidence that Magnan was correct, many psychiatrists have supported the view first propounded by Cleckley in 1941 and most recently stated by him : "Those called psychopaths are very sharply characterized by the lack of anxiety..."(1964).

Concern about this clinical confusion and therapeutic nihilism, therefore, has led to the present study, designed to investigate possible manifestations of anxiety in patients with antisocial personality disorders, and the influence of such symptoms or signs (if they exist) on clinical outcome.

METHOD

Subjects for this study were drawn from the Missouri Department of Mental Health (DHM) automated patient data base (Ulett and Sletten, 1969; Sletten and Ulett, 1972; Hedlund **et al.,** 1977). All adult first admissions to either inpatient or outpatient services from 1972 to September 1980 who had an automated mental status examination recorded within 30 days of their index admission and who had a "best" psychiatric diagnosis of antisocial personality (DSM-II diagnostic code 301.70) were selected for the "experimental" group. A control group of psychiatric patients who were not so diagnosed was also drawn from the automated data base, utilizing the first preceding case that matched each experimental subject with regard to age (plus or minus five years), sex, race, specific admitting facility, and general date and type of admission (inpatient or outpatient). From the 1,032 patients with a diagnosis of antisocial personality and the 24,289 patients with other psychiatric diagnoses that were initially identified for this study, 524 pairs of experimental and control subjects were thus matched.

Patients under the age of 18 years and all patients from mental retardation facilities were excluded from consideration. The "best" psychiatric diagnosis of "antisocial personality" (the basis for assignment to the experimental group) involved three different diagnostic fields on the DMH patient data base. If a patient had a final discharge diagnosis

recorded, this was accepted as the best diagnosis; if only a staff diagnosis was available, this was accepted; and if neither of these were recorded in the automated life, an admission diagnosis was accepted. Control cases selected only if **none** of these three diagnostic fields contained the antisocial personality code of 301.70.

The matched groups were then compared with respect to demographic features and presenting symptoms, as obtained from the computerized patient data base. Presenting symptoms were inferred for each patient from an automated mental status record which contains psychiatric ratings for 109 operationally defined signs and symptoms, grouped into ten major areas (which are also rated as "normal" or not): general appearance, motor activity, speech, interview behavior, flow of thought, mood and affect. content of thought, sensorium, intellect, and insight judgment, plus a seven-point global rating of severity of illness (Sletten **et al,** 1970; Evenson and Hedlund, 1976). Although each of the 109 specific mental status items was clinically rated on a four-point scale, the data herein are presented only as per cent positive (present) for each group, inasmuch as results of more quantitative analyses proved essentially equivalent to these simpler findings. Statistical significances are reported for chi-square tests of independence ($p=.05$ or less).

Similar comparisons of demographic features and presenting symptoms were also made for "anxious" and "non-anxious" subgroups of the experimental and control groups. These subgroups were defined by the presence or absence of anxiety as rated on Item 59 of the mental status examination ("anxious, uneasy, fearful feelings of apprehension that do not seem related to actual events or specific threatening objects"). Of the 524 patients with a diagnosis of antisocial personality disorder, 127 evidenced some degree of anxiety by this criterion, and of the 524 matched control patients, 136 evidenced such anxiety.

In order to study the relationship of severity of the total disorder to other presenting symptoms, mental status variables were also compared for those of the experimental group whose global ratings of severity

were "1" or "2" (mild) (N=41) and those whose global severity ratings were "5" to "7" (severe) (N=55).

RESULTS

Comparing the total groups of unmatched patients (1,032 psychopaths with 24,289 others) on demographic characteristics demonstrated results generally in the direction to be expected (see Table I). The psychopaths were significantly more likely to be male, younger, uneducated beyond high school, professing no religion, never married or presently unmarried, unemployed with no disclosed income, and referred on some forensic basis. Comparison of the 524 antisocial subjects with the same number of matched controls demonstrated similar differences except for those categories on which the match was made. A majority (57.8%) of the antisocial subjects had been admitted to inpatient services, but 66.9% of the "anxious" psychopaths had been so admitted. Comparison of diagnoses made at index admission with those for latest diagnosis revealed the interesting fact that approximately one-quarter of both the antisocial group and the matched controls were likely to receive an admitting diagnosis on the same or subsequent entry of alcoholism and/or drug abuse.

