

## Chapter 7

# Psychopathy and Risk of Violence: Assessment and Management

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The concept of psychopathy is poorly understood and characterised by stereotypes, such as Dr Hannibal Lector from the film *Silence of the Lambs*. This distorted image affects both lay people, as well as many health professionals. Moreover, having a belief in such stereotypes means you will miss 90% of psychopathic individuals who do not tend to be highly intelligent, urbane, educated, and only of European ethnicity. Criminal psychopaths display diverse chronic antisocial behaviour as their characteristic adaptation to society, with crimes marked by violence and a lack of remorse or empathy, but not typically cannibalism!

This chapter is intended to provide a brief background to the reader of the operationalisation of the concept, the utility of psychopathy in risk assessment, as well as discussing the controversy its clinical use has produced. Empirical support for the appropriate use of measures of psychopathy with a variety of forensic and offender populations will be presented, using where possible New Zealand research. Finally, the implications of psychopathy for the management and treatment of antisocial behaviour is discussed with a behavioural focus on changing the adaptation of the individual rather than core psychopathic personality traits.

### **What is Psychopathy?**

Psychopathic individuals are not a product of the 20th Century motion picture industry, with historical sources as far back as Aristotle, across cultures, reporting people who have committed acts of extreme antisocial behaviour, seemingly without remorse or guilt (Hare, 1970). However, while society prior to the 19th Century labelled such behaviour as “evil”, a label still used to this day, there was no clinical tradition of research into the psychological characteristics that might be present in these individuals. In fact, for many years criminologists dismissed the concept of psychopathy as a mythical entity or indeed a media derived monster, until Cleckley in the 1940's, and then Hare in the 1970's provided an assessment framework (Hart & Hare, 1996).

Cleckley's *The Mask of Sanity* (1941/1988) was the first attempt to operationalise the concept of psychopathy (Hare, 1970). Cleckley noted in his well known publication, *The Mask of Sanity*, that he had been astonished at the lack of material and research into individuals displaying psychopathic behaviour prior to his own investigations. From his extensive clinical observations of patients committed to psychiatric hospitals, Cleckley identified 16 factors that he considered constituted the main features of psychopathy:

“Superficial charm and good intelligence; absence of delusions and other signs of irrational thinking; absence of “nervousness” or psychoneurotic manifestations; unreliability; untruthfulness and insincerity, lack of remorse or shame; inadequately motivated antisocial behaviour; poor judgement and failure to learn from experience, pathological egocentricity and incapacity for love; general poverty in major affective reactions; specific loss of insight; unresponsiveness in general interpersonal relations; fantastic and uninviting behaviour with alcohol (and sometimes without); suicide rarely carried out; sex life impersonal, trivial, and poorly integrated; and failure to follow any life plan” (Cleckley, 1941:1988, p.337-338).

However, because few in Cleckley's mental health institution research population were criminals, his criteria tended to identify the “con artist” and hedonist, rather than those with extreme or violent chronic antisocial behaviour. This of course is the social adaptation of most interest for those seeking to predict and manage serious violent behaviour. In fact, Cleckley commented that only a small proportion of typical psychopathic individuals were likely to be found in penal institutions, as they did not tend to commit major offences and had the ability in the main to escape legal punishments and restraints. This observation on an ability to escape consequences may explain the inclusion of ‘good’ intelligence in Cleckley's criteria. The reality is that psychopaths have the same range of IQ as the normal population. Thus, the majority being assessed in the IQ range 85-115, and while they may believe they are brighter than others, they do make mistakes, and are usually detected and convicted by judicial authorities. Therefore, Cleckley's observations, while a valuable and helpful guide, did not indicate a theory to explain the behaviour, or a valid and reliable assessment approach for those of most concern, individuals meeting the criteria for psychopathy who commit serious crimes.

The clinical utility of psychopathy became further confused by the creation of diagnostic criteria for antisocial personality disorder (APD) in the second edition of the Diagnostic and Statistical Manual (DSM:II; APA 1968), without reference to the core interpersonal and affective deficits identified by Cleckley. Antisocial personality has long been linked to a higher risk of criminal behaviour (Andrews & Bonta, 2003). However, a distinction

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needs to be made between those meeting the diagnostic criteria for criminal psychopathy, and the population of manifestly similar individuals labelled with APD using the diagnostic criteria listed in the DSM-IV (APA, 1994).

Those attempting to understand psychopathy are often confused by the variety of clinical descriptors for what appears to be the same construct, APD, sociopath, or dyssocial personality disorder (Hare, Hart, & Harpur, 1991). These labels are all intended to refer to the same personality construct, with those identified as meeting the criteria for psychopathy usually fitting that for APD and dyssocial disorder (Lykken, 1995). In fact, it is estimated that 80% of inmates in prison usually meet the criteria for antisocial personality disorder, while only a small proportion, approximately 10% of these, would meet the criteria for psychopathy (Hare, 2003).

In a New Zealand study into the characteristics of 150 high risk offenders, 60% of the sample had the presence or prominence of APD (Wilson, 2004). Therefore, to maintain the focus on the highest risk offenders, a distinction needs to be made on the basis of the initiating and maintaining factors for the antisocial behaviour, to identify stable predictive variables. Individuals whose antisocial behaviour can be traced to neurotic motivations or sociological forces are not considered psychopathic, as they lack the primary affective deficits, and often have some insight into the need to change (Reise & Oliver, 1994). However, this does not mean they are not at risk of serious violent offending, rather that other risk factors reliably inform on their risk and they may not have the same management difficulties or responsivity barriers to therapeutic change.

### **Assessment of Psychopathic Traits**

The concept of criminal psychopathy and its link to the prediction of risk of violence is a relatively recent assessment challenge for mental health professionals. While psychopathy as a personality construct is not recent, it has only been the publication of the Psychopathy Checklist-Revised (PCL-R) in 1991 by Dr Robert Hare, that has provided a reliable and valid clinical assessment tool. The introduction of the Psychopathy Checklist: Screening Version (PCL:SV) (Hart, Cox, & Hare, 1995), and recently the Psychopathy Checklist- Youth Version (PCL-YV) (Forth, Kosson, & Hare, 2003) has expanded the range of reliable measures for forensic and youth populations.

While all are reliable and valid measures of psychopathic traits and serious recidivism, only the PCL-R is able to diagnose an individual as psychopathic. However, the utility of the concept of psychopathy as a predictor of serious reoffending has become the main applied focus of the majority of PCL assessments,

rather than diagnosis. The difficulty with diagnosis is what does it actually mean in terms of the individual's future behaviour? In addition, pejorative connotations from the diagnostic label 'psychopath' produce resistance from mental health professionals who are concerned that those receiving such labels will be treated unfairly (Gendreau, Goggin, & Smith, 2002).

