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# Violence and personality disorders: clinical and forensic implications

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Several studies have provided strong evidence that personality disorders (PD) represent a significant clinical risk for violence. This review has aimed to examine the relationship of greater risk for violence among persons with certain PD in terms of four fundamental personality dimensions: 1) impulse control; 2) affect regulation; 3) threatened egotism or narcissism; and 4) paranoid cognitive personality style. Two of these dimensions -impulse control and affect regulation- are probably substantially affected by virtually all PDs linked to violence. Narcissism or threatened egotism and paranoid cognitive personality style have also been empirically linked to violence and mental disorder. PD symptoms have proven to be even stronger predictors of violence than the PDs per se. In fact, increased symptoms of DSM-IV cluster A or cluster B PD, such as paranoid, narcissistic and antisocial PD symptoms, correlate significantly with violence. Finally, there are three important principles about the relationship between PDs and violence: 1) PDs are rarely egosyntonic; 2) most patients and violent situations that come to clinical attention involve comorbid conditions; and 3) violence and risk of violence are often associated with substance abuse. Implications of this review for further research are discussed.

**Key words:**

Violence. Personality disorders. Clinical implications. Forensic implications.

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## Violencia y trastornos de la personalidad: implicaciones clínicas forenses

En diversos estudios se ha demostrado que los trastornos de la personalidad (TP) representan un riesgo clínico significativo para las conductas violentas. El objeti-

vo de este artículo es examinar la relación entre los TP y la violencia en función de cuatro dimensiones de personalidad fundamentales: 1) la impulsividad; 2) la falta de regulación emocional; 3) el narcisismo y las amenazas al yo; y 4) el estilo de personalidad paranoide. Dos de estas dimensiones -la impulsividad y la falta de regulación emocional- están implicadas en todos los TP relacionados con la violencia. El narcisismo o las amenazas al yo y el estilo de personalidad paranoide se han asociado empíricamente a la violencia y a los trastornos mentales. Los síntomas de los TP han mostrado ser mejores predictores de la violencia que los TP por sí mismos. De hecho, los síntomas del clúster A o B de los TP, tales como los síntomas paranoides, narcisistas y antisociales, correlacionan de forma significativa con la violencia. Por último, hay tres principios fundamentales sobre la relación entre los TP y la violencia: 1) los TP son habitualmente egosintónicos; 2) los TP muestran comorbilidad con otros trastornos del Eje I o del Eje II; y 3) la violencia y el riesgo de violencia están asociados con frecuencia al abuso de drogas. Se comentan las implicaciones de esta revisión para la investigación futura.

**Palabras clave:**

Violencia. Trastornos de personalidad. Implicaciones clínicas. Implicaciones forenses.

## INTRODUCTION

The clinical and legal-criminal importance of personality disorders (PD) in serious and violent behaviors is unquestionable. These psychopathological abnormalities can affect the imputability of the criminal acts. They are an important factor in the evaluation of the risk of violence (criminal dangerousness). They determine the phenomenology, course, prognosis and response to treatment of other mental disorders and, finally, they condition adaptation to the penitentiary setting (and even hospital setting), with added difficulties in the rehabilitation and reinsertion of these subjects.

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The common denominator of PD-associated violence, with the some exceptions such as psychopathy, is anger. This is an emotion that is expressed with rage, resentment and irritability. The physical effects of anger include an increase in heart rate and blood pressure as well as epinephrine and norepinephrine levels. Anger can be considered as a part of the neurophysiological response to a threat or perceived harm.

Several circumstances can activate anger: a) suspicion, fanaticism, pathological jealousy or revenge (paranoid personality disorder); b) aversion to physical contact with other persons (schizoid disorder); c) intolerance to frustration and intense anger because of being treated in a different way than was expected (Narcissistic Personality Disorder); d) due to the need to release tension using splitting as a defense mechanism or due to fear of loss (borderline disorder); e) by the feeling of exclusion or rejection by the others (avoidance disorders); f) by feelings of boredom, dehumanization of the others, need for power and absence of empathy (antisocial disorder); g) the vital need to call attention or form a part in a group (histrionic and dependent disorders, respectively), and h) due to cognitive disorders and bizarre experiences (schizotypal disorders).

Anger is expressed with all its intensity with the adrenergic discharge of the psychostimulants or with alcohol or other drug provoked disinhibition. In many cases, some learning processes intervene (for example childhood abuse, influence of the new technologies and communication media or inappropriate education models) and personal failure, above all when connected to poor self-esteem and feelings of humiliation, shame or impotence.

The association between PD, drug usage and violence has a sufficient foundation, although this association may go in several directions: 1) violent behavior is a common way to obtain the drug; 2) violence (threats, hitting, wounds) may be a general condition to solve discussions between those distributing the drugs; 3) drug abuse and furious behavior may have similar causal factors and thus concur in certain subjects; and 4) some drugs, such as stimulants, increase the likelihood of having violent behavior due to the pharmacodynamic properties.

From the dimensional point of view, those personality traits having the greatest tendency towards violence are impulsiveness, deficient affective regulation, narcissism and paranoidism.<sup>1</sup> In regards to the proposal of the six domains contemplated in the draft of the DSM-V, those most involved with violent behaviors are negative emotionality (emotional lability and mistrust), introversion (restricted affectivity), antagonism and disinhibition. On the contrary, schizotypy and compulsiveness are much less involved in this type of behaviors.<sup>2</sup>

The forensic evaluation of PD is difficult, because no meticulous longitudinal and trans-situational evaluation is conducted and because these persons, when subjected to a legal process, provide little collaboration, but rather use direct manipulation or phenomena of simulation-dissimulation.<sup>3</sup> A correct evaluation of the PDs should involve a complete semistructured interview (for example, the IPDE), meticulous examination of the clinical history of the patient, analysis of the records of the cases on criminal background; and the study of the life history (family, school, work, partner relationships, etc.), this evaluation being supported by external informers and on some personality test (such as the MMPI-II, MCMI-III, 16PF5, TCI or the NEO-PI-R).

