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

The main objective of the research presented in this thesis was to examine the role of PCL-R psychopathy in the treatment of Dutch male forensic psychiatric patients involuntarily admitted to the Dr. Henri van der Hoeven Kliniek, a forensic psychiatric hospital in the Netherlands.

Chapter 1 offers an introduction to the subsequent chapters. First, we discuss the historical conceptualization of psychopathy as a clinical syndrome. Despite the fact that the concept of psychopathy has been obscured by a multitude of definitions, the clinical description of psychopathy provided by Cleckley (1941), reflecting both the affective and interpersonal characteristics that have traditionally been considered central to psychopathy, including egocentricity, failure to form close emotional bonds, callousness, and lack of guilt, has received widespread acceptance among contemporary researchers and clinicians.

Because traditional assessment procedures, including those based on clinical diagnosis and on self-report inventories, lacked demonstrated reliability and validity, Hare and his colleagues, expanding on Cleckley's conceptualization of psychopathy, and adding items related to antisocial behavior, developed a research tool for operationalizing the construct psychopathy — the 20-item Psychopathy Checklist-Revised (PCL-R; Hare, 1991). At least initially, factor analytic studies of the PCL-R showed that the PCL-R is composed of two distinct and moderately correlated factors. Factor 1 consists of a cluster of eight items reflecting the affective and interpersonal features (core personality traits) of psychopathy, and has been labeled "Selfish, callous and remorseless use of others". Factor 2 consists of nine items reflecting the social deviance features of psychopathy and has been labeled "Chronically unstable and antisocial lifestyle" (Hare, 1991). The remaining three items of the PCL-R did not load on either factor. Recently, however, several authors have suggested that a three-factor model that only uses the 13 items of the PCL-R that deal with personality traits (rather than delinquency and social deviance) might actually provide a better fit than the traditional two-factor model (Cooke & Michie, 2001; see also Skeem, Mulvey, & Grisso, 2003).

Each of the PCL-R items is scored on a 3-point ordinal scale (0 = item does not apply, 1 = item applies to a certain extent, 2 = item definitely applies), according to the
scoring criteria contained in the PCL-R administration and scoring manual (Hare, 1991). Examiners should score each of the 20 PCL-R items on the basis of the individual’s lifetime functioning. The total score can range from 0 to 40, reflecting the degree to which an individual resembles the prototypical psychopath. Hare (1991) suggested a cutoff score of 30 or more to assign a clinical diagnosis of psychopathy. In European research, however, a cutoff score of 26 is often used. Therefore, in our studies, we also used a cutoff of 26 to assign a clinical diagnosis of psychopathy (see Chapters 3-7).

The PCL-R has been rapidly adopted by numerous researchers and clinicians as the gold standard in psychopathy assessment. We review research examining the validity of the PCL-R in terms of covariation with psychological measures and psychophysiological processes. Empirical studies provide evidence that psychopathic individuals show a variety of neurocognitive abnormalities. Studies have uncovered impairments in fear conditioning, startle reflex priming, response modulation, linguistic processing, and autonomic responding to distress cues. Currently, psychopathy is linked to dysfunctioning in the amygdala and the orbitofrontal cortex.

The PCL-R has utility in the prediction of institutional misbehavior in residential settings in a variety of samples of adult male prisoners and forensic psychiatric patients. Moreover, in general, those who score high on the PCL-R show a distinctly negative response to treatment. Finally, research studies generally found that the PCL-R consistently predicts different types (i.e., sexual, violent, general) of recidivism across various clinical settings and samples, including male prison inmates, forensic psychiatric patients and adolescent (sex) offenders. The robust association between PCL-R psychopathy and future violence is evident even after controlling for traditional risk factors that may confound the relationship (e.g., criminal history and/or demographic characteristics).

Next, the main research questions addressed in this thesis are outlined, and the setting where the research was conducted, the Dr. Henri van der Hoeven Kliniek in Utrecht, the Netherlands, is described in some detail — with special reference to psychological assessment procedures used to periodically evaluate treatment progress.

In Chapter 2, we describe a special provision in the Dutch criminal code that allows for a period of treatment (custodial care) following a prison sentence for mentally
disordered offenders: *Terbeschikkingstelling* (TBS-order), which can be translated as ‘disposal to be treated on behalf of the state’. The purpose of TBS is to protect society from unacceptably high risks of recidivism, directly through involuntary admission to a forensic psychiatric hospital, and indirectly through the treatment provided there. Theoretically, treatment under the TBS-order is of indefinite duration if the offender continues to pose a risk to society. Every one or two years the court re-evaluates the patient in order to determine whether the risk of (violent) recidivism is still too high and treatment needs to be continued.