The use of the PCL score to identify individuals at high risk of recidivism does not have the same pejorative connotations as diagnosis. Indeed, risk is a concept that the judicial authorities are able to understand and value, and clinicians equipped to defend. Moreover, even those who are some of the sternest critics of the use of the PCL measures, acknowledge that it does identify something unique in the prediction of serious recidivism (Gendreau et al., 2002). It is therefore not surprising that other risk measures have included items assessing similar personality and behavioural factors as those included in the PCL measures (Gendreau et al., 2002; Hemphill & Hare, 2004). There is also a strong element for those opposing the use of the PCL measures of 'shooting the messenger' by seeking to throw doubt on its robust predictive accuracy (Freedman, 2001). However, this is a not uncommon defence reaction to the increased use of actuarial and structured measures for risk prediction, especially with the increased accuracy these approaches have delivered.

The very success of the PCL measures in predicting serious violent behaviour has attracted fierce and often emotional, rather than factual, opposition to the use of psychopathy in predicting risk. Due to the strong opposition to the PCL measures from defence counsel, clinicians need to be well prepared in terms of their understanding of the literature, and the statistical evidence supporting the reliability and validity of the measure, most importantly in terms of the predictive validity of the PCL measures in relation to risk of violence. It is also recommended that clinicians in interpreting PCL score acknowledge predictive limitations, use multiple risk assessment strategies, and make only conditional probability statements (Serin & Brown, 2000).

This chapter is designed to introduce the reader to the concept of psychopathy, its strong predictive ability for violent behaviour, and how it can be assessed using the PCL measures. However, it is important to note that the use of the PCL-R and its derivatives requires specific clinical qualifications and training, as specified by the test publisher, Multi-Health Systems. This is due to concerns over the serious implications for individuals subject to such assessments, as well as the risks to public safety from incompetent application of the scoring protocols. The test publisher guidelines designed to address these concerns are (Hare, 2003):

- PCL test administrators must have an advanced degree in the social, medical or behavioural sciences, such as such as PhD, D.Ed, or MD1.
- Must be registered with a registration body that regulates the assessment and diagnosis of mental disorder (e.g., psychological or psychiatric association). For New Zealand purposes this is believed to require registration as a psychiatrist or psychologist
- Have experience with forensic populations. This in general means completion of a practicum or internship in a clinical-forensic setting, or at least two years of relevant work-related experience
- Have attended an intensive workshop on the theory of psychopathy, the psychometric properties of the PCL instruments, and undertaken practice scoring of the PCL measures. Hare (1970) identified the difficulties faced in the assessment of individuals for psychopathy using unstructured clinical interview or self-report inventories. Although it is important to acknowledge that structured expert clinical judgement is part of the structured assessment approach of the PCL instruments (Serin & Brown, 2000). The PCL instruments are considered superior to self-report inventories, as they allow the objective structured assessment of interpersonal/affective characteristics of psychopathy, and are not reliant on full or actual co-operation from offenders/patients (Edens, Buffington, Tomicic, & Riley, 2001; Hare, 1985).

Health professionals working with offenders or those with patterns of antisocial behaviour, quickly become aware that impression management, and minimization, or indeed denial of intent for criminal behaviour heavily biases information from clinical interview. In fact, the PCL instruments can be reliably scored solely from collateral information of sufficient high quality (includes both file and the report of those who have had reliable contact with the client), but not from clinical interview alone. It is important to note that a considerable amount of the research on the predictive validity of the PCL measures comes from file only scored measures. Those reporting on PCL assessment scored solely from collateral sources need to indicate that interview did not take place. Reports should note that scores for items relating to interpersonal and affective deficits will be lower without the opportunity to interact with the person being assessed (Hare, 2003). Thus, PCL assessments based solely on collateral sources are likely to slightly under-estimate an individual's risk of serious recidivism.

The manuals for the PCL measures emphasise that conflicts between client interview information and collateral sources should be resolved through reliance on collateral sources, unless interview information is supported from other reliable sources. In addition, the assessment should weight evidence of patterns of behaviour, over short term change, even that observed in therapeutic settings. Change should only be viewed as reliable for items relating to socially

deviant and criminal behaviour, if present for five years or more. Thus, the PCL instruments while useful in assessing barriers to treatment are not recommended as accurate measures of behaviour change across treatment. The author has found in supervising a large number of PCL post treatment assessments that treating clinicians are often heavily influenced by short term prosocial change within therapy.

**The Psychopathy Checklist-Revised:** The 20 item PCL-R (scored on an ordinal scale, 0, 1, or 2), a score range of 0-40, with a score of 30 (plus or minus 3 [SEM]) or more identified in the manual as indicating the presence of criminal psychopathy (Hare, 2003). All PCL measures have a two-factor design, Factor 1 reflecting interpersonal and affective deficits (i.e., superficiality, grandiosity, lack of remorse and empathy) while Factor 2 relates to the display of socially deviant behaviour (i.e., impulsivity, poor behavioural controls and lifelong versatile antisocial behaviour), and is similar to the criteria for antisocial personality disorder (Hare, 1991). Factor 2 items closely match the DSM-IV criteria for antisocial personality disorder (APA, 1994), reflecting an impulsive, nomadic, irresponsible lifestyle with a persistent display of overt antisocial behaviour, and constitute a measure of the socially deviant components of psychopathy.

The PCL-R items were formed from Cleckley's 16 classic criteria with the inclusion of a number of items that identify chronic patterns of criminal behaviour. The PCL-R items listed in Table 1 have a great deal of face validity and explain why the PCL instruments, while not designed to assess risk of reoffending, are based on recognised theoretical explanations of criminal offending (Bonta, 2002), namely, past criminal behaviour being a good predictor of future offending, and antisocial personality (risk taking, impulsivity, etc) being linked to future persistent antisocial behaviour. The PCL-R has been extensively tested and has adequate internal consistency (alpha coefficient for pooled prison samples = .87), as well as high inter rater (prison inmates, average

**Table 1 — Psychopathy Checklist-Revised Items**

1. Glibness/Superficial charm	11. Promiscuous Sexual Behavior
2. Grandiose Sense of Self Worth	12. Early Behavioral Problems
3. Need for Stimulation/Proneness to Boredom	13. Lack of Realistic Long-Term Goals
4. Pathological Lying	14. Impulsivity
5. Conning/Manipulative	15. Irresponsibility
6. Lack of Remorse or Guilt	16. Failure to Accept Responsibility
7. Shallow Affect	17. Many Short-Term Marital Relationships
8. Callous/Lack of Empathy	18. Juvenile Delinquency
9. Parasitic Lifestyle	19. Revocation of conditional release
10. Poor Behavioral Controls	20. Criminal versatility

for two raters  $r = .91$ ), and test-retest ( $r = .94$ ), reliability (Cooke & Michie, 1997; Harris, Rice, & Quinsey, 1994). It has also been found to be effective with adult male and female forensic and criminal populations.

