Psychopathy in the treatment of forensic psychiatric patients: assessment, prevalence, predictive validity, and clinical implications
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CHAPTER 8

GENERAL DISCUSSION
Chapter 8 concludes the present thesis. First, the major findings are summarized and discussed. Subsequently, we discuss treatment-relevant motivational deficits that characterize psychopathic patients, and some of their motivational strengths. Next, some limitations of the research presented in this thesis are discussed, recommendations for clinical practice are given, and suggestions for further research on psychopathy in Dutch forensic psychiatry are outlined.
RESEARCH QUESTIONS ADDRESSED IN THIS THESIS

This study was designed to examine the role of psychopathy in forensic psychiatric patients involuntarily admitted to the Dr. Henri van der Hoeven Kliniek, a forensic psychiatric hospital in Utrecht, the Netherlands, using the Hare Psychopathy Checklist-Revised (PCL-R). The following five main research questions were addressed and studied in a sample of forensic psychiatric patients under the TBS-order in the Netherlands:

1. What is the reliability and factor structure of the Dutch language version of the PCL-R?
2. What is the association between psychopathy and DSM-IV Axis I and Axis II disorders?
3. What is the predictive power of psychopathy for inpatient disruptive behavior?
4. What is the relationship between psychopathy and change in dynamic risk factors during forensic psychiatric treatment?
5. Do rapists identified as psychopathic recidivate more and faster than nonpsychopathic rapists following the termination of treatment?

MAIN RESEARCH FINDINGS

Since results of the separate studies have been reported and discussed in detail in the previous chapters, only main issues will be reviewed in this section.

RELIABILITY AND FACTOR STRUCTURE

In Chapter 3 it is shown that the Dutch language version of the PCL-R can be reliably rated by trained professionals, based on the Dutch translation of the semi-structured interview schedule designed by Hare (1991) and a review of all the collateral information available upon admission to the hospital. We also found good to excellent reliabilities for PCL-R ratings based on file information only (Chapter 7). In general, the high levels of reliability found in the present study are consistent with those documented by other researchers.
PREVALENCE OF PSYCHOPATHY

Does psychopathy frequently occur in Dutch mentally disordered offenders involuntarily admitted to a forensic psychiatric hospital? We demonstrated that psychopathy is a quite common disorder: Approximately 30% of the male forensic psychiatric patients were classified as psychopathic, using a PCL-R cut-off score of 26.

DIAGNOSTIC VALIDITY

Association with DSM-IV Axis I disorders. A diagnosis of PCL-R psychopathy was positively associated with drug abuse/dependence and alcohol abuse/dependence. On the other hand, patients with a diagnosis of PCL-R psychopathy were more than three times less likely to receive a diagnosis of any Axis I disorder other than alcohol or other substance use disorders. Similarly, these patients were about three times less likely to receive a diagnosis of paraphilic disorder.

Association with DSM-IV Axis II disorders. Psychopathy was significantly positively related to Cluster B personality disorders (PDs). Most psychopathic patients had a DSM-IV antisocial PD (i.e., 88%); the reverse was not true. PCL-R scores were also positively correlated with dimensional scores of paranoid, borderline, and narcissistic PD, and with conduct disorder (below 15 years of age) and antisocial behavior since age 15. In general, these results are consistent with previous research, providing further evidence for the cross-cultural validity of the PCL-R (Chapter 4).

PREDICTIVE VALIDITY

To be clinically relevant for the treatment of TBS-patients, it is important that the PCL-R score has significant power to predict (1) the course of treatment or (2) treatment outcome. Ideally, to improve overall treatment outcome, psychopathy would be useful for either matching patients to treatment programs, or guiding the differential management of forensic patients to improve treatment compliance.

Treatment progress. Chapter 6 describes a study on the relationship between psychopathy and change in dynamic risk factors during treatment of male forensic psychiatric patients. The findings indicated that upon admission, psychopathy was significantly related to more disturbance on a number of dynamic risk indicators. However,
psychopathy was *not* found to be significantly related to change scores on indices of anger, egocentrism, impulsivity, lack of insight, negative attitudes, and stress tolerance.