Regarding treatment, the egosyntonic character of the PD in the absence of insight of the patient on their inadaptable traits hinders establishment of an adequate therapeutic alliance. The problem becomes worse when these PDs are associated to other psychiatric conditions (depression, anxiety disorders, alcohol and drug abuse or schizophrenia), because they are going to condition their torpid course and poor prognoses, favoring their deterioration. It must be remembered that psychoses are an important risk factor for violence, especially when associated to drug consumption and to poor treatment adherence.<sup>3</sup>

In summary, all the PDs may be related with violent behaviors, some more frequently than others, however the degree of variance they explain is probably less than expected. In the occurrence of such behaviors, many other endogenous, exogenous (social or situational) factors may play a role, and especially, interaction with the victim.

## ARE PERSONS WITH PD VIOLENT? PREVALENCE STUDIES AND EVALUATION OF RISK

There is a very high prevalence of PDs in the forensic and penitentiary populations. However, this varies greatly in the different studies according to the sample type and especially based on the evaluation instrument. The British government, in 1983, granted such importance to the risk of violence in those suffering PDs that it introduced the concept of Dangerous People with Severe Personality Disorder (*DSPD*), applied to the patients who fulfilled the following criteria: a) having a high likelihood of committing a serious offense; b) there being a possible relationship of causality between the PD and risk of violence and c) having a serious PD, classified as such when the subject has a score over 30 on the Psychopathy Scale (PCL-R), a score between 25 and 29 on the PCL-R together with the diagnosis of a PD of the DSM or two or more diagnoses of PD of the DSM. The introduction of this "political diagnosis" has been greatly criticized due to its nonscientific character and the ethical implications entailed.

Regarding the frequency of the PDs in the penal population, according to the meta-analyses of Fazel and Danesh,<sup>4</sup> who offered some very demanding criteria for inclusion and that included a global sample of 10,797 men and 3,049 women, the prevalence rate of the PD in men was 65%, especially the antisocial disorder (47%), and 42% in women, especially the borderline disorder (25%) and antisocial one (21%). In addition, in the Spanish penal population, Álvaro (2007), with the International Personality Disorders Examination (IPDE), found a 60% prevalence rate, with predominance of the antisocial disorder (30%), linked to drug abuse and a more severe penal profile, the borderline disorder (17%), associated to drug consumption and self-aggressive behaviors but without prognoses of violent behavior, and the unspecified disorder (14%).

In regards to the specific samples, in the study of Dunsieith et al. (2004) in the United States with a group of 118 sexual offenders, the most prevalent PDs were antisocial (55.8%), borderline (28.3%), paranoid (25.7%) and narcissistic (24.8%). In turn, Fernández-Montalvo and Echeburúa,<sup>5</sup> in Spain, with a sample of men condemned for serious violence against their significant other, using the MCMI-II, found greater prevalence for the obsessive compulsive (57.8%), dependent (34.2%), paranoid (25%) and anti-social (19.7%) disorders. However, the latter category (antisocial disorder) is considerably reduced in another study by the same authors<sup>6</sup> to 12%–15% when a more refined measurement regarding the psychopathy such as the PCL-R is used.

Another line of investigation uses the descriptive and statistical analysis of the legal sentences. Thus, for example, González-Guerrero<sup>7</sup> focused on the decisions of the criminal jurisdiction in Spain, both in the Provincial Audiences and the Supreme Court, made between 1983 to 2007, and concluded that the most prevalent PDs in delinquent males are antisocial (39.14%), borderline (28.18%) and paranoid (18.66%), while borderline disorder predominates in women. What is the most interesting in this work are the conclusions derived on the relationship between offender and victim.

This type of study may not be representative of the persons with violent behaviors as they are made up of prisoners or patients in confinement.<sup>8</sup> There is frequently psychiatrization of the criminal behavior and the PDs may be confused with simple enhancement of the personality traits as a consequence of the criminal procedure or imprisonment. Furthermore, processes of simulation-exaggeration that distort the results occur in these population. And from a methodological perspective, cross-sectional studies, especially those made with tests or other self-reports, prevent approaching two fundamental aspects reliably to made a diagnosis of PD: early onset and transtemporal and transsituational omnipresence of the inadaptable traits.<sup>9</sup>

For this reason, some longitudinal studies have provided more moderate results. In this way, according to the study of Coid et al.,<sup>10</sup> that made a five-year retrospective analysis in a general population of the United Kingdom by means of a survey of more than 8000 persons, 11% of those with PD reported violent behaviors versus 7% of the population without this disorder. However, this number reaches 52% if alcohol or other drug abuse is associated. Furthermore, according to the important MacArthur study for the evaluation of the risk of violence,<sup>11</sup> the prevalence of violent behaviors one year after discharge was greater in the PD group on drug abuse / dependency group (43%) than in the severe mental disorder group (schizophrenia, bipolar disorder, etc.) and drug abuse/dependency group (31.1%<sup>10</sup>) or in the group with only severe mental disorder (17.9%).

