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THE PROBLEM WITH ROBERT HARE'S PSYCHOPATHY CHECKLIST: INCORRECT CONCLUSIONS, HIGH RISK OF MISUSE, AND LACK OF RELIABILITY

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Abstract: In this article the reliability and usefulness of Hare's Psychopathy Checklist Revised (PCL-R) and the conclusions on basis of the scores are examined. It was concluded that, a) this checklist is a not a reliable tool, b) the conclusions that are linked to these PCL-R scores with regard to the treatability of psychopaths are incorrect, harmful and unethical, c) can easily be misused in legal systems and forensic psychiatric settings to dispose of problematic psychopaths, and d) the diagnostic category psychopathy should be rejected firmly because some items are subjective, vague, judgmental and practically unmeasurable, and the term psychopathy itself seems to be judgmental. Suggestions are made in order to prevent misuse of such assessment and prediction tools.

Keywords: Psychopathy; Hare's psychopathy checklist revised; anti-social personality disorder; forensic psychiatry.

INTRODUCTION

The Psychopathy Checklist revised (PCL-R, Hare, 1998a) is presented as a useful instrument for assessment of psychopathic personality disorder or psychopathic traits and prediction of violent behavior, and recidivism. He believes that psychopathy is a distinctive and useful diagnostic category, although the term is rejected by official psychiatric and psychological organizations and is excluded from current diagnostic manuals such as DSM-V (American Psychiatric Association, 1994). The current official term is antisocial personality disorder (American Psychiatric Association, 1994). Most alarming is Hare's conclusion that people who are diagnosed with his instrument (PCL-R) as high

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psychopathic (who display many psychopathic features) are untreatable (Hare, 1998b; Hare *et al.*, 2000). Hare even claims that psychopaths even actually get worse with help of psychotherapeutic treatment (Hare, 1998b; Hare *et al.*, 2000). He actually discouraged forensic psychiatric teams to treat psychopaths (Hare, 1998b; Hare *et al.*, 2000). However, many prominent investigators, specialists and therapists challenge these conclusions of Hare and his colleagues and the usefulness and reliability of his checklist. This will be discussed later. Furthermore, there is evidence that PCL-R can be easily misused in legal systems and some examples are provided (Edens, 2001; Edens *et al.*, 2001).

It is also very alarming that Hare's opinions are widely accepted and applied in the forensic psychiatric world. In this article the scientific basis of Hare's claims and opinions as well as the usefulness and reliability of his checklist will be examined and discussed.

Diagnostic Features

According to the criteria of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association; DSM-IV, 1994) antisocial personality disorder (ASPD) is characterized by features such as irritability and aggressiveness, impulsivity or failing to plan ahead, social maladjustment, reckless disregard for the safety of self and others, consistent irresponsibility, a lack of guilt or remorse, deceitfulness, pathological egocentricity, and criminality. These features also apply to psychopathic personality disorder (PPD). Additional diagnostic characteristics of psychopathy, which are not included in the DSM-IV criteria of ASPD are absence of delusions and other signs of irrational thinking; absence of "nervousness" or psychoneurotic manifestation; pathological egocentricity; and incapacity for love; specific loss of insight; unreliability and deceitfulness; untruthfulness and insincerity; superficial charm and good intelligence; suicide rarely carried out; sex life impersonal, trivial, and poorly integrated; unresponsiveness in general interpersonal relations; fantastic and uninviting behavior both with drinking and without; poor judgment and failure to learn from experiences (Cleckely, 1984); a conning/manipulative attitude; proneness to boredom/need for stimulation; pathological lying; promiscuous sexual behavior; grandiose sense of self-worth; shallow affect and/or callousness and lack of empathy; parasitic life-style; poor self-control; many short-term marital relationships; revocation of conditional release; early behavioral problems; juvenile criminality; and criminal versatility, among others (Hare, 1998a). Today the official term is antisocial personality

