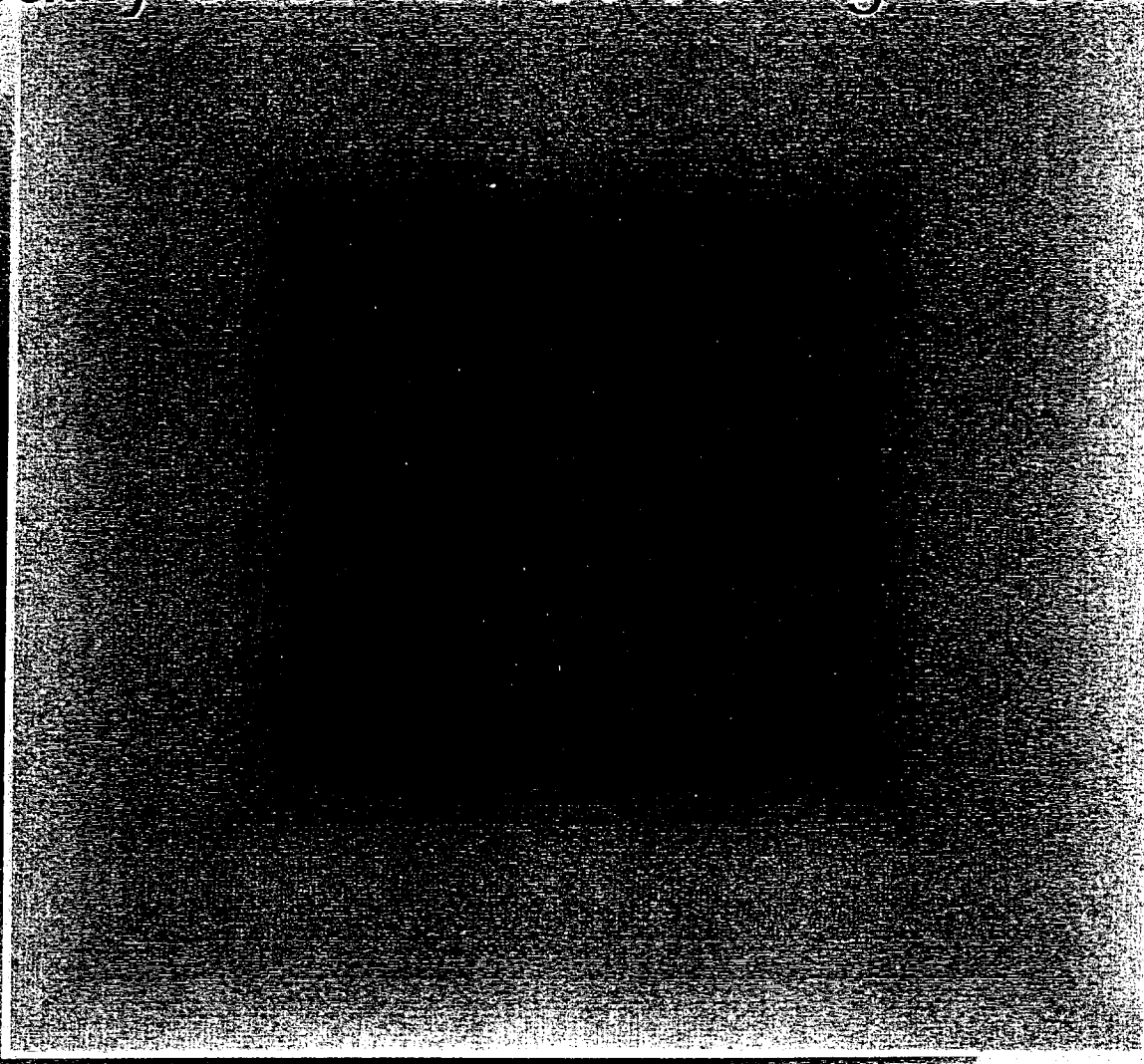
The HARE PCL:SV

Psychopathy Checklist: Screening Version



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Hare Psychopathy Checklist: Screening Version (PCL:SV)

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Publisher's Preface

We are pleased to present you with the Hare Psychopathy Checklist Screening Version (Hare PCL:SV). The original Hare Psychopathy Checklist Revised (PCL-R) has become the standard assessment measure for forensic and correctional populations. However, many professionals requested a brief instrument that has high validity and high reliability ratings similar to the complete Hare PCL-R. The authors arrived at this instrument to address this need.

The Hare PCL:SV was not designed to replace the Hare PCL-R but to offer an efficient tool to screen for the possible presence of psychopathy. The Hare PCL:SV is a 12-item scale based on a subset of the PCL-R items that can be completed in civic and forensic settings in under 1½ hours. In civic settings, the PCL:SV can be used in psychiatric evaluations, personnel selection, and community studies. Cutoff scores indicate when to follow up the screener with the complete Hare PCL-R, so it is easy to integrate the two instruments for ultimate accuracy.

I want to thank Dr. Gill Sitarenios, Joanne Morrison, Jeff Fitzgerald and the rest of the MHS staff who have contributed to the realization of the Hare PCL Screening Version.

The authors have done an exceptional and thorough job of developing this instrument and documenting the data behind it. However, please keep us informed of any research you conduct using this instrument so your data can be included in future revisions of this manual.

Steven J. Stein, Ph.D.
Publisher

Chapter One
Overview

This chapter provides an overview of the rationale behind the development of the Psychopathy Checklist: Screening Version (PCL:SV).