Of the 120 mental status items, 37 were found to be significantly different for psychopaths versus controls, including seven of the 11 general categories. Psychopathic subjects were significantly more often scored "normal" on the general categories of motor activity, speech, flow of thought, mood and affect, and on the global rating, and were significantly less often scored "normal" on content of thought and insight and judgment. The "anxious" antisocial subjects demonstrated significant differences from the "non-anxious" antisocial subjects on 30 mental status items, including seven of the 11 general categories. "Anxious" psychopaths were significantly less often scored "normal" on the categories of general appearance, motor activity, speech, interview behavior, flow of thought, and intellect.

Of the 109 specific items, 17 might be considered clinically characteristic of antisocial personality disorder. The psychopathic subjects were scored significantly more often than the matched controls on all of these items except "hostile facial expression," "homicidal plans," and "evasiveness," all three being relatively uncommon in either group and in each of which the differences were not significant. However, the diagnostic impression appears to have been formulated primarily on the basis of history (as is implicit in the definition of the disorder), since only on the items "poor insight" and "poor judgment" were the psychopaths scored significantly more often in a number approaching a majority.

Nevertheless, not only did a median of twice as many antisocial subjects as controls score positively on 14 of the 17 clinically characteristic psychopathy items, but higher scores on the items in four of 21 mental status factors (identified in previous large-scale analyses of this system) were found to be significantly more characteristic of the "experimental" group. These four factors included a generalized antisocial cluster plus one each for hostility, dangerousness, and impaired judgment and insight (see Figure I). Two other specific items that also conceivably might be considered characteristic of psychopaths—"blaming others" and "sexual preoccupation"—were also significantly more common among the antisocial subjects.

There were no significant differences between the percentages of psychopaths and those of matched controls when scored on the specific anxiety item (24.2% versus 26.0% respectively), and the median percentages scoring on all other anxiety factor items were also similar. And "depressed mood" was common in both groups (25.0% in the subjects versus 30.3% in the controls).

Two other factors of the 21 did show significant differences in item clusters, however. Median percentage scores of psychopaths on items indicating depressive ideation (exclusive of depressed mood) were significantly higher than those for controls, and median percentage scores on

items indicating motor retardation were significantly lower for psychopathic subjects than those for controls (see Figure II).

Several scattered items in which endorsement was uncommon in either group nevertheless showed significant differences, with more psychopaths than controls demonstrating poor remote memory, poor abstraction, and less perceived "intellect above normal" (all suggesting difficulties in intellectual functioning), as well as more somatic complaints but less evidence of being "unrealistic regarding illness."

When one compares the 127 antisocial subjets who scored positively on the specific "anxiety" item with the 397 other "experimental" subjects, one finds the former to be a more grossly disturbed group. Using median percentage scores on items where significant differences obtained, and assigning these items to conceptually-related "clinical clusters" derived from the 21 factors noted above, one finds marked differences on four such clusters, generally with two to three times as many "anxious" psychopaths scoring on these cluster" derived from the 21 factors noted above, one finds marked differences on four such clusters, generally with two to three times as many "anxious" psychopaths scoring on these cluster items as "non-anxious" psychopaths, as follows :

1. "Anxiety" items (worried facial expression, agitation, and tremors, with or without the specific anxiety item) ;
2. "Agitated depression" items (depressed mood, sad facial expression, suicidal thoughts, increased motor activity, excessive amount of speech, and somatic complaints);
3. "Difficulties in intellectual functioning" items (irritability, intelligence perceived as below normal, poor abstraction, poor serial sevens, inability to concentrate, paucity of knowledge, feelings of unreality, and repetitive acts); and
4. "Neurotic sensitivity" items (evasiveness, suspiciousness, avoidance of gaze, sensitiveness, and meticulousness). (See Figure III.)

