Journal of Forensic Research
ISSN: 2157-7145

Trifu, J Forensic Res 2013, 4:3
DOI: 10.4172/2157-7145.1000188

Conference Proceedings Open Access

# The Malignant Narcissistic Dimension in the Antisocial Personality Disorder

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## Abstract

Currently, the Antisocial Personality Disorder (ASPD) is at the far right of a continuum in regard to Cluster B personality disorders. Since a hundred years ago the psychotic core / the psychotic potential, due to a lack of reality testing, above a certain threshold, was brought into question. At least transitory psychotic decompensations certainly arise, as we referred to in this presentation.

We refer in this paper to theoretical and clinical exemplification on a patient in the "Prof. Dr. Alex. Obregia" Psychiatric Hospital in Bucharest, who is under prolonged hospitalization, subject to certain articles of the Code of Criminal Procedure concerning compulsory admission and treatment, as a result of committing a potentially antisocial act.

Explanatory perspective is based on the Treaty of Psychodynamic Psychiatry by Glen O. Gabbard, the primitive functioning of this woman raising suspicion of a personality disharmony located at the border between narcissistic (in the malign sense of the word) and anti-sociality. Explanatory concepts bring into discussion the primitive mental functioning, the immaturity of the defense mechanisms and of the thought and the behavior, characteristics of following type: projective identification, Self grandly designed, narcissistic collusion, flas Self, twinning, capacity to feel unconsciously the pulsating movements of the other, transferential – countertransferential dynamic.

The aspect of adequacy / temporary loss of contact with reality, the dimension of the intelligence and the intellect of this patient, assessing antisocial acts and their consequences, the possibility to function socially or not, and the quality of the compensatory resources must not be omitted.

The study has an explanatory evaluating perspective with comparative implications and rich literature references.

**Keywords:** Antisocial personality disorder; Psychopathology; Narcissistic collusion; Antisocial acts; Defense mechanisms; Disharmonic personality

## Epidemiological Data

This personality disorder has a prevalence of approximately 4% of the general population. Regarding the clinical population, the prevalence is about 15% and "in rehab wards as well as in the psychiatric-judicial wards their percentage is over 30% of the total patients" [1].

People with this disorder have a shocking variety of abnormal traits. There have been numerous attempts to identify an essential core of the disorder. The most useful of these are the following four traits: failure in creating connections based on affection, impulsive actions, lack of the feeling of guilt, inability to learn from negative experiences.

Failure in creating connections based on affection is accompanied by selfishness and in difference. In the extreme form there is a degree of hardness that allows that individual to commit cruel, painful and degrading acts onto others. This lack of feeling is often in striking contrast with a personal charm that allows the patient superficial and fleeting relationships. Sexual activity is conducted without tenderness. Marriage is often marked by the lack of concern for the partner, and sometimes by physical violence. Many marriages end in separation or divorce.

The characteristic impulsive behavior is often reflected by the frequent job change and frequent layoffs. This manifests itself in the entire lifestyle that seems devoid of any plan or fight for a purpose.

This impulsive behavior coupled with the lack of guilt or remorse is often associated with repeated violations of the law. Such offenses begin in adolescence with minor delinquent acts, lies and vandalism; many of them show a striking indifference to other people's feelings, and some commit acts of violence or gross carelessness. Often the behavior is emphasized under the influence of alcohol or drugs.

The sociopathic personalities may become inadequate parents who neglect and mistreat children. Some have difficulties in managing their finances, or organizing their family life from other points of view [2].

Clinicians tend to avoid these patients the most, because they can lie, cheat, steal, threaten, behave in irresponsible and misleading ways.

They were called "psychopaths", "sociopaths" or labeled as having "character disorders" – terms traditionally assimilated with "untreatable". There is also the opinion that they should be regarded as "criminals" and should not be included in the objectives of psychiatry.

The spectrum of patients considered "antisocial" range from those who cannot be treated to those who may be treated under certain conditions. According to the author Cleckley, the psychopath

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**Received** July 10, 2013; **Accepted** August 13, 2013; **Published** August 26, 2013

**Citation:** Trifu S (2013) The Malignant Narcissistic Dimension in the Antisocial Personality Disorder. J Forensic Res 4: 188. doi:10.4172/2157-7145.1000188

is an individual who was not clearly psychotic, but whose behavior was so erratic and so poorly adapted to reality and society demands that it indicated an apparent psychosis hidden under a seemingly normative functioning; they seemed that capable of having superficial relationships with other people, but they were completely irresponsible in all the relationships and they could not take into account the feelings or concerns of other people [3].

The term "sociopath" is the reflection of social rather than psychological origins of some difficulties arising in these individuals. Although the DSM-III criteria provided more diagnostic features than any other personality disorder, the focus of the disorder narrowed to a population of criminals more likely associated with poor, oppressed, and disadvantaged socio-economic strata.

ASPD is the category that represents over 75% of the prison population, these people being mostly accused of criminal acts. This entity exceeds the areas of clinical psychiatry and provides content to legal psychology. When applying DSM-III criteria onto the prisoners we see that 50-80% received the diagnosis of antisocial personality disorder.

The term "psychopath" denotes a particular psychodynamic and even biological features that are not included in the criteria of the DSM-IV-TR: *a person may be a psychopath without meeting the DSM-IV-TR criteria for ASPD, and conversely, a person can meet the DSM criteria for ASPD without being a psychopath.*

The criteria of DSM-IV-TR for antisocial personality disorder are the following:

- There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15, as is indicated by three (or more) of the following: failure to comply with social norms about legal behavior, as indicated by repeatedly committing acts that constitute grounds for arrest; unfairness, indicated by lying repeatedly, use of alibis, manipulating others for personal profit or pleasure, impulsivity or failure to plan ahead; irritability and aggressiveness; reckless negligence to his safety or that of others; considerable irresponsibility; lack of remorse.
- Antisocial behavior does not occur exclusively during schizophrenia or a manic episode.