Psychopathic patients did show the expected pattern of treatment noncompliance, compared to nonpsychopaths. It was found that psychopathy was significantly related to a lower level of involvement in treatment activities such as education and work. Factor 2 in particular was negatively associated with treatment involvement.

*Institutional misbehavior.* A significant relationship between PCL-R scores and inpatient disruptive behavior was observed in the studies described in Chapter 5 and Chapter 7. High psychopathy patients were involved in significantly more disruptive incidents. In particular, verbal aggression and violation of hospital rules were more characteristic of patients with high PCL-R scores than of patients with low PCL-R scores. In general, these findings are in line with earlier findings in forensic psychiatric patients supporting the value of the PCL-R as a significant predictor of disruptive behavior in forensic inpatients. In our view, treatment and management of this patient group should be particularly focused on their impulsivity, lack of behavioral control and sensation seeking tendencies.

*Recidivism.* Perhaps most importantly, it was found that rapists scoring high on the PCL-R (i.e., $\geq 26$) were more likely than other rapists to be reconvicted for a sexual, violent nonsexual or general offense (Chapter 7). Survival analyses provided considerable evidence that psychopathic rapists with *deviant sexual preferences* are at much greater risk of committing new sexual offenses than psychopathic offenders without deviant preferences or nonpsychopathic offenders with or without sexual deviance. It is concluded that any comprehensive risk assessment of sex offenders under the TBS-order should consider the combination of psychopathy and sexual deviance.

**Psychopathy, Treatment and Change**

It makes theoretical sense to presume that psychopathic patients are difficult to treat with psychological interventions. Psychopaths, by definition, experience little distress (remorse, guilt, anxiety) that might motivate them for treatment. They see little wrong with themselves, they lack insight, do not empathize with the possible adverse consequences of
their behavior for others, and they habitually manipulate other people to achieve their own ends. These characteristics are generally the opposite of those that have been found to be important for effecting positive therapeutic change (e.g., Hemphill & Hart, 2002).

Do our findings justify the conclusion that (PCL-R) psychopaths are ‘untreatable’? The answer to this question is a simple ‘no’, because there is an absence of good evidence. The principal limitation of the empirical literature on the treatment of psychopathic patients to date is that a treatment approach specifically developed for psychopathic patients has not yet been implemented and evaluated (Lösel, 1998). Before (see Chapter 6), we argued that a treatment program based on the principles of risk, need and responsivity, focusing on reducing the risk of violence and destructiveness by modifying the cognitions and behaviors that directly precipitate violent behavior, may maximize change. Subsequently, we argued that the standard of service delivery at the Dr. Henri van der Hoeven Kliniek could be increased by forming homogenous subgroups of patients allowing the development of specialized wards to target the needs of different groups of patients, with the specificity of each ward being based on both patients’ treatment needs and security requirements. As a standard procedure, criminogenic needs identified during baseline assessment should become treatment targets, and for each target an explicit treatment plan needs to specify how change is to be accomplished. Appropriate interventions delivered in this manner may produce favorable results in the treatment of this high risk group of offenders. Dolan and Coid (1993) mentioned that the ‘untreatability’ of psychopathic patients may, in part, result from professionals’ inadequate assessment of the disorder, followed by a failure to develop, describe and study theoretically sound treatment strategies. Methodologically sound studies would include large groups of clearly defined psychopathic patients, who receive well-designed treatments that are delivered consistently and evaluated systematically with long follow-up periods, using different measures of treatment outcome. In our opinion, and that of others (e.g., Hemphill & Hart, 2002), it seems ethically unjust to deny psychopathic (TBS) patients access to treatment programs on the grounds that they are untreatable. Instead, high priority should be given to designing, implementing, and evaluating treatment programs for these patients (Hildebrand, de Ruiter, & de Vogel, 2003).
**Motivating (Psychopathic) Patients to Change**

Offenders required to undergo treatment by legal compulsion are particularly likely to show resistance. Strategies for motivating them to change are deemed appropriate. What motivates (psychopathic) offenders to change?

