

Title: Are patients deemed 'dangerous and severely personality disordered' different from other personality disordered patients detained in forensic settings?

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
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5 Are patients deemed 'dangerous and 6 severely personality disordered' 7 different from other personality 8 disordered patients detained in 9 forensic settings? 10 11 12 13 14 15 16 17 18 19

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24

25 ABSTRACT

26 **Background** *In 1999, the UK government initiated a programme for the assessment*
27 *and treatment of individuals deemed to have 'dangerous and severely personality disorder'*
28 *(DSPD). After over 10 years of specialist service development, it is not clear*
29 *whether DSPD patients represent a distinct group.*

30 **Aims** *The aim of this study was to establish whether people admitted to DSPD hospital*
31 *units could be distinguished in presentation or personality traits from people with person-*
32 *ality disorder admitted to standard secure hospital services.*

33 **Methods** *Thirty-eight men detained in high-security hospital DSPD units were com-*
34 *pared with 62 men detained in conventional medium or high security hospital units,*
35 *using the Psychopathy Checklist—Revised (PCL-R) and other standard personality dis-*
36 *order, clinical and offending measures.*

37 **Results** *Compared with their counterparts in standard services, the DSPD group had*
38 *higher scores on PCL-R psychopathy, significantly more convictions before age 18 years,*
39 *greater severity of institutional violence and more prior crimes of sexual violence. Re-*
40 *gression analysis confirmed that only PCL-R Factor 1, reflecting core interpersonal*
41 *and affective features of psychopathy, predicted group membership.*

42 **Conclusion** *The DSPD group emerged as having higher psychopathy scores, but as*
43 *there is evidence that the core, affective features of psychopathy are currently not ame-*
44 *nable to treatment, there is little justification for treating high-psychopathy forensic*
45 *patients.*

patients differently from those with other disorders of personality. Copyright © 2011 John Wiley & Sons, Ltd.

Introduction

Driven by a public safety agenda, in 1999, the UK government initiated a programme for the assessment and treatment of individuals deemed to have ‘dangerous and severely personality disorder’ (DSPD Programme, 2004). Classifying an individual as ‘DSPD’ required the conjunction of three elements: (1) dangerousness, or high risk of harm to others; (2) severe personality disorder (PD); and (3) a functional link between (1) and (2). Severity of PD was defined by the presence of *either* (1) a sufficient degree of psychopathic traits, defined by a score of 30 or above on the Psychopathy Checklist—Revised (PCL-R, Hare 2003); *or* (2) a moderately high-psychopathy score (PCL-R 25–29) combined with at least one personality disorder other than antisocial personality disorder *or* two or more personality disorders (DSPD Programme, 2004).

The DSPD programme had its apologists and advocates (Howells et al., 2011) as well as critics and detractors (e.g. Howard, 2006; Mullen, 2007; Tyrer et al., 2010). It is currently being disestablished in favour of a reconfigured national strategy for managing offenders with personality disorder (Department of Health & Department of Justice, 2011), but what has been learned from those admitted to DSPD units? Did they, as the government intended, form a unique group and, if so, what characterised them? Better understanding of this would help inform the service change.

A study by Kirkpatrick et al. (2010), describing the characteristics of patients admitted for treatment to DSPD units, lacked a suitable comparison group and was thus unable to answer such questions. In their rejoinder to Tyrer et al. (2010), Howells et al. (2011) advocated ‘...systematically and organically building up knowledge about the (DSPD) population, their characteristics and needs...’ (p. 4). Our study presented here heeded this by examining a number of personality, clinical and historical variables, according to Home Office guidance on how DSPD should be construed and comparing their occurrence between men in DSPD units and men with personality disorder detained in standard secure hospital services. We had four sets of questions:

1. Do men presumed to have DSPD by virtue of their residence in a DSPD unit show a developmental history of criminal and antisocial activity, which can be distinguished from that of other hospitalised men with personality disorder? In particular, do men with DSPD show a disproportionately high rate of history of early-onset substance (particularly alcohol) abuse and childhood conduct disorder, two variables found to confer significant risk for antisocial

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4 outcomes, including violence, in adulthood (Wells et al., 2004; Gustavson
5 et al., 2007; Farrington et al., 2009; Buchmann et al., 2010)?