Psychopathy emphasizes the characteristics listed above, which are on the one hand in the category of psychodynamic / interpersonal features, and secondly in the category of antisocial acts [4].

Some individuals may lack empathy, insensitivity, can be manipulative and grandiose, but may not manifest their behavioral problems; however, psychopathy is much more severe (clinical manifestations, resistance to treatment); they probably have substantial neuropsychological differences compared to non-psychopathy, they may be more unscrupulous and more incapable of any sort of emotional attachment, except the sadomasochistic type of interaction based on power.

The clinician must first determine if a particular patient may be treated in such circumstances dilemma conceptualized by framing the antisocial personality as a subset of the narcissistic personality disorder, there is a narcissistic continuity of the antisocial pathology ranging from the most primitive psychopathy in its pure form to narcissistic personality disorder with egosyntonic antisocial traits up to narcissism, in which the patient is genuinely dishonest in the transfer process.

Clinicians can make a dynamically informed decision in the case of patients with antisocial traits if the patient is treatable and whether the conditions guarantee the therapeutic effort.

Regarding the clinical populations, the prevalence of ASPD is about 15%, and "in rehab wards as well as in the psychiatric-judicial wards their percentage is over 30% of all patients" [5].

A negative slip occurs during the life of the antisocial individuals who try to get easy money repeatedly until them "completely burn out" in the middle age, usually in association with severe alcoholism and exhaustion. Although impulsivity is improving with age, they continue to struggle with work, parenting activities and life partners; some die prematurely. There is a correlation between the antisocial personality pathology and substance abuse –they often coexist, but each has a separate etiology; criminal activity is intimately linked to substance abuse: 52-65% of offenders were drug abusers.

Family connections between psychopathy and somatization disorder (hysteria) were documented; explanation: gender affiliation seems to influence the fact that individuals with hysterical or histrionic personality tendencies will develop either antisocial personality or somatization disorder.

Clinicians may overlook the diagnosis in women due to sex role stereotypes; a seductive and manipulative woman that exhibits significant antisocial activity is most likely labeled as hysterical, histrionic or borderline. This tendency to mistakenly diagnose women with antisocial behavior is changing, as the social freedoms they enjoy are growing, and more of them change their lifestyle to traditionally male models. There is data showing a link between traditionally masculine traits and antisocial tendencies. Some speculations claim that histrionic personality disorder can be a female version of psychopathy.

## Onset

The disorder occurs before the age of 15, and in girls the first traits are outlined before puberty. However, due to the process-like characteristic of personality formation, the diagnosis can be certain only after the crystallization of this process, i.e. young adulthood. Probably that is why it is stated that the dissocial disorder diagnosis "cannot be set before the age of 18" [1].

## The Case of the Patient M

**M** was about 30 years old, of Christian-Orthodox religion and, when we met, she was married and worked as a medical nurse in a hospital in the city, in the operating room (surgery). She admitted herself voluntarily, during the summer, 6-7 years ago. She presented herself at the emergency room, accompanied by friends, and stating as reason for admission the fact that *she slashed her husband's face*. She denied a hereditary – collateral history and from her physiological records it appeared that she had had three abortions.

### Living and working conditions

She worked with her husband, who was 4-5 years younger than her. For M. this was her second marriage, the first one happening around the age of 18. She mentioned that she had a bad relationship with her mother-in-law, because she disagreed with the marriage of the two, due to the age difference between them, but also because of the fact that M. had a prior marriage.

**School level:** general medical assistant (nurse).

## The History of the Episode before the Admission

### Out of the patient's statements

Sunday, around midnight, after spending a romantic evening, drinking champagne together, they began to prepare for the following day. She was in bed, doing her manicure, and the husband was shaving. During their conversations, the husband said: *"I'm getting all nice and clean, because new resident girls are coming in the hospital."* After hearing this reply, M. spent one hour thinking, and then, when they decided to go to sleep, she took the blade and slashed his face, severing his facial nerve: *"I'm slashing you, so that you will be ugly! And no other woman but me will ever love you!"* After which, she got scared: *"Oh, what have I done!"*, and called some friends (a family, the lady being seven-months pregnant) and left to the hospital together. The tests done after collecting urine from her husband showed traces of Diazepam (M. denied any possible connection). The doctors from the Emergency Room called the police, which started an investigation into the incident in question. After research, it was discovered that M. had asked her co-workers an anesthetic spray, saying she needed it to fend off a dog which upset her in the building block where she lived.

## After Admission

### Day 1

The patient – accompanied by friends, completely split off from the offense. After two hours since the admission, she says: *"Oh my, what have I done! I slashed his face, I hope he will forgive me and he won't leave me cuz of this. You know, I'm a miserable girl from the countryside, I have a brother, my mother didn't love me and she wanted to have only boys. Nor did my father love me, you know how it is with the Oedipus ... I got married at 18, I was married for three years ... After the break-up I suffered a lot, I loved my mother-in-law, she was like a mother to me. I married a second time, I do not want to be abandoned. Because I was afraid my husband would leave me, I slashed his face, so he'd be ugly, and other women would stop looking at him."*

## Clinical Observations

What primarily caught my attention was her inability to experience empathy, remorse and guilt, the cleavage towards the acting out of the hatred against an object that could not guarantee permanence: *"I hope he will forgive me and not me leave because of this ..."*. The speech was centered on the idea of abandonment, the idea that she was not desired by her parents, due to the fact that she was a "girl". Also, she tried to get the maternal love by replacing the mother with her mother-in-laws and they also refused to accept and love her. It seems that, through the men she *had*, M. tried to actually repair the early maternal relationship: by having the object of maternal love (the husband) she could have had, by default, the maternal love. And then and later on us wondered, if, somehow, by slashing her husband's face, she wasn't, in fact, trying to destroy the object his mother's love and adoration, her own mother's fantasy boy. The idea of *abandonment* sends in anybody's mind a signal to a Borderline type structure.