Motivation for therapy is a multifaceted concept whose parameters are imprecisely defined. Matters relating to motivation to change have been the subject of considerable research in the treatment of addictions, and many addiction concepts and treatment approaches have been adapted for the treatment of offenders. Drawing upon conceptual and empirical frameworks (e.g., Prochaska, DiClemente, & Norcross, 1992; Rosenbaum & Horowitz, 1983) concerning motivation for therapy, Hemphill and Hart (2002) identified various important conditions for change to occur in (forensic) treatment. Acknowledging personal problems and participating in treatment, interest in changing, viewing problems as psychologically-based and believing that interventions could be beneficial, willingness to accept help and to establish a positive relationship with a therapist, striving for autonomy and independence, having clear and realistic treatment goals, and experiencing marked emotional distress, guilt, or shame regarding problems, are strong motivating agents.

According to Wong (2000), the Transtheoretical Model (TM) of change (Prochaska & DiClemente, 1986; Prochaska et al., 1992) may provide a useful heuristic towards a better understanding of how clinicians could provide (psychopathic) offenders with the appropriate treatment at the appropriate time as they progress through the change process. The TM was based on empirical identification of the common features and processes associated with change, and was originally developed in an attempt to explain change in addictive behaviors. Later, it has been expanded into the area of psychological and medical interventions for other disorders (e.g., phobias and depression) for both adults and adolescents (e.g., Belding, Iguchi, & Lamb, 1996; Hemphill & Howell, 2000; Miller & Tonigan, 1996). The TM provides a framework to understand readiness for and commitment to psychological change. The model postulates that individuals who modify their problem behavior move through a series of stages before attaining an identified goal (DiClemente, McConnaughy, Norcross, & Prochaska, 1986; Miller & Rollnick, 1991), including the pre-contemplation, contemplation, preparation, action and maintenance stages. Each stage is characterized by specific patient behaviors. Treatment interventions
that are effective for one stage may be ineffective (or even damaging) when applied to the same patient at other stages. Before being successfully treated, the patient may cycle through most or all of the stages more than one time. Relapse or cycling through the stages is considered to be the rule rather than an exception (Prochaska et al., 1992). Change is not considered possible until the patient moves beyond the pre-contemplation stage (i.e., not accepting that a problem exists) and the contemplation stage (uncertainty whether or not change is possible or necessary). Acceptance that a problem exists, and taking responsibility for past and present actions, may, for the (forensic) patient, be the most important step towards progress, facilitating all subsequent efforts in the direction of change. However, insight into the need to change is not in itself sufficient to produce or maintain change.

Motivational strengths. Do psychopathic patients have motivational strengths? Hemphill and Hart (2002) suggest psychopathic offenders may have at least four motivational strengths that may help them in therapy: (1) a strong status orientation, (2) a strong desire for and tolerance of novelty, (3) good interpersonal skills, and (4) a desire to be in control. In their opinion, to enhance the motivation of psychopaths, treatment programs should formally assess motivation to participate in treatment, highlight the view that leading a criminal lifestyle is low status, explain the rationale behind psychological interventions, explore their own contributions to personal problems, establish a non-threatening, positive therapeutic alliance with the therapist, emphasize self-sufficiency, attempt to manage antisocial behavior in stead of changing personality structure, focus on cognitive strengths rather than on affective problems, and teach them a variety of therapeutic strategies to change their behavior and maintain positive changes.

LIMITATIONS OF THE PRESENT RESEARCH

Several (methodological) limitations to the current research deserve attention. First, the treatment program in the hospital where this research was conducted was not specifically designed to address criminogenic needs of adult forensic psychiatric patients. Second, the sample(s) existed by convenience, and experimental manipulation and control could not be conducted.
Another limitation concerns the fact that data collection was restricted to only one forensic hospital. Therefore, caution is warranted regarding the generalizability of the findings. However, in our view, the current stage of development of theory and practice justified this kind of study. Also, we have no reason to believe that the samples we used in our studies were fundamentally different from those of other Dutch forensic institutions. In fact, we consider our sample(s) representative for Dutch offenders with a tbs-order, because they are largely similar in demographic, psychiatric and criminal characteristics (van Emmerik & Brouwers, 2001; de Ruiter, 2003). However, future research involving different, preferably larger (forensic) samples is recommended.