When one compares the 127 "anxious" psychopathic subjects instead

to the 136 similarly scoring "anxious" control patients, one finds that the psychopaths have significantly higher scores on all of the clusters and items that characterize the total group of antisocial subjects, as might be expected. There are, however. somewhat fewer differences between the "anxious" psychopaths and the "anxious" controls than between the former group and the "non-anxious" psychopaths, but the "anxious" psychopaths appear to be a distinct group **sui generis** because of significantly larger number than found in **either of** the other groups scoring on the "difficulty in intellectual functioning" clinical cluster, as well as on specific items indicating the presence of suicidal thoughts and somatic complaints.

Finally, comparing those antisocial subjects who received global ratings of "severe" versus those who received global ratings of "mild," those in the former group were significantly more often seen as hostile (irritable, angry, aggressive, and demanding) dangerous (more homicidal and assaultive ideas), antisocial (manipulative and with "attitudes at odds to society's generally accepted norms of morality, often illegal as well..."), with poorer insight and judgment. In general, increased global severity, much like specific anxiety, seemed systematically to increase the symptom differences of the antisocial group **including significantly** more depression, in this case with ideas of hopelessness and worthlessness.

DISCUSSION

The data in this study appear to define a clear subgroup of psychopaths (sociopaths, patients with antisocial personality disorders), characterized by the generally recognized behaviors and traits of other psychopaths but who also may be described as dysphoric — anxious and depressed, motor retardation, but with agitation, irritability, suicidal thoughts, somatic complaints, and difficulties in intellectual functioning, as well as what we have called "neurotic sensitivity" (see above). Such symptoms and signs have been previously noted, as suggested in DSM-III (1980): "Despite the stereotype of a normal mental status in this disorder, frequently there are signs of personal distress, including com-

plaints of tensions... [and] depression..." The possibility that anxious, depressed psychopathy represents a special syndrome does not appear to have been previously supported, however. Foulds (1965) put forward the argument that traits and attitudes emphasize the continuity of behavior, whereas symptoms and signs of illness emphasize the discontinuities. He felt that attacks of illness, of whatever nature, may punctuate the course of psychopathy, but cannot be intrinsic and necessary features of it. Our data do not contradict this position, but rather indicate that manifest anxiety and depression are relatively common in hospitalized psychopaths, probably as common as in matched controls who do not exhibit the pattern of antisocial personality disorder. The hint of organicity as a subtle etiologic influence should not be ignored.

The multiaxial system for psychiatric evaluation recommended in DSM-III (1980) fits our findings, with our subgroup of dysphoric psychopaths most probably being diagnosed under the rubrics: Axis I—Dysthymic Disorder (300.40) or Atypical Depression (296.82), depending primarily on duration; and Axis II—Antisocial Personality Disorder (301.70).

This subgroup of dysphoric psychopaths would appear in our data to constitute as many as a quarter of all patients with antisocial personality disorder seen in public psychiatric hospital and outpatient clinics. Although our definitions and methods are not exactly comparable to those described by L. Robins (1966), E. Robins (1967), or Guze (1976), this prevalence seems roughly similar to that found by them in psychopaths both community-resident and those in clinical settings, and perhaps twice as common as in those incarcerated (at least in Missouri penal institutions).

It is quite possible that our data are skewed because of interveiewer bias, inter-rater variability, or circular reasoning. However, the consistent and significantly higher endorsement of characteristic mental status items and demographic findings among our antisocial subjects compared to matched controls indicates at least an acceptable degree of face, concorrent, and construct validity.

The crucial question remains, does the presence of the dysphoric syndrome in persons suffering from antisocial personality disorder influence treatment and outcome ? Analysis of data to provide some answers to this problem is in progress.

FOOTNOTES

1. The several terms are used interchangeably in this paper, with the official rubric (during the period of data collection) being "antisocial personality" (DSM-II, 1968), which is "reserved for individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society... This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior...' Most such definitions suffer from vagueness, culture-binding, or confusion of traits with behavior; we are currently working toward the development of a culture-free, operational definition.