In any event, with the current DSM<sup>12</sup> and ICD classification model, the PDs in this type of population are overdiagnosed. The current diagnostic categories of DP have overlapping items. In this way, the polythetic evaluation makes it possible to reach a diagnosis complying with only some of the criteria, so that it is frequent to find 2, 3 and up to 4 diagnoses of DP in the same subject. Therefore, the data are overestimated. Furthermore, comorbidity with the mental disorders of Axis I is excessively high.<sup>2</sup> For this reason, when other comorbidity variables are controlled, the correlation between antisocial disorder and violent behavior, which increases in many studies due to contamination of multiple variables, is lower than that expected (0.23 in the Blackburn study<sup>13</sup>).

When violent behaviors are evaluated, one should not make the mistake of these so-called *fundamental attribution error*, a bias that consists in overestimating the dispositional influence and underestimating the situational influence (framework of the situation, interaction with the victim, different exogenous motivations, etc.).

In summary, it can be stated that more rigorous studies are needed to truly know the influence of the PDs in violent behavior and the true dangerousness of these subjects. Although the diagnosis of PD is a risk factor of recurrence in all the protocols in use of evaluation of risk,<sup>14, 15</sup> the following realities must be kept in mind: 1) most of those suffering from PD are not violent and never have been; 2) many abnormal personalities are more propitious victims than delinquents; 3) no PD is necessarily associated to violent behavior permanently, and 4) from a dynamic and motivational position, PD alone cannot explain violent behavior.

## DIAGNOSTIC CATEGORIES OF THE PDS AND VIOLENT BEHAVIORS

Although the DSM-V work group on PDs has the project of reducing the current diagnostic categories from 11 to 5,

establishing a prototypical evaluation and also making the dimensional analysis of 37 trait-facets and 6 domains,<sup>2</sup> this article has analyzed the taxonomy of the DSM-IV-TR in force, that includes 10 categories, divided into 3 clusters, and one residual one (unspecified disorder).

The three current clusters have significant characteristics globally. The patients in group A are, in general, less violent than those of group B, but suspicious attitude, bizarre forms of thinking, social isolation of the subjects of this group are related with the most serious types of violence.

Group B is, undoubtedly, the most related to criminal behavior in general and violence in particular. Furthermore, it is the most connected to alcohol/drug abuse, which is a clearly precipitating factor of violence.

In turn, group C is that which contributes the least to violence. It is made up of submissive persons, with need for security and who are related with the "overcontrolled" personalities. The factors "anxious" and "obsessive", in general, have a negative correlation with anger and violence.<sup>16</sup> However, the patients from group C, behind an appearance of acceptance and docility, may have intense anger and rage due to fear of abandonment or rejection. Thus, serious acts of violence against the significant other<sup>5</sup> and sexual predators<sup>4,17</sup> are relatively frequent. Alcohol consumption is a participating element of violence in these personalities.

### Paranoid personality disorder (PPD)

Paranoids have partially lost contact with reality and attribute hostile attitudes and intentions to the others. These subjects are permanently distrustful and suspicious, hypersensitive to disdain, with a tendency to attribute malicious intentions, they do not forget an insult and are always ready to become angry and to counterattack.<sup>18</sup>

In the forensic population, it is the second most frequent PD in males and the third most frequent in females.<sup>19</sup> This usually concerns 40-50 year-old male subjects, prosecuted for crimes against persons, with criminal backgrounds in 40% of the cases and that are violent against known persons they are suspicious of or whom they feel have betrayed them.<sup>7</sup>

The dynamics of violent behavior of the paranoid is characterized by the following elements:

1. Frequent pre-meditation and malice. Persons with this PD do not improvise, but rather elaborate plan with astuteness and lucidity and use means or strategies that assure their objective.

2. Prodromic component prior to homicide. There is a latent period from the first violent act to the homicide. This aspect is essential regarding prevention of the homicide, especially in the case of chauvinistic violence. The paranoid generally gives warning through minor or threatening attacks, that should not be ignored or minimized.
3. Stressful circumstance prior to the offense. It is normally a real or imaginary aggression to one's self-esteem.
4. Fundamental motivation mediated by revenge, rancor, feelings of humiliation, shame or jealousy.
5. Violent behavior usually committed alone.
6. Justification of the violent behavior as unavoidable, in compliance with an obligation, and therefore, absence of remorse, without attempting to escape.
7. Tendency to lawsuits and fights after minimum provocations (real or imaginary snubs).

Paranoid personalities commit aggressions due to distorted interpretations and exaggerated reactions to daily situations, especially when the possible victim undertakes physical or verbal action that is interpreted as a personal attack.<sup>20</sup>

An important grade of paranoidism observed in some mass or serial killers and also in persons who, after providing services to the society, frequently soldiers, have felt scorned or undercompensated for it. This type of personality is also frequent in significant other abuse perpetrators and is associated to greater presence of traumatic symptoms.<sup>21</sup>

### Schizoid personality disorder (SPD)

Persons with this PD act alone and may commit violent behaviors against other persons, as well as crimes against sexual freedom. Normally, schizoids are not violent, but they have serious anger attacks if their personal space is invaded or they are disturbed. The association between a paranoid disorder and schizoid disorder of the personality may be especially serious. In the study by Stone<sup>22</sup> on serial killers, up to 47% met the criteria of SPD.

Violence in persons with this disorder is unlikely, but may be extreme. It is an expressive violence, that is mediated by fantasies and lack of feelings towards the persons. There is frequently an absence of clear external precipitating causes, so that the aggressions, as they are responding to the imaginary world of the subject, are unexpected and consequently unpredictable.

These individuals have very low self-esteem and serious difficulties for interpersonal relationships. As they are resentful with society, they have negative emotions of anger and revenge. Their isolation and absence of social skills

generate rejection, which precipitates the violent act, that may be an isolated, serial or mass one. When dealing with multiple assassinations, final suicide is frequent.

