

Monster or Clown; Bad or Crazy: Who can tell the difference?

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Abstract.

Monsters, clowns, the bad, mad or crazy all behave in ways unacceptable by societal norms. Such individuals often find themselves the focus of criminal justice system investigation. Frequently at this point, his or her behaviour is assessed for the first time. Unfortunately, prior to such assessment, the behaviour of mad or bad individuals can wreak havoc on themselves, their family and friends and the society in which they reside.

Forensic psychologists are expected to determine whether such behaviour is that of a psychopath or one who is mentally ill. A miscalculation can have devastating effects on the individual being assessed and on society at large. There is an inherent risk to society if a psychopath is unidentified, untreated and their behaviour unrestrained. On the other hand, an incorrect diagnosis of psychopathy is a difficult one to extinguish and may lead to inappropriate treatment regimes.

Presented in this paper are case studies of individuals assessed in the forensic setting which will illustrate mad and bad behaviours in the context of offending activities. The distinction between mental health illness and psychopathy and associated comorbidity is also examined. Finally, the difficulties associated with an incorrect diagnosis of psychopathy are discussed.

Key Words: psychopathic assessment; incorrect diagnosis; psychopathy or mental illness; mad or bad.

1. Introduction.

Psychopathic behaviours may or may not be inherently acquired. As in many psychological deliberations about how one becomes who he or she 'is', the age old debate of nature and nurture comes into play when considering the psychopathic individual. The outcome of which is open for interpretation. What is apparent however is that once psychopathic behaviours become evident in an individual, they can wreak havoc on the life of the individual and those associated with him or her. In many cases however, a 'bad' person goes unrecognised by agencies and his or her behaviour is nominated as that being of a 'mad' person and vice versa. A correct diagnosis is of paramount importance, not only for the individual, but also for the safety and potential risk to the individual and community. If the diagnosis is incorrect, the devastation caused to the individual, his or her family and the community at large may be irreparable.

In this paper, the distinction between those who are bad and mad is discussed, as is the possibility of comorbidity. Case studies are presented in each section to illustrate the differences as well as the similarities. The difficulties experienced by an individual and his or her community when a diagnosis is incorrect are then discussed. Finally, concluding remarks are made.

To provide some contextual information, my role in the forensic setting, particularly when dealing with offenders, is to write their story, with a particular emphasis on what was happening for them around the time of the offences. Lawyers brief me to interview and psychologically assess individuals who have been charged with criminal offences, determine what underlying issues and/or behaviours were associated with the offences and make recommendations for treatment. My role in conjunction with that of the legal defence facilitates a global representation of the incident including the legal interpretation of the offences along with a psychosocial interpretation of the offending behaviours of the accused. The Judge then considers all legal and psychological information presented prior to determining an appropriate sentence for the offender. Often, community corrections officers either in the custodial setting or in the probation and parole setting are given the pre sentence report to provide information relating to ongoing therapeutic needs and interventions.

A number of case studies are presented in this paper. Please note that to facilitate anonymity of my clients no real names are used.

2. Those who are bad!

Early in my career, I met a young man who was eventually 'diagnosed' as exhibiting psychopathic tendencies. This was a most illuminating meeting for me at a professional level. All of my training in the forensic setting effectively 'went out the window' yet, as weird as it might seem, I am

eternally grateful to this young man for the insight he provided. In this paper I will call him Steven.

I had been briefed to interview and assess a young male adult who had been charged with 'torture' and whose charge was ultimately upgraded to 'man slaughter' when his victim later died in hospital. Steven and his victim had been taking drugs and drinking together whilst 'camped' by a river close to the city centre. When his victim did not give him money for more drugs and/or alcohol Steven took to him with a knife, carved a variety of symbols in his victim's legs and torso and effectively left him for dead after rummaging through his belongings and stealing what little money he had. What I originally thought was a 'drug fuelled incident gone wrong' turned out to be part of a pattern of behaviours that had become dominant in Steven's life.