In Chapters 3-7 empirical studies are described. Chapter 3 concerns a study examining the reliability and factor structure of the Dutch language version of the PCL-R. In addition, the potential role of two different information sources for scoring the PCL-R, real-life interview versus videotaped interview, was evaluated. Results indicated that the interrater reliability of individual items and of the PCL-R total score was good to excellent. Good agreement on the categorical diagnosis of psychopathy was also obtained (weighted Cohen’s κ = .63 for simultaneous comparison of three raters). The internal consistency of the PCL-R was high, as indicated by a Cronbach’s alpha of 0.87, with an alpha of 0.83 for both Factor 1 and Factor 2. Comparisons between real-life and videotaped interview demonstrated that the information source did not influence the raters’ coding. Confirmatory factor analysis (CFA) indicated that the two-factor structure obtained by Hare (1991) in the standardization samples did not fit the current data well. CFA also failed to confirm the three-factor model identified by Cooke and Michie (2001). Exploratory principal components analysis using oblique rotation extracted two main factors, which accounted for 44% of the variance. It is concluded that the Dutch language version of the PCL-R can be reliably rated by trained professionals, its factor structure resembles the traditional two-factor model to some extent, and future research should include larger samples of different populations such as prisoners and general psychiatric patients.

In Chapter 4, the association between PCL-R psychopathy and mental disorders defined according to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) was examined. Axis I diagnoses were lifetime diagnoses based on consensus between four independent raters. The Structured Interview for DSM-IV
Disorders of Personality (SIDP-IV) was used for the assessment of Axis II disorders. The overall psychiatric morbidity in the sample was high; co-morbidity was the rule, regardless of the degree of PCL-R psychopathy. Psychopathy was significantly positively related to non-alcohol substance use disorders, antisocial and other Cluster B personality disorder (PD). Eighty-eight percent of patients with a PCL-R score ≥ 26 had a DSM-IV antisocial PD; 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 (< 15 years) and antisocial behavior since age 15. In general, results are consistent with previous research, providing further evidence for the cross-cultural stability of the PCL-R.

The purpose of the research described in Chapter 5 was to study the predictive validity of the PCL-R by examining the relationship between PCL-R scores and various types of institutional misbehavior. From daily hospital information bulletins, incidents of verbal abuse, verbal threat, physical violence and violation of hospital rules were derived. Also, the number of seclusion episodes was recorded. Significant correlations were found between PCL-R scores and verbal abuse, verbal threat, violation of rules, total number of incidents, and frequency of seclusion. Psychopaths (PCL-R ≥ 26) were significantly more often involved in incidents than nonpsychopaths. Multiple regression analyses revealed that the PCL-R Factor 2 score in particular contributed uniquely to the prediction of the total number of incidents. Administration of the PCL-R at admission may enable hospital staff to make appropriate initial placements with respect to treatment needs as well as disruptive potential; PCL-R psychopaths undermine the treatment milieu, specifically through verbal aggression and violation of hospital rules, and treatment and management of this patient group should focus on their impulsivity, lack of behavioral control and sensation seeking tendency.

The main objective of the study presented in Chapter 6 was to measure treatment outcome by change in indices of dynamic risk factors (i.e., impulsivity, lack of insight, anger, egocentrism, stress tolerance, negative attitudes). It was hypothesized that patients identified as psychopathic would score more unfavorable on indicators of dynamic risk than nonpsychopathic offenders, upon admission to the hospital. In addition, psychopathic patients were expected to show more limited improvement after 20 months of inpatient treatment than nonpsychopathic offenders. Also, the relationship between psychopathy and
treatment compliance, as indicated by the attendance rate of therapeutic activities, was investigated. Results indicated that the total patient sample showed limited improvement on indicators of dynamic risk, using different assessment techniques. Psychopathy (PCL-R score ≥ 26) was significantly related to pathology on a limited number of indicators of dynamic risk. Contrary to our hypothesis, psychopathy was not found to be significantly related to change scores on any of the indicators of dynamic risk. However, psychopaths did show the expected pattern of treatment noncompliance, compared to nonpsychopaths. Psychopathy was significantly associated with a lower level of involvement in treatment activities such as education and work. Especially Factor 2 was negatively associated with treatment involvement. It is argued that lack of progress should not be too easily attributed to psychopathy, and psychopathic patients should not be excluded from forensic inpatient treatment in advance.

In Chapter 7, the role of psychopathy and sexual deviance in predicting recidivism in a sample of 94 rapists involuntarily admitted to the Dr. Henri van der Hoeven Kliniek between 1975 and 1996, was investigated. The predictive utility of grouping offenders based on combinations of psychopathy and sexual deviance was also investigated. Furthermore, we explored the relationship between PCL-R scores and serious institutional misbehavior (i.e., unauthorized absence, physical violence, alcohol/drug use, and episodes of seclusion). Base rates for sexual, violent nonsexual, violent (including sexual) and general recidivism were 34%, 47%, 54%, and 71%, respectively. Receiver Operating Characteristic (ROC) analyses provided moderate to strong support for the predictive validity of the PCL-R for inpatient disruptive behavior and recidivism outcomes. Patients scoring high on the PCL-R (≥ 26) were more likely than other patients to be reconvicted for a sexual, violent nonsexual or general offense. Survival analyses provided strong 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 not all rapists are equally likely to reoffend, and comprehensive risk assessment should consider the combination of psychopathy and sexual deviance. Further research is needed to determine whether these factors are changeable by treatment.
Chapter 8 concludes the present thesis. The major findings are discussed, a critical analysis of the thesis is presented, recommendations for clinical practice are given, and suggestions for further research on psychopathy are outlined. Finally, some of the concerns about the potential misuse of the PCL-R are briefly discussed.