### Schizotypal personality disorder (STPD)

This is a disorder that is scarcely diagnosed in forensic samples. A relatively high percentage of these subjects (25%-44%) are erroneously diagnosed of schizophrenia.<sup>23</sup>

Persons with schizotypy lack an adequate level of empathy and interpret messages and signs of others in a distorted way. The social communications are tinged with idiosyncrasy and lost in tangentialities, personal irrelevances, circumstantial speech and metaphoric digressions. Thus, they easily confuse fantasy and reality and tend to settle into an unreal and subjective life, disconnected from logic and from the common values. Their interest in magical and esoteric subjects and in paranormal and unknown phenomena contribute to this. This leads them to be superstitious, to feel that they have special powers and to have a sensation of control over the events and persons, either through telepathy or rituals. In the same way, they also suspect the capacity of other persons to influence them, controlling them.

They carry out their violent behaviors alone. They are the result of inappropriate affectiveness. They lack a clear motive and occur impulsively, without planning. The motivation may be extravagant, messianic or based on magical or illusionary thoughts, which makes this type of behavior very difficult to predict. The victims are frequently known persons (family or caregivers).

As the violence arises impulsively and lacks planning, the aggressor is easily identified.

### Antisocial personality disorder (ASPD)/ Psychopathy

This disorder is defined as a general pattern of disregard for and violation of the rights of others. This is the PD most related with violent delinquency, both in males and in some samples in women. However, there is a tendency to overdiagnosis it in the forensic and prison populations.<sup>16</sup>

The violent behavior linked to this PD is characterized by its early, stable, versatile onset (applied in different contexts) and frequently within a group. A criminal background and escalation of violence are the rule. In general, these are persons who have low empathy and intolerance to frustration, do not obey authority, feel

fascination for violence, a vital need for new experiences and show susceptibility to boredom.

In regards to the victims, they are generally strangers (55%) or those with whom they have little bond, such as neighbors or simple acquaintances (20%), who they dehumanize.<sup>7</sup>

The antisocial personality disorder is imprecise and makes up a heterogeneous condition<sup>24</sup> (see Table 1). In fact, a group in which reactive or emotional violence and another having predominance of proactive or instrumental violence can be differentiated. In the subgroup of *emotional delinquency*, more weight is obtained by the behavioral items and violence against known persons predominates. From the point of view of the Cloninger model, these persons are characterized by elevated sensation seeking, high harm avoidance and low reward dependence. They were sensitive and impulsive children and respond with anger to frustrations. In this subgroup, comorbidity with anxiety disorders (ranging from 47% to 53%) and mood state (about 27%) is elevated.<sup>25,26,27</sup>

In the subgroup of *instrumental delinquency*, the affective items of deceitfulness and absence of remorse regarding the behaviors predominate. In this case, violence in regards to strangers is more frequent. In the Cloninger Temperament and Character Inventory (TCI), they score high

Table 1

#### Diagnostic criteria por antisocial personality disorder

- A. A general pattern of disregard for and violation of the rights of others occurring from age 15 years, as indicated by three (or more) of the following items:
  1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  3. Impulsivity or failure to plan ahead
  4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
  5. Reckless disregard for safety of self or others
  6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- B. The subject is at least 18 years old.
- C. There is evidence of antisocial disorder that begins before 15 years of age
- D. The antisocial behavior does not appear only during a schizophrenia or manic episode.

on sensation seeking and low on harm avoidance and reward dependence. These are less impulsive persons, who have low levels of anxiety and high levels of psychopathy.

The subjects with this PD have suffered an attention deficit hyperactivity disorder (ADHD) or frequently have antisocial backgrounds and their childhood and adolescence. They join groups of a specific slang, consume alcohol/drugs from an early age, frequently intimidate or harass others, generally initiate physical fights, have used some weapon, have been cruel with animals or persons, have confronted or robbed a victim, caused a fire with intention of causing serious damage, frequently lie to achieve favors or avoid obligations, they do not adapt to the school setting or have run away from home.

The young people with these anti-social traits have failed at school, lack adequate moral development, have no limits, tend to seek strong emotions, are egocentric, lack scruples and it is hard for them to have empathy with others. The central motivation is hedonism, with incapacity to postpone reward and plan for the future (focused on the here and now) with it is hard for them to learn from experience and they are unreactive to punishment. On an impersonal level, there is seeking of power and control and scarce development of communication and problem-solving skills.

The families of these young people generally have multiple problems, are frequently dysfunctional or come from marginal settings. Beyond the frequent existence of abuse or emotional negligence within the family setting, the educational style is generally inadequate (punitive, permissive or erratic).

Even though antisocial personality disorder (APD) and psychopathy share some diagnostic criteria, both conditions measure different constructs.<sup>28,29</sup> It is exactly this overlapping between anti-social behaviors and criminal behaviors that is one of the limitations of the DSM-IV-TR and that can lead to confusing a disorder with a common delinquency. While the APD is essentially based on antisocial and criminal behaviors, the interpersonal and affective symptoms of the subject with psychopathy are not taken into account very much.<sup>30</sup>

The defining traits of psychopathy are narcissism, coldness and emotional numbing regarding the others, frequently associated with a high level of intelligence at the service of their interests, of manipulation or faking. These subjects may have a good oral intelligence level but show executive disorders and, especially low emotional intelligence. Psychopaths may "understand" the feelings of others, but they do not empathize with the pain or suffering of others, so that they act as human depredators. The comorbidity with paraphilias generally leads to crimes against sexual freedom. In most of the cases, the psychopath who is being

evaluated or questioned does not have autonomic activity and thus, his/her pulse, blood pressure and respiratory rhythm remain at baseline and they do not have the usual signs in stressful situations, such as psychomotor restlessness, mouth dryness or sweating.