As I walked into the watch house interview room, Steven was on the other side of the glass wall waiting for me. He seemed quite comfortable in the sterile environment of the Police Watch House and sat draped over the plastic chair as though he was sitting in a lounge chair.

I introduced myself and advised him that his lawyer had asked me to interview him and write a pre sentence report. He advised that he had spoken to 'hundreds' of social workers and psychologists over his relatively short life and would have me "twisted around (his) little finger" by the time we were finished. My immediate thought was 'no you won't, I'm trained in all this', yet a few hours later as I walked out of the interview room I realised that Steven had indeed 'gotten to me'.

Steven's story was 'so sad' and as a mother of sons around his age, I felt for him. Fortunately, I was able to distance myself from Steven's 'story', disentangle the fact from fiction and according to those involved in the case, make an appropriate diagnosis and associated recommendations. However, as a relatively naïve forensic psychologist, it took some time, energy and research for me to do so. I had just met my first 'monster' and something in my 'gut' told me so, but as I had never experienced that feeling before, as a professional I had no idea that this was a significant sign for me. Now many years later, although I would never admit it in Court, if my 'gut' instinct kicks in I follow that feeling and in some way this directs certain aspects of my interviews. Of course as a psychologist who has access to psychometric testing and a significant amount of collateral information prior to and after the interview and assessment process, there is a balance between my subjective and objective views during the writing process and when in Court. However, from my experience the 'gut' feeling has some role in the process.

Back to Steven's story! Steven had a particularly difficult background, but one that is not unusual in offenders of this type. At age three his mother re-partnered with yet another violent man and by the time he was seven

Steven was living on the streets in Sydney. He reported his home life was violent and he was often the victim of abuse by his 'new step-dad' not only because of his own behaviour, but because he would step in and try to stop his stepfather from assaulting his mother. Steven reported helping his mother was not so much to assist her, but more to make sure he had somewhere relatively safe to stay. Nonetheless, he eventually 'got kicked out' by his stepfather and his mother "didn't do a thing to stop him".

Sydney is a relatively cold city during winter and as with many itinerants in Australia Steven eventually made his way up the East coast to North Queensland where living on the streets is more comfortable given the tropical weather. However, during the fifteen years or so it took for him to relocate the 2700 kilometres to Cairns, Steven's personality and offending behaviours evolved. He progressed from being a relatively naïve child to a serial criminal who regularly manipulated others for his own gain. His offences became more serious as his offending behaviours escalated and his type of offending expanded to cover all offending categories, including sexual offending.

During his relatively short life, Steven had spent a significant amount of time in custodial settings including several 'boys' homes'. He had also engaged in treatment regimes whilst in prison which were expected to address his offending behaviours including an attempt to facilitate victim empathy. Treatment regimes however did not work for Steven and inherently do not work unless the individual is identified as having psychopathic tendencies and an appropriate regime facilitated¹². The attempt to teach victim empathy in fact taught Steven skills, which allowed him to manipulate his victims more easily.

Steven reported several incidents which revealed how he utilised his skills in manipulation and he revelled in his newfound abilities which included focusing on those who were struggling on the streets and using the information he gleaned from drunken or drug induced 'sessions' with them to 'get them to do what he wanted'. He would set himself up to 'be a mate' and purport to protect his newfound friend until he had fleeced them of whatever they had that he needed, or more particularly, desired. He could manipulate others into providing him with drugs, alcohol, money, shelter particularly during the wet season and sexual favours to name but a few. When he was finished with 'his friend', he would simply leave, or if his 'friend' caused him any problems, as in the case of the torture/man slaughter, he would simply, but aggressively, take matters into his own hands.