## Culture

The psychometric properties of the PCL instruments appear to be stable across cultures and not just applicable to criminal populations of European descent (Hare, 1985; 2003). In fact, there are clear parallels in vastly different cultures to the Western concept of psychopathy. The Yoruba tribe from Nigeria describe a person who goes his own way regardless of others, who is uncooperative, full of malice, and bullheaded (Raine, 1993). One of the best general descriptions of psychopathic behaviour comes from the Eskimo or Inuit people where they describe some tribe members as “his mind know what to do but he does not do it, applied to man who repeatedly lies and cheats and steals things and does not go hunting and when the other men are out of the village takes sexual advantage of many women, does not attend to reprimands and is always brought to elders for punishment” (Raine, 1993 p.35). It is noted that the Inuit strategy in dealing with such individuals is to “take them hunting and when no one looking push off ice”!

Discussion with Māori who work with offenders by the author on the relevance of the concept of psychopathy brought acknowledgement that they have descriptors within Maori culture for such individuals who present with psychopathic behaviour. They refer to these individuals as being black inside, and that they have dead eyes, with no wairua or spirit, who are tika (external), rather than pono (internal) in presentation. While some also felt that many also worked for government departments or were indeed members of parliament, this was not felt to be a reliable descriptive variable!

New Zealand research (Wilson, 2003) did not find any cultural bias in item ratings between Maori and European subjects using the PCL:SV, possibly due to the study assessors being trained to identify superficial and grandiose behaviour for a New Zealand context. The PCL items relating to effective superficial presentations and recognised grandiose behaviour are those most subject to cultural bias in assessment. Examples of unique New Zealand superficial presentations are ‘a good keen man’ (‘larrikin’ in Australia!) or asserting kaumatua status when this is not confirmed by appropriate cultural assessment. In terms of grandiosity, again it is necessary to make a within group comparison. This ensures that the rater does not rely solely on the PCL Manual’s North American item descriptors, to ensure those from New Zealand with high but unstable self-esteem, displayed perhaps in entitlement beliefs and behaviour rather than verbal boasting, are not underscored.

Moreover, a further study by Cooke and his colleagues that compared PCL-R ratings from 359 Caucasian and 356 African American participants found no cross group differences in factor structure, indicating that the structure of psychopathy was the same for both ethnic groups (Cooke, Kosson, & Michie, 2001). While this study also found small but significant differences in the performance of five of the 20 items between the groups, these items differences cancelled each other out when the test functioning was examined, thus providing support that the PCL-R can be used in an unbiased way with African American participants.

## **Psychopathy and violence**

The huge increase in research in the area of criminal psychopathy and the applied use of the concept of psychopathy to the prediction of criminal behaviour and violence since 1991 has surprised many in the field of forensic and criminal psychology. While the PCL-R, and the PCL:SV were not designed to assess risk of reoffending, the last 12 years have seen them become robust predictors of serious violent behaviour. This predictive accuracy for the PCL measures has been found across a range of offender and forensic patient groups, as well as male and females, from adolescents to the aged.

When the focus is specifically on offenders who are psychopathic, the correlation to serious recidivism is high. A summary of criminal reoffending prediction literature by Salekin, Rogers, and Sewell (1996) looked at 29 studies that had included psychopathy as a risk variable for sexual recidivism ( $r = .27$ ), while for general recidivism this increased to  $.32$  when violence was the outcome variable. However, the next question for clinicians and others involved in assessing risk of further violent behaviour is, how do you use the concept of psychopathy in explaining risk?

## **Why Does Psychopathy Predict Violence?**

In looking at why measures of psychopathy predict violence, it is important to consider that psychopathic violence has marked quantitative differences. These differences relate to the PCL Factor 1 items that measure interpersonal and affective deficits, with Factor 2 scores predicting general violence based on previous chronic antisocial behaviour (Hare, 1996). Psychopathic violence is more likely to be predatory in nature, characterised by intentful, planned use of violence to obtain readily identifiable goals that relate to the offender's desires and rights (Hare, 2003).

Instrumental violence is designed to gain access, compliance, or to escape negative consequences for antisocial acts. This does not mean that there is



no anger or frustration displayed, but rather that such affect is intended to intimidate, or is superficial in nature, almost hyperarousal rather than rage, and over quickly. Research has established that instrumental violence predicts a higher risk of further violence due both to the endorsement of inappropriate beliefs about the effectiveness of violence and the affective deficits that serve to disinhibit to the effects of injury and distress on victim(s) (Cornell et al., 1996). Indeed, many will attempt to present their violence as reactive rather than instrumental in an effort to hide the calculated nature of their violence. Violent acts by those with psychopathic traits are also typically carried out in a callous, calculated manner, without the deep emotional context that usually characterises the violence of other offenders (Williamson, Hare, & Wong, 1987).

Hare and McPherson (1984) reported that psychopaths were more likely than non-psychopaths to commit armed robbery, assault, and possess and use a weapon. However, they differed in having lower rates for murder. Williamson et al. (1987) explained this difference in terms of motivation. They found that psychopaths committed violent crime for material gain, whereas non-psychopaths were motivated by strong emotional arousal. Such strong emotional arousal (rage) was linked to frenzied attacks in which murder victims were bludgeoned or stabbed or shot multiple times resulting in a disorganised crime scene. They also found that psychopaths differed from non-psychopaths in that their victims tended to be strangers. This use of instrumental aggression for goal-orientated purposes was confirmed in a study by Cornell et al. (1996). This study found that instrumental offenders could be reliably distinguished from reactive offenders on the basis of level of psychopathy.

Serin (1991) conducted a study that confirmed the strong relation between violent behaviour and psychopathy. When he compared violent psychopaths and violent non-psychopaths he found that psychopaths had a greater likelihood of using instrumental aggression, threats, and weapons. Psychopaths were found to attribute more hostile intent to others, either in the community or in prison, and had criminal and institutional misconduct histories that featured impulsive, predatory, and varied violent crimes (Hare, 1991; 2001).

The link between psychopathy and serious chronic institutional misconduct was also found in New Zealand research where those with high PCL:SV scores had higher rates of violent misconducts, over time with little response to escalating punishment regimes by prison management (Wilson & Coldham-Fussell, 2000). This study also found behaviour tended to be 'anti-authoritarian' and 'status-seeking'. Prison misconducts identified as being anti-authoritarian in function included acts such as aggression, violence, and verbal abuse when charged, ordered, or reprimanded, and aggression

and defiance when thwarted. Anti-authoritarian prisoners reflected the traits of grandiosity, poor anger control, and impulsive behaviour. Status-seeking behaviour reflected the desire to be seen as 'better' than those around them. The chronic misconduct group also justified their antisocial behaviour when asked for an explanation, thus reflecting a consistent failure to take responsibility for their behaviour.

A study by Serin (1996) followed up a sample of 18-59 yr old offenders (N = 81) assessed with the PCL-R and a number of actuarial risk measures based on static predictors for an average of 30 months. The recommittal or general recidivism rate for the entire sample was 57%, and the violent recidivism rate was 10%. While all instruments were significantly correlated with general recidivism, the PCL-R was the best predictor of violent recidivism. Compared to the other actuarial scales, the PCL-R had a higher predictive efficiency (Relative Improvement Over Chance) and yielded fewer decision errors. Most importantly, Factor 1 of the PCL-R was a better predictor of violent recidivism than Factor 2, suggesting that the core trait construct of psychopathy makes a unique contribution to the prediction of violent recidivism.