2. Item 116—"poor judgment"—is defined here less concretely than in some mental status protocols, as "inability to evaluate situations and make sound decisions leading to appropriate, acceptable, and effective action."

3. The other ten items not listed in the text which might be considered clinically characteristic of psychopathy were : angry outbursts; irritable, hostile, aggressive, manipulative, and demanding behaviors; assaultive ideas; homicidal thoughts; antisocial attitudes (immoral, illegal, or "criminal" ideas); and thoughts of running away.

4. Item 63—"depressed mood"—is defined here as "abnormally lowered spirits of feeling tone, unusually strong feelings of dejection and despair."

5. Item 32—"irritability"—was subsumed in the prior comprehensive analyses of this system under the factor "hostility." However, in the data analyses in the present study, this item appreared to

shift statistically, correlating at times with that factor, and at other times with the clusters of "difficulties in intellectual functinong" and/or "agitated depression."

6. About five per cent of those persons diagnosed as psychopathic will die by suicide—less than primary depressives, alcoholics, schizophrenics, or opiate abusers, but substantially more than persons with any other psychiatric diagnoses or those considered "normal" prior to the act (Weiss, 1981).

TABLE I

Selected Demographic Characteristics of 1,032 Diagnosed Psychopaths Compared to 24,289 Other Missouri DMH Patients (Percentages)

		Psychopaths	Others
Sex	Male	84.3%	62.3%
Age	18-30	74.6	37.1
	30+	Rapid decrease	Flat distribution
Education	<8 years	7.8	13.8
	8-12	83.8	75.2
	12+	7.4	11.0
Religion	None	19.6	13.3
	Protestant	55.5	64.6
Marital Status	Never married	52.7	36.9
	Married		
Occupation:	Laborer	26.3	21.0
	Unemployed	38.9	31.0
Income:	None	28.1	21.5
Facility:	Forensic	14.1	10.6
Type of Commitment:	Voluntary	71.4	82.9
	Forensic	14.3	4.5
Type of Referral	Self	15.2	19.9
	Relative	11.2	16.5
	Medical Facility	12.7	23.7
	Court	43.8	23.2

