

Differentiating and Diagnosing Sociopathy, Psychopathy, and Anti-Social
Personality Disorder

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INTRODUCTION

The current study will examine if, and to what degree, there exists a difference in the definitions of sociopathy, psychopathy, and antisocial personality disorder. By examining these possible distinctions, possible differences in diagnoses may be required based on criteria distinctive to the disorder. Because of the broad associations that the public, law enforcement, and the judicial system make between these disorders and criminal behavior, a more thorough understanding of how these disorders are defined and diagnosed is important not only in the treatment of individual patients, but the efficacy of treatment of these individuals can affect society in general by reducing the recidivism of those prone to engaging in criminal behavior and proactively addressing personality issues that can manifest into criminal behavior itself.

The current study will examine how these disorders were defined and diagnosed in the past, the current methodologies and instruments most commonly in use surrounding these disorders, and new directions in diagnoses, instruments, and definitions.

HISTORICAL PERSPECTIVE

An understanding of the construct of these disorders is of primary importance. A review of literature on the subjects show that the terms sociopathy, psychopathy, and antisocial personality disorder are often used interchangeably and at the same time, professionals in the psychiatric and psychological fields have been struggling to define their differences.

Key to all three designations is a lack of caring or empathy for others. In 1806, Philip Penal described certain individuals as suffering from moral insanity (Siegel, 2005). Specifically, mania without delusion in that there is something disordered about one's temperament, attitude, and/or impulses while their intellectual faculties are unaffected, and they do not suffer from delusions or hallucinations. J.C. Prichard utilized the terms moral insanity and moral imbecility in early attempts to diagnose moral disorders, those that fit the description of what we consider psychopathy today (Begun, 1976). While this is an admittedly broad category, the criteria of the more modern term, sociopathy, fits within it.

Sociopathy

Earlier descriptive criteria for diagnosing sociopaths in the 1950's and '60, as defined by the MMPI 4-9 coding, besides showing "clear manifestations of psychopathic behavior" described traits like "overactive...extroverted, talkative, ambitious, and energetic, frequently irritable and occasionally violent". For females, traits typically associated with them included "flippant, self centered, under-controlled, histrionic, irritable, amoral and manipulative". These patients also "displayed sexual maladjustment, used drugs or alcohol to excess, and showed no response to treatment" (Gynther, et al, 1973). Starting in the '40's, psychiatrist Hervey Cleckley sought to define sociopathy (alternately defined as psychopathy by others) by a group of characteristics

comprised of personality traits and behaviors. The 16 main characteristics included (Cleckley, 1982 in Barlow & Durand 2005):

Superficial charm and good intelligence	General poverty in major affective reactions
Absence of delusions and other signs of irrational thinking,	Absence of nervousness and other psychoneurotic manifestations
Pathological egocentricity and incapacity to love	Fantastic and uninviting behavior with or without drink
Unresponsiveness in general interpersonal relationships	Poor judgment and failure to learn by experience
Failure to follow any life plan	Unreliability
Sex life impersonal, trivial and poorly integrated	Lack of remorse and shame
Suicide rarely carried out	Specific loss of insight
Inadequately motivated antisocial behavior	Untruthfulness and insincerity

Cleckley also made distinctions between primary and secondary sociopaths, the primary sociopath distinguished by a low autonomic nervous system response that prompts them into sensation-seeking to raise arousal to a comfortable level. The secondary sociopath's antisocial behavior stems from anxiety associated with frustration or internal conflict and, opposite from primary sociopaths, can learn from aversive experience and punishment (Fagan & Lira, 1980). Fagan and Lira's 1980 work sought to determine if primary sociopaths engaged in more serious and more frequent antisocial behaviors than secondary sociopaths using the Minnesota Multiphasic Personality Inventory (MMPI) and State-Trait Anxiety Index (STAI).

The MMPI has been utilized quite extensively in diagnosing sociopathy. Of most importance is Scale 4 (Psychopathic Deviate) and Scale 9 (Hypomania) and high scores on both

measures. Scale 4 is predictive of personality disorders and emotional instability, involving traits and behaviors of immaturity, aggressiveness, a wide variety of social and interpersonal difficulties, and substance abuse. Scale 9 features involve religiosity, talkativeness, grandiosity, hostility and being prone to work and drinking problems (King & Kelley, 1977). Much of the prior research in using this measure indicated that those scoring high on both scales have been consistently described as “impulsive, immature, hostile, irritable, amoral and being “relatively free from anxiety, depression and guilt, as having a criminal record and problems with work, heterosexual relationships, drugs and alcohol, finances, and poor judgment” (King & Kelley, 1977).