- 6 2. Do men presumed to have DSPD show a distinctive personality profile in
7 terms of greater severity, higher co-morbidity rates and/or greater severity
8 and/or prevalence of Axis I disorders? Individuals with co-morbid bipolar dis-
9 order, schizoaffective disorder or schizophrenia are typically excluded from
10 admission to DSPD units. Nonetheless, given the high co-morbidity between
11 personality disorders and DSM Axis I disorders (e.g. Zimmerman & Coryell,
12 1990; Fossati et al., 2000), it was of interest to see whether DSPD patients
13 might differ from other forensic patients with personality disorder in terms
14 of the degree of Axis I co-morbidity they show.
- 15 3. Are men with presumed DSPD more 'psychopathic' in terms of traits identi-
16 fied *either* using the PCL-R, *or* by the presence of the triad of childhood con-
17 duct disorder, adult antisocial personality and adult borderline personality.
18 The latter constellation of traits constitutes a 'complex personality disorder
19 characterized by explosive and psychopathic traits...' (Gustavson et al.
20 2007, p. 198) and has been found to associate with a range of antisocial out-
21 comes, including severe and frequent violence (Freestone, Howard, Coid &
22 Ullrich, submitted).
- 23 4. Which of the personality and clinical characteristics that supposedly distin-
24 guish DSPD patients in terms of the criteria used for their admission – e.g.
25 severity and co-morbidity of personality disorder, PCL-R score – best predict
26 DSPD group membership?

27 28 29 **Method**

30 31 *The sample*

32 Participants were men recruited from the Peaks and Paddock DSPD Units at
33 Rampton and Broadmoor Hospitals, respectively, from the personality disorder
34 services of these hospitals and from the personality disorder unit at Arnold Lodge
35 medium security hospital unit. Inclusion criteria were (1) having been detained
36 under the Mental Health Act 1983 category of psychopathic disorder¹; (2) having
37 at least one personality disorder according to the International Personality Disor-
38 der Examination (IPDE); (3) age 18–50 years; and (4) full-scale IQ 70 or greater.
39 Patients were excluded if they had received a psychosis or bipolar affective disor-
40 der diagnosis according to DSM-IV (American Psychiatric Association, 1994)

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43 ¹The UK 1983 Mental Health Act defined 'psychopathic disorder' as 'a persistent disorder or dis-
44 ability of mind (whether or not including significant impairment of intelligence) which results in
45 abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'. This
46 has been abolished in a subsequent revision of the Mental Health Act (2007) in favour of the ge-
47 neric term 'mental disorder'.
48

or if they had a history of head injury or epilepsy. After excluding those who did not meet study criteria, and those who met the criteria but refused consent (23% DSPD: 22.5% PD patients), there were 38 patients in the DSPD group and 62 in the PD group, the latter drawn equally from high and medium security (31:31). The groups were also well matched for full-scale IQ (means DSPD 91: PD 89.5) and age at assessment (means 37.1 and 33.9 years, respectively).

Clinical and psychometric assessment

A computerised version of the National Institute of Mental Health Diagnostic Interview Schedule (C-DIS) (Robins et al, 1989) was used to screen patients for DSM-IV Axis I disorders (American Psychiatric Association, 1994). DSM-IV personality disorders were assessed using the interview version of the IPDE (Loranger et al, 1997). The PCL-R (Hare, 2003) was used to generate an overall psychopathy score and scores on factor 1 (F1) (selfish, callous and remorseless use of others) and factor 2 (F2) (chronically unstable and antisocial lifestyle). Severity of personality disorder was measured on a 5-point severity scale ranging from 0 (no personality disorder) to 4 (severe personality disorder) (Tyrer & Johnson, 1996). An additional point (5) was added to the scale to indicate very severe personality disorder, where, as well as meeting the Tyrer and Johnson criteria for 'severe', the patient scored 25 or above on the PCL-R. Impulsivity was assessed using the Urgency, Perseverance, Premeditation and Sensation seeking scale (UPPS), a 44-item self-report inventory (Whiteside & Lynam, 2001). Each item was rated on a 4-point scale from strongly agree to strongly disagree. Patients' case files were inspected to obtain information about their IQ and collateral information for the psychopathy assessment as well as their index offence and history of offending.