The criteria currently used to describe psychopathy have been systemized by Hare,<sup>31,32</sup> based on the previous descriptions of Cleckley, and currently form a part of the psychopathy evaluation scales. The 20 items that make up the *Psychopathy Checklist-Revised* (PCL-R) attempt to cover 4 facets divided into 2 factors, as shown in Table 2. Elevated scores on this scale (above 30) have been considered the best predictor of violent behavior and criminal recidivism.<sup>33,34</sup>

The diagnosis of PAD and of psychopathy has its pros and cons.<sup>30</sup> It is easy to diagnose a PAD, but it has scarce validity, since there is a significant tendency to overdiagnose in legal settings (and the opposite in clinical samples). On the contrary, considerable experience is necessary to diagnose a psychopathy, however its predictive capacity regarding violent crimes and recidivism is much greater.

Antisocial personalities develop more in unfavorable settings of the society, in which economical deficiencies, lack of family cohesiveness, scholastic failure, low intellectual level and social learning facilitate early adoption of antisocial behaviors and unconventional alternative reward seeking. However, neurobiological alterations that would make the subject prone to behave in a certain way, many times antisocial and violent have been described in psychopathy.<sup>35</sup> Among these dysfunctions, reductions of up to 11% of frontal lobe volume<sup>36</sup> or alterations in the amygdala have been described. Some experimental studies indicate that these dysfunctions cause the emotional response of psychopaths to be abnormal.

In spite of what has been said, not all delinquents and violent persons are psychopaths nor are all psychopaths violent, so that this diagnosis only accounts for a minority of the cases.<sup>37</sup> Therefore, when analyzing the relationship between a disorder in violent behavior, other variables must be taken into account, as, for example, type of aggression. Psychopaths are mostly involved in acts of *instrumental violence*, in search of a specific objective or benefit, while mental patients generally have a *reactive response*: they react violently to a real or imagined stimulus.

Psychopaths have an important lack of emotional resonance: they lack affect, emotions and feelings. They know what is good and bad, but they do not feel it. They know what they do, but they do not feel guilt. All these subjects have elevated dangerousness because of their indifference to rules, affective coldness and incapacity to learn. The crimes in which they are frequently involved (in

Table 2	Items of the Hare Psychopathy Revised Classification scale by factors and facets (Hare, 2003)	
FACTOR 1	Facet 1 - Interpersonal	1. Glibness/superficial charm. 2. Egocentrism/Grandiose sense of self-worth. 4. Pathological lying. 5. Cunning/manipulative.
	Facet 2 - Emotional	6. Lack of remorse or guilt. 7. Emotionally shallow. 8. Insensitive/lack of empathy. 16. Failure to accept responsibility for own actions.
	Facet 3 - Style of life	3. Need for stimulation/proneness to boredom. 9. Parasitic lifestyle. 13. Lack of realistic, long-term goals. 14. Impulsiveness. 15. Irresponsibility.
FACTOR 2	Facet 4 - Antisocial	10. Poor behavioral control. 12. Early behavior problems. 18. Juvenile delinquency. 19. Revocation of conditional release. 20. Criminal versatility.
ADDITIONAL ITEMS (TRAITS NOT RELATED WITH EITHER FACTOR OR FACET)		11. Promiscuous sexual behavior. 17. Severe short marital relationships.

decreasing order) are: lesion crimes, against sexually freedom and against property. All of this tends to generate great social alarm, even more so when the studies indicate that homicides are instrumental acts, that is, without a specific precipitating factor.<sup>38</sup>

### Borderline personality disorder (BPD)

This personality disorder is increasingly diagnosed in forensic samples with violent crimes. In fact, it occupies the second place in men (together with paranoid personality disorder) and the first in some samples of women. It is the most common in violent women, although self-aggressiveness predominates over heteroaggressiveness in them.

Impulsiveness, poor identity, emotional deregulation and drug consumption leads these persons to violent behaviors. In some neuroimaging studies, it has been seen that it is difficult for these patients to identify neutral faces, while they often misinterpret them as threatening. In these cases, violence is typically reactive. The fundamental emotion is anger and the principle motivation is relief of tension.<sup>10</sup>

Dutton<sup>21</sup>, in a setting of violence against the significant other, give a detailed analysis of *abusive personality* whose central axis is the personality borderline disorder and called it "Organization of the Borderline Personality." This is characterized by emotional instability and psychological

abuse, insecure attachment (anxiousness and avoidance), real or imaginary rejection and jealousy, as well as the tendency to the external locus of control - placing the blame on all the problems on the significant other.

Together with antisocial disorder and avoidance, it is generally frequent in samples of sexual predators.<sup>39, 40</sup> Patients with PBD are characterized by fear of abandonment, intense and unstable relations, identity disorders, emotional instability and impulsiveness, all of these being factors related in some way to sexual aggression.

Violent behaviors are enhanced in PBD when there is a comorbidity with drug abuse (in 65% of the cases, above all, with cannabis, cocaine, alcohol and psychopharmaceuticals) and with ADHD (in 37% of the cases). Even more, comorbidity between these three clinical pictures may be 18% of the cases. The comorbidity is also extended to the mood state disorders (depression and bipolar disorder).