Fourth, of particular concern are the relatively small sample sizes of the different studies reported here, which may have affected the results of the data analyses. The different studies reported in this study all included a total of ± 90 - 95 male patients, and the group classifications that were formed on the basis of the PCL-R total scores contained significantly fewer participants. Larger samples would have resulted in increased power. However, as stated before, this is considered a relatively minor problem given that there is such a paucity of research on the role of the PCL-R in the treatment of Dutch forensic psychiatric patients. Indeed, no prior study has examined the predictive validity of the PCL-R among Dutch forensic patients.

DIRECTIONS FOR FUTURE RESEARCH

The current study suggests several avenues for future research. Here, we consider several important areas that, in our view, should be research priorities in Dutch forensic psychiatry.

TEMPORAL STABILITY

Psychopathy is presumed to surface early in life and to remain stable across the lifespan. A corollary of this is that PCL-R scores should demonstrate high test-retest reliability over long time spans. Moreover, individuals identified with psychopathic traits early in life should be the same individuals as those identified with psychopathic traits later in life. This line of research is important for both conceptual and practical reasons. From a
conceptual point of view, the stability of PCL-R scores supports the view that psychopathy reflects a stable constellation of personality and behavioral characteristics. The PCL-R is expected to show high test-retest reliability because of the emphasis during assessment on lifetime functioning across several domains. The stability of the PCL-R is suggested by the finding that it consistently is among the most powerful risk factors for antisocial and violent behavior (Harris, Rice, & Quinsey, 1993; Steadman et al., 2000), and that the PCL-R score is a significant predictor of future criminal behavior with long (i.e., ≥ 10 years) follow-up periods, and in different samples (e.g., Hemphill, Templeman, Wong, & Hare, 1998; Hildebrand, de Ruiter, & de Vogel, 2004; Rice, Harris, & Cormier, 1992). However, little research has been conducted to investigate the test-retest reliability of the PCL-R. Schroeder, Schroeder, and Hare (1983) were the first to examine the test-retest reliability, using the original 22-item PCL. They conducted a study, using a sample of 42 inmates, with a test-retest interval of approximately 10 months, and obtained a generalizability coefficient of .89.

Rutherford, Cacciola, Alterman, McKay, and Cook (1999) examined the two-year test-retest reliability of the PCL-R in male \( n = 200 \) and female \( n = 25 \) methadone patients. Stability of the PCL-R was reasonably good, whether it was evaluated as a dichotomous or dimensional measure. Utilizing a diagnostic cutoff score of 25 or more the intraclass correlation coefficients (ICCs) were .48 for men and .67 for women. For the PCL-R total score ICCs were .60 and .65 for men and women, respectively (Rutherford et al., 1999). According to Andrews and Bonta (2003), however, viewing psychopathy as a stable personality trait that changes little over time may be a mistake because there is no \textit{a priori} reason to assume that re-administration of the PCL-R following appropriate treatment would not produce changes in scores. Andrews and Bonta (2003) further argue that the assumption that psychopathy is immutable has diverted researchers from studying the dynamic possibilities of the PCL-R.