Introduction

Observers of human behavior have long argued that people can be classified into types on the basis of their personalities (Tyrer & Ferguson, 1988). In modern clinical psychology and psychiatry, abnormal types are referred to as personality disorders — characteristic ways of perceiving and relating to the world that result in social dysfunction or disability (e.g., American Psychiatric Association, 1994; Millon, 1981). Psychopathy, or psychopathic personality disorder, can be differentiated from other personality disorders on the basis of its characteristic pattern of interpersonal, affective, and behavioral symptoms (e.g., Cleckley, 1976; Hare, 1991; McCord & McCord, 1964). Interpersonally, psychopaths are grandiose, egocentric, manipulative, dominant, forceful, and cold-hearted. Affectively, they display shallow and labile emotions, cannot form long-lasting bonds to people, principles, or goals, and lack empathy, anxiety, and genuine guilt or remorse. Behaviorally, psychopaths are impulsive and sensation-seeking and tend to violate social norms — the most obvious expressions of these predispositions involve criminality, substance abuse, and a failure to fulfill social obligations and responsibilities. Robert Hare, in his recent book *Without Conscience* (Hare, 1993), offers a readable introduction to the concept of psychopathy.

The assessment of psychopathic personality disorder has been a topic of growing interest over the past decade. There are probably two main reasons for this. The first is the success of diagnostic criteria for psychopathy — specifically, the Psychopathy Checklist (PCL; Hare, 1980) and its recent revision (PCL-R; Hare, 1991). There is now considerable literature attesting to the reliability and validity of the PCL and PCL-R in forensic settings: Of particular importance is their predictive validity with respect to criminal behavior (for reviews, see Hare, 1991; Hare, Forth, & Strachan, 1992; Hare & Hart, 1993).

The second reason for the growing interest in psychopathy is disenchantment with the diagnostic criteria for antisocial personality disorder (APD) contained in recent editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, namely, the DSM-III, DSM-III-R, and DSM-IV (American Psychiatric Association, 1980, 1987, 1994). The criteria for APD in these manuals consist largely of a list of overt delinquent and criminal behaviors. These criteria have been severely criticized for their neglect of interpersonal and affective symptoms historically associated with the construct of psychopathy, such as superficiality, grandiosity, callousness, manipulativeness, lack of remorse, and so forth (e.g., Hare, 1983; Hare, Hart, & Harpur, 1991; Millon, 1981; Rogers & Dion, 1991; Widiger & Corbitt, 1995). Interestingly, in the text of the DSM-IV, the American Psychiatric Association now recognizes explicitly the importance of interpersonal and affective symptoms in the diagnosis of APD:

> Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy and may be particularly distinguishing of Antisocial Personality Disorder in prison or forensic settings where criminal, delinquent, or aggressive acts are likely to be nonspecific (1994, p. 647).

The problem is that the DSM-IV provides no guidelines concerning how to assess these symptoms (Hare & Hart, 1995).

In this manual, the development and validation of the Screening Version of the Hare Psychopathy Checklist, or PCL:SV, is described. The PCL:SV is a 12-item scale, derived from the PCL-R, that has two major purposes: to screen for psychopathy in forensic settings and to assess and diagnose psychopathy outside of forensic settings.

Use of the PCL:SV

The PCL:SV has good validity as a screening tool and can be used in forensic and nonforensic environments. The following sections elaborate on the uses of the PCL:SV.

Screen for Psychopathy in Forensic Settings

The PCL-R must be considered the method of choice for assessing and diagnosing psychopathy in forensic (i.e., correctional and forensic psychiatric) settings due to its excellent psychometric properties and well-established validity. However, it is rather time-consuming and expensive to administer routinely. In contrast, the PCL:SV is a relatively quick and inexpensive way of assessing psychopathic traits in offenders and forensic patients.

Individuals with high scores on the PCL:SV can be administered the full PCL-R, providing a more detailed and reliable assessment of psychopathy.

This manual presents research indicating that the PCL:SV has good validity as a screening test. Overall agreement between the scales is fair to good, although the PCL:SV overpredicts psychopathy relative to the PCL-R while making virtually no false negative errors. Therefore, only individuals with a high PCL:SV score need to be re-evaluated using the PCL-R; those with low PCL:SV scores can be diagnosed safely as nonpsychopaths.

Administering the PCL:SV can result in substantial savings in settings that routinely screen for psychopathy. For example, a forensic psychiatric hospital receives 100 transfers annually from local prisons for the purposes of evaluation and treatment. Currently, the hospital routinely uses the PCL-R to assist in making institutional classification and treatment decisions, including the identification of patients who are at high risk for institutional misbehavior and those who may be inappropriate for group psychotherapy. Experience suggests that about 10% of admissions are diagnosed as psychopathic according to the PCL-R. Assuming that completion of the PCL-R requires about 2½ to 3 hours of clinician time per patient, then psychopathy assessments would require a total of 275 clinician-hours per year. On the other hand, if the same patients were evaluated using the PCL:SV, the routine screening would require only 1 to 1½ clinician-hours per patient, or a total of about 125 clinician hours per year. About 20% of the patients would receive high scores on the PCL:SV and be referred for follow-up PCL-R assessments, requiring an additional 1½ to 2 hours per patient, for a total of 35 clinician-hours. Thus, using the PCL-R alone would require 275 clinician-hours per year, whereas using the PCL:SV and PCL-R in combination would require only 160 clinician-hours — an annual savings of 115 clinician-hours (about 15 clinician days) or over 40% in clinical labor costs.