Steven had no remorse for his behaviours and would happily recount the intimate details of his actions to anyone who would listen, particularly other inmates. He took great glee in doing so for two significant reasons. Firstly, telling others about his 'adventures' elevated his 'profile', particularly when

on the streets and when in the custodial setting. Secondly, his recounting of offending behaviours allowed him to relive his 'wonderful' past experiences, those which he perceived as forming the foundation of his personality. Without these behaviours, he, in his own words 'does not exist'.

Steven's offending behaviours and presentation in our interview, along with his history is typical of one with psychopathic tendencies. Dr. Robert Hare Ph.D. devised the Hare Psychopathy Checklist which "has become the standard assessment measure for forensic and correctional populations"³. Hare⁴ describes eighteen criteria which fall into two factors that allow an assessment of psychopathic individuals. Factor 1 includes: glibness/superficial charm; grandiose sense of self worth; pathological lying; conning/manipulative; lack of remorse or guilt; shallow affect; callous/lack of empathy; and failure to accept responsibility for own actions. Factor 2 includes: need for stimulation/proneness to boredom; parasitic lifestyle; poor behaviour controls; early behavioural problems; lack of realistic, long-term goals; impulsivity; irresponsibility; juvenile delinquency; revocation of conditional release; and criminal versatility. Finally, two other criteria are considered when assessing psychopathic behaviours, those being promiscuous sexual behaviour and many short term marital relationships⁵. If an individual is found to exhibit psychopathic tendencies they have a significantly higher propensity to offend (or if in the forensic population – reoffend) than those who do not have psychopathic tendencies⁶. Given his profile, Steven is likely to reoffend after release from custodial, if not whilst in the custodial setting.

With respect to a treatment regime for Steven, given his previous history of engagement in therapy, it is unlikely that his 'state' will be moderated by the interventions provided in the custodial setting. Steven's reaction to therapeutic interventions was similar to that described in a BBC series on psychopaths⁷. Specifically, but somewhat disturbingly:-

Research shown on the film was damning of the standard approach to the treatment of psychopaths. An analysis of the study demonstrated that those patients or prisoners who received the conventional treatment of group therapy were actually more likely to commit further horrendous crimes than those who did not. It seems that the lengthy group discussion and thorough observation of their fellow inmates teaches the psychopath how to manipulate society even more efficiently; during group sessions they learn about human psychology, human frailty –and how to exploit it⁸.

There was nothing in Steven's profile that indicated psychological distress. As far as he could be, he was satisfied with his lot and could not see

any need for change. He did not experience difficulties with any clinical condition and was not driven to offend for any other reason except to benefit his own perceived needs. He was driven purely to sustain his own sense of entitlement; in his mind, the world revolves around his needs and wants.

3. Those who are mad!

The Diagnostic and Statistical Manual of Mental Disorders (4th Ed.) Text Version [DSM-IV-TR] is the Psychologist's Bible. In it is found four levels or Axes on which an individual's state can be psychologically assessed, those being: Axis I - clinical conditions (i.e., Major Depressive Disorder, Schizophrenia, Substance Abuse etc.); Axis II – personality disorders (i.e., Antisocial Personality Disorder – the closest personality disorder to psychopathy described in the DSM-IV-TR); Axis III – medical conditions (i.e., Diseases of the Nervous System and Sense Organs etc. which, in the forensic setting are generally mitigating rather than contributing factors discussed in a pre sentence report) and Axis IV – psychosocial and environmental problems (i.e., problems with primary support group, educational problem, housing problems etc.)⁹.

When considering the 'mad' offender, it is generally an Axis I diagnosis that is considered. On occasion, when considering a particularly difficult case, Axis II and Axis IV indicators are apparent during the assessment process and are described in the pre sentence report. Medical conditions (i.e., Axis III indicators) are seldom associated with offending behaviours, but are often taken into consideration when indicating sentencing possibilities (i.e., if the offender is dying of Cancer, then they are unlikely to reoffend, thus reducing potential risk to the community and as a result the offender may be released for treatment or not sentenced to a period of imprisonment).