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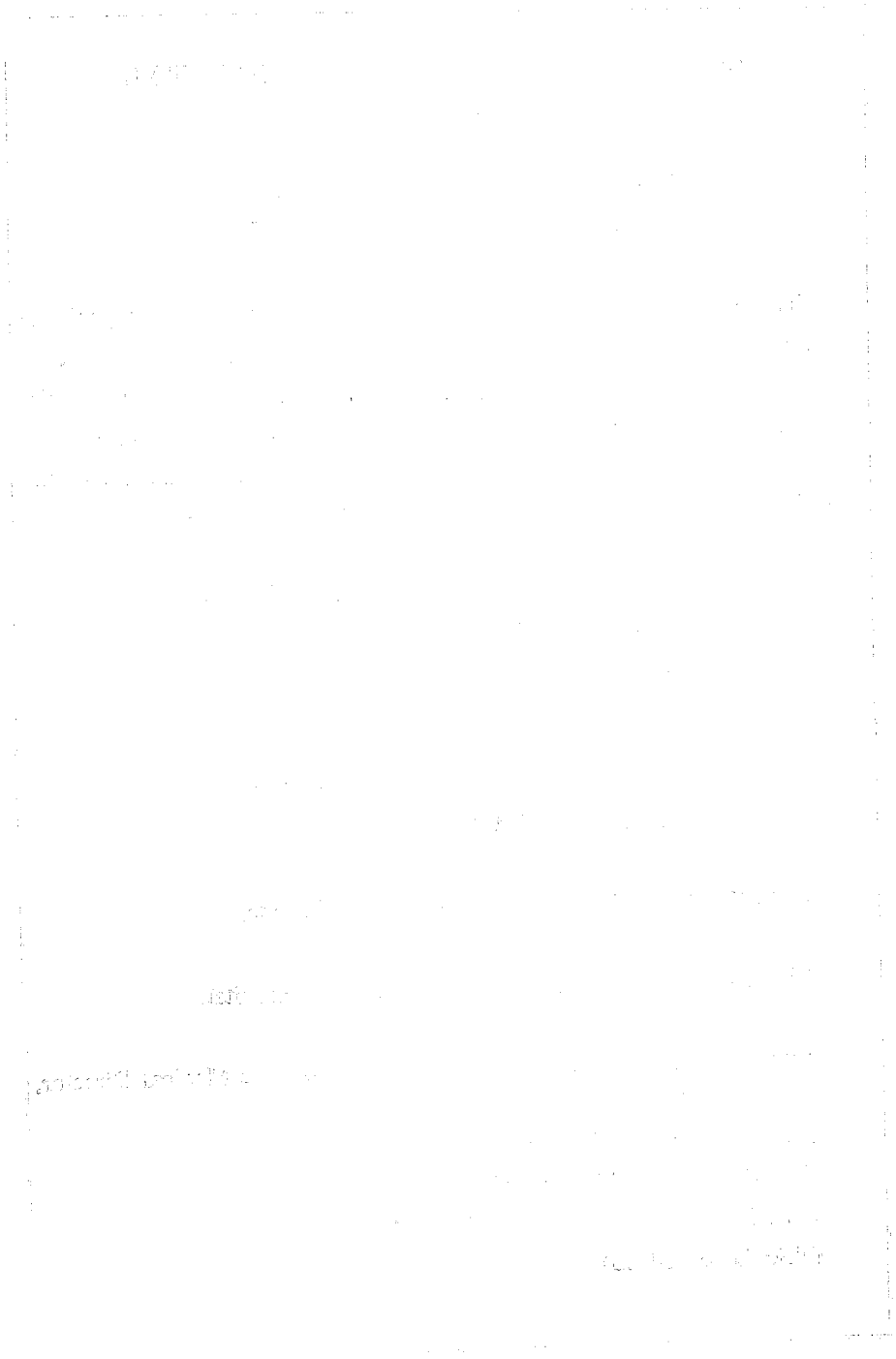
