Canadian Journal of Rural Medicine | Journal canadien de la médecine rurale

Summer 2002 Table of Contents • Été 2002 Table des matières

The patient with Antisocial Personality Disorder: practical tips for the rural physician

Gordon Brock, MD, CCFP
Alan Buchanan, MD, FRCP

CJRM 2002;7(3):194-7

Antisocial Personality Disorder is described, with practical office and Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnostic criteria, the differential diagnosis and recent theories as to the cause. Some rural-specific tips for managing patients with this disorder in the family practice setting are provided, as is a discussion of how and when to terminate the therapeutic relationship.

Cet article décrit le trouble de la personnalité antisociale et présente des critères pratiques de diagnostic au cabinet et à l'aide du DSM-IV, le diagnostic différentiel et les théories récentes sur la cause. On offre quelques conseils particuliers au milieu rural pour la prise en charge en médecine familiale des patients atteints de ce trouble et l'on indique comment et quand mettre fin à la relation thérapeutique.

The stereotype of a patient with Antisocial Personality Disorder is that of the tattooed, tough-looking criminal-type biker but, depending on the person's intelligence, social class and other skills, he or she may be charming, well dressed and a good talker. Doubtless, many con men and "scammers" are people with Antisocial Personality Disorder.

General description

The patient with Antisocial Personality Disorder has no conscience, or lacks "super-ego development." He (as explained below, most antisocial personalities are males) believes the rules of civilized society do not apply to him. He will get what he wants, when he wants, however he wants. He'll get it by lying, stealing and cheating — and in extreme cases even by killing — and from everyone, including his physicians.

These patients are often stressful for physicians to care for, perhaps more so in a rural area, where there is less anonymity. You may be aware of this person's reputation, and he may know where you live.

We present the basic features of a patient with Antisocial Personality Disorder, review the diagnosis and differential diagnosis and offer some rural-specific practical tips for management.

Incidence

Antisocial Personality Disorder occurs in 3% of men and 1% of women.1,2 Synonyms for the disorder include "psychopath" and "sociopath."

Cause

There appears to be a strong genetic component associated with the disorder. In twin and adoption studies, often the biologic father is either a criminal or an alcoholic. These facts have a far greater influence on whether a child will grow up to become antisocial than does the influence of an adoptive father.3

Recent research has demonstrated, through the use of MRI in antisocial men with no previous history of brain trauma, the first evidence of a structural brain lesion in patients with Antisocial Personality Disorder. An 11% reduction in prefrontal gray matter was associated with reduced autonomic activity during a fear-provoking stressor. This structural deficit may underlie the patient's lack of conscience, poor fear conditioning, inability to reason in risky situations and the reckless, irresponsible behaviour described in the criteria for patients with Antisocial Personality Disorder (see below).4

The interview

Depending on their education, ability to articulate, and social skills, these patients may present their problems to you as a litany of misfortunes — everything is someone else's fault: their spouse, boss, authorities. They tell whatever story they think you will believe; they are never to blame for anything that has befallen them. Even when they're caught "red-handed" they will be remarkably calm and nonchalant. They can "talk their way out of anything," and some can act very nicely at times. But this is a sham and, often, it just resembles bad acting. Typically, patients with Antisocial Personality Disorder love to regale physicians with tales of their "smarts" (as they see it) and will try to impress by using medical jargon they have picked up over the years.

The diagnosis

The disorder begins in childhood and pervades all spheres of the patient's life — family, job and

social milieu. This aspect distinguishes these patients from the run-of-the-mill criminal or gang member who steals for monetary gain and whose behaviour outside the crime sphere may be normal. Look for the following behaviours2 (see also Appendix 15).

- Difficulty, since adolescence, in following the rules of society. This pervades all spheres of the person's life.
- Schoolyard fights, running away from home, skipping or being suspended from school.
- Adolescent petty crimes, early sex.
- Inability to hold down a job; although, those from wealthier families, with supportive parents or good intelligence sometimes end up in managerial positions (the so-called "boss from hell").
- General recklessness, driving while impaired, nonpayment of debts.
- Inability to maintain a long-term relationship with a spouse (usually less than a year).
- Attention Deficit Disorder or substance abuse —associated disorders. Often there are hystrionic and borderline traits.
- Arrests for behaviours such as assault and theft.