## Psychiatric Examination of the Present State

The patient, in neat attire, coherent, cooperative, with a low-pitched voice, self- and all psychic oriented. Hipomobile mimics and gestures. She made eye contact. She denies qualitative disorders of perception during the time of examination. Reduced attention and concentration ability. Memory: no significant disturbances during examination. Thinking: ideation flow and rhythm are slightly low; she denies ideation of psychotic intensity, speech centered on the idea of abandonment.

**Affectivity:** Inability to live the emotionally charged situation.

### Day 2

**Treatment:** minimum dose of antipsychotic + antidepressant. The patient is oriented in reality, in life. Out of her statements we find that she owns two studio apartments, which she inherited after taking care of two old ladies. She confesses that she wanted to live *only with him*, to be just the *"two of them"*. On this occasion, she starts detailing a past episode in which she prepared everything for them to die together, making love. M. had to fill the bath tub with water, to drink champagne, and then she would have placed two electrical wires in the water, thinking that they would die by electrocution.

## Interpretative Assumptions

Her life story, about the two studio apartments she owned, determined us to observe that the orientation of M. in reality and in life was reaching the optimum levels of functioning, which came into a clear conflict with the facts M. told during the admission.

Behind the Borderline-type attitude of loyalty, there is, however, an egosyntonic sadism, that raises big questions: *"That's how I wanted to do it now, too: after I'd slash him, I would slash myself as well. To be the same, the both of us!"*

Perhaps in a childhood - mimetic movement of the *"I know I was wrong, but I'm really sorry"*-type, the patient seems to regret her wrong-doing and seems to understand the moral issues present *in the others*, but cannot invest in relationships, other than in a superficial manner, putting her inflated self-esteem on the line.

### Day 3

We found out that, for almost a year, M. went to see a witch, where she spent a lot of money. Around the age of 21 she had a conversive crisis, accompanied by disturbances at a perception level, in which *she saw the devil and giving her aborted children to eat.*

The police, during the investigation, get interested about the diagnosis given within 72 hours of admission. Friends come back to the hospital, trying to help her, saying that *they do not know what's going on with her, that she is no longer who she used to be ...* Her family makes their appearance (her brother and mother). They are worried about the girl, but do not critic the dimensions of the crime she has committed. The mother-in-law brings photos of her son with his face slashed, perhaps in order to exacerbate the situation, but with no other interest than *for her son to separate from the woman, without paying other damages.*

The patient is admitted to the supervised ward and she seems to accept this with detachment.

## Childhood, School Period, Meaningful Social Relationships

M. was a little girl who lived a lonely childhood with a brother, significantly invested by his mother, who was six years younger than her. It seems that all the important people in her entourage, during the formation years, are missing completely. She tells stories about the mountains and the valleys, about caroling, about a patriarchal life, where time seems frozen, a godforsaken place, a village where the tableau is dominated by grassing cattle on the green pasture, where

all that can take the symbolic shape of a formal or informal teaching method seems to be inexistent. The environmental influence doesn't seem to stand-out either, be it good or bad, or be it the one coming from the other children's to by.

Her father is an absent figure, too weak in the face of what her mother has idolized and super-elaborated in regard to the love for her son. M. has no supporting point and no contoured image of the future up to 14 years-old. There seems to be a lack of significant intelligence or priory perceptual acuity over the world and over life itself, in M.'s case. It appears as if she lives in a dream world, where she uses apotheosis as a moment when she will have been build an oneiric eternity, only in her imagination, in an atypical, subcultural world, with phantasmagorical happiness, isolated from the world where she is her own actor and spectator of herself.

At the age of 14 she leaves home, mother and father having no opinion in regard to that fact (neither pro, nor against it), without any kind of hope for the future that awaits this girl. She goes to high-school, living in a dorm, along with other girls, which seem insignificant in the life history of M. The structure of a world surrounding a narcissistic person with intense malignant features seems to suffer some kind of a dissolution, in which no one and nothing appear to exist. At the edge, a demythisation seems to take shape, a depersonalization and annihilation of both the environment and the entourage. M. is unable to recall anything from her years in the dorm, during high school, all those surrounding faces turning into the same type of screen-defense: no name, no face and no number.

After graduating high school, she reaches the capital, where she enters a postsecondary school of Medical Nurses, a private school which she finishes with average grades. None of her academic evolution supports the idea of an intelligence which would have exceeded (at least as fleeting sparks) the average level, her level being imprinted forever by the subcultural coordinates. Choosing and investing in a profession seems an extremely determined gesture, in a subconscious register, to which M. always stays in a sort of a contact. As if knowing what those interests are and at what level to maintain them. On completion of her post-secondary school she uses her powers of seduction, qualities of her body, a sort of elaborated histrionic scheme, developed to have an impact on a certain category of men (between two ages, at key-moments in their emotional development, willing to invest in what appears to be a transiently love, a love they will later learn it has profound implications by directly imprinting, in an emotional malignancy register, that sort of aura that makes its presence felt much later). In this manner, using one of these men, M. gets to have a job as a nurse, in the largest emergency hospital in the capital, somehow by-passing a natural, upward career progression, short-circuiting exams, tie-breaks, even possible failure situations.

Working here, she speculates the same line of emotional intelligence - more mimed than lived - identifying it with her own False Self. This is what helped her boost her career and it also facilitated a meeting with two elderly women, patients of her, that she manages to seduce (while working as a nurse in the hospital). M. promises the two women some sort of "eternal youth and life without death", as a type of special care at home, so that both of them will leave her, through their will, the two homes. The elder patients are consciously and intentionally chosen, they do not have families, but do have an unstable mental capacity at the time of the decision-making, needing empathy, help, spiritual communion, skills that M. trained herself to have and which she effectively mimic. The manner in which she took care of the old ladies was impeccable, similar to the manner in which M. cares for - and attends - everyone else from her hospital department, any person in suffering. We have no information on how the two elderly ladies have ended their lives. No one has ever challenged their testament made in favor of M.