Assessment of violence

Assessment of violence was based on offending history (number of violent offences, including violent sexual offending considered separately) and a severity of violence rating scale adapted from the Gunn and Robertson (1976) scale, validated in hospitalised offender-patients by Wong et al (1993). Each patient was rated on a 5-point scale from 0 (no violence) to 4 (severe violence) for the admission (index) offence, the criminal record prior to that and behaviour during the current period of hospitalisation. The latter, a variant developed for this study, was scored 0 (no incidents); 1 (evidence of occasional intimidation, verbal aggression or minor property damage); 2 (verbal threats of serious violence or one or two incidents of physical aggression to others not causing significant injury); 3 (three or more incidents of physical aggression resulting in non-serious injury); 4 (one or more severely violent episodes, or an incident involving use of a weapon against another person).

Assessment of drug and alcohol use

Detailed drug and alcohol use histories were obtained using a standardised drug and alcohol assessment developed for use with mentally disordered offenders (Lumsden et al, 2005). This included a series of questions regarding the participant's early experiences of alcohol (e.g. *When did you start to drink alcohol regularly, say once or more a month? How old were you when you first got drunk?*). Information was obtained about how much patients drank in units of alcohol per week across their lifetime. The threshold for early alcohol abuse was defined as consumption of 42 or more units of alcohol per week for at least 6 months continuously before the age 20 years. We used the number of months in which the individual consumed 42 or more units of alcohol for 6 months continuously before the age 20 years to derive a continuous measure of early-onset alcohol abuse (mean = 21.19, SD = 24.8). This measure was supplemented by two additional measures of early-onset alcohol abuse (EOAA): age when first tasted alcohol (mean = 11.4 years, SD = 4.4) and age when first got drunk (mean = 14.6 years, SD = 4.5). A weighted measure of EOAA was derived using the sum of the following weighted scores: (1) number of months in which the individual consumed 42 or more units of alcohol per week before age 20 years (0 = 0 month; 1 = 1–19 months; 2 = 20–59 months; 3 = more than 60 months); (2) age when first tasted alcohol (0 = age > 20 years; 1 = age 16–20 years; 2 = age 11–15 years; 3 = age 6–10 years; 4 = age ≤ 5 years); and (3) age when first got drunk (scored similarly as in (2)). Detailed information was obtained about lifetime use of the following classes of drugs: opiates, stimulants, ecstasy, cannabis, hallucinogens, sedatives/tranquillisers, anabolic steroids and solvents.

Data analysis

Between-group comparisons on all dependent variables (see Table 1) were carried out using SPSS, version 18.0. For continuous variables, Mann–Whitney *U*-tests were used to compare means on any variable found not to be normally distributed. Otherwise, *t*-tests were used, provided the assumption of equal variances was confirmed. The chi-square statistic was used for all categorical variables. Differences between high secure (excluding DSPD) and medium secure patients were also compared (see Tables 1–3).

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Regression analysis was carried out in two steps. In the first step, the relationship between personality disorder category (DSPD:PD) and all key variables was examined using point biserial correlational analysis. In the second step, logistic regression was carried out with personality disorder category (DSPD:PD) as the dependent variable and the variables, which correlated significantly with the personality disorder category as predictor variables. Hosmer and Lemeshow's goodness-of-fit test was used to test the hypothesis that the observed data are significantly different from the predicted values from the model.

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Table 1: Characteristics of DSPD and PD groups