Pervading all this is a total lack of remorse for anything and, frequently, a lack of any feelings. The disorder is said to peak in the late teens and early adulthood and then diminish after age 40.1,3

Differential diagnosis

As is the case for all personality disorders in family practice, do not over-diagnose. The disorder must have begun in adolescence and must pervade all spheres of the patient's life: his family, job and social milieu.

Do not presume that because a patient has committed criminal acts he or she has Antisocial Personality Disorder. Most criminals are not antisocial personalities, and many people with Antisocial Personality Disorder do not have criminal records. Antisocial behaviour that occurs during schizophrenic or manic episodes is excluded. Substance-Related Disorders or alcohol abuse and Antisocial Personality Disorder may coexist as separate entities (and should be listed as such under Axis I),6 but for the diagnosis of Antisocial Personality Disorder to be made, it must have begun in childhood and it will continue even after the Substance Disorder or alcohol abuse ceases.

Dealing with patients with Antisocial Personality Disorder7,8

There is often an aura of romance and mystique surrounding violent people. Perhaps this is because they allow us to "project" our forbidden impulses. They do the things some people only dream of doing. For example, you might wish to punch your boss, that nasty neighbour, or the person who insults you. You may find yourself either mysteriously attracted to or, conversely,

totally repelled by this patient. As when treating patients with other personality disorders, it helps to consider your own feelings.

1. Keep your distance, literally and figuratively.
2. Never meet with these patients outside regular office hours or in another location.
3. Patients with Antisocial Personality Disorder like to brag. To help establish a rapport, you could use statements such as "Tell me about yourself" or "Everyone says you're a good man to have around in a fight" or "Nobody ever messes with you, I'm sure" or "You seem to be pretty smart. You seem to be able to get away with murder. How do you do it?" Remain as neutral as possible and do not voice approval of their actions.
4. Set limits early in your relationship: you will not tolerate threats. But don't fight back — these patients have a lot of experience with people who fight back. Just wordlessly get up and leave or, if in your own office, politely ask him or her to leave.
5. Establish a security system such as a coded message to your staff to call the police. If you are going to refuse the patient something, such as narcotics, have a second person in the room if possible — for security and as a witness.
6. Be extremely cautious when prescribing benzodiazepines or narcotics. These patients have a high risk of substance abuse. Also, they may sell or "redirect" these drugs.
7. Don't leave the patient alone in your office even for a second. Among other things, prescriptions might be stolen.
8. Remember that he or she has probably never had a trusting relationship with a parent or anyone else. You may be seen as an authority figure. It will take a lot of work to gain trust and form a therapeutic relationship in which you can solve any general medical problems.

Specific tips7,8

1. Exploit your own advantages
Most patients with Antisocial Personality Disorder have no patience and are usually seeing you only because they want something — a prescription, a letter excusing them from an obligation, co-existent anxiety. If you get into a tight spot, stall for time, but carefully. Remember, he or she has no patience. Here are some stalling tactics.

"Percodan? I don't use it much. I don't know how to prescribe it. Let me read up about it. Come back later."

"I can't do that right now. Can you come back another time?" (Don't be too definite as to a time.)

"We're not allowed to prescribe narcotics in the emergency department of this hospital."

2. Do not expect too much
Routine referral to a psychiatrist is not indicated. Don't expect too much. Allowing them to escape the consequences of their acts will not help them — or you — in the long run, nor will a

punitive approach (chastising them). You may, however, be able to teach them some alternative ways to handle some of their day-to-day life problems, or treat any coexistent Axis I problems, such as depression or alcohol abuse.6

Self-help groups such as Alcoholics Anonymous are sometimes useful, although this type of therapy may be sabotaged by the patient's tendency toward self-importance and bragging.

3. Prepare a "contract"
These patients have a high "sense of entitlement."8 It might be wise to have a verbal or written contract with the patient, specifying what you will reasonably provide.