When Fagan & Lira examined the primary/secondary distinction they found that, in partial support of their hypotheses, primary sociopaths engage in more frequent and more serious antisocial behavior than secondary sociopaths but found no difference in the antisocial behaviors of highly anxious non-sociopaths and secondary sociopaths (1980).

Sutker et al used the MMPI in 1974 as a diagnostic tool to determine if sociopaths scored lower on the Wechsler Adult Intelligence Scale (WAIS). Their results found no differences in overall intellectual functioning but did find significant differences in sociopaths' higher performance in Picture Arrangement and Picture Completion than in the normal control group, which “reflects the ability to observe relevant details in the physical environment”. The study also showed that Wechsler had incorrectly predicted that sociopaths would have difficulties in abstract thinking and attention to stimuli that didn't satisfy their immediate needs.

However, not all researchers have supported the use of the 4-9 and 9-4 codes of the MMPI as diagnostically relevant in sociopathy. Gynther et al postulated that replication with alternate samples and the representativeness of samples, calls into question the consensus on the

validity of the MMPI. In their study, those coded for 4-9 and 9-4 scored lower on items indicative of sociopathy than previous studies and that the highly inter-correlated items on the MMPI will exhibit unreliability in difference scores (1973).

Psychopathy

While sociopathy and psychopathy have been used interchangeably, Robert Hare states that the difference may lie in how one considers the contributing factors. As Hare explains, sociologists may be more apt to use the term sociopath as they view the behavior arising from social conflicts, whereas a psychologist may utilize the term psychopathy to describe a condition influenced by genetic, psychological, biological, and environmental factors (1999). David Lykken also agrees there is a distinction between the two definitions in that psychopaths are born with cortical under-arousal and an impulsivity that leads to risk seeking and an inability to conform socially. Sociopaths are a product of a negative environment that includes poverty, broken homes, and delinquent peers. While he considers that both environmental and biological factors play a role in both disorders, psychopaths lean toward these biological factors while sociopaths are more defined by environment (1995).

The Psychopathic Checklist-Revised (PCL-R), developed by Hare is one of the most commonly used tools for diagnosing psychopathy. Additional versions included the PCL-Screening Version (SV) for a non criminal population or for quicker clinical assessments, and the PCL-Youth Version (YV) for adolescents. It was originally a two-factor model including the affective and interpersonal factor describing the “selfish, callous, remorseless use of other” and the behavioral factor describing the “chronically unstable and antisocial lifestyle” (Hare, 91 in Cooke and Michie, 2001). In consideration that the two factors may not be a good fit for data, a

three-factor model was developed (Cooke and Michie, 2001). It consists of 20 items divided under three factors. It is scored on a three-point scale which defines severe psychopathy with a score ≥ 30 . The items are as follows:

Interpersonal dimension

- Glibness/superficial charm
- Grandiose sense of self-worth
- Pathological lying
- Conning/manipulative
- Lack of remorse or guilt
- Shallow affect
- Callous/lack of empathy
- Failure to accept responsibility for own actions

Affective dimension

- Need for stimulation/-proneness to boredom
- Parasitic lifestyle
- Poor behavioral controls
- Early behavioral problems
- Lack of realistic, long-term goals
- Impulsivity
- Irresponsibility
- Juvenile delinquency
- Revocation of conditional release

Behavioral dimension

- Promiscuous sexual behavior
- Many short-term marital relationships
- Criminal versatility