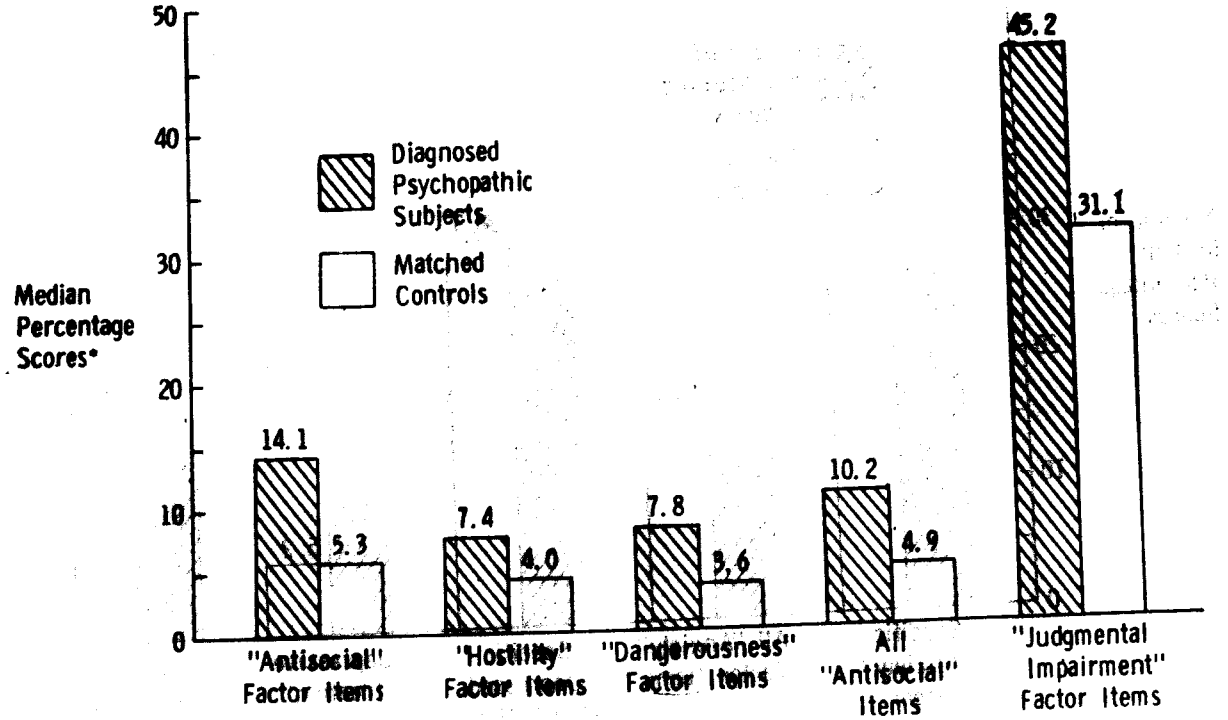
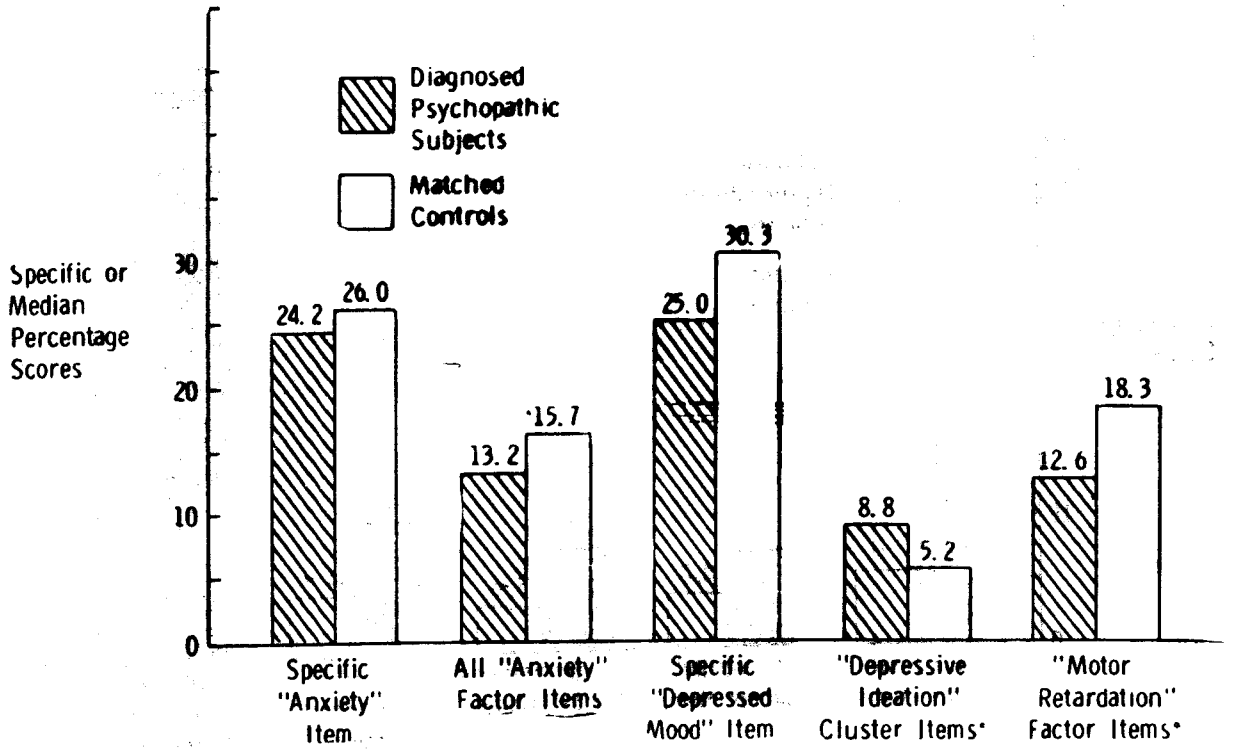