**Applicability of Revised Models of (PCL-R) Psychopathy**

At the time we started our research, PCL-R psychopathy was generally believed to be a two-factor construct. However, the results of recent empirical investigations suggest that psychopathy may be composed of three (Cooke, & Michie, 2001) or even four factors
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(Hervé & Hare, 2002). In essence, the three-factor model posits that a 13-item PCL-R assesses the superordinate factor of psychopathy, which is underpinned by the three factors *Arrogant and Deceitful Interpersonal Style* (items 1, 2, 4, and 5), *Deficient Emotional Experience* (items 6, 7, 8, and 16), and *Impulsive and Irresponsible Behavioral Style* (items 3, 9, 13, 14, and 15). Compared with the traditional two-factor model, the three-factor model of psychopathy places less emphasis on antisocial/criminal behavior; is more weakly associated with nonspecific indices of social deviance; and, more importantly, appears to better fit data on forensic patients (Cooke & Michie, 2001). Skeem, Mulvey, and Grisso (2003) independently cross-validated the new three-factor model in a large sample (N = 870) of civil psychiatric patients, using the Screening Version of the PCL. They concluded that “Cooke and Michie’s (2001) three-factor model of psychopathy is more plausible than the traditional PCL two-factor model with these patients because it better describes the structure of the PCL:SV and more specifically assesses personality deviation” (p. 51). Using these recently-developed factor models may yield important information about the robustness of these factors in diverse populations. However, new research is needed to determine whether the revised factors are anchored in theoretically consistent ways to a broad range of key psychophysiological, clinical, personality, and other variables. For example, does Cooke and Michie’s (2001) *Deficient Emotional Experience* factor relate uniquely to deficits in emotional processing? Does it correspond more closely than the *Arrogant and Deceitful Interpersonal Style* or the *Impulsive and Irresponsible Behavioral Style* factor with observational ratings of detached, unempathic interpersonal behavior? In a related vein, future research could also examine whether or not the revised factors are differential predictors of reoffending (i.e., sexual, violent nonsexual, general). For example, does the *Impulsive and Irresponsible Behavioral Style* factor better predict sexual recidivism in rapists, than the *Arrogant and Deceitful Interpersonal Style* factor? This kind of research may lead to the discovery of meaningful subtypes of psychopathy, possibly also with specific neurobiological correlates (see Blair, 2003).

**COMPARATIVE AND INCREMENTAL VALIDITY**

In applied settings, it is often useful to examine the unique and shared contributions that psychopathy and other risk factors make to the clinical task at hand. In the area of
recidivism research, for example, researchers may want to investigate not only the predictive validity of the PCL-R, but also the additional contribution, if any, that the PCL-R makes to the prediction of (different types of) recidivism beyond that offered by other variables (e.g., number prior convictions) or simple actuarial instruments, such as the Static-99 (Hanson & Thornton, 1999), an actuarial sex offender risk scale. For example, by using multivariate analyses (e.g., binomial logistic regression) researchers may estimate which measure contributes uniquely to the prediction of violence, taking the other measures into account. By building a literature that examines the incremental validity of different measures, clinicians will be in a better position to identify the unique and shared contributions of different variables/measures and to select measures that each contribute unique information to the clinical task.

TREATMENT PROGRESS AND OUTCOME

Methodological issues. Research which evaluates the efficacy of treatment for psychopathy is clearly a priority. Virtually no methodologically sound treatment study has been conducted to evaluate the effectiveness of a contemporary treatment program for psychopaths (see Chapter 6). Such a study would include a large sample of clearly defined psychopathic patients (i.e., assessments made by raters who have the requisite and experience), who have received state of the art treatment interventions that have been delivered consistently and evaluated systematically across long-follow-up periods, using multimodal measures of treatment outcome. We agree with Hemphill and Hart (2002) that although research methodologies have improved greatly over the years, there is still considerable room for improvement for studies that investigate the efficacy of treatment among psychopathic patients.

Measurement refinement. Future research should also seek to refine measures’ sensitivity to change. The majority of the measures used to assess change in dynamic risk factors during inpatient treatment demonstrated no change (see Chapter 6). Although it is possible that these traits truly did not change during the course of treatment, it is also possible that the measures themselves were not sensitive to change.

Risk, need, responsivity. One explanation for our findings (Chapter 6) that patients did not improve on dynamic risk factors is that it may be that the treatment program
provided at the hospital deserves review and alteration. We argued that alteration of the treatment program into a multimodal cognitive-behavioral program, based on the principles of risk, need and responsivity, may increase the likelihood of actual change. It may be that the standard of service delivery could be increased by forming homogenous groups of patients and allowing the development of specialized wards to target the needs of different groups of patients (Müller-Isberner, 1993; Rice, Harris, Quinsey, & Cyr, 1990; see also Chapter 7). The treatment program of each ward would then be based on both patient’s treatment needs and security requirements. In our view, implementation of a policy of specialization would encourage professional development of therapeutic methods inside the hospital.