Especially devastating is the Association of PBD with antisocial disorder, due to the serious impulsiveness enhanced by drug abuse. This profile predominates (77%) in women in high-security jails, in 62% of men admitted to prison hospitals and in 30% of men in middle security centers.<sup>8</sup>

Regarding suicide attempt, suicide attempt in the patients diagnosed of PBD is the most frequent cause of hospitalization in this clinical category. In fact, the presentation of this clinical

picture is frequently that of risk of suicide. Suicide attempt and parasuicidal behaviors, motivated by love or family problems and with a depressed mood state, occurs in young women (18-25 years), between 60% and 75% of the cases and consumed suicides, with a follow-up of 15-20 years, appears, above all, in 30-35 year old men, in 8-10% of the cases.<sup>23</sup> The method used in parasuicides is the use of drugs and superficial mutilation of the wrists.<sup>41</sup>

### Narcissistic personality disorder (NPD)

Together with paranoid traits, narcissistic style increases the risk of violent behaviors.<sup>1</sup> Narcissists feel an unhealthy need for admiration. They are arrogant and exquisitely sensitive towards any type of rejection or disdain, but are not capable of recognizing feelings of others. For them, it is more important to presume than to be. Their arrogance, with an excessive eagerness for notoriety, is often linked to envy regarding the success of others. Different facets of narcissism, such as authoritarianism and exploitation of others, are strongly related with aggression.

Although the NPD is little diagnosed in forensic samples, the prevalence rate reaches 6% and even 25% of men in the prison psychiatric population.<sup>42</sup> The victims of violent acts of these subjects are generally known persons.

Their violent reactions are in response to an injury to their ego (*narcissistic injury*), a frequent response also in psychopathic personalities.<sup>1</sup> Narcissism is a frequent trait in all types of violence subjects, especially antisocials and psychopaths, who usually give preference to their desires over the needs and rights of the others.<sup>22</sup> Narcissistic personality disorder has been found in different samples of sexual offenders,<sup>40</sup> a fact that could be related with the direct satisfaction of narcissistic needs and with the belief that the rest of the people are a mere tool to achieve their objectives. The narcissistic personality also makes it possible to differentiate between different types of offenders against the significant other, and it is associated to paranoid characteristics within them.

Several attempts have been made to establish subgroups in NPD.<sup>43, 44</sup> It is possible to speak of *malignant narcissist*, coupled with the psychopath, characterized by the grandiose self and by egosyntonic cruelty and involved in behaviors that have serious violence, of an *arrogant narcissist*, characterized by grandiose fantasies, and by disdain for the society and involved in sexual abuse behavior and finally of a *compensated narcissist*, who attempts to compensate his/her low self-esteem with the search for social recognition by means of violence and illegal behaviors, who may have a history of anxiety and depression and who may be manipulated by psychopathic personalities.

### Histrionic personality disorder (HPD)

The most characteristic of the historic personalities, sometimes arising in an overprotective family framework, is hypersensitivity and tendency to attribute important disaster to trifle things, as well as the tendency to fantasy. Thus, they proceed to perceptible errors, emotional overreactivity, variability of the mood states and the ease with which they may feel humiliated.<sup>45</sup>

Violent behaviors are only common in this disorder when there is comorbidity with antisocial disorder or with narcissistic disorder. This disorder sometimes appears in antisocial gang leaders who have early onset maladaptive behaviors, with inadequate stress management, who may have some capacity of seduction and who many manipulate the members of their group to involve them in violent behaviors.<sup>13</sup>

### Obsessive-compulsive personality disorder (OCPD)

Violence in this PD is rare, but may appear when the affected subject experiences episodes of lack of control and accumulated anger, normally accompanied by abusive alcohol consumption. This disorder is frequently comorbid with mood state disorders.

The precipitating factor in these cases is the anger that arises due to intolerance to criticisms, humiliation and failure.<sup>19</sup> Violence, exercised alone, generally refers to known victims. Therefore, this may be frequent in persons accused of chauvinist violence or harassment. Thus, in the study of Fernández-Montalvo y Echeburúa<sup>5</sup> on a sample of males who had committed serious acts of violence against their significant other, it is a frequent category (57.8%), at least as it appears evaluated with the MCMI.

### Dependent personality disorder (DPD)

There are submissive persons, who constantly need approval and affect. They may feel anxiety and intense rage because of real or imaginary embodiment, which may lead them, especially, to chauvinistic acts of violence, above all when there is alcohol abuse.

The dependent persons, if they are abandoned, may feel such a degree of hopelessness that they may commit suicide or expresses violence against the person who has rejected them. On other occasions, the strong feeling of insecurity and jealousy may precipitate emotional states of rage that may lead them, in the most extreme cases, to commit homicides, sometimes followed by suicide.

Persons with the PD may be influenced by psychopathic personalities, given their great need for esteem and group integration, and, in this way, they may become accessories to violent crimes.

### Anxious-avoidant personality disorder (AAPD)

This type of disorder, together with the antisocial and borderline ones, is frequently seen in sexual delinquents.<sup>46,39,40</sup> These subjects have some feelings of revenge against women, since they feel rejected because they are not capable of establishing relationships or because they feel they have been ridiculed by them in the past.

These persons are characterized by lack of self-confidence, insecurity and inferiority feelings, fear of being humiliated and fear of showing themselves as they are, and the lack of social skills. All of this leads to social inhibition and of showing themselves as hypersensitive to any criticism. When an avoidance pattern with negativistic characteristics (passive-aggressive) occurs, we are faced with subjects with a typical withdrawal, but also with impulsive hostility and more aggressive reactions, who may attack others when they feel that their affective needs have not been recognized.<sup>29</sup> The victims are generally known persons that the subject feels has rejected them or strangers who symbolize the real or imaginary rejection.