disorder as defined in the DSM-IV (1994). Nevertheless, the diagnosis psychopathy (which includes criteria that are additional to and distinctive from ASPD) is widely used in assessment tools (such as PCL-R and adaptive versions; see Gacono et al., 2002; Gendreau *et al.*, 2002; Gray *et al.*, 2003; Hare *et al.*, 2000), in (forensic) psychiatric settings (Freedman, 2001; Hall *et al.*, 2004; Reiss *et al.*, 2000; Skeem *et al.*, 2002), and even in the court room (Edens, 2001; Edens *et al.*, 2001). Because this study analyses the use and misuse of the assessment and correlated diagnosis of psychopathy, I will use the unofficial term psychopathy in this article when this is relevant.

Psychopaths are Treatable

In contrast to Hare's suggestions that psychopaths are untreatable and that they actually become worse with help of psychotherapeutic treatment there is overwhelming evidence that psychopathic patients can be treated successfully and that they even can obtain remission (Kernberg, 1984, 1992; Martens, 1997, 1999, 2000, 2002a; Skeem *et al.*, 2002). Furthermore, a review of 42 treatment studies on psychopathy revealed that there is little scientific basis for the belief that psychopathy is an untreatable disorder (Salekin, 2002). Psychopaths can be treated successfully (Kernberg, 1984, 1992, 1995; Martens, 1997, 1999, 2002a; van Marle, 1995; Skeem *et al.*, 2002), mostly as a consequence of a) experienced and very capable therapists (who understand the problems of psychopaths) (Kernberg, 1984, 1992; Martens, 1997, 1999, 2002a; van Marle, 1995) b) a combination of psychotherapy, neurologic treatment (such as neurofeedback, pargyline for normalization of disturbed EEG-pattern, d,l-fenfluramine for reduction of impulsivity and aggression), and psychosocial guidance/counseling (Martens, 2002a), c) favorable circumstances (friendship, impressive events, confrontation, maturation and so on). However, treatment progress might be in association with aspects (such as biological changes, increased life experiences, impressive life events and responsibilities) of the aging process that is frequently paired with maturation (Black *et al.*, 1995; Martens, 1997, 1999; 2000, 2002, 2003a, 2003b; Robins, 1966). A lack of successful treatment in psychopaths might be linked to factors that lie beyond the responsibility and capacities of the patient (Martens, 2000a, 2000b). Furthermore, the author suggests that intensive involvement of psychopaths in their treatment planning (Martens, 2004a), involvement of remitted psychopaths in the treatment of fellow psychopaths (Martens, 2004d), adequate therapeutic attitude (Martens, 2004b), and the introduction of new promising psychotherapeutic models or approaches (Martens, 2001b, 2001c, 2002a, 2003c,

2004c, 2004d) might significantly enhance the opportunity of improvement of remission in ASPD and PPD.

Usefulness and Reliability of Hare's Revised Psychopathy Checklist

Hare *et al.* (2000) will let us believe that the Hare Psychopathy Checklist-Revised (PCL-R) provides researchers and clinicians with a common tool for the assessment of psychopathy, and has led to a surge in replicable and meaningful findings relevant to the issue of risk for recidivism and violence, among other things. Hare and colleagues concluded that the ability of the PCL-R to predict recidivism, violence, and treatment outcome has considerable cross-cultural generalizability, and that the PCL-R and its derivatives play a major role in the understanding and prediction of crime and violence (Hare *et al.*, 2000). According to Hare the Psychopathy Checklist-Revised and its derivatives measure one of the most explanatory and generalizable predictors identified to date. Its validation includes, but is not limited to, its role in risk assessment (Hemphill & Hare, 2004). Some commentators have questioned the validity of the Psychopathy Checklist-Revised because it does not consistently outperform purpose-built risk instruments (Hemphill & Hare, 2004).

The Psychopathy Checklist-Revised (PCL-R) has been conceptualized as indexing two distinct but correlated factors. However, more recent findings suggest that the PCL-R psychopathy construct may encompass three distinguishable factors, reflecting affective, interpersonal, and behavioral symptoms. The interpersonal factor was related to social dominance, low stress reactivity, and higher adaptive functioning; the affective factor was correlated with low social closeness and violent offending; and the behavioral factor was associated with negative emotionality, disinhibition, reactive aggression, and poor adaptive functioning (Hall *et al.*, 2004).