In my practice, the most predominant Axis I indicators/diagnoses which relate to adult offending behaviour are Substance Abuse, Major Depressive Disorder, Bi-Polar Disorder and Schizophrenia. In young adults or child offenders Conduct Disorder and Attention Deficit/Hyperactivity Disorder [ADHD] dominate.

Paul is an example of a young man with a history of ADHD for which he had been medicated, but after medication ceased in his late adolescence he resorted to illicit substances to moderate his distress and became addicted. His drugs of choice were Amphetamines, Ecstasy and when available Cocaine. Additionally, he regularly used Marijuana and alcohol as coping mechanisms and when necessary 'to come down'. Once his addictive behaviours became uncontrollable and expensive, he lost his job, lost the support of his parents and friends, and in his words "ended up robbing and assaulting people to get the drugs or the money to buy them".

By the time Paul was interviewed by me he had “been in and out of rehab, but that didn’t help and (he) was positive (he) was going to gaol”. He was depressed as a result of his situation yet out of control and unable to stop his drug use and associated offending behaviours. He had lost everything that was meaningful to him in terms of family and friends and was isolated by his drug use and offending behaviours. His whole life revolved around obtaining and using drugs. His break and enters and associated assaults to obtain funds for the drugs he used caused significant distress to his victims and he was acutely aware of that and expressed his remorse, yet he was driven to offend by his need for ‘the next fix’ and so that he could fund his addiction.

In the end, Paul was sentenced to a period of imprisonment which allowed him to ‘clean (his) act up’ in that he was not able to gain access to his drugs of choice as readily in the custodial setting as he could when in the general community. Additionally, whilst in custody he was able to access relevant programs that specifically addressed his substance abuse, his psychological distress and his offending behaviours. He was also away from his drug taking associates and had a roof over his head and did not need to consider his basic needs whilst in custody. For Paul being in custody was a good thing, it allowed him to ‘pause and reflect’ and upon release, although somewhat concerned about returning to similar circumstances that were ‘his life’ prior to being sentenced to prison, he was positive about his prospects. Unfortunately, he returned to his old habits, reoffended and was again sanctioned by the Court. However, this was not because of psychopathic tendencies, rather his recurring behaviours were as a result of his addictions.

Sheryl is another case of being mad rather than bad. She was a young mother who was experiencing difficulties with Post Partum Depression. She had a difficult family history and little support. Her mother had a history of being in and out of violent relationships, suffered a variety of psychological disorders and had a tendency to leave Sheryl alone at a young age. Sheryl, as a young adolescent, exhibited behaviours that were consistent with Borderline Personality Disorder including slashing her arms, throwing tantrums so that her mother would not leave her and frequent but difficult relationships.

Sheryl described the events just prior to her daughter being taken from her by the Department of Child Safety as being ‘extremely difficult’. She reported her child (aged eight weeks at the time) “wouldn’t sleep, wouldn’t eat and cried all the time”. As a result she was experiencing sleep deprivation, was exhausted and unable to cope. She went to see the Community Nurses who diagnosed her as having Post Natal Depression and who were organising support for her and her baby. However, she reported “it was all too late, by then the damage had been done”. Sheryl had taken her daughter to the Doctor “because she wouldn’t shut up and (she) was getting

thoughts about shaking her”; the Doctor could not identify the problem and sent her to the hospital. At the hospital, the child was identified as having a broken leg and several broken ribs, some of which had started healing. The conclusion being that the child had been the victim of physical abuse on at least three separate occasions. Sheryl was charged with ‘torture’.

Sheryl denied any inappropriate behaviour, but acknowledged that ‘something happened’. She had lost the right to care for her child or even see her child without supervision and was fighting both her criminal charges as well as the Department of Child Safety. Her depression had deepened and she was being medicated for the disorder. She also accessed therapy and attended parenting classes. Nonetheless, the risk to any future children she may have is significant, particularly in the context of her propensity to Post Partum Depression, her personality disorder traits¹⁰ and her lack of familial and social supports. She has a potentially dangerous ‘mix’ of psychological conditions but does not exhibit psychopathic tendencies.