Even at her workplace, key-figures such as friends don't appear in her discourse, the existence of a particular entourage isn't outlined, but the emphasis is rather put on the dream world, where M. lives, perhaps as an *excuse* for her insufficient contact with reality. Beyond this apparent sense of detachment, M. is significantly engaged to the whole notion of "deserving", translated through "taking something important out of life". But unfortunately, this happens in a marked material and mercantile way, expressing the patient's need to clutch at objects. Even the representative beings in M.'s life are viewed through the same prism, the need to cling to them instead of simply enjoying their presence in her life.

## Clinical Observations

She talks about the desire of an omnipotent control of the relationship, through acts that reach the scope of manic defenses. In a psycho-dynamic sense, her antisocial act means "escaping" out of anxiety, depression and nostalgia and cancellation of the dangers of regression in which she had the feeling that she would have been losing her own limits. We have in mind: *"Instinctive monomania, without impairment of judgment, affecting the will"* [6].

The absence of criticism about the size of the acts she committed, as far as the patient's mother is concerned, makes us reflect on the role models taken by M. during early childhood. It is reasonable to ask ourselves to what extent had the environment obstructed the development within normal limits of her Super-Ego's structures, her reality Ego, etc., and favored operating models specific to antisocial personalities.

### Day 4

During hospitalization, all her medical tests have been made. During her psychological testing, she tore the Szondi test pictures, with a typical hysterical motivation, for instance: *"Those are very ugly devils!"*, then she pulled the wires on her EEG, refusing examination and stating that *she is pregnant, a devil that transforms itself, being possessed.*

### Day 5

She was examined by a medical committee, situation in which she presented a circumstantial speech, psychotic anxiety, narrating actions with bizarre motivation, delusional interpretation and persistent faith in charms, which led the commission to diagnose her evolving into an **"**acute psychotic episode**"**.

## After Increasing Compliance (day 7)

M. is quieter, says she has a resting sleep, psychotic anxiety is still present, delusional interpretation, ideas of body transformation and possession: *"I feel that I turn into something else, my face and hands turn into something else. It all starts with me being afraid that someone will take him away!", "At night I am afraid to leave the windows open, because the devil might enter!", "I feel that I am being transformed into the Devil, it entered inside of me when my husband left me, that's why I'm sure I'm pregnant ", " The cat cursed me, because I kicked it out and it died."*

## Szondi Test Results

In the forefront there is the delusional interpretation and paranoid side. M. seemed to have found refuge on an island where fantasies come to life; demons and fears are materializing, expressing psychotically all her non-lived feelings, anxieties and retaliating fears, specific to a yet unstructured psyche.

Specific to her personality, dormant, we observe a marked emotional immaturity, low resistance to frustration, aggression. Sub-dormant, she exhibited depression and vulnerability, decompensating under stress.

Operational efficiency was slightly low, logic slightly below average. There is absence of realistic goals, failure to tune the Self to the surrounding reality and difficulties in integrating her primary narcissism.

## After Two Weeks

Circumstantial speech and interpretativity remain, M. is calmer and more cooperative: *"I think those were visions out of my imagination ..." "My mother-in-law cast charms over me, with linden tree flowers, for fertility", "Now I believe more in 'the church' side. I am calmer."*

## Cross Psycho-dynamic Perspective

It became increasingly clear that M. had a profound inability to access and become aware of her affects and emotions, which she poured chaotically onto her behavior, impulses and states of mind: *"I used to have a light, happy attitude, but I have changed a lot after marriage, because my father did not attend the ceremony"; "I always had to have some concern, to be on the streets, to be near my husband."*

She showed hyperactivity, by trying to act on what was clearly evading the act of living, verbalization, secondary processes, specific to a functioning that is within the range of normality.

## Two years into the Admission

M. remained hospitalized for two years under the 114 Article of the Criminal Code of Law. Over this period, there are some significant issues to be reported:

- She looked after all the old ladies in the surveillance ward, making ostentatious intentionally the work of the medical staff on that ward, especially doing the tasks that might be considered humiliating.
- She manages to convince the others of her good intentions and is transferred to a reserve outside the surveillance ward.
- M. "takes" the boyfriend of a fellow reserve friend, whom she later, literally, gets into a fight with.
- She manipulates a nurse to let her stay alone inside the reserve, with her visitor and gets pregnant.

## Transference Movements

M. had a fascinating ability to sense in each of the therapeutic team (including nurses and orderlies) what kind of activities they have and what their satisfactions are. Almost all the theoretical descriptions warn about this ability of the psychopathic patient to get in touch with the needs of others, in order to manipulate them.

The ward is a clinical department and, therefore, it runs academic and university activities. So, M. was more than happy to participate as a subject at seminars and courses held for students. That fact in itself had a direct connection to us, in that she "felt" how much we invest in this side and she wanted, therefore, to produce a breach that she could use for her own transfer. M. plays the *role-model patient*: she is the "perfect patient", the treatment is very effective, and she is "cured" under our own eyes. And yet … she tells us, with that unconscious desire for self-disclosure, about an incident that occurred in the operating room – when she was still working, *she **deliberately** confused* a hydrogen peroxide container with another vial, containing a harmful substance, so that the patient on the operating table (a witch by profession) *"burns inside the belly"*. She continues, saying that they opened an investigation in which, thanks to her personal charm, she was "covered up" by her direct superior. Subtly and unconsciously, she told us: "I want to seduce you in order to be covered up, in case I commit any heinous acts." Also, she repeatedly told the students the story of how she "impressed" the doctor of the expertise team of the Forensic Institute.

## Counter-Transference Reactions

In M. and, in general, in patients with antisocial pathology, we find the same inability to mentalize and digest within the cognitive and affective area the impulses and instincts, which will always cause a massive tendency to act it out. An ordinary person feels he is so angry at *another* that he could kill him, but at a secondary mental processes level, he knows with certainty that he is not going to commit a crime. The Super-Ego function intervenes, which integrates and interrelates the rules of social conduct.

Risk factors resulting from the inability of awareness are:

- Failure to live the affects within the range of depression.
- Impossibility to metabolize impulses.