Assessment and Diagnosis of Psychopathy Outside of Forensic Settings

Because the PCL:SV can be completed in the absence of criminal record information, it is more appropriate than the PCL-R for use outside of forensic settings. In particular, the PCL:SV is well-suited for use in civil psychiatric evaluations, studies of community residents (e.g., epidemiological research), and personnel selection (e.g., screening of law enforcement, correctional, or military recruits). The publication of the PCL:SV will permit researchers to further study the nature and consequences of psychopathy outside of prison walls.

Chapter Two
Theoretical and Empirical Review

This chapter provides a detailed description of the construct of psychopathy and a thorough review of existing assessment procedures related to this construct.

The Nature of Psychopathy: Four Assessment Issues

It is relatively easy to construct a test or measure that is more or less reliable (i.e., is internally consistent) and has reasonable criterion-related validity (i.e., is at least moderately correlated with other measures of the same construct). It is more difficult to fully evaluate its construct-related validity. Establishing construct-related validity is difficult because it requires a reasonably thorough understanding of the construct being measured (i.e., American Psychological Association, 1985). Thus, any discussion or evaluation of procedures for assessing psychopathy must be guided by theory and research concerning the nature of the disorder. This section makes four fundamental assumptions concerning psychopathy and discusses their implications for assessment.

Two-Facet Structure

The first assumption is that **two oblique dimensions are both necessary and reasonably sufficient to provide a comprehensive description of psychopathic symptomatology**. The evidence supporting this assumption comes from two sources: first, clinical and empirical studies identify the key symptoms of psychopathy; and second, research indicates that these key symptoms form two natural clusters.

The major clinical description of the psychopath is found in Cleckley's classic text, *The Mask of Sanity* (1976). In it, he describes sixteen characteristics of the disorder:

- superficial charm and good intelligence
- absence of delusions and other signs of irrational thinking
- absence of nervousness or psychoneurotic manifestations
- unreliability
- untruthfulness or insincerity
- lack of remorse or shame
- inadequately motivated antisocial behavior
- poor judgment and failure to learn from experience
- pathological egocentricity and incapacity for love
- general poverty in major affective relations
- specific loss of insight; unresponsiveness in general interpersonal relations
- fantastic and uninviting behavior with drink (and sometimes without)
- suicide rarely carried out
- sex life impersonal, trivial, and poorly integrated
- failure to follow any life plan.

Note that this list includes characteristics that in the DSM-IV would be considered symptomatic of antisocial, narcissistic, histrionic, and borderline personality disorder.

Other clinicians, before and after Cleckley, have described longer or shorter lists of characteristics, yet their conceptualization of the disorder is remarkably similar (e.g., Buss, 1966; Craft, 1965; Karpman, 1961; McCord & McCord, 1964; Millon, 1981). Reviews and content analyses of the empirical literature (e.g., Albert, Brigante, & Chase, 1959; Fotheringham, 1957) and surveys of mental health and criminal justice professionals (e.g., Davies & Feldman, 1981; Gray & Hutchinson, 1964; Livesley, 1986; Rogers, Dion, & Lynett, 1992; Rogers, Duncan, Lynett, & Sewell, 1994; Tennent, Tennent, Prins, & Bedford, 1990) suggest that researchers and practicing clinicians are in close agreement with Cleckley.

Several studies indicate that when a reasonably comprehensive set of psychopathic symptoms is factor-analyzed, the resulting structure yields two correlated factors. For example, Harpur, Hakstian, and Hare (1988) factor-analyzed the 22 items of the PCL. These items were heavily influenced by Cleckley's list of 16 features (Hare, 1980). Harpur et al. attempted to identify a factor structure, underlying the items, that was stable across samples, sites, and investigators. They used PCL ratings from six samples, with a total N of 1,119. For each sample, they extracted between 2 and 8 factors, then subjected the factors to a variety of orthogonal and oblique rotations. The stability of various solutions both within and across samples was determined using split-half cross-validation and congruence. The results strongly supported an oblique two-factor solution. Factor 1, labeled the "selfish, callous and remorseless use of others", comprised items tapping egocentricity, superficiality, deceitfulness, callousness, and a lack of remorse, and empathy — all features that the antisocial personality disorder criteria have been criticized for neglecting. On the other hand, Factor 2, labeled a "chronically unstable and antisocial lifestyle" or "social deviance," comprised items tapping impulsivity, sensation-seeking, irresponsibility, aggressiveness, and criminality. The two factors were correlated about $r = .50$. An identical factor structure has been reported for the 20 items of the PCL-R (Hare et al., 1990). The two factors are differentially correlated with important external variables such as violence, substance use, and interpersonal style (Harpur, Hare, & Hakstian, 1989; Hare, 1991).

In another study, Livesley, Jackson, and Schroeder (1989, 1992) developed self-report scales to measure symptoms of personality disorder (identified via literature review, so as not to limit the domain of traits to those found in the DSM). They conducted factor analyses of the scales in both patient and nonpatient samples. With respect to the prototypical psychopathy/APD symptoms, Livesley et al. found a two-factor structure isomorphic to that reported by Hare and colleagues; they labeled the factors "interpersonal disesteem" and "conduct problems". Livesley and Schroeder (1991) have also identified these same two factors in a study of the factorial structure of the existing DSM-III-R APD symptoms.