Protective factors. Why do some psychopathic offenders recidivate while others (seemingly) do not? As yet, there are no definite answers to this important question, however, several researchers have speculated that the presence of various protective, or resiliency, factors may play a significant role in abstinence from further criminal offending (e.g., Grisso, 1998; Hoge & Andrews, 1996; Hoge, Andrews, & Leschied, 1996; Levenson, Kiehl, & Fitzpatrick, 1995). In this context, protective factors are generally defined as factors that may be responsible for keeping some individuals, who may otherwise be at high risk for engaging in violent or antisocial behavior, from reoffending. Much of the research regarding protective factors has been conducted with juvenile offenders (e.g., Hoge & Andrews, 1996). The purpose of this research is primarily to identify high-risk juveniles and predict which juveniles are most likely to engage in antisocial behavior, usually through an examination of risk or causal factors. As a result of this research, scholars have identified several potential protective factors. Protective factors include biological, psychosocial, and social variables (e.g., Carson & Butcher, 1992). Results from relatively recent studies suggest that a wide variety of variables, related to a number of different psychosocial domains, may act as protective factors: positive family relations, intelligence/education, employment, high self-esteem, absence of a psychiatric history, positive peer relations, and participation in an organized religion (e.g., Grisso, 1998; Melton, Petrila, Poythress, & Slobogin, 1997; Monahan et al., 2001; Plutchik, 1995). Research suggests that the more protective factors an individual has, the less likely it is that the individual will engage in serious antisocial behavior (Grisso, 1998).
Several scholars have specifically addressed the question why some psychopaths, including noninstitutionalized psychopathic individuals, do not engage in antisocial behavior (e.g., Levensohn et al., 1995; Rogers et al., 2000). It may be useful for future research to systematically assess (1) the presence and (2) perceived impact of protective factors after the PCL-R interview is completed, especially in relation to treatment outcome and possible reoffending.

In addition, we are particularly in need of studies that closely monitor patients over time, so that we can identify important dynamic risk factors. For example, determining what dynamic factors are most relevant during the early phases of release versus those that do not become important until the TBS-patient’s life has stabilized would yield substantial operational gains.

Impact of motivation. While many authors propose a link between patient motivation, or willingness to engage in treatment, and treatment success (e.g., Hanson, 2000; Mann, 2000; Mann & Rolnick, 1996; Serin & Kennedy, 1997), little empirical evidence exists substantiating this relationship. Motivation is best understood as a dynamic state. This allows a conceptualization of motivation as a responsivity factor that can be positively influenced to enhance treatment effectiveness. The underlying rationale for the study of motivation is that individuals who are not motivated to actively participate in treatment generally appear to make less progress in intermediate treatment targets and ultimately have greater recidivism rates. For example, Stewart and Millson (1995) identified motivation as a significant factor predicting release outcome. They found that level of motivation was directly related to rates of reoffense. A useful line of future research would be to investigate the applicability of the transtheoretical model of change (described above) in conceptualizing and evaluating patient motivation for treatment. Confirming motivation as a relevant responsivity factor would be an important contribution to the (Dutch) forensic treatment literature since there is now substantial

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1 Of course, it would be preferable to use an empirically-validated measure specifically designed to measure the presence of protective factors. To the best of our knowledge, no such instrument is currently available. However, de Vogel, de Ruiter, and Bouman (2003) recently introduced a checklist of 17 protective factors for (sexually) violent behavior that can be used for research purposes in forensic clinical practice in combination with the HCR-20 and/or SVR-20.

2 Note that the stage of change model is only one of many models that could be employed.
evidence in the general psychotherapy literature that motivation itself can be positively influenced (e.g., McConnaughy, 1987; Miller & Rollnick, 1991).

**Psychopathic Traits in Children and Adolescents**

Future research in Dutch forensic psychiatry should also investigate psychopathic symptoms in children and adolescents. Although the assessment of psychopathic traits in children and adolescents remains controversial (Edens, Skeem, Cruise, & Kaufman, 2001; Frick, 1998, 2002; Hart, Watt, & Vincent, 2002, Lynam, 2002; Seagrave & Grisso, 2002), there are reasonable grounds to believe that it is possible to assess childhood traits that are similar to psychopathy in adulthood (e.g., Forth & Burke, 1998; Forth, Hart, & Hare, 1990).