	PD Mean (SD)	DSPD Mean (SD)	Mean diff. (95% CI)	Sig.
No. non-violent offences	18.7 (26.3)	23.3 (27.7)	-4.61 (-15.56, 6.34)	$T = -836, p = 0.355$
No. violent offences	13.5 (20.6)	11.1 (8.5)	2.37 (-4.6, 9.4)	$T = 0.676, p = 0.066$
Age first offence	15.2 (5.1)	15 (2.3)	0.179 (-1.64, 2)	$T = 0.194, p = 0.846$
Age first violent offence	18.3 (5.7)	17.2 (3.9)	1.07 (-0.98, 3.12)	$T = 1.035, p = 0.303$
Mean age at index offence (SD)	24.6 (6.5)	28.2 (7.8)	-3.6 (-6.5, -0.7)	$T = -2.493, p = 0.014$
No. of convictions before age 18 years	5 (7.1)	13.6 (24)	-8.643 (-15.11, -2.16)	$T = -2.649, p < 0.001$
History of violent sexual offending	0.65 (1.4)	3.11 (4.9)	-2.47 (-4.12, -8)	$T = 3.72, p = .005$
Severity of violence scale				
Index offence	2.9 (1)	2.6 (1.1)	0.345 (-0.97, 0.786)	$t = 1.548, p = 0.316$
Past offences	2.3 (1.2)	2.4 (1.1)	-0.167 (-0.639, 0.305)	$t = -0.703, p = 0.484$
Institutional	1.5 (1)	2 (1.4)	-0.585 (-1.07, -0.09)	$t = -2.348, p = 0.021$
Total	6.6 (2)	7 (2.3)	-0.4 (-1.2, 0.4)	$t = -0.923, p = 0.385$
Conduct disorder dimensional scores (IPDE)	12.3 (6.7)	12.1 (7.5)	0.2 (-2.6, 3.1)	$t = 0.175, p = 0.862$
Early-onset alcohol abuse (weighted score)	5.3 (1.9)	4.9 (2.7)	0.3 (-0.5, 1.3)	$t = 0.848, p = 0.437$
Regular/daily use of	N (%)	N (%)		
Cannabis (%)	40 (59.7)	27 (40.3)		$X^2 = 0.455, p = 0.5$
Stimulants (%)	24 (54.5)	20 (45.5)		$X^2 = 1.853, p = 0.173$
Opiates (%)	17 (60.7)	11 (39.3)		$X^2 = 0.027, p = 0.869$
C-DJS diagnoses	N (%)	N (%)		
Conduct disorder	48 (63.2)	28 (36.8)		$X^2 = 0.180, p = 0.671$
ADHD	17 (68)	8 (32)		$X^2 = 0.509, p = 0.475$
Alcohol dependence	31 (76.4)	15 (32.6)		$X^2 = 1.051, p = 0.305$
Major depression	36 (64.3)	20 (35.7)		$X^2 = 0.282, p = 0.595$
On prescribed psychotropic meds.	34 (63)	20 (37)		$X^2 = 0.046, p = 0.83$

Table 2: Measures of personality disorder (IPDE) by group

Measures of PD	PD		DSPD		Sig.
	Mean (SD)	Mean (SD)	Mean (SD)	Mean diff. (95% CI)	
Cluster A	10.2 (6.1)	10.2 (8)		0.02 (-2.8, 2.8)	$t = 0.015$, $p = 0.098$
Cluster B	38.5 (14.8)	43 (15.6)		-4.5 (-10.7, 1.6)	$t = -1.454$, $p = 0.149$
Cluster C	10.4 (6.5)	7.3 (6.1)		3 (1.3, 0.4)	$t = 2.330$, $p = 0.022$
APD + BPD dim score	31.6 (11)	33.7 (12)		-2.06 (-6.7, 2.57)	$t = -0.884$, $p = 0.379$
No. (%) with APD + BPD co-morbidity	32 (59.3)	22 (40.7)			$X^2 = 0.374$, $p = 0.541$
No. of PDs/patient	2.87 (1.4)	2.84 (1.5)		0.029 (-0.567, 0.625)	$t = 0.096$, $p = 0.924$
PD severity score (Tyrer & Johnson, 1996)	3.1 (1.3)	3.1 (1.5)		-0.035 (-0.607, 0.537)	$t = -0.121$, $p = 0.904$
No. (%) scoring severe/very severe	31 (64.6)	17 (35.4)			$X^2 = 0.261$, $p = 0.609$