## **New Zealand Research into The Ability of the PCL to Predict Violence**

The only large scale research in New Zealand into the predictive validity of the PCL measures involved the PCL:SV rather than the PCL-R (Wilson, 2003). The PCL:SV is recognised as a measure with excellent psychometric properties in relation to reliability and validity. It has that same scoring and factor structure as the PCL-R, with a score range of 0-24, and 12 items instead 20 for the full PCL measure (Hart et al., 1995). Its ability to assess psychopathy from total scores has been found to be so "strongly and linearly related to the PCL-R total scores that the scales can be considered metrically equivalent measures of the same psychological construct" (Cooke, Michie, Hart, & Hare, 1999, p. 11).

While most of the literature about psychopathy and risk of recidivism and violence comes from studies involving the PCL-R there is rapidly accumulating evidence of the ability of the PCL: SV to predict aggression and violence in forensic populations and criminal populations (Hart, 1998). Hill, Rodgers, and Bickford (1996) found that scores on the PCL: SV correlated .69 with aggressive behaviour after release and individuals with high scores had a higher mean number of institutional incidents. A further study found that a PCL: SV group classified as psychopathic were 9.9 times more likely to be arrested for a violent crime than a non-psychopathic group (Douglas, Ogloff, & Nicholls, 1997). An article generated from the MacArthur Violence Risk Assessment Study (N = 1,136) confirmed that

the PCL: SV was a strong predictor of violence (individuals with scores of over 12 were four times more likely to commit a violent act) although the predictive power was reduced after controlling covariate antisocial behaviour and comorbid personality disorders (Skeem & Mulvey, 2001).

***Ability of the PCL:SV to Predict Violence in New Zealand:***

The author of this chapter in a study towards his PhD, set out to establish whether the PCL: SV was an effective predictor of serious reoffending for a New Zealand criminal population (Wilson, 2003). The majority of the men included in this study (N = 199) had been imprisoned for violent crimes, most were middle aged when released, with approximately half identified by file information as of Māori descent, the majority of the rest were European. The sample had high mean scores for the PCL: SV, with 34% rated as likely to be diagnosed as psychopathic if subject to a full PCL-R assessment. This high percentage of probable psychopathic offenders, over a third, was similar to that found in international research using equivalent serious offender samples.

The scores from two other validated actuarial risk measures, both scored from an analysis of previous official criminal history, were compared with the PCL:SV scores. All the measures correlated with each other, and with the recidivism variables relating to time to reconviction or reimprisonment. The PCL:SV total, Factor 1, and Factor 2 scores correlated .50, .37, and .47, respectively, with reconviction, and .49, .40, and .47, with reimprisonment. Analysis of the reoffending by the sample for a five-year period found a high rate of reconviction (71%) and reimprisonment (38%), with the majority of recidivism occurring within two years of release for serious violent offences. An examination of recidivism over time using survival analysis confirmed this pattern of serious reoffending within a relatively short time of release into the community. Survival analysis also confirmed that the reimprisonment group appeared stable in size after four years, with the majority of serious failure captured in this time period (see Figure 1).

The ability of the study risk measures, and in particular the accuracy of the PCL: SV, in predicting serious recidivism was examined. Significant mean score differences were found for PCL:SV scores for the reimprisonment and non-reimprisonment groups. In addition, the reimprisonment group were found to be significantly younger, with more of the serious recidivists of Māori descent. The score distributions for the PCL:SV were used to generate reimprisonment risk cut-off criteria, taking into account the best balance between the false positive and false negative decision error rates. A PCL: SV total score of  $\geq 16$  (false negative decision error = 24%; false positive decision error = 25%) was found to be the best cut-off criterion to identify those at higher risk of serious violent reoffending (see Figure 1).

An analysis of the type of recidivism that was punished by sentences of reimprisonment for the sample confirmed the serious nature of the reoffending. The majority (79%) committed violent offences, with 59% reimprisoned for very serious violent acts, including a number of murders. A strong relationship was found between the PCL: SV scores and longer sentences and shorter time to reoffending.

While the PCL:SV total score of 16 appeared the best cut-off score in determining a high risk group in the study, the individual PCL:SV score rates of serious reoffending were plotted in Figure 2. This enables the relationship between serious reoffending and the PCL: SV scores to be shown for the five year follow-up period. Figure 2 indicates that none of the sample with low scores in the 1-6 range were reimprisoned. There was a sharp increase in the rate of reimprisonment after 16 with this levelling off at approximately 70% after 19, through to a high of 80% for the top score of 24.

The other significant relationship of note for the PCL:SV New Zealand research related to time to reimprisonment ( $r = -.41$ ). Regression eliminated all study risk measures except for high PCL: SV Factor 1 scores (8-12) indicating a relationship with speed of violent recidivism. There is a need for conditional risk statements to take account of the time period in which an individual is at high risk in making a risk parameter statement. Information on high Factor 1 scores provides actuarial support to such assessment of the probability that an individual will commit a serious violent offence within a short time of release from an institution. This information can be used to increase supervision/management of the individual in a targeted approach or to delay release if their risk is deemed too high by a parole or release authority.

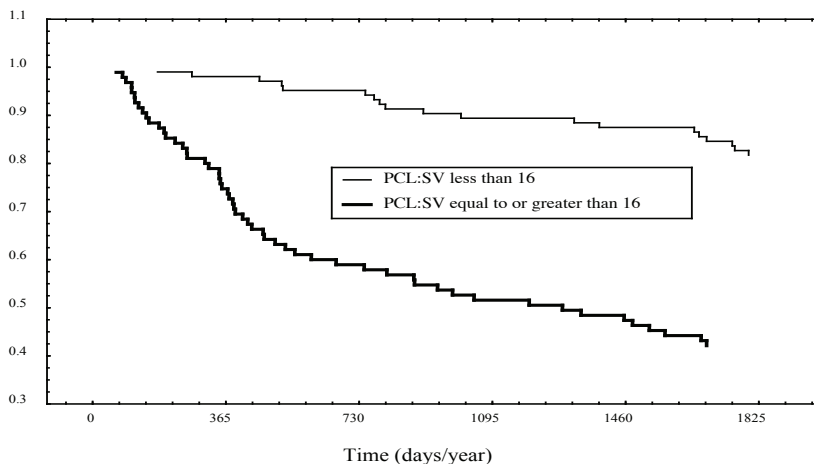
Splitting the reimprisonment sample into high and low risk groups based on PCL: SV scores produced clear graphic evidence of the differential for the higher risk group for higher percentage of serious recidivism and rate of reoffending (see Figure 1). Finally, in relation to the accuracy of the instruments, ROC analysis was used to provide an estimation of measure accuracy. This found that the PCL: SV had a high degree of predictive validity for serious violent reoffending using Receiver Operator Curve analysis ( $AUC = .80$  or overall 80% accuracy).