Although Hare and others (such as Hall *et al.*, 2004; Hemphill & Hart, 2003) claimed that the Psychopathy Checklist-Revised is a reliable instrument that will precisely predict outcome (recidivism, aggressive behavior, serious institutional misconduct), other studies do not support these results and their conclusions. The declaration that the Psychopathy Checklist-Revised (PCL-R) is the "unparalleled" measure of offender risk prediction is challenged by Gendreau et al. (2002). It is argued that such an assertion reflects an ethnocentric view of research in the area and has led to unsubstantiated claims based on incomplete attempts at knowledge cumulation. Another more comprehensive

risk evaluation, the Level of Service Inventory-Revised (Andrews & Bonta, 1995), notably surpasses the PCL-R in predicting general and violent recidivism (Gendreau *et al.*, 2002). Gray *et al.* (2003) revealed that PCL-R had only moderate predictive ability, while other Scales such as the Historical, Clinical, and Risk Management Scales (HCR-20; C. D. Webster, D. Eaves, K. S. Douglas, & A. Wintrup, 1995) Psychiatric Rating Scale (BPRS) were the strongest predictors of violent behavior. Gacono et al. (2002) analyzed the admissibility of PCL-R testimony by available legal and professional standards. While the PCL-R weathers tests and standards for admissibility, errors in its application may compromise the admissibility or utility of PCL-R findings (Gacono *et al.*, 2002). Freedman (2001) reviewed research on the reliability and validity of the Psychopathy Checklist-Revised (PCL-R) as an essential tool in violence risk assessment and prediction of future dangerousness. Research literature on cutting scores and base rates of the PCL-R, outcome variables, false-positive rates, and correlation coefficients is described. Given its high false-positive rates, the PCL-R should not be used in forensic or clinical settings where life and liberty decisions are at stake (Freedman, 2001). The PCL-R is by no means a reliable and valid tool for predicting future dangerousness (Freedman, 2001). The results of the study of Reiss et al., (2000) showed, in contrast to previous North American research, that the PCL-R did not predict any of the outcome factors for a nonrandom sample (n = 89) of male mentally disordered offenders treated in an English high security hospital. Because the PCL-R was able to identify psychopaths in this population but failed to predict their prognosis, it is possible that their outcome may have been improved by the treatment they received in hospital.

The author suggests that there is enough evidence that the PCL-R is unreliable in the prediction of future violent behavior and recidivism and that as a consequence all conclusions that are drawn with regard to treatability and outcome on basis of the scores of the PCL-R also will be unreliable. Furthermore, it was discussed before that even when the predictive value of PCL-R was indisputable the conclusion on the basis of the findings that patients with high psychopathic scores are untreatable is wrong.

Hare's claim that his checklist can assess a clinical phenomenon that is distinctive from antisocial personality disorder and therefore can predict more exactly violent behavior and recidivism compared with the DSM-IV is in fact weakened by Skilling *et al.*, (2002). Skilling *et al.* (2002) found in two studies on male offenders (n=74, n=684)) a large correlation between scores on the Psychopathy

Checklist-Revised (PCL-R) and the Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM-IV; American Psychiatric Association, 1994) antisocial personality disorder criteria scored as a scale. Skilling and colleagues revealed a discrete class (or taxon) underlying scores on items reflecting antisocial personality disorder and psychopathy (Skilling *et al.*, 2002). The high association among these sets of items and their similarity in predicting violence suggested that the same natural class underlies each. Results indicated that life-course-persistent antisociality can be assessed well by measures of psychopathy and antisocial personality disorder (Skilling *et al.*, 2002).

The author believes that the PCL-R because of its huge overlap with DSM-IV in the assessment and prediction of life-long persistent antisocial behavior should be replaced by the world-wide accepted and scientific and socially acceptable DSM-IV.