Among the risk factors for the others are the following:

- Significant interferences with the treatment, attitude and emotional states of other patients.
- Stirring a sense of chaos in others.
- Lying, corruption, undermining therapeutic relationships and alliances.
- Matching the metaphor: "The fox in the chicken pen."

An interesting fact in regard to the counter-transferential reactions among antisocial patients is that the women are somehow under-diagnosed due to the association of the concept of *female* with the one of *vulnerability*. Such female patients will rely on seduction through fragility and their life stories (most often, dramatic ones), although initially

contributing significantly to the onset of the pathology, are then transformed into powerful weapons against the diagnosis. Specialists may react instinctively and counter-transferentially to the "cry for help" behavior through intense unconscious relational involvement, unwilling to accept the emotional detachment of someone like M., by malignant projective pseudo identification.

In working with such patients we can come to see rather their narcissistic side, their emotional immaturity, the pathology of abandonment, and of course, out of the desire to respond to that intense demand of care, we may find ourselves caught in the trap of "flair" and experience. The inclination of our profession to rather see the disease and disability can increase our vulnerability to exploitation

and can cause, in a first instance, to "avoid" counter-transferentially the idea of antisocial pathology.

In the case of M., the diagnosis was Acute Psychotic Episode and may have very well been explained by a debut that happened previous to the time when she committed the offense (by about a month, with a functioning marked on delusional interpretation) or it may have been produced reactive to the trauma (being aware of her behavior and the consequences of her actions). Just as well, it could have been believed that M. was either mimicking psychosis or she suffered from a disorder out of the classic area of hysteria (the current trance and possession disorder).

I reflected on the patient's pre-morbid personality and I concluded that M. presents a polymorphism of "psychopathic" state (in the classical sense of the word), respectively:

- Displaying features of the Borderline area (abandonment).
- Paranoid features (emotional coldness, sensitiveness, a tendency of over-analysis).
- Narcissism (inflated self, insufficient contact with her own being).
- Histrionic elements (seduction).
- Antisocial elements (no remorse, no empathy, manipulation, collusion).

Functioning in a relationship, through the stress – diathesis model (stress occurring over a genetic vulnerability and / or imposed by the environment), was dependent on M. having been an unwanted child, with parents unable to manage a growth and an education that would have promoted the normal development of the Super – Ego functions, a harmonious integration of the gender identity. Thus, it affected M.'s ability to metabolize feelings and impulses in the cognitive area, with cumulative trauma in the area of abandonment, on a feminine / maternal line. Stressors such as the imminence of abandonment (real or fantasy) turned M. to use the dysfunctional defenses, in which the omnipotence and the grandiose Self remained the only means of defense against massive de-structuring.

Among the counter-transference reactions that M. raised in others were the following:

- Splitting the clinic's personnel in "good people and bad people."
- Sadistic counter-transference – the feeling of a *maze with no exit* regarding the acute outpouring of grief.
- Sentencing = the feeling that M. is untreatable and the therapeutic efforts will not bring any change.
- Projective identification, with the patient's aggression massive introjections.
- The major difficulty in accepting that M. is fundamentally different.
- The desire to destroy the therapeutic relationship with such a patient.

Obviously, M was able to exploit the counter-transference, the reactions she aroused in the others, within the same dynamic of antisocial personality, subordinating the relationships to her own interest, without any concern for the safety or welfare of the others, using the so-called "correct" models and paradigms to simulate a type of thinking and behavior that is socially adequate (narcissi twinning). So that she could, ultimately, turn her aggressive fantasies into reality.

As I said earlier, working with such a patient makes the whole therapeutic effort of the team a true ordeal, it raises questions about our own vulnerabilities (which our profession doesn't make an exemption from, it only helps us to understand and detect them, so that they do not become obstacles!), about the ethics and the professional conduct.

The therapeutic principles that should accompany us in such cases are: tenacity, consistency and incorruptibility, constant monitoring of the counter-transference in order to avoid our own acting out, as specialists. It is vital for us to self-analyze, so as to understand what the patient evokes in us, what is not ours, what unconscious projections of hers collide with unconscious content or insufficiently explored areas within ourselves. Again, to tolerate the inevitable limitations of therapeutic interventions and to avoid excessive expectations in relation to recovery or future functioning of such a subject may raise questions in the mind of younger or less experienced specialists.

In working with the antisocial patients, we face their massive denial and the tendency to minimize their acts. It is also important to establish, with the patient, the possible link between their actions and their potential emotions that have preceded and / or accompanied them. Both during daily practice, as well as in specialized literature, the idea that *genetic* interpretations are less effective than the confrontations of the "here and now" in relation to the behavior, the affects and motivations of the patient, is outlined.

## Psychodynamic Understanding

The following elements contribute to the pathogenesis of ASPD: the biological and genetic factors: correlation to crime is 2-3 times higher in monozygotic twins than in dizygotic twins. APSD emerges as a template disorder that examines the interaction between genes and the environment; the genetic vulnerability, influenced by environmental adverse factors, can lead to antisocial or criminal behaviors.

Caspi conducted a prospective study on 1,037 children starting from the age of 3 concerning maltreatment (maternal rejection, repeated loss of main career, harsh discipline, physical abuse and sexual abuse); it was established that a functional polymorphism of the gene responsible for MAO-A enzyme moderates the effect of maltreatment; males with low activity of the MAO-A genotype who were maltreated in childhood showed high antisocial scores. Male patients with an increased activity of the MAO-A genotype showed no elevated antisocial scores, even if they had experiences of maltreatment during childhood. Among male patients with low activity of the MAO-A genotype, but also with severe maltreatment experiences, 85% developed anti-social behavior.

Studies show that the genotype shapes the children's sensitivity to environmental stressors and that a combination of genetic vulnerability and negative experiences may cause an antisocial behavior.

The family reaction to hereditary traits according to Reiss D [7] can have four forms: exacerbating the child's negative attitudes, improving the child's "desirable" traits; protecting the child from negative results related to a demanding behavior; the parents' tendency to withdraw when facing the difficult child in an attempt try to protect the brother with better chances.