Together with depressive and passive-aggressive personality, it is affirmed that the avoidance style is that most frequently found in prison samples with a mental disorder.<sup>47</sup>

### Unspecified personality disorder (USPD): sadistic personality disorder

Unspecified PD makes up a residual category that is applied in two situations. First, when the personality pattern of the subject meets the general criterion of a PD, there are traits of several types of PD, but they do not fulfill the criteria for a specific subtype. The second category is when the subject fulfills the general criterion of a personality disorder, but his/her symptoms do not fit into any of the existing ones in the subtypes (for example, sadistic personality disorder).

Psychopathy is especially dangerous when it is accompanied by a paraphilia. This is what occurs in the sadistic personality disorder. In sadistic psychopaths, there is compatibility between the aggressive and sexual responses, which are mutually inhibitory in normal persons.<sup>40, 48</sup> This causes the perpetrator to achieve sexual arousal through the suffering inflicted on the victim. In the case of a violation followed by murder, the facial disfigurement of the cadaver

or even dismembering of it may aim to delay or make identification of the victim impossible, it may be a consequence of the resistance of the victim or a reflection of taking it out on the victim, such as an act of revenge due to old grudges, or of a sadistic attitude, even with a ritual character.<sup>49</sup> The most important characteristics of sadistic psychopaths are the following: antisocial and impulsivity traits, social withdrawal, repeated violent sexual fantasies, fascination for violent and pornographic literature, drug consumption, interest for subjects on genocide/Nazism, collections of knives, weapons, etc. In these cases, their behaviors are performed as if they were a game, with the emotion of the hunt.<sup>50</sup>

Sadistic psychopaths commit their violent behaviors in a meticulous, organized way, and appear to have a personality and style of life that makes them go unnoticed. Frequently, these subjects have multiparaphilias or other coded disorders on the Axis I and have experienced a violent childhood. A description of this profile, included in the Brittain (Modified by Esbec),<sup>3</sup> is shown in table 3.

Relatively few investigations have been carried out up to date in relationship with this sadistic personality disorder. Those that have been carried out generally have some methodological weakness derived from the use of very small samples in forensic population. Furthermore, the fact that this is a nonofficial PD (it was proposed in the DSM-III-R, but was eliminated from the ICD-10 and the DSM-IV, probably for criminal policy reasons), may have resulted in the assignment of a high number of subjects to other groups of disorders. In this sense, it should be noted that the sadistic personality disorder is significantly associated with compulsive disorder, and with narcissistic and antisocial disorders.

### INCIDENTS OF PDS IN THE IMPUTABILITY AND THE FORENSIC SETTING

Unimputable persons cannot respond criminally for their violent behaviors because they act, or rather have acted, *without freedom*. Mental disease may be interpreted as a condition of freedom, that prevents the patient from acquiring the full dimension of being an intelligent and intentional being. Under these conditions, the subject cannot control his/her behavior from an adequate and objective perception of him/herself and the setting, or from a capacity of self-determination that allows the subject to behave according to planned decisions and chosen consciously from a cognitive and normal emotional structure. However, all those who commit an *abnormal* act from the moral point of view are not necessarily *abnormal* (mental patient) from a psychological and medical point of view.

Table 3	Sadistic profile
<p>Male under 35 years of age. There are rare cases of women.</p> <p>Introverted and distant. The person has few friends, solitary. Goes to the movies alone, reads, listens to music, timid although pedant. Few hetero-sexual relationships. Is frequently single. Has a private room or shed where he stays for hours</p> <p>Pseudo-intellectual. Is classified as rare or extravagant. Great fantasy and fluency of ideas. Imagines scenes that could be interpreted perfectly. Fascination for weapons. Violent literature, comics.</p> <p>Educated. Good manners, enchanting. Refined. Calm in general, does not return the violence.</p> <p>Organized, obsessive even at the scene of the crime. Rarely drinks or smokes in excess.</p> <p>Egocentric, narcissistic, apprehensive and hypochondriac.</p> <p>Subject likes to humiliate in presence of others; punish subordinate harshly; is amused by, or takes pleasure in, the psychological or physical suffering of others; has lied for the purpose of harming; dominates through intimidation, restricts the autonomy of the others.</p> <p>Commits crimes after some aggression to his/her self-esteem. Planned crime, cold, easily excited, much strength, after continues with great relief. Observation of suffering excites him more. It is an organized criminal who leaves few signs.</p> <p>Without guilty complex. The subjects likes to read the news on his/her crimes. He/she generally collect trophies of his/her victims. Imperturbable in the courts.</p>	

The simple personality traits (impulsiveness, egocentrism, poor tolerance to frustration, sensitivity to rejection, paranoid traits, etc.) do not affect the condition of being imputable. In the case of the PD, although the cognitive and volition capacities remain whole, the affected subjects may not use them effectively due to impulsiveness and emotional instability (*borderline disorder*), due to lack of empathy and severe difficulty to adapt to rules (*antisocial disorder*), due to severe attribution errors (*paranoid disorder*) or due to absolute dependence (*dependent disorder*).

In regards to the psychopath, this person can only be considered as having a mental disease to some degree. The psychotic is a patient while the psychopath is a deviated personality. Even so, considering it is a mental disease, its relevance in regards to unimputability does not have to be affirmed. The analogic extenuating circumstance or incomplete excuse (art. 21.1) may be applied in some cases to the psychopath. The psychopathy is only taken into account, for effects of complete or incomplete excuse, in those cases in which it coexists with mental disease (schizophrenia, alcoholism, paraphilia, etc.). Furthermore, the imputability is more restricted when the psychopathy is complicated with drug addiction (Supreme court sentence

[SCS] of 4 May 2000) or with mental deficiency or when it entails a serious maladaptation to daily life.