Finally, Harpur, Hare, Zimmerman, and Coryell (1990) conducted a factor analysis of DSM-III Cluster 2 (Dramatic-Erratic-Emotional) personality disorder symptoms in a large sample of community residents (relatives of psychiatric patients and a control group, consisting of relatives of nonpatients). All subjects were assessed using the Structured Interview for DSM-III Personality (Stangl, Pfohl, Zimmerman, Bowers, & Corenthal, 1985), a reliable and well-validated instrument. Several factors emerged, including two that comprised symptoms of antisocial and narcissistic personality disorder and were isomorphic to the PCL factors.

In sum, considerable research suggests that the construct of psychopathy has an underlying structure consisting of two correlated factors. A corollary is that any procedure designed to measure psychopathy should assess both facets of the disorder.

Chronicity

The second assumption is that **psychopathy is a chronic disorder**. There is research indicating that the disorder is first evident in early childhood (Frick, O'Brien, Wootton, and McBurnett, 1994) and persists into adulthood (e.g., Hare, McPherson, & Forth, 1988; Robins, 1966). Indeed, these characteristics are necessary symptoms in the DSM-III, DSM-III-R, and DSM-IV criteria for APD criteria and contributory symptoms in the PCL criteria for psychopathy; they were also seen as highly prototypical of the disorder in the reviews and surveys described above.

Further evidence of chronicity comes from studies indicating that treatment does little to alter the behavior of criminal psychopaths (Harris, Rice, & Cormier, 1991; Ogloff, Wong, & Greenwood, 1990; Rice, Harris, & Cormier, 1992). In fact, the results of one of these studies (Rice et al., 1992) suggests that some treatments may even *increase* the likelihood of recidivism in psychopaths. There may be a decrease in the frequency of some types of overt antisocial behavior in psychopaths after age 45 or so, particularly property offending (Hare, McPherson, & Forth, 1988). There is no evidence, however, that this is a real "burnout" phenomenon (as it is sometimes misleadingly labeled) because most behavioral symptoms of psychopathy are still present and there is no evidence at all that interpersonal or affective symptoms diminish (Rice et al., 1992).

One corollary of the argument that psychopathy is a chronic disorder is that assessment procedures for psychopathy should have high test-retest reliability even over relatively long periods of time. A second corollary is that measurement procedures should be relatively immune to the effects of state variables, such as mood at the time of assessment.

Association with Criminality

The third assumption is that **psychopathy and criminality are distinct but related constructs**. Given the characteristics of psychopathy (callousness, remorselessness, impulsivity, and so forth), there is every reason to expect that psychopaths are particularly likely to engage in criminal behavior (Hare & Hart, 1993). This statement should not be interpreted to mean that all psychopaths are criminals (i.e., have official criminal records) or that all criminals are psychopaths — if this was the case, the construct of psychopathy would lose its distinctiveness. Rather, it should be expected that offender populations will have a high base rate of psychopathy relative to other populations, such as community residents or civil psychiatric patients. In addition, within any particular population, psychopaths should be at an increased risk for antisocial behavior (e.g., Hart, Kropp, & Hare, 1988). Two main lines of evidence support this point. First, the surveys and reviews cited earlier indicate that repeated antisocial behavior is considered to be a highly prototypical symptom of psychopathy, and indeed, it is included in the DSM and PCL (-R) criteria. Second, considerable research indicates that psychopathic criminals have a higher frequency of offending than do nonpsychopaths, even when controlling for previous criminal behavior to avoid circularity in prediction (see reviews cited earlier).

To reiterate, psychopathy is related to but distinct from criminality. The most important corollary of this statement is that procedures for the assessment of psychopathy should have significant predictive and/or convergent validity vis-a-vis measures of criminality. Also, as psychopathy is not limited to criminals, a second corollary is that assessment procedures should be suitable for use in both forensic and nonforensic settings.

Association with Deceitfulness

The fourth and final assumption is that **deceitfulness — lying, deception, and manipulation — is closely associated with psychopathy**. As is the case with criminality, deceitfulness is considered to be a prototypical symptom of psychopathy and is included in most diagnostic criteria for the disorder. There is also some empirical evidence that psychopaths are more likely than nonpsychopaths to engage in dissimulation, at least in certain contexts (e.g., Kropp, 1992; Hart, Dutton, & Newlove, 1993). The major point is that assessment

procedures for psychopathy should directly assess deceitfulness and that assessment procedures must control for deceitfulness, as this symptom may interfere with the assessment of other features of the disorder.

The Need for a New Scale: A Review of Existing Assessment Procedures

There are five commonly-used procedures for assessing psychopathy. Three are self-report measures: the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1940) and its recent revision (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989); the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983) and its recent revisions (MCMI-II and -III; Millon, 1987, 1994); and the original and revised California Psychological Inventory (CPI; Gough, 1957, 1987). The other two measures are "clinical-behavioral" (Hare, 1985): the DSM criteria for APD (American Psychiatric Association, 1980, 1987, 1994) and the original and revised Psychopathy Checklist (Hare, 1980, 1991).

Self-Reports[1]

Clinicians are cautioned against the use of self-report inventories for assessing psychopathy, particularly in forensic evaluations. Although these inventories may yield useful information about other aspects of personality or test-taking attitude, and although they may be useful for some research purposes, self-reports tend to be poor or, at best, fair measures of psychopathy per se. There are a number of reasons for this. First, most self-reports have limited applicability to forensic populations. For example, the MMPI-2 and CPI have norms for adult community residents ("normals"), and the MCMI-III has norms for patients undergoing assessment or treatment in mental health settings. None of these inventories has separate norms for correctional offenders or forensic patients.