There are striking connections between the low responsiveness of the autonomous nervous system and the risk for developing a criminal behavior. Increased responsiveness of the autonomous nervous system appears to be protective against the criminal behavior.

From the psychodynamic perspective, individuals with strongly internalized standards of right and wrong often associated with a Super-Ego and an ideal Ego may experience anxiety and increased autonomous responsiveness in the form of guilt when they violate those moral standards.

APSD can be induced by neuropsychological deficits from the childhood: children with ADD have a higher risk, boys exposed prenatally to severe maternal nutritional deficiencies.

Studies in the MRI showed an 11% reduction in prefrontal gray matter volume compared to healthy subjects and it was suggested that the structural deficit may be related to low self-excitation, lack of awareness and the difficulty of decision-making typical to these individuals (therefore it would be an effect, not a cause).

There are differences between psychopathy and ASPD, namely: low electro-dermal responsiveness, lack of the Moro reflex; decreased facial expression; significant lack of fear; general shortage of emotional information processing; statistically significant increase in the volume of white matter of the corpus callosum and its length; reduction of 15% of the width of the corpus callosum; increased interhemispheric functional connectivity; atypical neural development processes involved in stopping the early axonal migration or the increased myelinization of the white matter may be responsible for these abnormalities of the corpus callosum. The experiences of childhood abuse may induce symptoms of ASPD in adults; the etiology cannot be reduced to the simple formula that victims become persecutors.

Heredity characteristics of a child, often composed of perinatal brain damage lead to difficulties in his growth; the child can be hard to calm down, he may lack normal emotional responsiveness the parents expect; sometimes the parents may already have abusive tendencies due to their own psychopathology; others time they may gradually become impatient and irritated as they observe the absence of a desirable response from the child.

Meloy describes two processes in the development of antisocial individuals: a profound detachment from any kind of relationship or emotional experience in general and sadistic attempts to relate with the others for exerting power and capacity for destruction.

There is a significant problem in the internalization of others (because of genetic / biological deficits of the child and the unfavorable home environment), which leads to a massive failure of development of the Super-Ego – the classic particularity, in the dynamic sense, of the psychopath; one of their dissuasive characteristics is the absence of any moral sense, they seem devoid of humanity; their only system of values supports the exertion of an aggressive power, the only development traces of the Super-Ego [8].

Patients of a higher degree of lacunae in the Super-Ego, due to more favorable constitutional factors and environmental experiences from the growing up period, have some resemblance of consciousness, but with areas circumscribed in which the Super-Ego does not seem to work and some of them were encouraged in their antisocial behavior, in a more or less subtle way by one or both parents [9].

Often intellectuals criminals fall into this category of the Super-Ego lacunae; their narcissistic personality structure allowed them to succeed; it is important to distinguish between an antisocial behavior and an antisocial personality.

In behaviors of antisocial nature we encounter an inquisitive pressure, a neurotic conflict or a psychotic thinking; in these cases they have nothing to do with ASPD.

Another aspect of the Ego pathology, more characteristic of a true psychopath, is a complete lack of moral justification or rationalization of antisocial behavior; psychopaths respond that the victims of their antisocial acts got what they deserved; they often choose to lie or to avoid taking on any kind of responsibility for their behavior.

The psychodynamic differentiation of the treatable narcissistic patient with antisocial traits of higher level compared to the untreatable true psychopath is a very complicated approach also because of the tendency of all antisocial patients to mislead the clinicians.

## Treatment in the Hospital

Patients with serious antisocial behavior do not benefit from a therapeutic approach exclusively through ambulatory type of psychotherapy. These action-oriented individuals will never acknowledge their own emotional states as long as they have the possibility to free their impulses through behavior; only when they are forced to remain hospitalized, one can observe the manifestation of emotions like anxiety or hollowness. The decision of hospitalization of these patients in ordinary psychiatric units that have patients with a wide variety of diagnoses usually leads to regret; the psychopath's aggressive behavior can seriously interfere with the treatment of other patients and can bring the therapeutic programs in an atmosphere of chaos; they will steal from the other patients, will sexually exploit and attack them, they will lie and ridicule the medical staff, they will secretly bring drugs and alcohol in the hospital, they will ridicule the therapeutic techniques and will corrupt staff members to participate in unethical activities; some will systematically destroy any therapeutic alliance that other patients have established with the members of the medical staff.

Because they are aware that the hospital is a much more comfortable solution than prison, they try to trick the doctors that the treatment is very effective; they can be very charming and can convince the staff that they can be discharged earlier than originally scheduled.

There is a widely accepted consensus that true psychopaths have no place in ordinary psychiatric clinics because they cannot have any benefit from treatment because they tend to turn this experience into an exploitative situation like "fox in chicken pen" to a certain degree of success.

There are specific programs that rely heavily on confrontation in pairs in the group with other psychopaths. When they are confronted persistently, their effectiveness is neutralized. These programs also involve a fixed structure with clear rules and rigidly imposed (because they lack the Super-Ego) [8]; the consequences of breaking these rules are implemented quickly, without any permission for bargaining or explanation from the patient. As these institutions have blocked the normal channels for discharging the unpleasant affects through action, they can begin to accept their own states of anxiety and aggression.

A small group of patients with antisocial traits, usually those with borderline or narcissistic personality disorder, may benefit from a voluntary hospitalization in a general psychiatric ward; mental health professionals, by nature of their profession, are inclined to be charitable and kind to those they treat; they are likely to award their patients the benefit of the doubt and see them as more or less treatable. They can minimize the importance of the psychotic patients' evilness and may assume that their antisocial behavior really is a "cry for help"; they can provide tremendous energy trying to relate to the patient who has no interest whatsoever in such relationships and can reach in a collusion with these patients' tendency to minimize the extent of

their antisocial behavior and their Super-Ego pathology as a denial of counter transference [8].