For the effects of imputability, the Supreme Court (SC) has maintained a changing attitude over time. During the 1980's, within the PDs under the generic name of "psychopaths" or "psychopathic personalities," the general tendency was to consider them as simple character disorders that did not affect imputability (SCS of 2 November 1983). However, in the 1990's, the SC, echoing the psychiatric doctrine and the inclusion of these conditions in the ICD-10 and DSM-III-R, evaluated psychopathy, not without controversies, as an analogic extenuating condition (for example, SCS 23 November 1997) or even as an incomplete excuse, as long as there is a causal relationship between this PD and the violent crime committed (SCS 23 January 1993).

Beyond psychopathy, the most recent jurisprudence (SCS 11 March 2010; SCS 8 April 2010; SCS 23 April 2010), indicates *the complexity and difficulty of establishing a general doctrine on the incidence of PD in the capacity of guilt*, and insists that it should be studied case by case. As a general rule, the Supreme Court understands that the PDs are evaluated criminally as an analogic extenuating condition, that the simple maladaptive personality traits do not affect imputability and that incomplete excuse is rare and is reserved for very serious cases or those associated to drug addicts or other mental disorders: *a personality disorder, per se, is not sufficient basis to consider an incomplete excuse* (SCS of 23 April 2010).

In regards to specific PD, borderline personality disorder (BPD). insofar as these patients have an extensive psychiatric background, they have level of emotional suffering that may even lead them to desire death and they suffer from other comorbid disorders. It is the PD having the greatest possibilities of being taken into consideration as an extenuating factor by the Courts. Furthermore, when the existence of a paranoid personality disorder is accredited, the tendency is towards the very qualified extenuating circumstance (Standardized Assessment of Personality [SAP] of Madrid, 12 March 2010). However, neither antisocial disorder nor unspecified personality disorders, even when serious or more than a specific category, generally mean a decrease of imputability.<sup>51</sup>

Many persons with PDs are involved in episodes of chauvinistic violence. There may be different reasons: intolerance to frustration and anger of abandonment in the antisocial and narcissistic PD, or deep emotional suffering due to abandonment in the borderline, dependent or obsessive PD. However, on the jurisprudential level, *personality disorders and mood states derived from a failed relationship, considered alone, do not have sufficient importance to be considered an incomplete excuse that*

would make it possible to significantly reduce the foreseen sentence.

Finally, the advances in biopsychopathological etiology of the PD, on the genetic, neurotransmitter and brain area levels,<sup>52,53</sup> may have very important legal-criminal consequences in the future. There is no doubt that the demonstration of some incapacity to act differently must affect the level of criminal accusation.

## CONCLUSIONS

Only a small part of the violence is the work of mental patients, which, more than actors, tend to be victims of the violence based on their grade of defencelessness. The true actors of the destructive behaviors are not a product of the insanity, but a consequence of the marginalization and wickedness. The social perception of violence is not, however, in this way.<sup>54</sup>

Studies on the possible relationship between mental disease in violent behavior are controversial. Many of the factors that are associated most with violent behavior and mental patients, such as psychopathy, anti-social behavior, drug abuse/dependence or anger, are predictors of significant violence among subjects without mental disorders, so that the independent effect of the mental disease and violence is not clear.<sup>55</sup> The divergence between studies may be due to the use of different diagnostic criteria, different definitions of violence, the use of heterogeneous study samples and a frequent existence of psychiatric comorbidity.<sup>56</sup>

The principal predictive factors of violent behaviors among mental patients are the following: a) previous background of aggressions; b) denial of the disease and consequent rejection of treatment; c) alcohol or drug abuse and their comorbidity with personality disorders; d) psychopathic traits; e) family and social withdrawal and environmental stressants; and f) thought disorders, especially delusional ideas of persecution and hallucinations that imply orders to act violently. Drug consumption, together with personality disorders and paraphilias, are an explosive cocktail.<sup>57, 58</sup>

However, psychotics who commit violent behaviors can be reincorporated into society once they are receiving medication and attended to, since they immediately stop being dangerous. In these cases, the disease is *compensated* or *stabilized*. The same does not occur with psychopaths or with paraphilias.<sup>59</sup>

In regards to the PDs, there are 6 types of personality disorders especially involved in the violent behaviors: antisocial, borderline, paranoid, narcissistic, and to a lesser

degree, dependent and anxious-avoidant. There may sometimes be a mixed personality disorder, with antisocial, histrionic and paranoid traits. However, the PDs also have a value based on the different types of violence: *instrumental* (characteristic of psychopaths and antisocial subjects), *impulsive* (characteristic of bipolar and borderline subjects) and the *psychotic* (characteristics of delusional and paranoid subjects). In any case, it is of greater interest to evaluate active symptoms and dimensional traits instead of the categorial diagnoses of specific disorders. Furthermore, some personality traits, such as impulsiveness, irritability, intolerance to frustration, narcissism and paranoidism, may be of greater interest than a specific personality disorder.<sup>56</sup>

Finally, according to Zimbardo,<sup>60</sup> in the explanation of surprisingly "abnormal" events due to cruelty, we should not focus exclusively on dispositional factors, believing that these behaviors are found within disturbed persons, different from most, and with some characteristics that makes them act in this way. The most important, and this has been demonstrated by years of investigation in psychology, are the situational variables, that make persons act in one sense that we would never have imagined in certain contexts and when the important factors concur.

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