Odds ratio analysis is also typically used to provide easily understood information on the increased risk individuals have who score over the mean on a measure. The odds ratio is a non-parametric test that calculates the odds of a 0-1 categorised dependent variable occurring for an independent variable determined by those above or below the mean of the relevant measure. Those scoring over the mean score for the PCL: SV (14), were eight times more likely to be reconvicted and six times more likely to be reimprisoned (the majority for violence).

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**Figure 1.**

Comparison of proportion surviving reimprisonment based on PCL: SV score cut-off (Lower risk <16, Higher risk  $\geq$ 16).



In conclusion, this New Zealand study supported that the PCL: SV is able to predict reimprisonment with a high level of accuracy, a level that is accepted as providing accurate evidence for assessment of risk for forensic and judicial settings (Hare, 2003). It compared well to the current New Zealand Corrections Department computer generated measure, (RoC\*RoI) which uses a number of static risk predictors sourced from computerised criminal history records. The PCL: SV, which has both stable and dynamic variables, was found to be as accurate as the purely static measure. In addition, the PCL: SV Factor 1 score was able to demonstrate a unique strong relationship with speed of violent recidivism. The ability of the PCL: SV to add support to the prediction of recidivism risk by supporting measures reliant on static factors provides further support for psychopathic personality as a valid predictor of reoffending.

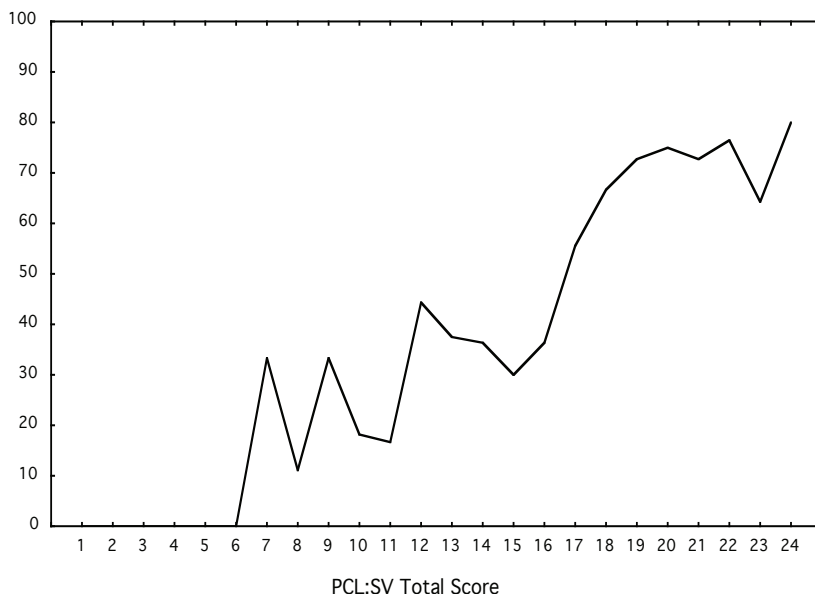
## **PCL Measures and Risk of Violence in Female, Forensic, and Youth Populations**

### ***Female Antisocial Populations:***

While there is no New Zealand normative data available as yet for any of the PCL measures for female offenders, there is a considerable international

**Figure 2.**

Rates of reimprisonment for study participants at each PCL: SV total score for a five year follow up period



female sample available for comparison purposes ( $N = 1218$ ) (Hare, 2003). Most of this sample came from a study of 528 non-psychotic female inmates (Vitale, Smith, Brinkley, & Newman, 2002). This study by Vitale and her colleagues found that the PCL-R was able to identify a group of offenders who met the criteria for psychopathy and who also had the predicted high recidivism risk. In a small study of released female offenders, 62% of those with high PCL-R scores ( $\geq 30$ ) reoffended within 1 year of release from prison. Another small study of general recidivism by released female offenders found moderate predictive accuracy ( $AUC = .64$ ) (Salekin, Rogers, Ustard, & Sewell, 1998). This predictive accuracy would be expected to be higher if the outcome variable was violent recidivism, as with male offender populations.

In spite of growing empirical support for the reliability and validity of the PCL-R in female offenders, assessing psychopathy as a risk factor should be done cautiously. This caution is due to the lower prevalence of psychopathy in women, the limited research to date, and higher co-morbidity with other personality pathology (Vitale et al., 2002).

### ***Mental Health Populations:***

The PCL measures have also been found to be predictive of violence (both institutional aggression and violent crime) in mental health populations, although the prevalence of the personality construct is slightly lower (Hare, 2003). While there is evidence supporting the validity of the PCL-R with mental health populations (Heilbrun et al., 1998; Hill et al., 1996) most of the predictive research has been carried out using the PCL:SV. The most famous study in this area being the MacArthur Violence Risk Assessment Study (N = 1,136), which confirmed that, the PCL: SV was a relatively strong predictor of violence for male and female adult civil psychiatric inpatients (Monahan et al., 2001). Individuals with scores of over 12, were four times more likely to commit a violent act, the single best predictor variable out of the 134 potential risk variables examined in the study. Although the predictive power was reduced after controlling covariate antisocial behaviour and comorbid personality disorders (Skeem & Mulvey, 2001).

### ***Youth Offenders:***

In the Psychopathic Checklist: Youth Version (PCL: YV) a number of items have been changed to reflect the different presentation of psychopathic traits between adolescents and adults (Forth et al., 2003). The PCL: YV has the same scoring, use of 20 items and score range as the PCL-R but cannot be used to diagnose an adolescent as psychopathic with its principal use being in risk assessment. Kosson, Cyterski, Steuerwald, Neumann, & Walker-Matthews (2002) found that the PCL: YV had high internal consistency and inter-rater agreement in a community adolescent sample. Kosson et al. also found that the PCL-YV predicted antisocial behaviour, childhood psychopathology, interpersonal behaviours associated with adult psychopathy, and a lack of attachment to parents.

The PCL: YV has also performed well in New Zealand research (Wilson & Rolleston, 2004) with a mean score (25.09) found in a sample of imprisoned youth offenders (N = 69) that was similar to male adolescents imprisoned for violence in validation studies from the manual (Forth et al., 2003). The ethnicity of the 69 participants in the New Zealand study was evenly split between European and Maori with non significant differences found for PCL:YV scores between the ethnic groups. The average age of participants was 17.5 years of age and participants had a mean sentence length of 2 years 8 months with the most frequent index offences for Aggravated Robbery followed by Dishonesty. However, when all violent and sexual crimes were added, 70% had index offences for serious violence/sexual offending.