Misuse of PCL-R

Situations in which the prediction of "future dangerousness" is at issue appear to be logical areas in which the assessment of psychopathic traits would be relevant to decision making. One recent application of psychopathy has been its inclusion in death penalty cases, where Psychopathy Checklist-Revised (PCL-R) scores have been introduced to support the position that a defendant will represent a "continuing threat" to society-even if serving a life sentence in prison. Despite such claims, a review of the relevant research indicates that the empirical basis for these conclusions is minimal at present (Edens *et al.*, 2001). The PCL-R can be misused and misrepresented in legal settings. Moreover, because of the considerable implications of the "psychopathy" diagnosis in forensic contexts, misuse of this instrument could be especially damaging to the integrity of the adjudicative process. Edens (2001) presented two case examples illustrating quite different misapplications of the PCL-R. Case 1 involved the attempted introduction of PCL-R results as an aggravating factor in the penalty phase of a capital murder trial; in Case 2, PCL-R data were used to support expert testimony that a defendant was unlikely to be a sex offender (Edens, 2001). It is very worrying that such an unreliable instrument as PCL-R (even when it was reliable) also is misused for scientific and socially unjust purposes that may have far-reaching and negative consequences for the patients in question.

Many problematic psychopathic patients can easily be sidetracked from

treatment on the basis of PCL-R scores and associated conclusions. Our international "W. Kahn Institute of Theoretical Psychiatry and Neuroscience" (including also a department of forensic psychiatry, - psychology and - psychotherapy) has many contacts all over the world and we revealed that many forensic therapists and forensic psychiatric staff members who are frustrated by a lack of treatment progress in psychopathic patients are motivated to use these PCL-R scores as legitimizing the exclusion of psychopathic patients from treatment. Actually, many staff members already excluded psychopaths from forensic psychiatric treatment on the basis of PCL-R scores. The author and the World Psychiatric Association strongly disapprove such exclusion of a whole category of patients from psychiatric treatment and certainly on the basis of a controversial and unreliable checklist (Martens, 2001a). Moreover, it was discussed before that there exists a whole variety (and combinations) of treatment approaches that evidently might contribute to improvement and remission even in "hardcore" psychopaths.

CONCLUSIONS

The Psychopathy Checklist-Revised appears not to be a reliable tool for prediction of future violent behavior and recidivism in psychopaths and should therefore be officially declared by psychiatric, psychotherapeutic and psychological associations and governments as an unsound instrument. The conclusions that are drawn by Hare with regard to treatability on basis of the scores of his PCL-R are incorrect, unethical and harmful. Furthermore, psychopathy is not a useful distinctive diagnostic category, because of vague, subjective and unmeasurable items and because some items and the diagnostic terms are judgmental (see addendum at the end of the article). Only official diagnoses (which are tested, controlled and accepted by the international psychiatric and psychological associations) such as antisocial personality disorder should be employed in order to avoid failures, misuse and arbitrariness. The PCL-R as a selection tool for (exclusion of) treatment should be rejected more consistently and powerful since it is scientifically and socially undesirable and because it is a violation of the ethical rules of psychological (American Psychological Association, 2002) and psychiatric organizations (World Psychiatric Association, 2002). According to these international accepted ethical rules and guidelines it is acceptable to use assessment, diagnostic and research instruments which a) can be harmful and which are misused to exclude categories of patients from treatment, b) are not approved by appropriately

constituted ethical committees (World Psychiatric Association, 2002), and c) are not accompanied by informed consent (such as in the case of the PCL-R; see Regehr et al., 2000). The psychiatrist must protect and take care of the psychiatric patient (should provide fair and equal treatment) and he must inform and advise the patient about the purpose of and consequences of tests that should be carried out (eventually exclusion from forensic psychiatric treatment) (American Psychological Association, 2002; World Psychiatric Association, 2002).