The presence of psychopathic symptoms in adolescents has been confirmed (Forth et al., 1990; Mailloux, Forth, & Kroner, 1997; Smith, Gacono, & Kaufman, 1997). Studies have begun to develop evidence for the construct validity of measures — such as the Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, in press) — to assess psychopathic traits in adolescents (e.g., Brandt, Kennedy, Patrick, & Curtin, 1997; Chandler & Moran, 1990; Forth et al., 1990; Kosson, Cyterski, Steuerwald, Neumann, & Walker-Matthews, 2002). The psychometric properties of the PCL:YV closely correspond to those of the adult PCL-R (Forth et al., 1990; Harpur & Hare, 1994). Furthermore, the PCL:YV has exhibited reasonably strong predictive validity for violent recidivism in forensic samples of adolescents (e.g., Forth et al., 1990; Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001; Harpur & Hare, 1994; Kosson et al., 2002; O’Neill, Lidz, & Heilbrun, 2003). However, a clear demonstration from longitudinal research is needed to prove that psychopathic symptoms in children/adolescents persist into adulthood. It may be that psychopathy-related traits disappear by adulthood as a result of maturation or other factors; it is also possible that these traits emerge in early adulthood in some individuals. To put it differently: Which adolescents are true positives (youth with life course persistent antisocial conduct who will mature into adult psychopathic individuals) and which are false positives (youth who appear antisocial during a developmental phase of adolescence but will adapt in less antisocial ways as they mature; see Moffitt, 1993). If it turns out that it is possible to identify children or adolescents on a
developmental trajectory toward adult psychopathy, then perhaps it will be possible to develop early intervention programs that prevent or reduce psychopathic symptoms (e.g., Frick & Ellis, 1999; Gresham, Lane, & Lambros, 2000). Potential ethical problems with this development should be closely monitored (Edens et al., 2001; Ogloff & Lyon, 1998).

**Final Remarks**

In many jurisdictions, PCL-R psychopathy now plays an important role in procedures for the prediction of recidivism, violence and response to treatment (e.g., Hare, 1998c). In fact, psychopathy is recognized as a critical factor in violence risk assessment (Hart, 1998), affecting decisions involving parole from prison, access to treatment, and detention under dangerous offender legislation (e.g., Hart, 2001; Lyon & Ogloff, 2000; Zinger & Forth, 1998). Accordingly, the assessment of psychopathy needs to be a fundamental skill for the clinical-forensic psychologist. Although this point seems obvious, particularly in forensic contexts where important psycholegal decisions are made and lives may be greatly affected, Hare (1998c) has amply documented a number of disconcerting examples concerning the misuse of the PCL-R, including (1) mental health professionals using PCL-R assessments based on clinical opinions in stead of the scoring criteria for the items, (2) biased — intentional or otherwise — ratings, and (3) judges “playing psychiatrist” (p. 111). The expert who brings the concept of (PCL-R) psychopathy into the courtroom carries with him a host of ethical and professional issues. Clearly, he needs to have a thorough understanding of the disorder (e.g., prevalence, symptomatology, and implications of the disorder) and appropriate training. Additionally, the expert must maintain his expertise by keeping abreast of new research findings and developments. This is particularly true of psychopathy, which has become the subject of intense empirical investigation over the last decade.

The PCL-R provides researchers and clinicians with a reliable and valid operational measure of a construct that has direct implications for the mental health and criminal justice system (e.g., Chapter 7). What this means for the law is that while psychopaths are more likely than nonpsychopaths to be violent, to recidivate violently, and to cause problems in the institutions in which they are incarcerated or treated, it likely never will be
entirely satisfactory for the law. This is because in an individual case, the law does not concern itself with how most people with similar PCL-R scores behave, but, rather, with how the particular individual in question will behave.\(^3\)

According to Hart (1998), the comprehensiveness of a forensic assessment is in doubt where the legal issue relates to (violence) risk but (PCL-R) psychopathy has not been considered. In these situations, experts who are unable to provide a strong justification for not considering psychopathy may not be fulfilling professional standards. However, psychopathy must never become the only consideration.

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\(^3\) A fundamental difference between psychology — indeed with science — and law is that science deals with normative data while the law deals with individual cases. This is why researchers are so concerned with sample size and replication, and why statutes are written in an intentionally vague manner, creating a lot of liberty in applying the law to the individual case.