4. Drugs or psychotherapy
There is little, if any, place for psychiatric drugs or psychotherapy for patients with Antisocial Personality Disorder in the rural family practice setting.

5. Terminate the relationship
If threats continue, if the patient steals things from your office, or "redirects" drugs you prescribe, you are within your rights to terminate the relationship. This is always a difficult procedure, especially in the rural setting with the issues of decreased physician availability and the rural physician's need to take emergency call.

Send the patient a registered letter informing him or her of your intention, and keep a copy in the chart.9 Check with your college of physicians for the requirements for terminating a physician–patient relationship.9 The letter should be personalized. Clearly state that you are terminating care, and provide the reasons.

Allow the patient time to arrange alternative care, depending partly on the urgency and seriousness of comorbid conditions. Be reasonably helpful in arranging alternative care and in transferring records. Depending on availability of physicians regionally, you may have to inform the patient that you can only see him for emergencies when you are on ED duty. Inform your staff of the termination of care.

6. Support your staff
Be sure your staff understand your plan for dealing with these difficult, and sometimes scary, patients.

The female patient

As previously stated, Antisocial Personality Disorder is less common in women than in men.1,2 In the past, women with this disorder were believed to be not as violent as their male counterparts, although this may be changing. They follow, qualitatively at least, a similar pattern to the male, showing an inability to follow the conventions of society and to have meaningful

relationships in all spheres. Early and unprotected sexual activity is common.

Especially if you are a male physician, be careful. They may be charming, and dress and act seductively. It is wise to have a female attendant in the room when you examine a female patient with this disorder.

Conclusion

Patients with Antisocial Personality Disorder are often difficult and sometimes outright scary. We hope that this basic understanding of their psychodynamics and some simple, common sense behavioural tips will help rural physicians deal with these stressful patients.

Gordon Brock, MD, CCFP, Family Physician, Temiscaming, Que., Assistant Professor, Department of Family, Medicine, and Lecturer, Department of Anesthesia, McGill University, Montreal, Que.; Alan Buchanan, MD, FRCP, Clinical Professor, Department of Psychiatry, University of British, Columbia, Vancouver, BC, Vydas Gurekas, MD, CCFP, Family Physician, Temiscaming, Que., Lecturer, Department of Family Medicine, McGill University, Montreal, Que., and Director of Professional Services, CLSC Temiscaming, Temiscaming, Que.

Correspondence to: Dr. Gordon Brock, Centre de Santé, 180 Anvik, Temiscaming QC J0Z 3R0; geebee@neilnet.com

---

References

1. Robinson DJ. DSM-IV personality disorders explained. London (ON): Rapid Psychler Press; 2000.
2. Frances A, First MB, Pincus HA. DSM-IV guidebook. Washington (DC): American Psychiatric Press; 1995.
3. Freedman AM, Kaplan HI, Sadock BJ, editors. Comprehensive textbook of psychiatry. 2nd ed. Baltimore: Williams and Wilkins; 1975.
4. Raine A, Lencz T, Bihrle S, LaCasse L, Colletti P. Reduced prefrontal gray matter volume and reduced autonomic activity in antisocial personality disorder. Arch Gen Psychiatry 2000;57(2):119-27.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). 4th ed, Text Revision. Washington (DC): American Psychiatric Association; 2000. p. 706.
6. American Psychiatric Association. Multiaxial Assessment. In: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). 4th ed, Text Revision. Washington (DC): American Psychiatric Association; 2000. p. 27.
7. Othmer E, Othmer SC. The clinical interview using DSM-III-R. Washington (DC):

American Psychiatric Press; 1989.
8. Pare MF, Rosenbluth M. Personality disorders in primary care [review]. Prim Care 1999;26(2) :243-78.
9. College of Physicians and Surgeons of Ontario. Ending the Physician–Patient Relationship [policy no. 4-00]. Members Dialogue 2000;Sept/Oct. Available: www.cpso.on.ca/Policies/ending.htm (accessed 2002 June 26).

© 2002 Society of Rural Physicians of Canada