A recent study into the predictive validity of the PCL: YV by Catchpole and Gretton (2003) for violent young offenders ( $N = 74$ ) with 54% of European descent, 29.7% of Aboriginal, 8% Asian, and 5.45 other, had a mean of 23.8 ( $SD = 6.9$ ). Of this sample 26.9% were classified as high on psychopathy (high risk) based on total scores of 30-40. The New Zealand study had 27% in this score range. Catchpole and Gretton found that the PCL: YV high risk group (scores 30-40) had a 40% violent recidivism rate within 12 months of release. Odds ratio analysis identifying this high risk group as four times more likely to commit a violent offence as others in the sample. The PCL: YV was found to have a moderate/high overall accuracy ( $AUC = .78$ ) for general offending, and for violence ( $AUC = .73$ ). While no predictive validity was able to be established in the New Zealand study due to use of a prospective design, the PCL: YV score had the highest significant correlation with previous total violent convictions ( $r = .35$ ) (Wilson & Rolleston, 2004). A similar correlation was found in a large validation study for the instrument by Forth (2002) (cited in Forth et al., 2003).

## **PCL Instruments and the Prediction of Sexual Recidivism**

Psychopathy has also been found to assist in the prediction of sexual violence. Psychopathic men often obtain sexual gratification opportunistically, regardless of whether it involves their preferred mode of sexual activity, or whether it is legal (Quinsey, Rice, & Harris, 1995). Quinsey and colleagues in a follow-up of 178 treated rapists and child sex offenders concluded that psychopathy was a good general predictor of both sexual and violent recidivism. Another study found that rapists had higher psychopathy ratings than child molesters (Serin, Malcolm, Khana, & Barbaree, 1994). However, Dorr (1998) stated that the majority of paedophiles are psychopathic, or manifest to a significant degree the psychological characteristics of psychopathy, in other words a high level of interpersonal and affective deficits. There appears to be a high rate of comorbidity between the two forms of behavioural disorder. The primary aims of the paedophile and the psychopath being viewed as the same, to dominate, to use, and to subjugate another person to seek a personal reward.

A recent review of recognised actuarial sexual risk prediction instruments found that the PCL-R score on its own was a moderate predictor of general recidivism ( $AUC = .71$ ) for a population of sex offenders who had participated in treatment, but was poor for sexual recidivism ( $AUC = .61$ ) (Barbaree, Seto, Langton, & Peacock, 2001). The best actuarial measure in predicting sexual recidivism for this sample was the Rapid Risk Assessment of Sexual Recidivism ( $AUC = .73$ ) based on four static criminal history items. It is



noted that the PCL-R is an item in the 14-item Sex Offender Risk Appraisal Guide and the 12-item Violence Risk Appraisal Guide. The single item PCL-R score has been shown to account for the majority of the predictive power of the Sex Offender Risk Appraisal Guide (Seto & Lalumiere, 2000)

Hare (2003) argued that criminal psychopaths are generalised offenders with a pervasive disregard for the rights of others and a history of versatile offending. Therefore, such offenders are unlikely to specialise in one form of offending. This factor coupled with the low base rate for sexual recidivism and judicial authorities often modifying charges to violence in response to plea-bargaining, could explain why the PCL-R is only a low-moderate predictor of sexual recidivism. Offenders with an index offence for rape in the New Zealand (31% of sample) PCL:SV study, were responsible for a significant percentage of the serious violent recidivism for non-sexual offending, and the vast majority of predatory reoffending (resulted in a Preventive Detention sentence), as well as two of the three murder convictions (Wilson, 2003).

### **Guidelines for the Use of the PCL Measures in Risk Assessment**

With the widespread use of the PCL instruments in risk assessment there is a need for clinicians and parole authorities to be aware of the limitations of the instruments (standard error of measurement, decision error rates, and appropriate validation samples). Any actuarial measure of risk used in judicial settings, such as assisting parole decision-making, or sentencing options will attract legal and ethical challenge to its use.

Therefore, mental health professionals need to attend to a series of best practice guidelines to reduce such challenge. These guidelines have been outlined for the applied use of the PCL-R in risk prediction by Serin and Brown (2000), and for recidivism assessment in general, by Bonta (2002). The first guideline is that risk assessment should be based on actuarial measures of risk rather than solely clinical judgement or unstructured or untested measures (Bonta, 2002). In fact, it is becoming established that risk assessment that fails to incorporate such measures as part of risk assessment may even be regarded as unethical or unprofessional (Grove & Meehl, 1996; Quinsey et al., 1998).

Bonta (2002) points to measures, such as the PCL-R and PCL:SV being defined by being structured, quantitative, and empirically linked to a relevant criterion. It was acknowledged by Bonta, that the PCL instruments are designed to assess antisocial traits (Factor 1) and behaviours (Factor 2). In addition, Andrews and Bonta (2003) confirmed that the PCL instruments have theoretical support from a perspective with the most empirical support, the personality and social model of criminal behaviour.

The next guideline proposed by Bonta (2002) is that any measure used for risk assessment must demonstrate predictive validity. In other words it must be evaluated on its ability to predict particular recidivism outcomes such as reimprisonment. In addition, such validation should have been carried out using an offender population (age, ethnicity, index offending etc) that is applicable to the one to whom you propose to administer the PCL-R or PCL: SV (Serin & Brown, 2000). Bonta (2002) states that general personality measures should not be used for risk assessment that were not specifically designed to predict criminal/violent behaviour, such as the MMPI or MCMI-III.

As it is accepted that criminal behaviour has many causes (Andrews & Bonta, 2003), it is unlikely that any one risk appraisal instrument will apply equally for all offenders and predicted outcomes (Serin & Brown, 2000). Therefore, comprehensive multi-domain assessment should be the norm in risk assessment (Bonta, 2002). The PCL measures should not be the only measure or aspect considered in assessing an individual offender's risk of recidivism. While it does assess multiple domains, interpersonal and affective deficits related to antisocial personality and previous criminal/antisocial history, it does not assess many other domains associated with criminal behaviour (Bonta, 2002). In particular, the PCL measures do not directly assess a number of dynamic risk or potential protective factors such as family/marital support, substance abuse, employment, antisocial associates, and deviant arousal. However, the use of multi-measure assessment does not necessarily mean increased precision, as the inter-correlation between such measures is high leading to possible bias from shared method variance (Serin & Brown, 2000).

This leads on to my final point that the PCL measures should only be used to support conditional risk prediction statements. No one is at risk of committing any offence, twenty-four hours a day, in all settings (Ogloff, 1995). In interpreting a high score on the PCL measures, no static predictions of risk should be made, for example, 'John' will always be at high risk of violent reoffending. Risk is not a static entity alone and a number of dynamic predictors and clinical factors exist that identify exacerbating and resilience factors and situations (Andrews & Bonta, 2003).