Of distinct importance in the accurate diagnoses of psychopaths (and those with antisocial personality disorder) is that they can be utilized in addressing the criminal behavior that is (arguably) associated with these disorders. Heilburn found mixed results in the literature in his study of the connection between violence and psychopathy (1979). His study utilized aspects of the Pd scale of the MMPI, combined with the Socialization scale of the California Personality Inventory (CPI) in conjunction with the IPAT Culture Free Intelligence Test. His results indicated that the “unsocialized personality qualities defining the psychopath and lower intelligence [were] found to be associated with violent crime” (1979). This result runs contrary to the conception of high intelligence in psychopaths proposed by Cleckley. However, Vitacco, Neumann, and Jackson’s 2005 study, referenced below, counters Heilburn’s results. Ultimately, additional research must be conducted to assess the correlation between intelligence and psychopathy as Salekin et al demonstrated in 2004 with their mixed results on incarcerated youths. They found that some “psychopathy traits reflecting a superficial and deceitful interpersonal style were positively related to verbal skills” in the K-BIT intelligence test and the non-traditional measure of intelligence, the STAT. However, the authors also found that psychopathy traits related to problems in affective processing were negatively related to verbal intellectual abilities (Salekin et al, 2004).

Antisocial Personality Disorder

The DSM III introduced a new paradigm to the definition of these disorders. The APA considered sociopathy and psychopathy as outdated terms that are synonymous with antisocial personality disorder and dropped the category of psychopathy, replacing it with antisocial personality disorder (APD) in the 1980 edition (Hare, 1996). Robert Hare claimed that this renamed psychopathy is now distinguished by “persistent violation of social norms” rather than the “affective and interpersonal traits” that traditionally defined psychopathy (Hare, 1996). However, by focusing on observable behavioral criteria, clinicians will be more assured of making reliable diagnoses. The current DSM IV definition for APD is: “characterized by a lack of regard for the moral or legal standards in the local culture. There is a marked inability to get along with others or abide by societal rules. Individuals with this disorder are sometimes called psychopaths or sociopaths”. The criteria for APD consists of “a pervasive pattern of disregard for, and violation of the rights of, others occurring since age 15, as indicated by three (or more) of the following”:

- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults
- Reckless disregard for safety of self or others
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

- Lack of remorse, as indicated by being indifferent to, or rationalizing, having hurt, mistreated, or stolen from another

The manual also lists the following additional necessary criteria: that the individual is at least 18 years old, there is evidence of conduct disorder with onset before age 15, and the occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode (Barlow & Durand, 2005). As evidenced by the above criteria, there is significant crossover between the PCL-R and the diagnostic criteria of the DSM IV, and also some notable differences.

Diagnosing APD has gone beyond utilizing the MMPI or the PCL-R. Practitioners and researchers still recognize the utility of differentiating and defining psychopathy outside of APD. In 1992, Gacono and Meloy utilized the Rorschach test to assist in understanding APD by examining psychopathic and non-psychopathic APD subjects. The authors utilized 20 variables from Exner's Comprehensive Scoring System that are indicative of psychopathic disturbances. Their results showed that psychopathic APD subjects had significant differences from non-psychopathic APD subjects in areas of narcissism, omnipotence, and defensive strategy utilization.

In 2001, Messina et al also took a different approach and compared the diagnostic instruments of the Structured Clinical Interview for DSM III-R (SCID-II) against the self-reported inventory of the Millon Clinical Multiaxial Inventory (MCMI-II) in diagnosing APD amongst substance abusers. As they expected, they found minimal agreement between the two measures, with the MCMI-II diagnosing APD more often than the SCID-II. The authors note the differences may result because of the difference in the traits being measured. The SCID-II is

more useful in measuring observable behavior while the MCMI-II taps into pathological personality traits that may be found more in the criminally-prone substance abusing population (Messina et al, 2001). Not everyone is comfortable with making the simple associations between APD and criminality and are aware of the distinction between behaviors and personality traits. The PCL was criticized on the tautological issue of its score being used to identify the criminally prone while simultaneously measuring their criminality. In 1983, Wulach considered the difference between the definition found in DSM II of psychopathy and the definition of APD in DSM III. While essentially a redefining of the same disorder, the criteria changed drastically from the personality traits in the DSM II to observable behaviors in the DSM III in an effort to increase diagnostic reliability (Wulach, 1983). This new diagnostic criteria resulted in a greatly increased prevalence of diagnosis of APD in the criminal population as the over-inclusiveness of the criteria may result in some common behaviors occurring in adolescence to be indicative of APD. Wulach also notes that there is no good way to distinguish between a chronic pattern of behavior and a series of occasional acts over time, both of which would result in a diagnosis of APD.