Figure 1. Comparison of 524 Diagnosed Psychopaths vs. 524 Matched Controls on "Antisocial" Mental Status Items



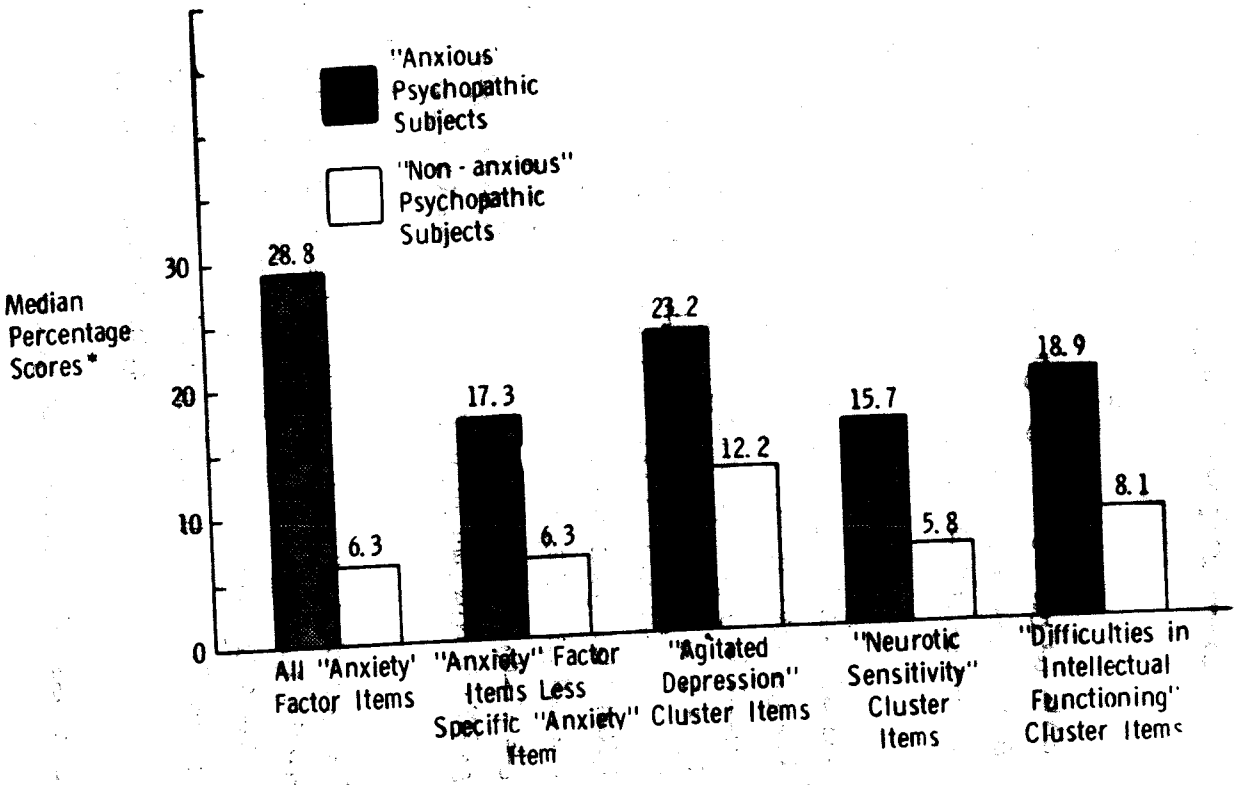
*On items demonstrating statistically significant differences

Figure 11 Comparison of 524 Diagnosed Psychopaths vs. 524 Matched Controls on "Anxiety/Depression" Mental Status Items



*Scores on items demonstrating statistically significant differences

Figure 11: Comparison of 127 "Anxious" Diagnosed Psychopaths vs. 397 Other Diagnosed Psychopaths on Significant Mental Status Items