Table 3: Measures of personality by group

	PD		DSPD		Sig.
	Mean (SD)	Mean (SD)	Mean (SD)	Mean diff. (95% CI)	
PCL-R F1	7.9 (3.8)	11.2 (2.9)		-3.2 (-4.7, -1.8)	$t = -4.526$, $p < 0.001$
PCL-R F2	12.1 (3.9)	14.3 (3)		-2.1 (-3.6, -0.6)	$t = -2.885$, $p = 0.005$
PCL-R total	21.6 (6.9)	28.3 (4.5)		-6.6 (-9.1, -4.1)	$t = -5.298$, $p < 0.001$
Impulsivity (UPPS) Urgency	32.4 (8.4)	32.8 (9.4)		-0.37 (-3.969, 3.229)	$t = -0.204$, $p = 0.839$
(Lack of) premed	26.2 (7.4)	24.2 (7.9)		1.941 (-1.166, 5.048)	$t = 1.239$, $p = 0.815$
(Lack of) perseverance	22.8 (7)	20.8 (5.4)		2.017 (-0.596, 4.630)	$t = 1.532$, $p = 0.129$
Sensation seeking	31.8 (9)	32.4 (8)		-0.722 (-4.239, 2.796)	$t = -0.407$, $p = 0.685$
UPPS total	111.3 (24.7)	110.3 (23.2)		0.9 (-8.9, 10.8)	$t = 0.193$, $p = 0.848$

PCL-R = Psychopathy Checklist—Revised; UPPS = impulsivity scales.

Results

Do DSPD patients show a distinct developmental history of criminal and antisocial activity? Are they clinically a distinct group in terms of co-morbid Axis I disorders?

Measures of criminal history and developmental psychopathology, together with clinical diagnoses, are shown in Table 1. The groups differed significantly on only four variables: age at index offence, number of convictions before age 18 years, severity of institutional violence and violent sexual offending, with DSPD patients being older and scoring higher than PD patients. Although the groups did not differ significantly in terms of co-morbidity of any single Axis I disorder, inspection (from Table 1) of the proportion of patients in each group who suffered from an Axis I disorder reveals a pattern, across all diagnoses, of greater Axis I co-morbidity in the PD group, who were also more likely to be on prescribed medication.

Do DSPD patients differ from PD patients in terms of their personality disorder type and/or severity? Do DSPD patients show a distinct PD profile?

Scores on IPDE-derived measures of personality disorder are shown in Table 2. The DSPD group scored slightly but significantly lower on Cluster C (anxious and avoidant) PD traits. Otherwise, there were no significant differences between PD and DSPD groups. In particular, the DSPD group were no more likely to have APD/BPD co-morbidity, nor did they score higher on the Tyrer and Johnson (1996) measure of PD severity.

Are DSPD patients different from PD patients in terms of their personality traits, particularly traits of psychopathy defined by PCL?

Scores on PCL-R and UPPS are shown for each group in Table 3. It may be seen that the DSPD group scored significantly higher than the PD group on PCL-R total and on both Factor 1 and Factor 2. The groups did not differ significantly on any measure of impulsivity defined by the UPPS scales.

Which personality and clinical characteristics best predict DSPD group membership?

Point biserial correlational analysis revealed that a number of variables correlated significantly with DSPD status. These included violence severity rating for institutional behaviour ($r^2 = 0.231$, $p = 0.021$), PCL F1 ($r^2 = 0.416$, $p < 0.0001$), PCL F2 ($r^2 = 0.280$, $p = 0.005$), IPDE Cluster C dimensional scores ($r^2 = -0.229$, $p = 0.022$), age at index offence ($r^2 = 0.244$, $p = 0.014$), number of convictions before age 18 years ($r^2 = 0.260$, $p = 0.009$), and daily/regular use of hallucinogens ($r^2 = 0.249$, $p = 0.012$).

Results of the logistic regression analysis are shown in Table 4. As can be seen, only factor 1 of the PCL-R ($p < 0.002$) and age at index offence ($p = 0.041$) significantly predicted DSPD outcome, with over 75% of the cases being correctly classified as DSPD or PD. Hosmer and Lemeshow's goodness-of-fit test showed a non-significant p value indicating that the model does not differ significantly from the observed data ($X^2 = 6.068$, $p = 0.640$). PCL F1 was by far the strongest predictor: a 1-point increase on PCL-R F1 increased the odds of DSPD as an outcome by a factor of 1.253 (95% CI = 1.084–1.448). In contrast, a 1-point increase in age at index offence increased the odds of DSPD outcome by a factor of 1.081 (95% CI = 1–1.165). Tests for multicollinearity (e.g. Myers, 1990; Menard, 1995) showed acceptable tolerance and variance inflation factor values (0.98 and 1.02, respectively) indicating that multicollinearity between the predictor variables was unlikely.