A second concern with self-report measures of psychopathy is that they fail to assess and control for the effects of deceitfulness. This is particularly true for the CPI, which has no separate validity scales. The MMPI-2 and MCMI-III have validity scales; however, they assess only a small number of self-presentation strategies, and the number of strategies for which they control is even smaller. For example, self-reports cannot correct for the biasing effects of random responding, yea-saying, or nay-saying.

A third issue is the temporal stability of self-reports. Although the MMPI-2, CPI, and MCMI-III all have, on average, at least moderate test-retest reliability over periods of time ranging from a few days to a few weeks (and, in the case of the MMPI-2, several years), all psychopathy-related scales on these inventories are correlated significantly with measures of emotional state at the time of assessment (e.g., depression, anxiety).

Fourth, the content-related validity of self-reports is problematic. The MMPI-2, CPI, and MCMI-III scales related to psychopathy all tend to focus on delinquent and antisocial behavior to the exclusion of interpersonal and affective symptoms. As a result, all are correlated significantly with Factor 2 of the PCL-R, but not with Factor 1. In addition, the MMPI-2 and CPI contain some items that appear either unrelated to psychopathy or even theoretically inconsistent with the disorder. Although this may not be a problem in many clinical settings (where the emphasis is pragmatic), it is potentially a big problem in forensic evaluations — lawyers may ask psychologists to account for the inclusion of "subtle" items in an inventory in an attempt to discredit that inventory (or the psychologist!).

A fifth concern is that the criterion- and construct-related validity of self-reports is limited. There is considerable research suggesting that the CPI reliably distinguishes between delinquents and normals or between adult offenders and normals, and both the CPI and the MMPI-2 are weakly related to future criminal behavior. There is no research on the ability of the MCMI-III to predict criminal behavior. There is no literature supporting the usefulness of these inventories in laboratory research on psychopathy.

DSM-IV Criteria for Antisocial Personality Disorder

This section examines the DSM-IV criteria for Antisocial PD in the context of psychopathy and the PCL:SV. A description of the criteria and a discussion of the reliability, norms, and validity follow.

Description. The DSM criteria for APD are fixed and explicit psychiatric diagnostic criteria. The DSM-IV list four criteria, two of which contain multiple subcriteria: (1) antisocial behavior since age 18; (2) current age at least 18; (3) conduct disorder before age 15; and (4) occurrence is not limited to periods of schizophrenia or mania. The criteria are monothetic in nature: each one is necessary, and together they are jointly sufficient to diagnose APD. The criteria and subcriteria are summarized in Table 1.

The content of the DSM-III APD criteria was decided by a committee of the American Psychiatric Association's DSM-III Task Force and was revised slightly by another committee for the DSM-III-R (Widiger, Frances, Pincus, Davis, & First, 1991). In drafting criteria, these committees were heavily influenced by the clinical and research traditions at the Washington University in St. Louis, which eschewed the use of inferred personality traits for the diagnosis of an APD field trial (Hare & Hart, 1995; Widiger et al., in press).

The APD criteria do not constitute a scale or test. Their development was not guided by psychometric principles, they do not have a response format per se, and

[1] A more detailed description of the self-report measures is given in the appendix.

Table 1
Antisocial Personality Disorders (Summarized from DSM-IV)

301.7 Antisocial Personality Disorder

A. There is disregard for the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) failure to conform to social norms with respect to lawful behaviors
(2) deceitfulness
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness
(5) reckless disreagrd for safety of self or others
(6) consistent irresponsibility
(7) lack of remorse

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

they do not yield a score. Rather, the assessor determines if each (sub-) criterion is present/true or absent/false. The final decision is dichotomous — if the criteria are all present, then a lifetime diagnosis of APD is made; if one or more is absent, no such diagnosis is made[2]. Despite this, many researchers (e.g., Hart, Forth, & Hare, 1991) and some diagnostic interviews (e.g., Loranger, 1988) use the criteria to obtain dimensional APD "scores", such as symptom counts.

The DSM also does not specify a particular method for assessing APD. In the empirical literature, researchers have employed methods ranging from a structured interview to a semi-structured interview plus a review of case history information to file review alone. Structured interviews probably should be avoided unless the interviews are supplemented with case history information, as they may be highly susceptible to the effects of deceitfulness. Depending upon the method employed, assessment of APD probably takes 30 to 60 minutes.

Reliability. The DSM-IV criteria are too recent to have been the focus of published research. Unfortunately, the DSM-IV APD field trial provided no useful information in this respect because the APD criteria, as they appear in DSM-IV, were never actually tested in the field trial (Hare & Hart, 1995). Consequently, the reliability of the DSM-IV must be inferred from research on the DSM-III-R criteria (see Table 2).

Criterion A of DSM-III-R (B in DSM-IV) typically is not analyzed in studies, as it is a simple decision regarding the subject's age. It presumably has near-perfect interrater and short-term test-retest reliability in adults, with the only errors being due to assessor error or deceitfulness on the part of the subject.

Criterion B of DSM-III-R (C in DSM-IV) has moderate to high interrater reliability. Kappa coefficients of interrater agreement for the presence versus absence of this criterion, using the interviewer-observer method, have ranged from .34 to .69 (e.g., Hart, Forth, & Hare, 1992; Widiger et al., in press). Its temporal stability is unknown but almost certainly is moderate to high, given the stability of overall APD diagnoses (see below). However, problems have been identified with specific subcriteria.