CURRENT ISSUES

While the MMPI and Wechsler Intelligence scales have been featured prominently in the work of forensic psychology, there is still little data on the prevalence of usage with other measurement scales. In 2006, Archer et al sought to determine just how prevalent the use of some of the other psychological instruments were. Multi-scale inventories, clinical scales, and cognitive and neuropsychological measures, among others, were examined for the frequency of use in the forensic evaluation field. The MMPI was the most widely used multi-scale inventory,

the most frequently used unstructured personality test is the Rorschach, and by far the most used instrument for risk assessment/psychopathy are the PCL versions. In forensic examination of adolescents, the MMPI was the most frequently used instrument however, the PCL-YV was used relatively infrequently (ranked 7th out of 12 measures) (Archer et al, 2006)

Despite the fact that the PCL-R is the “premier” measure of psychopathy, Skeem and Cooke (2010) caution against equating a measure (PCL-R) with the construct of psychopathy itself, noting that behaviors investigated in the PCL-R have an inordinate focus on criminal behavior and excluded fearlessness. That is, a diagnosis of psychopathy may really be measuring an individual’s antisocial criminal behavior and not psychopathy itself. Hare’s checklist eliminated emotional stability “because it did not predict delinquency and therefore could not be part of psychopathy” (Skeem & Cooke, 2010) They criticize Hare for failing to forward a theory that explains how antisocial behavior and a lack of emotional attachment coalesce into psychopathy. Their suggestion is for a new focus on psychopathy that separates personality deviation from social deviance. Hare and Neumann suggest an expanded four-factor model utilizing Interpersonal, Affective, Lifestyle, and Antisocial factors with a total of 18 items, which may be a better fit for data (Neumann et al, 2006). The four-factor model was found to be a good predictor of violence and other aggression and also for intelligence, which is consistent with Cleckley’s 1941 claim that “some aspects of psychopathy may be associated with good intelligence.

An alternate, global measure of the antisocial construct was developed by the World Health Organization, the ICD-10. Their criteria for Dissocial Personality Disorder are similar to that of APD. Diagnosis is characterized by the presence of at least three of the following:

- Callous unconcern for the feelings of others and lack of the capacity for empathy.

- Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.
- Incapacity to maintain enduring relationships.
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
- Incapacity to experience guilt and to profit from experience, particularly punishment.
- Markedly prone to blame others or to offer plausible rationalizations for the behavior bringing the subject into conflict.
- Persistent irritability.

The diagnostic criteria are meant to encompass antisocial, sociopathic and psychopathic personalities (<http://www.who.int/classifications/icd/en/>).

Though different efforts have been made to refine the definition of the disorder(s), there continues to be distinct similarities between the diagnostic criteria. Indeed, the traits listed for the ICD-10 bear a striking similarity to the DSM criteria. In fact, quite a number of Cleckley's criteria have analogs in the PCL-R, ICD-10 and the DSM IV (see Table 1). The PCL-R, however, has the highest number of items unique to its instrument.

Table 1. Diagnostic Criteria by Measure

	CLECKLEY	PCL-R	ICD-10	DSM IV
Callousness or lack of empathy	X	X	X	X
Irresponsibility/Inability to take responsibility	X	X	X	X
Lack of remorse, guilt, or shame	X	X	X	X
Failure to maintain relationships	X	X	X	
Failure to follow life plan/meet goals	X	X		X
Lying, deceitfulness, conning	X	X		X
Crime and violent behavior		X	X	X
Disregard social norms			X	X
Lack of affective reaction	X	X		
Poor judgment/Failure to learn from experience	X		X	
Impulsiveness		X		X
Impersonal, trivial sex life	X	X		
Superficial charm/Glibness	X	X		

A LOOK TO THE FUTURE

Indeed, the DSM IV-TR lists both sociopathy and psychopathy as dissocial personality disorders, aspects of antisocial personality disorder in general but it is possible they may constitute separate disorders themselves.

The traits are typically associated with both sociopaths and psychopaths, however some in the field consider the DSMIV-TR incorrect in equating psychopathy & sociopathy to Antisocial Personality Disorder as APD is diagnosed by behavior and social deviance and

psychopathy is diagnosed thru affective and interpersonal personality factors (Barlow and Durand, 2005).