Discussion

Other than their higher PCL factor 1 score, consenting men from both the high security hospital DSPD units were strikingly similar in most characteristics of their personality and offending to men with personality disorder who had not attracted the DSPD label.

In terms of their criminal careers, both DSPD and PD groups started their offending at around the same age (15 years) and their violent offending at around 18 years. Only four significant differences emerged: first, the DSPD group were older at the time of their index offence; second, they received on average a greater number of convictions before age 18 years; third, they scored slightly but significantly higher on severity of institutional violence; and fourth, they scored significantly higher on crimes of sexual violence. Being older at the time of committing the index offence may indicate that individuals classified as DSPD tend to be life course persistent offenders with an offending trajectory starting in

Table 4: Logistic regression analysis using personality disorder category (DSPD:PD) as the dependent variable

Predictors	B	Sig.	Odds ratios (95% CI)
PCL F1	0.226	0.002	1.253 (1.084, 1.448)
PCL F2	0.029	0.741	1.030 (0.865, 1.226)
IPDE Cluster C dimensional score	-0.063	0.141	0.939 (0.862, 1.021)
Age at index offence	0.078	0.041	1.081 (1.003, 1.165)
No. of convictions before 18 years old	0.040	0.079	1.041 (0.995, 1.088)
Violence severity rating for institutional behaviour	0.081	0.726	1.084 (0.690, 1.703)
Daily/regular hallucinogen use	-0.667	0.377	0.513 (0.117, 2.252)
Constant	-4.500	0.028	0.011 (NA)

childhood that continues into adolescence and into adulthood (Moffitt, 1993). Their greater adolescent offending is consistent with their higher PCL-R psychopathy score, as Factor 2 of the PCL-R taps, among other aspects of deviant disinhibition, serious antisocial conduct in adolescence (Hare, 2003). The greater severity of DSPD patients' institutional violence is similarly attributable to their higher psychopathy score, as a high PCL Factor 1 (but not Factor 2) score was recently found to predict incidents of institutional aggression in DSPD patients (Langton et al., 2011). Although it may in part be attributable to a policy, early in the DSPD programme, of selectively admitting sex offenders (particularly to the Broadmoor DSPD unit), the greater degree of sexual violence found here in DSPD patients suggests that their violence might be more sexually motivated in comparison with that of PD patients. In contrast to their institutional and sexual violence, PD and DSPD groups did not differ in terms of either the severity or quantity of their violent offending, either in relation to their index offence or their past history of offending. This indicates that, overall, the DSPD group was no more dangerous than the PD group.

In terms of their personality disorder characteristics, PD and DSPD groups were again remarkably similar, with the exception that DSPD patients scored significantly lower on Cluster C (anxious and avoidant) traits. This is consistent with their greater psychopathy, which classically is associated with an absence of neurotic traits (e.g. Cleckley, 1941). DSPD patients did not present with a more severe PD according to the criteria of Tyrer and Johnson (1996). Nor did they show any greater degree of PD co-morbidity compared with their PD counterparts. In particular, they were no more 'psychopathic' in terms of the degree of APD/BPD co-morbidity, which is associated with risk of violence and with a history of severe conduct disorder and substance abuse (e.g. Soderstrom et al., 2004; Gustavson et al., 2007; Freestone et al.,). It is therefore not surprising that both groups showed an equally high prevalence of both early-onset alcohol abuse and CD. Although the prevalence of co-morbid APD/BPD was similarly high (40–60%) in both groups, this figure needs to be seen in the context of a considerably lower (0.3%) prevalence in the general UK population.

Although there was no significant relationship between group and Axis-I co-morbidity for any given C-DIS diagnosis, nonetheless, there was a tendency for the DSPD group to show overall less Axis-I co-morbidity, e.g. major depression, and not to be on prescribed psychotropic medication. This again is consistent with their higher PCL psychopathy, which has previously been reported to be inversely related to depression in mentally disordered offenders (Stålenheim & Von Knorring, 1996).