## **Management Issues**

### ***Psychopathy and Criminal Careers:***

Criminal psychopaths have been described as typically making an early start to their criminal careers (Lynam, 1996; 1998) with an apparent reduction in offending after the age of 40 (Hare, McPherson, & Forth, 1988). Several

authors propose that psychopaths eventually 'burn out' or stop offending sometime between 25 to 30 years of age (Hare, 1993). However, this phenomenon appears to reflect a loss of physical strength (or disability from engagement in high risk activities), long incarceration, the long-term effects of chronic substance abuse, and mental illness from co-morbid disorders (Dolan & Coid, 1993). New Zealand research into a group of aging violent offenders who had scored high on the PCL:SV and who had not returned to prison confirmed that enfeeblement from a chronic antisocial lifestyle was a factor reducing their risk (Wilson, 2003). However, this research also identified that as a group these offenders had changed their adaptation to their environment through changes in lifestyle, namely, geographic isolation, reduced substance abuse, and avoidance of antisocial influences. This changed their characteristic adaptation to interactions with the community but was not accompanied by reductions in the interpersonal and affective deficits.

Hare and colleagues (1988) speculated that the age-related reduction in offending reflected developmental or maturational changes in the psychopath and that the psychological wear and tear associated with persistent offending caused a change in their behaviour. However, further research on age as a factor in the reduction of offending in psychopaths found that there was no reduction in the display of Factor 1, the cluster of affective and interpersonal traits central to psychopathy. There was, however, a decline in Factor 2 scores that describe the antisocial behaviours associated with an unstable, unsocialised lifestyle, or social deviance (Harpur & Hare, 1994). Therefore, the basic personality trait does not appear to change. The expression of this trait, however, may be subject to change. In colourful terms, psychopaths may lack the ability to engage in overt physical antisocial behaviour and instead become "nasty old men" (Moffitt, 1993), or as has been shown in the study by Vitale et al. (2002), women who are lifelong recidivists.

Dolan and Coid (1993) report on the higher rates of death from unnatural causes associated with severe personality disorders. This higher mortality rate makes sense when related to the psychopathic individual's inability to recognise when the pursuit of a reward should be abandoned in the face of a competing, possibly dangerous punishment. Individuals we would classify as psychopathic with chronic offending would therefore be expected to engage in high-risk activities such as driving too fast, and experimentation with 'A' and 'B' classified illegal substances (Moffitt, 1993).

### ***Adaptation or Maturation?***

Investigation of this issue occurred in New Zealand by the author (Wilson, 2003) who followed up a small group of serious chronic offenders (N = 32). These offenders were classified as a false positive error group by virtue of their

high recidivism probability based on high PCL:SV scores but no subsequent detected serious recidivism within five years of release. This group was of interest both to establish if they were indeed subject to prediction error, and to learn from them about how they had managed their high assessed risk of reoffending. Had they gone through a maturation process developing social skills, empathy, remorse, and increased responsibility for their behaviour? (Zamble & Quinsey, 1997). Or instead, was there an adaptation in response to years of escalating punishment and increased awareness of age related changes (Haggard, Gumpert, & Grann, 2001).

The false positive group had a mean age of 34 years when released, with approximately half of Māori, and half of European descent. Half the sample had an index offence of murder, and the rest for rape, or Class A drug supply convictions. A comparison of the false positive group with the rest of the main validation sample who were actually reimprisoned (N = 76) found no significant differences on risk, and that they were accurately assessed as at high risk of serious reoffending. The majority of the group were originally imprisoned for violent crimes (usually rape or murder) and a computerised search of their criminal convictions records indicated almost all were reconvicted, although not reimprisoned after release, in the majority of cases for driving, dishonesty, or minor assault offences.

A detailed examination of this group of offenders found that two had died within 18 months of release and that another three had actually committed serious offences that resulted in reimprisonment within the five-year period, one under another name (a change in identity from being placed in the secret witness protection programme!), and the others after long periods in remand, with conviction and sentence occurring after the five-year period. After eliminating these five individuals as not meeting the false positive error criteria, the majority of the rest of the sample agreed to interview about their life over the five to ten years since their release from prison.

Interview and psychometric assessment with this group that appeared to have 'beaten the odds' found that none of those interviewed had significant personality pathology other than psychopathy, or clinical syndromes (mental disorder). The majority were geographically isolated by choice, with this being in marked contrast to their location in larger more central population centres prior to their imprisonment for their index offences. This avoidance, (adaptation) formed their principle strategy to deal with problems and stressors, and was also noted in relation to their isolation from antisocial peers. A clear majority of those interviewed indicated they no longer associated with former criminal friends or family. However, while many were isolated, they tended to have an intimate partner who provided a high level of prosocial support after release. The interview participants were quick to point to their partners' support as important in reducing their return to

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serious reoffending, although these relationships seemed more instrumental than emotion based.

An examination of their procriminal beliefs found all continued to have frequent thoughts of offending behaviour, although these had reduced over the years since their release. They were also clear that an awareness of the negative consequences of a return to prison inhibited such thoughts and any intent to act on them. Another area that served to inhibit a return to serious criminal behaviour was their high level of enfeeblement; this was either health related or a result of poor physical condition related to aging.

Physical difficulties had reduced their ability to carry out previous antisocial patterns of behaviour, and also made them aware of how difficult a return to the aversive prison environment would be. Their enfeeblement also reduced their ability to find gainful employment. The participants commented that gaining control of substance abuse problems was part of their increased management of their recidivism risk. When the participants were asked about their own beliefs, about why they had not returned to prison, their comments as predicted reflected the themes of prosocial partners' support, avoidance of antisocial associates, and an increased awareness of the punishing consequences of a return to prison. What was not expressed or observed was any increased empathy for victims, remorse for their previous antisocial behaviour, or increased social competency.

While Zamble and Quinsey (1997) propose a model of maturation where improved problem solving, prosocial conflict resolution, and increased emotional control are involved, there is some growing evidence that for some serious offenders social and geographic isolation, and some limited support from a prosocial intimate partner can produce a successful adaptation. While those who in the New Zealand study form a very small sample it certainly points to enfeeblement also being a protective factor in reducing violent recidivism. It appeared to have increased self awareness of the likelihood that these offenders could become victims rather than predators if they were to return to prison. The chronic antisocial lifestyle they experienced had resulted in serious health related consequences when they reached late middle age. The study by Haggard et al. (2001) of high-risk chronic offenders also found a high level of physical disability with half his small sample classified as disabled. This finding has also been confirmed in other research into the impact of old age on late criminal lifestyles (Hare et al, 1988; Harpur & Hare, 1994; Moffitt, 1997).

## Poor Response to Treatment?

The literature on the use of therapy to change the antisocial behaviour associated with criminal psychopathy tends to paint a gloomy picture, with

most studies recommending excluding such individuals from treatment (Salekin, 2002). A study by Ogloff and colleagues evaluated the progress of 80 male forensic patients being treated in a therapeutic community programme (Ogloff, Wong, & Greenwood, 1990). They found that programme participants with high scores on the PCL-R ( $\geq 27$ ) showed less motivation, effort, and improvement in treatment than non-psychopaths. Individuals identified as psychopathic are said to also be more likely to disrupt group unity (Hobson, Shine, & Roberts, 2000), endanger security, (Buffington-Vollum, Edens, Johnson, & Johnson, 2002), and to terminate treatment without warning (Rice, 1997). In fact, there is some controversial evidence that intensive therapeutic therapy may actually increase the risk the recidivism rate of psychopaths.