ADDENDUM

Items of Hare's Checklist that are hardly measurable and too speculative and suggestive

- Glibness/superficial charm - How should glibness and superficial charm be measured in an objective and reliable way. Hare does not define these terms precisely. What do they really mean? How does the investigator know if the charm of a particular patient is superficial enough to be pathological? Glibness and superficial charm are characteristics that can contribute substantially to academic, vocational and even social success and status and these features are rather common and widely accepted as necessary tools for surviving in this complicated modern world. Why should such socially accepted traits (almost every president in the modern world needs and shows such charm and glibness) be rated as pathological? I do not say that I consider this trait as socially acceptable, but it must be well demonstrated why a specific feature is pathological and diagnostically relevant and when that motivation is missing.
- Need for stimulation/proneness to boredom - Many modern people demonstrate an excessive need for distraction and stimulation. In which way do psychopaths distinguish themselves in this respect from normal persons? How could this specific pathological need for stimulation be defined? We found no significant difference between excessive need for distraction and stimulation in many normal people and in psychopaths (Kahn *et al.*, 2002). Not that the need for stimulation in psychopaths was different from normal individuals but the fulfillment of this need may be at variance. Moreover, we found nowhere a useful definition or scientific reliable adequate method for measurement of a specific psychopathic pathological need for stimulation.
- Shallow affect - How should shallow affect be distinguished from "real" affect in a scientific way? How do we know if an affect is shallow or not? Martens (2003d) discovered that many psychopaths do not demonstrate shallow affect but rather a different kind of emotional processing, which might not be considered per se as inferior to that of normal persons. Furthermore, "shallow" affect in psychopaths might only be linked to one or more specific areas (sexuality, special obligation) or persons.

- Callousness/lack of empathy - This feature is also subjective and too generalizing . Most psychopaths do not suffer from a general lack of empathy or callousness (see former item), but it becomes obvious only in specific areas (inability to form close bonds and/or development of moral activities that are linked to empathy with specific persons) and/or in relation to specific categories of persons (for instance victims of disasters, immigrants and persons with a particular cultural, educational or ethnic background).
- Parasitic lifestyle - Some psychopaths demonstrate a lifestyle that is characterized by dependence on others (might be the result of comorbid dependent personality disorder), but this might not be a matter of free choice. A parasitic (severely prejudicial term) lifestyle suggests a harmful planning of misuse of other persons. This is not the case in most of the psychopaths we studied (Martens, 1997, 1999, 2002a; Kahn *et al.*, 2002). Those who demonstrated a "parasitic lifestyle" are not able to cope with the world, because of their emotional suffering and social-emotional and moral incapacities and they believe that they can only survive in this way. For example, some patients were unable to keep jobs despite their good intentions in this respect because of social interactional problems and the consequences of other diagnostic features which are frequently neurobiologically determined. (see (Martens, 2000, 2002a, 2002b) such as impulsivity, aggression and recklessness (recklessness might also appear as a subjective phenomenon, but by means of the Reckless Behavior Questionnaire [Arnett, 1996; Shaw, 1992] pathological recklessness can be assessed). Furthermore, only a minority of the psychopaths which were studied demonstrated a dependent lifestyle, and such lifestyle can not be regarded as typically psychopathic. Many other patients with mental disorders and also normal persons show a dependent lifestyle.
- Lack of realistic, long-term goals - What are realistic long-term goals? In the eyes of normal people many brilliant scientists and artists (until they became famous or recognized) did not have realistic goals. Some psychopaths (also a minority) indeed have fantastic and remarkable goal-setting, indeed (Kahn *et al.*, 2002). Even those "non-realistic" aims appear to be realistic, because the patients in question are obviously able to realize those aims with help of a therapeutic team, or when their life becomes less turbulent and chaotic (Martens, 1997, 1999, 2002a).

References

American Psychiatric Association. Diagnostic and statistical manual of mental disorders 4th edn (DSM-IV). Washington DC: American Psychiatric Association, 1994.

American Psychological Association. Ethical principles and codes of conduct. Washington, DC: APA, 2002.