The APA's stance as presented in the DSM IV-TR is that psychopathy and sociopathy are obsolete synonyms for APD. However, the working group on DSM V are seeking to reformulate the disorder to Antisocial/Psychopathic (AS/P) Type with a greater emphasis on character traits rather than behavior. Indeed, the new edition of the DSM will seek to reduce the pantheon of personality disorders into five specific types. The prototype dimensional model for AS/P utilized the Shedler-Westen Assessment Procedure-200. Patients will be compared to a prototypical description and scored on a five point scale. Other measuring schemes were analyzed including the FFM, but their results indicated that while personality types could be derived from FFM criteria, incorrect diagnoses were exhibited without the diagnostic attempt being put into a clinical context (www.dsm5.org). In light of this, multiple candidates for inclusion were considered and it appears that a hybrid model incorporating normative traits and personality disorders would be a valid option.

DISCUSSION

Since the time Cleckley presented his criteria there has been vigorous debate on what a psychopath is exactly and the best way to diagnose them. It is somewhat akin to the classic description of obscenity from the U.S. Supreme Court, in that the term is difficult to articulate but "I know it when I see it". However, this subjectivity does not serve the public, the criminal justice fields', or the mental health fields' interests. While the basic description of a cold, calculating individual who'll use any means necessary to achieve their goals, even at the expense

of others, provides us with a model of these individuals, if we do not delve further into the aspects of the disorder, we run the risk of casting an excessively wide net over individuals who simply don't conform to the norms of society. Without definitive diagnostic tools, the aspersions we place on individuals can have a negative effect on society. As Wulach (1983) points out, when the DSM incorporates overly inclusive criteria for APD, we run the risk of over-diagnosing a personality disorder in a population that may be sensitive to a labeling effect, i.e. individuals are sensitized to the label placed on them, just as society is, and in establishing congruence with this self image, adopt the persona that they have been labeled with. In the process, we overextend the resources of the mental health and criminal justice fields and are still no closer to being able to predict and determine who are the predators in society. While the debate over the difference between sociopaths and psychopaths may be more of a historical footnote, we are still left with a problem in how best to diagnose a personality disorder that has the potential of causing serious interpersonal and societal problems.

Central to this debate is the issue of whether behavioral features or personality traits are the best indicator of the disorder, and which features or traits will succeed in being the best particular indicators in diagnoses. It is understandable that the use of personality trait measures to define the disorder may assist practitioners and clinicians in the field, however a very real concern to society is not just that these individuals have deficits in their personalities that are reflected in the interpersonal relationships and other dealings with society but that given the nature of the disorder, how this personality deficit will manifest itself in outward behaviors. While there is debate over whether one can use the presence of criminal behavior to be a predictor of criminal behavior, what is less debatable is the fact that this disorder facilitates and fosters attitudes that can easily be manifested in criminal behavior.

In that sense, it may be wise to move past some of the “gold standards” of diagnoses like the PCL & MMPI as the sole means of diagnosing this disorder and consider developing a more detailed index that incorporates multiple measures to capture the true nature of the disorder. Undoubtedly, if we wish to predict criminality in order to spare society to some degree, we have to consider the level of threat that individuals with this disorder actually present. Being an egocentric individual who has difficulty getting along with others is not a crime, nor does it necessarily predict criminality. It is only when we determine who among those with the disorder that are most at risk for criminal behavior can a higher societal goal be reached. To that goal, in conjunction with a measure of personality traits, a definitive measure of behavior or behavior propensities needs to be incorporated in diagnoses. Outside of direct observation, measuring behavior can be problematic but utilizing, for example, a series of vignettes may give an indication of likely behavior patterns. Unfortunately, the very nature of the disorder, that of glibness, cunning, and deceit, may make any self reported behavioral indicators of questionable validity. To fully assess an individual who may have the disorder, an index that incorporates a number of instruments that measure different aspects of the individual should be developed; personality traits, behavioral proclivities, criminal and life histories, intelligence, and social and coping skills. The nature of the disorder may very well make this a daunting task. However, as evidenced by the vast amount of literature published on the disorder over the past half a century, there is no dearth of professionals who are willing to devote the appropriate time and resources to solving the problem of developing an index that will not only accurately diagnose the disorder but allow practitioners, clinicians, and researchers to predict and determine the level of threat that a portion of those with the disorder actually present to society.

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