The Oak Ridge programme (Harris, Rice, & Cormier, 1991) found a general recidivism rate of 87% for treated participants with high psychopathy ratings versus 90% for an untreated group with similar ratings. This difference was not significant. However, when the recidivism variable was violent reoffending the difference was significant, with the treated rate being 77% versus 55% for the untreated group. Many in the Corrections field have taken the results of this study to mean that treatment will make those identified as psychopathic worse. However, this was not the conclusion of the study authors who felt that the results pointed to the need for specialist programmes to address responsivity issues particular to individuals with high ratings of psychopathy. The treatment programme used in the study is also viewed as controversial due the focus on a therapeutic community approach, insight orientation, use of participants in leadership roles to effect change in antisocial behaviour, nude encounter therapy, and LSD! In addition, the study used only a small sample, 46 subjects in each of the treated and untreated psychopath groups.

A recent study into recidivism by English offenders with high scores on the PCL-R found similar results for those exposed to treatment to those found in the Oak Ridge study when Factor 1 scores were used as the measure of psychopathy (Hare, Clarke, Grann, & Thornton, 2000). The most common programmes offered to inmates in Her Majesty's Prison Service were short-term treatment initiatives focused on anger management and social skills. When variables such as age at release and previous criminal history were controlled for, those with high scores on Factor 1 had an 85.7% violent recidivism rate versus 58.7% for those with low scores. Hare (1993) proposed, in explaining the increased recidivism by psychopaths, that those that are involved in therapeutic group treatment learn how to appear more empathetic, but use this information to increase their ability to manipulate and deceive others. An increased but unstable self-image may also explain the increase in aggressive recidivism by psychopaths after treatment that was designed to bolster self-esteem (Baumeister, Smart, & Boden, 1996).

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There has been some limited success reported in achieving short-term management/ treatment goals using cognitive behavioural treatment focused on specific aspects of behaviour or attitude. However, these approaches are believed unlikely to effect changes in personality-disordered clients (Dolan & Coid, 1993). Therefore, from the limited research into cognitive behavioural approaches, it would appear that there is a reduction of specific maladaptive and disruptive behaviour (such as aggression or poor social skills) in the short-term that may have great value in the management of psychopaths in institutions or prisons (Losel, 1998).

Therapeutic pessimism is, therefore, based on studies that do not agree on the defining characteristics of psychopathy, thus assessment criteria differ. In addition, the confusion over the etiology of the disorder means that treatment targets vary across programmes and may not address the maintaining factors for antisocial behaviour. Finally, few of the studies into the effectiveness of treatment with those identified as psychopathic have made efforts to provide long term follow up data (Salekin, 2002). Therefore, the area of treatment or management of psychopathic behaviour is one that is yet to receive rigorous study. Thus, the exclusion of individuals meeting the diagnostic criteria from appropriate therapy is in the opinion of the author not justified at this stage.

### ***Treatment Recommendations:***

It seems reasonable based on the available evidence that treatment aimed at psychopathic individuals should be cognitive-behavioral in orientation, as such intervention has been found to be more effective with high risk offender groups. Given the nature of the problems experienced by psychopathic offenders (i.e., of a longstanding and varied nature) longer treatment programs of nine months or more are required. The focus of treatment should be on a relapse prevention approach in recognition that Factor 1 behaviours (i.e., lack of empathy, remorse) are not appropriate intervention targets, rather, they are indicated as responsivity barriers to treatment.

Structured inpatient based approaches also seem to offer some promise over therapeutic communities or approaches that give offenders a provider role. Structured intensive programs allow the program staff to monitor the behaviour of offenders when they are not in program across time and settings. Inconsistencies between what clients say in treatment and their behaviour on the unit can be discussed with a view to decreasing such inconsistencies and reducing the concerning higher recidivism for those rated as having succeeded in treatment. Programmes which follow these guidelines are currently being run in Canada at the Saskatoon Regional Forensic Centre, and at various sites in England including the forensic facility at Broadmoor (the 'Paddock' unit).

While these programmes are experimental, and in the case of the English programmes embryonic, the Saskatoon programme has shown some success, reducing violent recidivism by 30% with psychopathic high risk offenders (Steve Wong, *personal communication*, June 2004).

## Conclusion

The use of the PCL measures as part of the assessment of risk of serious offending, in particular, violent or sexual offending, has become a generally accepted practice in forensic and correctional settings. While there is some pejorative connotations from a diagnosis of psychopathy, the appropriate use of the PCL measures in the prediction of serious recidivism has provided an important source of information for clinicians and judicial authorities. The PCL structured assessment measures while not designed to predict risk of reoffending have been shown in a wealth of empirical evidence over the last 25 years, including New Zealand research, to be robust predictive measures across forensic and offender populations, for both male and female, and adolescent populations.

The use of the PCL measures enables reliable and valid assessment of psychopathy, a set of personality traits uniquely associated with serious violent and sexual recidivism. Assessment of psychopathy should be part of responsible multi-method clinical assessment of risk of serious violent recidivism. The appropriate identification of those in our society by who are likely to be predatory in nature, display intentful violent behaviour to gain rewards for themselves, without regard for their victim(s), is an ethical and professional responsibility for mental health professionals.

Individuals found to be high on measures of psychopathy have an early antisocial onset that continues throughout their lifespan, with only enfeeblement from age and the negative consequences of a risk taking antisocial lifestyle forcing a more prosocial adaptation. The chronic offending and serious antisocial behaviour by psychopathic individuals identifies a group for whom treatment is a priority target. However, the nature of their personality pathology indicates caution in the selection of appropriate treatment targets and measurement of actual and real change in risk.

There is a need however, not to be captured by the gloomy picture portrayed in past attempts to treat psychopathic individuals due to critical flaws in historical treatment initiatives. Review of treatment research to date does not support the continuation of this 'urban myth of untreatability' and the exclusion of individuals high on psychopathy from appropriate intensive structured treatment initiatives. Appropriate treatment for psychopathic



individuals should involve a focus on relapse prevention, behavioural approach, without inclusion of inappropriate treatment targets relating to interpersonal and affective deficits. This approach combined with an understanding both of their reward dominant learning and manipulative style, is most likely to increase management of further serious violent behaviour and objective assessment of therapy progress.

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(Endnotes)

<sup>1</sup>In Canada, (2003 FC 870) the Federal Court ruled on a challenge to a clinician not having an advanced degree as stipulated in the manual. The clinician in this case had a Master's degree and the defence attempted to invalidate the assessment by stating that this was not in keeping with the manual guideline "should possess an advanced degree ... such as PhD, D.Ed, or MD". The Court of Appeal dismissed this challenge holding that for Canadian purposes a Masters' level degree was sufficient to provide knowledge of test construction as it enabled professional registration. This argument would also seem applicable to New Zealand registered clinicians.