Coolidge, Merwin, Wooley, and Hyman (1990) examined APD symptom self-reports in college students and their family members. They found that several subcriteria had extremely low prevalence rates and/or low item-total correlations; overall, the internal consistency of the subcriteria was moderate (alpha = .63). Using the Spearman-Brown prophecy formula, the estimated item homogeneity was also low to moderate (MIC = .12). It could be argued that the poor performance of the subcriteria directly resulted from the low prevalence of APD diagnoses in the sample (less than 10%). However, similar results were reported by Hart, Forth, and Hare (1992), who used an interview plus file review procedure in samples of incarcerated male offenders, forensic psychiatric patients, and college students. Despite a much

[2] The DSM does allow the assessor to use certain modifiers to clarify the diagnosis. For example, APD can be diagnosed as present but not currently active (i.e., in full or partial remission), or as probably present (i.e., provisionally diagnosed). Some researchers also structure their assessment methods to yield probabilistic diagnoses (e.g., Loranger, 1988).

Table 2
Summary of the DSM-III-R Criteria for Antisocial Personality Disorder

Criterion/Subcriterion

A. Current age at least 18

B. Conduct disorder before age 15, as indicated by at least three of the following:

1. Truant
2. Ran away
3. Fought
4. Used weapons
5. Forced sex on others
6. Cruel to animals
7. Cruel to people
8. Destroyed property
9. Set fires
10. Lied
11. Stole
12. Robbed

C. Antisocial behavior since age 15, as indicated by four or more of the following:

1. Poor employment record
2. Repeated criminal acts
3. Irritable and aggressive
4. Poor financial record
5. Impulsive
6. Lies
7. Reckless
8. Irresponsible parenting
9. No monogamous relationships
10. Lacks remorse

D. Occurrence of antisocial behavior not exclusively during the course of Schizophrenia or Manic Episodes.

higher prevalence of APD, at least in the two forensic samples (64.2% and 15.7%, respectively), a number of symptoms had low prevalence, low item-total correlations, or low interrater reliability. The internal consistency of the subcriteria was moderate (median alpha = .66), as was the item homogeneity (median value of mean inter-item correlation = .12). Symptoms identified as problematic in both studies included B-4 (Used weapons), B-5 (Forced sex on others), B-6 (Cruel to animals), B-7 (Cruel to people), and B-12 (Robbed)[3]. Note that all these problematic subcriteria were retained in DSM-IV.

Criterion C of DSM-III-R (A in DSM-IV) has adequate interrater reliability, with researchers reporting kappas of about .50 (Hart, Forth, & Hare, 1992; Stangl et al., 1985). Like criterion B, its temporal stability is unknown but presumably high. In addition to the Coolidge et al. (1990) and Hart, Forth, and Hare (1992) studies, evidence concerning the C subcriteria comes from the DSM-IV APD field trials (Widiger et al., in press). All three studies indicate that several subcriteria have low prevalence, poor interrater reliability, or low item-total correlations in both forensic and civil samples. The subcriteria that performed poorly in at least two studies were C-4 (Poor financial record), C-8 (Irresponsible parenting), and C-9 (No monogamous relationships). Internal consistency of the C subcriteria was low to moderate in the Hart, Forth, and Hare (1992) study (median alpha = .55) and item homogeneity was low (median value of mean inter-item correlation = .10).[4] None of these problematic subcriteria appear in DSM-IV; instead, they were collapsed into a single, broad subcriterion (A-6, Irresponsibility).

Criterion D in DSM-III-R (also D in DSM-IV) has not been analyzed in studies of the APD criteria. This finding is unfortunate, as there are at least two reasons to believe that the reliability of Criterion D may be low. First, the assessor must diagnose schizophrenia and manic syndrome — diagnoses which themselves are of imperfect reliability — in addition to APD. Second, the assessor must determine whether all the APD symptoms occurred during active periods of schizophrenia or mania.

Irrespective of any problems with its constituent criteria, there is general agreement that APD is adequately reliable, particularly relative to the other DSM-III-R Axis II disorders (Widiger et al., in press; but cf. Rogers & Dion, 1991). Interrater agreement, using the interviewer-

[3] Morey (1988a,b,c) examined the internal consistency of the 1985 draft DSM-III-R APD subcriteria. Results were not reported separately for B and C subcriteria. The overall alpha was .82 (Morey, 1988a,c); none of the B subcriteria had a corrected item-total correlation of less than .30 (Morey, 1988c).

[4] In Morey (1988c), the only C subcriterion that had a corrected item-total correlation less than .30 was Impulsive (.27).

observer method, was good in Hart, Forth, and Hare's (1992) inmate sample (kappa = .63) and fair to good in the DSM-IV field trials (median kappa = .50). Higher interrater reliability has been reported in studies that used structured diagnostic interviews (e.g., Jackson et al., 1991; kappa = 1.00). APD diagnoses also have acceptable test-retest reliability, at least over brief periods of time (e.g., Alterman, Cacciola, & Rutherford, 1993)[5]. APD assessments appear to be relatively unaffected by state variables, such as subjects' mood at the time of assessment (Widiger et al., in press).