Under diagnosis may result from the fact that these patients are seen rather as narcissistic as as psychopaths, as immature, with a character structure that is not yet well "formed", or as consumers of substances as first cause. Some doctors will say that treating this substance use will eliminate the antisocial behavior, but a comorbid substance use does not improve the prospects of the psychopath for psychological changes. There is the possibility of counter transference contamination in differentiating between the treatable antisocial patient and the true psychopath, but we cannot rely on the "gut" regarding various good features of some patients. Only long-term hospital treatment is likely to produce a sustained change in these patients; they naturally try to continue their pattern of reacting impulsively, transforming their feelings into facts; from the beginning the physicians should

anticipate and address potential forms of acting out in the hospital; if the patient is a chronic user, all the correspondence should be open in front of the medical staff to prevent drug smuggling; they will be explained that they will be accompanied by medical personnel whenever they leave the clinic and will remain this way for quite a long time; they should have restricted access to the phone, money or credit cards; the treatment will be initially a test to determine which therapy is most appropriate for the patient. Healthcare professionals should closely monitor their counter transference reactions, each one individually, so that it does not get to disbelief, collusion, condemnation or other reactions.

**Distrust:** Denial that the patient really is very sick – the staff considers the antisocial behavior as being caused by substance use or adolescence problems, therefore the patient will be considered depressed or misunderstood.

**Collusion:** The antisocial patients often try to bribe the medical staff; tending to help the patient, they may commit illegal acts or may act unethically; they may lie in favor of the patient, falsifying medical records, they may enter into sexual relationships with the antisocial patients or help them leave the hospital; these counter transferential developments are part of the projective identification process whereby a corrupt aspect of the patient's Self enters the caregiver and transforms his behavior – "it's like I'm not myself"; these collusions may also be the result of malignant pseudo identification: "the psychopath consciously imitates or unconsciously simulates a certain behavior to increase the victim's identification with this individual, thus increasing the vulnerability of the victim to exploitation; simulating tears, remorse or sadness, the antisocial patients manipulate the medical personnel to empathize with them; if only one carer sees this presentation of the simulated Self, it can reach a split within the medical staff; those involved in malignant pseudo identification will strongly defend the patient against the "attacks" from the other members of the personnel; these simulated emotions can often be identified by sadistic counter transference feelings in front of a sadness overflow of the patient and by seemingly quick rewarding him, leaving observers with the impression that they were witnessing a performance.

**Condemnation:** Expressions of medical staff, like the patient is completely untreatable and not worth any effort to establish a therapeutic relationship; it is often an automatic reaction to evoking the history of the patient's antisocial actions; it is based on the doctor's previous experience with other similar individuals; the condemnation that arises from an intense collaboration with the patient.

Other reactions that may occur are feelings of helplessness and powerlessness, desires to destroy the patient (they arise from anger, feelings of incapacity), fear of aggressive attacks (they are often threatening and dangerous, sometimes evoking an intense fear just by a glance; because of this, the staff can avoid imposing a firm organization), taking into account the psychological complexity of these individuals, the medical staff in clinical institutions often have great difficulty in accepting the fact that the psychopath is fundamentally different from them; he has no kind of concern for the feelings or safety of other people and interacts with the staff only for his own interest; he can exploit this sensitive aspect of the counter transference by presenting himself as identical to his caregivers, the so-called context of "narcissistic twinning". This is a common strategy to enlist the medical staff in a corrupt collusion; he wins their trust, more freedom and power; this reflects the strong sense of empathy present in many psychopaths, despite their traditional image of not being empathic towards the others.

**Focusing on faulty thought processes:** when they pose as victims, they should be faced with the responsibility for what they do, the health professionals must function as an auxiliary Ego in terms of judgment, and must continually emphasize that these patients fail to anticipate the consequences of their treatment.

The antisocial patient tends to pass directly from impulse to action. Healthcare providers need to help him insert thinking between impulse and action. The patients need to learn that impulses and actions arise from feelings; often the emotional language is so foreign to them that they cannot identify their own inner experiences. Because of impulsivity, they pose a high risk of suicide.

These strategies are based on the "here and now" domain. Exploring the origins of childhood in these patients is often useless; any attempt to corrupt the medical staff must be faced it occurs, otherwise the patient may remove the acting out behavior from his mind and he may forget it. The lack of empathy is considered a feature of ASPD, but many antisocial have a well developed ability to recognize internal feelings of another person in order to exploit it.

## Individual Psychotherapy

Outside the hospital, in severe antisocial patients, individual psychotherapy is doomed to failure; the affects translate into facts for which there is no framework that can keep them under control; the lies and deceits are so widespread that the therapist will no longer know what is real in the patient's life. Meloy developed a general axiom: the severity of psychopathy should be inversely proportional to the therapeutic efforts; major concerns: the safety of the clinician, the availability of supervision. The true psychopath, in the dynamic sense, will not respond to psychotherapy, and so this should not be attempted. The patient with a narcissistic personality disorder with severe antisocial traits is more easily influenced; he can subtly reveal the feelings of dependence in the transfer process, his antisocial behavior may have an exasperated feature about him and his internal "ideal object" may be something less aggressive; he may attempts to justify or explain the behavior. The treatability will be determined by the ability to achieve some semblance of an emotional attachment towards others and the ability to perform certain functions of a primitive Super-Ego.

The presence of a true depression is a good sign for response to therapy, as a positive response to the hospitalized treatment. Clinicians assessing antisocial patients should feel calm when they do not recommend any treatment. Clinical features that would contraindicate any form of psychotherapy are: a history of violent or sadistic behavior

that resulted in serious injury or death; total absence of any form of remorse or explaining the behavior; very high degree of intelligence (particular understanding of the patient to undermine the therapeutic process) or a light degree of mental retardation (cognitive inability to understand the therapist's interventions); the inability to develop an emotional attachment towards others; intense counter transference reaction from the part of the clinicians, fear for their own safety, even in the absence of clear precipitant behavior of the patient.