4. Can they be both?

True psychopathic behaviours are relatively rare in both the general and forensic populations. Finding an individual with both psychopathic tendencies and psychological/psychiatric conditions is less likely, but not impossible¹¹. Some clinical conditions that are comorbid with psychopathy are Schizophrenia^{12 13}, Substance Abuse¹⁴ and in late adolescent populations with Conduct Problems and ADHD¹⁵. In each case, the influence of comorbid conditions associated with psychopathy relate to the propensity of violent behaviours in the context of psychopathy rather than the clinical condition (i.e., a Schizophrenic patient/offender is more likely to act in a violent manner if they also have psychopathic tendencies). Nonetheless, in cases where comorbidity is an issue, it is important that all conditions are recognised and treated appropriately.

5. What happens if the diagnosis is wrong?

Apparent from the above is the possibility that an incorrect diagnosis of psychopathy might be made, particularly in the forensic setting and with offenders presenting with similar charges/offences. Incorrect diagnoses can and do occur and the fall out can be significant.

In a case of an incorrect diagnosis of psychopathy, the offender can be held in custody for a significant amount of time. An example of an incorrect diagnosis was a case where some twenty years ago Matt was convicted and charged with murder. He had a history of substance abuse and whilst under the influence of a cocktail of illicit substances killed an elderly woman. He also experienced difficulties with ADHD and had a hearing disability as a

result of being abused by his mother's boyfriend when a young child. He therefore had difficulty expressing himself both in the written form and in speech. He would get frustrated when he was misunderstood. However, he was a very good artist.

On initial contact with the criminal justice system, when he was sentenced for the murder, a social worker determined that he was a psychopath and fifteen years later and after ten applications for parole he, on the basis of the incorrect diagnosis, was still in custody. The prison General Manager who reported he was a good prisoner, having been rehabilitated, and the Parole Board who had some difficulty understanding why he had been diagnosed as being psychopathic asked that he be re-assessed. With the benefit of appropriate psychometric testing and interviews, there was no indication that he was or had ever been psychopathic. His difficulties were related to his drug use, difficulties trying to get people to understand him and associated frustrations and behaviours associated with ADHD. He was eventually released, continued with his artistic aspirations and now lives a relatively 'normal' life. He still struggles with the label 'psychopath'.

On the other hand as mentioned above, had Steven been appropriately diagnosed and been able to access appropriate therapy in which his psychopathic tendencies were specifically targeted, or at the very least if he were to be monitored, then his victim may not be dead. To have an unrecognised and untreated psychopath in the community is risky to say the least. Serial killers, serial rapists and offenders exhibiting other psychopathic behaviours have terrified communities. Unfortunately, it is not until they have a significant history of offending behaviours that the psychopath is likely to come to the attention of those able to adequately make the distinction between psychopathic tendencies and other offending behaviours. Additionally, particularly when faced with an offending adolescent, psychologists are reluctant to label their behaviours as potentially psychopathic. As mentioned above, such a tag can create significant difficulties for the individual, particularly for one so young.

6. Conclusion.

Offenders are inherently difficult to assess, particularly if the offender exhibits psychopathic tendencies. However an incorrect diagnosis can create difficulties for the individual and society at large. The risk to the community when a psychopath is unidentified and not adequately treated can result in unfettered serial offending by the offender with the risk of danger to community members, including family, 'friends' and associates of the offender. On the other hand, and perhaps less politically correct, the offender who has been incorrectly diagnosed as being a psychopath is unlikely to be able to access adequate treatment regimes that might facilitate the appropriate

management of their particular underlying issues and behavioural problems. It is imperative therefore that offenders are adequately assessed and where evident, psychopathic tendencies adequately addressed.

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