Andrews DA, & Bonta J. (1995). LSI-R: The Level of Service Inventory - Revised. Toronto: Multi-Health Systems, Inc.

Arnett JJ. Sensation seeking, aggressiveness, and adolescent reckless behavior. *Personality and Individual Differences* 1996; 20: 699-702.

Black DW, Baumgart CH, Bell SE. A 16- to 45-year follow-up of 71 men with antisocial personality disorder. *Comprehensive Psychiatry* 1996; 36: 130-140.

Cleckley HM. The mask of sanity. St. Louis: Mosby, 1984.Freedman D. False prediction of future dangerousness: Error rates and Psychopathy Checklist--Revised. *Journal of the American Academy of Psychiatry and the Law* 2001; 29(1): 89-95.

Edens JF. Misuses of the Hare Psychopathy Checklist-Revised in court: Two case examples. *Journal of Interpersonal Violence* 2001; 16(10): 1082-1093.

Edens JF, Petrila J, Buffington-Vollum JK. Psychopathy and the dealth penalty: Can the psychopathy checklist-revised identify offenders who represent "a continuing threat to society?" *Journal of Psychiatry and Law* 2001; 29(4): 433-481.

Gacono CB, Loving JL, Evans FB, Jumes MT. The Psychopathy Checklist-revised: PCL-R testimony and forensic practice. *Journal of Forensic Psychology Practice* 2002; 2(3): 11-32.

Gendreau P, Goggin C, Smith P. Is the PCL-R really the "unparalleled" measure of offender risk? A lesson in knowledge cumulation. *Criminal Justice and Behavior 2002*; 29(4): 397-426

Gray, NS, Hill,-C, McGleish A, Timmons D, MacCulloch MJ, Snowden RJ. Prediction of violence and self-harm in mentally disordered offenders: A prospective study of the efficacy of HCR-20, PCL-R, and psychiatric symptomatology. *Journal of Consulting and Clinical Psychology* 2003; 71(3): 443-451.

Hall JR, Benning SD, Patrick CJ. Criterion-Related Validity of the Three-Factor Model of Psychopathy: *Personality, Behavior, and Adaptive Functioning. Assessment* 2004; 11(1): 4-16.

Hare RD. The PCL-R assessment of psychopathy: some issues and concerns. *Legal and Criminological Psychology* 1998a; 3: 100-122.

Hare RD. Without conscience: the disturbing world of the psychopaths among us. New York: Guilford Press, 1998b.

Hare RD, Clark D, Grann M.,Thornton D. Psychopathy and the predictive validity of the PCL-R: an international perspective. *Behavioral Sciences and the Law* 2000; 18(5): 623-45

Hemphill JF, Hare RD. Some misconceptions about the Hare PCL-R and risk assessment: A reply to Gendreau, Goggin, and Smith. *Criminal Justice and Behavior* 2004; 31(2): 203-243.

Hemphill JF, Hart SD. Forensic and clinical issues in the assessment of psychopathy. In: Goldstein, Alan M. (Ed). (2003). Handbook of psychology: Forensic psychology, Vol. 11. (pp. 87-107). New York, NY, US: John Wiley & Sons, Inc.

Kahn W, Martens WHJ, Oppenheimer Ch. The art of sublimation: Transformation of antisocial into social features. W. Kahn Institute of Theoretical Psychiatry and Neuroscience (WKITPN) Publication 55, 2002(4): 301-330.

Kernberg OF. Severe personality disorders: psychotherapeutic strategies. New York: Jason Aronson, 1984.

Kernberg OF. Aggression in personality disorders and perversions. New Haven: Yale University Press, 1992.

Kernberg OF. Aggression and transference in severe personality disorders. *Psychiatric Times* 1995; 12: 2- 18.

Martens WHJ. Psychopathy and Remission. PhD-thesis, Tilburg University, The Netherlands. Maastricht: Shaker Publishing, 1997.

Martens WHJ. Marcel - A case report of a violent sexual psychopath in remission. *International Journal of Offender Therapy and Comparative Criminology* 1999; 43(3): 391-399.