Cheating others is a way of life for antisocials, a state of delight or enormous joy when they manage to fool their therapist; unconscious envy of the therapist's positive traits lead to this repetitive cycle of deceptions; feeling of triumph towards the success of a lie is accompanied by contempt - defense mechanism against envy; avoiding entering a close collaboration with the therapist has the role of preventing feelings of envy, but leaves the patient with a sense of emptiness on the inside.

Therapists cannot expect to maintain a neutral position with regard to antisocial activities of the patients. Trying this is guaranteed collusion with the patient's actions; moral outrage of the therapist will be evident in countless verbal communications and intonations of voice, so that the patient sees any effort neutrality as hypocritical; when therapists are shocked by the behavior of the patient, they should simply say so. Empathy, in agreement with the psychological approach of the Self is both unspecified as well as a conspiracy in such cases.

Trying to be effective can backfire against the therapist; competent therapists, able to fend off from being destroyed by the patient, are those who most frequently wake in the patient intense feelings of envy that can come out as hatred towards the idealized or loved object and that will ultimately lead to a negative and refractory therapeutic reaction.

## Perspectives on Prevention

Kindergarten boys with a high level of hyperactivity and opposition show a higher risk for persistent aggression; their characteristic feature: at birth, the mothers were of adolescent age and had a low educational level – only the mother's characteristics had predictive value, not the father's.

Antisocial behavior is partly predictable by the excessively harsh parental reactions to the inherited characteristics of the child. An early intervention with family therapy or perhaps individual therapy for children with high-risk mothers may be useful in prevention. Home visits of a social worker had an impact on the child's antisocial behavior: a social worker has been appointed to the new high-risk mothers, visits began during pregnancy and continued until the child was 2 years-old; the enrolled mothers: 85% were young, unmarried or with a low socio-economic status. Visits by social workers were on average 9 times during pregnancy and 23 times during the postnatal period up until the child was 2 years-old. There has been focus on three aspects of maternal functioning: health-related behaviors, competent care of the child and maternal personal development. After a follow-up of 15 years, the adolescents born to mothers who received assistance had significantly lower rates of antisocial behavior than the control subjects; they also had lower rates of substance abuse and fewer sexual partners over their lifetime.

Early psychotherapeutic interventions may help influence the expression of genes that lead to antisocial behavior. Individual therapy has a positive impact on the patient's children. In addition, the prevention strategies have a crucial importance from the point of view of public health.

## Conclusions

### Theoretical conclusions, supported by specialized literature

This paper wants to underline the main point in the general approach of Anti-Social Personality Disorder (ASPD), which is the fact that, situated at the edge, a personality with narcissistic traits of malignant intensity is equivalent to the structuring of that personality in an Antisocial type of disorder, in which the psychotic core isn't expressly emphasized, but an erratic behavior is intercepted, a mal-adapted behavior to the requirements of reality, a kind of hidden psychosis, just below the surface.

There is a specialized research literature, such as a study made on 137 cocaine dependent women [10], of which more than a quarter were diagnosed with ASPD after the DSM criteria, projecting personality traits such as: irresponsibility; impulsivity; lack of realistic, long-term goals; promiscuous sexual behavior; early behavioral problems; parasitic lifestyle; insensitivity and lack of empathy; shallow affect, lack of remorse; susceptibility to boredom, grandiose sense of self-appreciation.

Regarding the antisocial personality construction, the primary conclusion of the specialized literature reflects the combination of a particular psychodynamics with biological characteristics (unfortunate combination of severe impulsivity and genetic factors). This refers to significant neuropsychological differences as oppose to normal subjects, determining, at a psychological level, a lack of scruples and inability of emotional attachment, except of the interactions based on a *Sado – Masochistic* type of power.

Redefined in this way, M. represents the psychopathy in its primitive form, the narcissistic personality disorder lying at the edge, through egosyntonic antisocial traits. ASPD thus appears as a template used to examine the interaction between environment and genes. It is known from the specialized literature that genotype models the sensitivity of a former child at the stress factors from the surrounding environment and that a combination of genetic vulnerability and negative experiences can cause antisocial behavior. Following this line [11-13], support striking theories and connections between the low responding time of the autonomic nervous system and the risk to develop a criminal behavior. Increased responsiveness of the autonomic nervous system is thus protective against criminal behavior. Individuals who have strongly internalized standards of right and wrong, often associated with an ideal Super-Ego may experience anxiety and increased autonomic responsiveness in the form of guilt at the moment of violating the moral standards.

### Practical conclusions, regarding M.'s personality structure

Neuropsychological deficits, maternal gaps, low electro-dermal responsiveness, reduced facial expression, a marked lack of fear, general deficit of processing emotional information are features of M. that support the diagnosis of ASPD. Her experiences of childhood abuse (in particular form a quasi-dismissive attitude from her parents, as if she did not even exist) facilitates a narcissistic "filling" and a superfluous growth out of her own complacency, which will induce, in M.'s future adult life, symptoms of ASPD area.

However, the etiology of M.'s behavioral disturbances cannot be reduced to a simple formula based on which the ex-victim became the persecutor. Maybe M.'s parents have alienated themselves from her, precisely because she was a difficult child, missing the normal emotional responsiveness, which, to some parents, is to be expected.

This fact might have prompted the mother to turn all her attention towards her son. In adult life, M. lives in a similar manner a profound detachment from any kind of relationship or emotional experience in general. She has sadistic attempts of attachment, enjoyment and exclusive exacerbations of various forms of her power and its capacity for destruction. She has significant problems in internalizing the others, massive failure in development of her Super-Ego, the absence of any moral sense and lack of humanity.

There is a strong opinion towards the ASPD diagnosis, of which the narcissistic side is not excluded, but on the contrary, being the one thing that boosted her social and professional success. Antisocial behaviors, such as M's, were born from a prying pressure, at the boundary between a magical thinking, driven by a kind of immaturity, a weakness in the adult, cognitive - intellectual organization, and a psychotic thinking, occasionally and sequentially altered. M's gesture remains, however, lacks the moral justification or rationalization, expressing orientation towards action and relieving stress through behavior.

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