*On items demonstrating statistically significant differences

مظاهر القلق فى المرضى باضطراب نمط الشخصية من النوع المضاد للمجتمع

اعتقد الباحثون أن تواتر الافتقار الى قلق ظاهر صريح فى حالات الشخصيات السيكوباتية هو من المعوقات أمام برامج العلاج والتأهيل ، الا أن أبحاثا أكثر حداثة دلت على أن أعراض القلق وعلاماته قد تظهر فى أشخاص يعانون من هذا الاضطراب المزمن ٠

وفى الدراسة الحالية ، ثم فحص كل الناضجين الذين أدخلوا الخدمة العامة للصحة العقلية فى ولاية ميسورى فى المدة من سنة ١٩٧٢ الى سنة ١٩٨٠ ، وقد وجد أنه من بين ٢٥٫٣٢١ مريضا قد تم تشخيص ما يقرب من ٤٪ من هؤلاء تشخيصا على أعلى درجات الدقة بأنهم ذو شخصية مضادة للمجتمع ، ومن كل المجموعة تم فحص ٥٢٤ زوجا من العينة التجريبية وعينة ضابطة مماثلة ، وتحت المقارنة على أساس دليل فحص الحالة العقلية « أتوماتيا » ، وقد أظهرت الحالات المضادة للمجتمع نسبة أعلى فى السمات المضادة للمجتمع ، والعدوانية ، والخطورة ، وضعف البصيرة والحكم على الأمور ، وقد أظهرت قلة محترمة قلقا واكتئابا بتواتر ليس فارقا ذا دلالة مع العينة الضابطة ٠

وقد تم اظهار وتحديد أعراض بذاتها فى المرضى السيكوباتيين وخاصة أولئك الذين عولجوا من خلال تسهيلات مؤسسات الصحة النفسية ، اظهرت أعراضا مثل زملة عسر العواطف ، والتهيج ، والاكتئاب (دون تباطؤ حركى) مع تركيز خاص على صعوبات فى العمل الذهنى ، وعلى الحساسية العصابية، والشكاوى الجديدة ، وسرعة الاستثارة ٠

كذلك أظهر البحث الاختلاف فى نتاج العلاج ٠ ثم فحص هذه الاختلافات ٠

ABSTRAIT

Les manifestations de l'anxiété chez des patients présentant une personalité pathologique du genre antisociale.

L'absence répétée d'une anxiété manifeste chez les psychopathes a été considérée comme un facteur s'interposant avec beaucoup de programmes de thérapie et de réhabilitation. De plus nouvelles recherches ont montré que les symptomes et les signes de l'anxiété pouvaient exister chez des patients souffrant d'un tel trouble chronique. La question est encore discutable et demande à être résolue pour pouvoir mettre des plans de traitement et de prévention efficaces.

Dans l'étude actuelle, toutes les premières admissions des adultes aux hôpitaux des aides de la santé mentale publique à l'état de Missouri de 1972 à 1980 ont été examinés. Parmi 25321 de ces admissions quatre pour cent approximativement ont reçu comme 'meilleur' diagnostic personalité antisociale. Dans le groupe total 524 paires des sujets expémentés et du groupe de contrôle ont été choisis et comparés suivant un index 'automated' du status mental. Les sujets antisociaux ont montré d'une façon significative une plus grande fréquence de traits antisociaux généralisés de l'hostilité, du danger, une perspicacite et un jugement pauvres. Une minorité substantielle a révélé de l'anxiété et de la depression avec une allure de fréquence qui n'est pas différente d'une façon significative du groupe de conrôle comparé. Parmi les psychopathes un syndrome dysphorique a été delinée parmi les psychopathes particulièrement parmi ceux qui sont traités par les aides de la santé mentale. Ce syndrome est constitué par de l'anxiété de l'agitation depression sans inhibition motrice mais avec une accentuation particulière des difficultés du fonctionnement intellectuel, une sensitivité neurotique des plaintes somatiques ainsi qu'une irritabilité. Les diffèrences dans les résultats des traitements courrants ont été examinés.