Martens WHJ. How treatable are "untreatable" forensic psychiatric patients? International. *Journal of Offender Therapy and Comparative Criminology*

2000a; 44(3): 367-369.

Martens WHJ. What shall we do with untreatable forensic psychiatric patients? *Medicine and Law* 2000b; 20(1): 389-396.

Martens WHJ. Antisocial and Psychopathic Personality Disorders: Causes, Course and Remission - A Review Article. *International Journal of Offender Therapy and Comparative Criminology* 2000c; 44(4): 406-430.

Martens WHJ. Necessity to adapt psychiatric treatment to relevant ethical guidelines. *Medicine and Law* 2001a; 20(3): 393-403.

Martens WHJ. Agitation therapy for antisocial and psychopathic personalities. *American Journal of Psychotherapy* 2001b; 55(2): 234-250.

Martens WHJ. A theoretical framework as ethics therapy as a distinctive therapeutic specialization. International *Journal of Offender Therapy and Comparative Criminology* 2001c; 45(2): 383-394.

Martens WHJ. The hidden suffering of the psychopath. *Psychiatric Times* 2002a; 19(1): 1-7.

Martens WHJ. Criminality and moral dysfunctions: neurologic, biochemical and genetic dimensions. *International Journal of Offender Therapy and Comparative Criminology* 2002b; 46(2): 170-182.

Martens WHJ. Multisystemic therapy for antisocial juveniles: suggestions for improvement. Acta Psychiatrica Scandinavica 2003a; 108: 138 .

Martens WHJ. Multisystemic therapy for antisocial juveniles: A critical comment. *International Journal of Offender Therapy and Comparative Criminology* 2003b; 48(3): 389-394.

Martens, WHJ. Spiritual psychotherapy for antisocial and psychopathic personalities. *Journal of Contemporary Psychotherapy* 2003c; 33(3): 205-218.

Martens WHJ. Emotional capacities and sensitivity in psychopaths. *Dynamical Psychology* 2003d; May: 1-20.

Martens WHJ. Optimal involvement of antisocial patients in planning their own treatment route; some positive effects. *Annals of the American Psychotherapy Association* 2004a; 7(4): 12-17.

Martens WHJ. 14 Ways to disturb the treatment of psychopaths. *Journal of Forensic Psychology Practice* 2004b; 4(3): 51-60.

Martens WHJ. Therapeutic use of humor in antisocial personalities. *Journal of Contemporary Psychotherapy* 2004c; 34(4): 351-361.

Martens WHJ. Involvement of remitted psychopaths in the treatment of fellow psychopaths. American Journal of Forensic Psychiatry 2004d; 25(4): 53-58.
Regehr C, Edwardh M, Bradford J. Research ethics and forensic patients. *Canadian Journal of Psychiatry* 2000; 45: 892-898.

Reiss D, Meux C, Grubin, D. The effect of psychopathy on outcome in high security patients. *Journal of the American Academy of Psychiatry and the Law* 2000; 28(3): 309-14.

Robins LH. Deviant children grown up: A sociological and psychiatric study of sociopathic personality. Baltimore, MD: Williams & Wilkins, 1966.

Shaw DS. The factor structure of the Reckless Behavior Questionnaire. *Journal of Youth and Adolescence* 1992; 21(3): 305-323.

Skeem JL, Monahan J, Mulvey EP. Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. *Law and Human Behavior* 2002; 26(6): 577-603.

Skilling TA, Harris GT, Rice ME, Quinsey VL. Identifying persistently antisocial offenders using the Hare psychopathy checklist and DSM antisocial personality disorder criteria *Psychological Assessment* 2002; 14(1): 27-38.

Van Marle HJC. A closed system: A psychoanalytic framework for forensic therapeutic communities. PhD-thesis, Utrecht University. Arnhem: Gouda Quint, BV, 1995.

World Psychiatric Association. Madrid declaration on ethical standards for psychiatric practice. Geneva: World Psychiatric Association, 2002.