Norms. There are no systematic norms concerning the prevalence of DSM-III-R APD symptoms or diagnoses. The recent DSM-IV field trials for APD (Widiger et al., in press) reported prevalence rates in five settings, each with approximately 100 subjects. The settings and prevalence rates were as follows: outpatient substance abusers attending a VA clinic, 17%; male prison inmates, 70%; psychiatric and substance abuse inpatients, 36%; adopted-away offspring, 1%; and psychiatric inpatients, 34%. Other research confirms a high prevalence rate (typically 50% to 75%) in forensic populations using either DSM-III or DSM-III-R criteria (Correctional Service of Canada, 1990; Hare, 1983, 1985; Hart, Forth, & Hare, 1992; Hart & Hare, 1989; Roesch, in press).

Some inferences can be drawn about the prevalence of APD from the results of the Epidemiologic Catchment Area (ECA) project (Robins & Regier, 1991), which used the DSM-III criteria. In the ECA, a structured interview, the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981), was administered to a stratified random sample comprising nearly 20,000 adults residing in five large geographic centers in the United States. The respondents included community residents, as well as those institutionalized in psychiatric hospitals, geriatric homes, prisons, and residential substance use programs. According to Robins, Tipp, & Przybeck (1991), the lifetime prevalence of APD was 2.6% (SE = 0.16%). APD prevalence rates were significantly higher in men versus women (by a factor of about 5), in urban versus rural residents (by a factor of about 2), and in those below age 30 versus those above age 64 (by a factor of about 10). There were no significant racial differences in prevalence.

Validity. The content-related validity of the DSM-III-R APD criteria were severely criticized on a number of grounds.

First, the content of the criteria and subcriteria was thought by many writers to be too long, overly-specific, and arbitrary — in the words of Millon (1981), "picayunish". Their complexity apparently gave rise to a number of problems, including an over-reliance on retrospective self-reports for assessment, a failure to adhere to the actual criteria in clinical practice, and extreme heterogeneity among those meeting the criteria (Hare, Hart, & Harpur, 1991; Morey & Ochoa, 1989; Rogers & Dion, 1991).

Second, the criteria appeared to assess primarily the social deviance facet of psychopathy, ignoring many affective and interpersonal symptoms (Hare, 1985; Hare, Hart, & Harpur, 1991; Millon, 1981). Even in their assessment of social deviance, they may have focused too much on rare, violent symptoms (Rogers & Dion, 1991). Thus, in the opinion of many commentators, they were virtually synonymous with severe and persistent criminality (e.g., Hare, 1991). As Widiger et al., (in press) notes, such criticism led to speculations that the criteria were at once both too broad, overdiagnosing APD in criminal populations, and too narrow, failing to identify true psychopaths in noncriminal populations[6].

Third, some of the criteria were criticized on logical grounds. For example, Criterion A may have been unnecessary. DSM-III-R made clear in its overview to Axis II that personality disorders persist into adulthood. Thus, no APD diagnosis should be made in the case of someone whose antisocial behavior spontaneously remits after adolescence. No other Axis II disorders included an age criterion. Similarly, Criterion B itself may have been redundant. The DSM-III-R stated that symptoms of a personality disorder are usually first evident in childhood, and no other Axis II disorder had specific childhood symptoms that were a necessary criterion.

Finally, Criterion D, like other exclusionary criteria in the DSMs, was of unknown validity (Boyd et al., 1984). Note that although the DSM-IV criteria set for APD is shorter and somewhat less picayune, many of the criticisms raised against DSM-III-R are still relevant. In particular, the revisions in DSM-IV did nothing to improve the coverage of interpersonal and affective features.

Once again, due to the fact that the DSM-IV criteria are new and have not been the subject of published research, this review of the criterion- and construct-related validity of APD is based on research using DSM-III or DSM-III-R criteria. With respect to concurrent validity, DSM-III and DSM-III-R APD diagnoses are correlated .55 with PCL-R total scores, and have moderate to high levels of agreement with the PCL-R (Hare, 1983, 1985, 1991). Similar levels of agreement were observed between

[5] Given the monothetic nature of the criteria, their internal consistency is irrelevant; however, it is of interest to note that the association between the presence versus absence of Criteria B and C was only moderate in the Hart, Forth, & Hare (1992) study, with kappas of .15, .32, and .67 in the inmate, forensic patient, and student samples.

[6] Interestingly, Morey (1988a) found that symptoms of APD tended to covary with certain symptoms of other personality disorders (e.g., narcissistic, passive-aggressive) to form a cluster that he labelled "psychopathic". This tends to support the view that, although the APD symptoms may be internally consistent, they fail to provide adequate coverage of the domain of the psychopathy construct.

APD and the ICD-10 criteria for dysocial personality and criteria for psychopathic personality disorder (based on the PCL-R) in the DSM-IV APD field trials (Widiger et al., in press). Turning to self-report measures, APD diagnoses have low to moderate correlations, typically around .30, with MCMI-II Antisocial/Aggressive (*6A*) and Sadistic (*6B*) scales, MMPI Psychopathic Deviate (*Pd*) and Hypomania (*Ma*) scales, and the CPI Socialization (*So*) scale (Hare, 1985; Hart, Forth, & Hare, 1992). When dimensional measures of APD (e.g., symptom counts) are used, the correlations are somewhat higher, but still only moderate in magnitude (Hart, Forth, & Hare, 1992; Widiger et al., in press). However, these relatively low correlations may reflect a problem with the self-report scales rather than with the APD criteria.