When all factors associated with being DSPD were entered into a linear regression model, only PCL Factor 1, representing core interpersonal and affective features of psychopathy, was found to significantly predict membership of the DSPD group. As a high PCL-R score forms a critical element in the criteria for 'severe PD' according to the DSPD Programme (2004), it is not surprising that

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4 a high PCL score *overall* should have differentiated DSPD from PD. However, it
5 appears paradoxical that DSPD patients, supposedly admitted on account of their
6 alleged dangerousness, showed personality features that according to results of the
7 Yang et al. (2010) meta-analysis are not associated with increased risk of violence
8 in men. A recent study by Coid et al. (2011) found that none of the Factor 1
9 PCL items significantly predicted violent reconvictions in 1353 men following
10 their release from prison (one Factor 1 item, *Conning/Manipulative*, negatively
11 predicted violence). Notably, Coid et al. (2011) found that *need for stimulation/*
12 *proneness to boredom* was one of three Factor 2 items that predicted violence sig-
13 nificantly. It is possible that, had the present study examined violent offending in
14 terms of its motivation, differences between PD and DSPD patients might have
15 emerged, with DSPD patients' violence – particularly their sexual violence – be-
16 ing motivated predominantly by a quest for excitement. This has been suggested
17 as a critical link between severe personality disorder and violence (Howard,
18 2011). Excitement seeking, particularly for destructive ends, is an important ele-
19 ment in *meanness*, which together with *boldness* and *disinhibition*, has been iden-
20 tified by Patrick (2010) as key a characteristic of the classic Cleckleyan
21 'psychopath'.
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24 *Limitations of the study*

25 There were several limitations of this study. First, the sample size was fairly small
26 (100 PD patients and 38 DSPD patients). All the latter had completed the assess-
27 ment phase post-admission, and one can probably assume that they did not in-
28 clude any who might, on assessment, have been deemed not to meet criteria.
29 Second, the sample did not include those (nearly a quarter of those approached)
30 who did not consent to take part in the study. The proportion of non-consenting
31 patients was roughly equivalent for each group, so that neither group was biased
32 towards non-consenters. Nonetheless, the sample as a whole may have been bi-
33 ased in favour of more compliant patients. Third, many of the measures relied
34 on retrospective patient reports, e.g. of their conduct disorder and of their early
35 alcohol use. Veracity of the data relied on interviewees being truthful in their
36 responses and accurate in their recollections. It has previously been noted that
37 self-report can result in both false-positive and false-negative errors, particularly
38 for recalled childhood behaviours (Rueter et al., 2000).
39
40

41 **Conclusions**

42
43 It appears that the primary factor determining the admission of offenders with per-
44 sonality disorders to the hospital DSPD units was their high PCL score, reflecting
45 particularly the presence of core personality features captured by PCL Factor 1.
46 This appears paradoxical as these affective and interpersonal features of
47
48

psychopathy are not associated with increased risk of violence in men (Yang et al., 2010). DSPD patients, more so than other forensic PD patients, appear to show the triad of features – meanness, boldness and disinhibition – identified by Patrick (2010) as characteristic of the classic Cleckleyan ‘psychopath’. Even if one could treat these traits – psychopathy in this Cleckleyan sense, at which so far attempts to do so have failed (Ogloff & Wood, 2010) – it is not clear why one would want to do so as it is associated neither with violence nor with subjective distress and felt need for treatment. Q4

Implications for practice:

- Only the core, affective personality features of psychopathy differentiate DSPD patients from patients entering other forensic PD services.
- These are currently neither amenable to treatment nor associated with increased risk of violence.
- There appears therefore to be no justification for treating personality disordered offenders who show such features any differently from other offenders with personality disorders.

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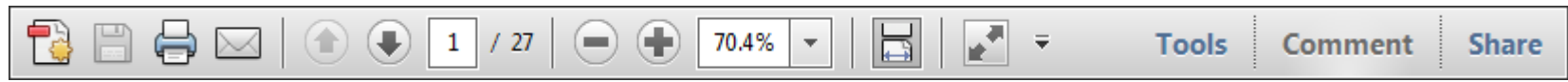
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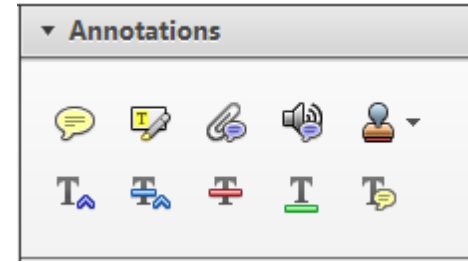
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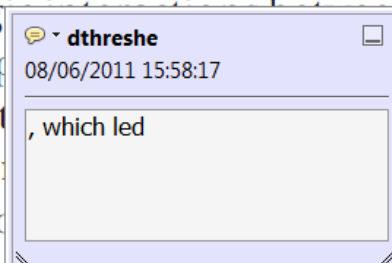


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standard framework for the analysis of microeconomics. Nevertheless, it also led to the emergence of strategic behavior in the number of competitors in the industry. This is that the structure of the industry, which led to the emergence of strategic behavior, are exogenous to the industry. Important works on this by Shirasaka (henceforth) we open the 'black b



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there is no room for extra profits and the number of competitors are zero and the number of competitors (net) values are not determined by the number of firms. Blanchard and Kiyotaki (1987), perfect competition in general equilibrium. The effects of aggregate demand and supply in the classical framework assuming monopoly power. An exogenous number of firms

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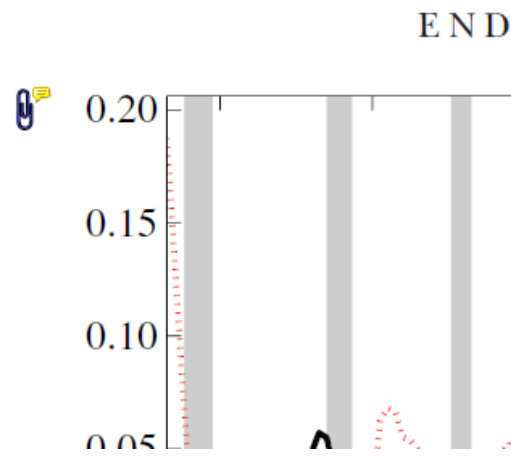
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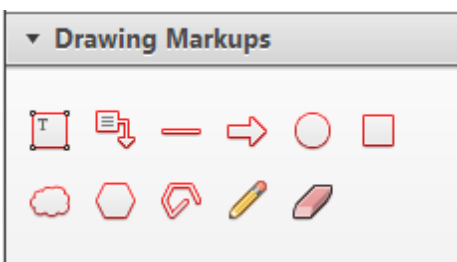


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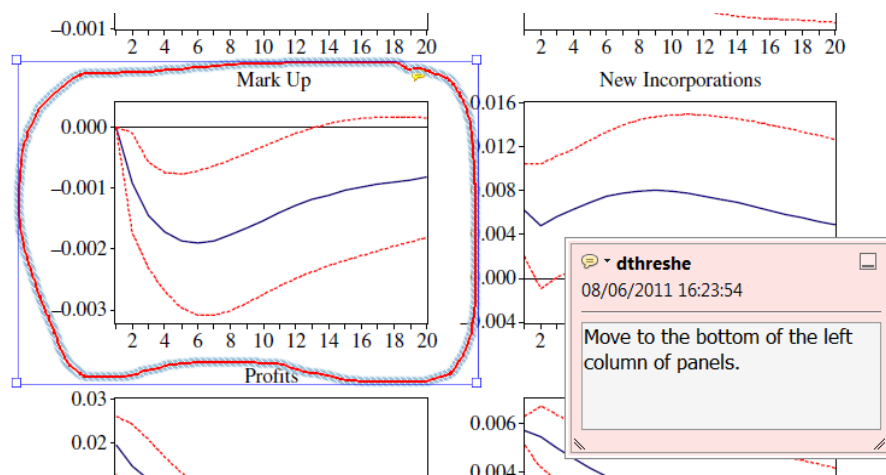


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