There has been little research looking at the predictive validity of APD. There is limited evidence that APD is associated with poor response to treatment in substance abuse and correctional treatment programs (e.g., Woody & McLellan, 1985; Harris et al., 1991). However, its predictive efficiency appears to be weak both in absolute terms and relative to that of other measures, such as the PCL-R (e.g., Hare, 1991; Hart et al., 1988; Harris et al., 1991).

With respect to construct-related validity, there is a large body of literature examining the association between APD and substance use. Probably the most common findings are that APD is significantly comorbid with substance use disorders and that substance use patients with APD are more socially deviant or have worse treatment outcomes than other patients (e.g., Liskow & Powell, 1990, 1991; Stabenau, 1990; Woody & McLellan, 1985). Another common finding in the personality disorder literature is that APD frequently is comorbid with other Axis II, Cluster B (Dramatic-Erratic-Emotional) disorders, particularly borderline personality disorder (e.g., Gunderson, Zanarini, & Kisiel, 1991). These findings are not inconsistent with clinical views of psychopathy, and can thus be considered evidence supporting the concurrent validity of APD (although the comorbidity with substance use may be great enough to impede differential diagnosis; Gerstley, Alterman, McLellan, & Woody, 1990). However, there is also evidence of unexpected or theoretically inconsistent comorbidity, such as overlap with schizophrenia and mania when the exclusion criterion (D) is ignored (Boyd et al., 1984; Robins et al., 1991).

There is no systematic experimental evidence to support the construct-related validity of the APD criteria. Other reviewers (e.g., Widiger et al., in press; Widiger & Corbitt, 1995) have referred to a body of supportive evidence that includes biochemical, genetic, and adoption studies, but many (if not most) of the studies cited did not use the actual DSM-III or DSM-III-R criteria, so the equivalence of DSM-III(-R) and other (e.g., RDC or Feighner et al., 1972) criteria is questionable (Widiger et al., in press) and the relevance of these studies is unclear.

Summary. Little is known about the DSM-IV criteria for APD. The DSM-III-R criteria for APD have adequate interrater reliability and temporal stability, although some of the subcriteria have extremely low prevalence, poor interrater reliability, and/or low item-total correlations; DSM-IV is likely to be similar with respect to reliability. There are no normative data for DSM-III-R or DSM-IV symptoms or diagnoses. DSM-IV will likely have marginal to fair criterion and construct-related validity, similar to that of DSM-III and DSM-III-R; however, its content-related validity is uncertain.

Much of the criticism reviewed here suggests that the APD criteria focus too much on antisocial behavior, lack a clear two-facet structure, and may be indistinguishable from severe or persistent criminality. These are serious weaknesses that make the APD criteria problematic for research and clinical practice in forensic populations. On the other hand, they have two potential strengths. First, with respect to chronicity, they are likely to be relatively stable over time. Second, at least when the assessment is based on collateral information in addition to interview data, they may be relatively immune to the effects of deceitfulness.

Hare Psychopathy Checklist-Revised (PCL-R)

In this review of existing assessment procedures, the Hare Psychopathy Checklist-Revised is important. A description of the instrument and an examination of its reliability, norms, and validity follows.

Description. The PCL-R is a 20-item symptom construct rating scale intended for use in forensic (i.e., correctional and forensic psychiatric) settings. To control for the effects of deceitfulness, ratings are made on the basis of a semi-structured interview and a review of collateral information (although they can also be based on collateral information alone, if necessary). Each item consists of a one-page description of a rather complex, high-level trait (e.g., Shallow Affect or Criminal Versatility); the summary labels of the items are presented in Table 3. The response format is a 3-point scale (0 = item does not apply, 1 = item applies somewhat, 2 = item definitely applies); items also can be omitted under certain conditions. Individual items are summed (and prorated if items were omitted) to yield dimensional scores ranging from 0 to 40 that reflect the severity of psychopathic traits. A cutoff score also can be used to yield lifetime diagnoses of psychopathy ($\leq$ 29 = nonpsychopath; $\geq$ 30 = psychopath). In addition, the PCL-R yields factor scores reflecting the two facets of psychopathy. Administration and scoring of the PCL-R takes about 2½ to 3 hours.

The PCL-R was constructed using a mixture of methods. First, more than a hundred items were generated through a literature review and clinical experience. Second, these items were piloted and those that were redundant or could not be scored reliably were dropped.

Table 3
Items in the PCL-R

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

Third, the shortened item pool was used on a sample of adult male inmates for whom clinical global ratings of psychopathy were available. Items were dropped if they did not discriminate between those identified as psychopaths and nonpsychopaths according to the global ratings or if they did not correlate with the other items.

The original target population of the PCL-R was incarcerated adult male offenders (Hare, 1991) and most research using the scale has focused on Caucasian, North American offenders in federal or state/provincial prisons. However, the PCL-R has also proved to be useful in research on forensic psychiatric patients (Hart & Hare, 1989; Rice et al., 1992) and has been used with female offenders, young offenders, a variety of ethnic minority offender groups, and offenders in Britain and Europe. Some researchers have even used the PCL-R with noncriminals (see Hare, 1991).

Reliability. In the PCL-R manual, Hare (1991) presents summary reliability data from 11 forensic samples (N = 1,632). The individual PCL-R items have acceptable prevalence, interrater reliability, and item-total correlation. The internal consistency reliability is quite high — the median alpha coefficient across the 11 samples was .87, and the median MIC (mean inter-item correlation) was .25. The interrater reliability of total scores is acceptable — the median intraclass correlation coefficient for PCL-R total scores (ICC_1; Bartko, 1976) in 6 samples that used multiple raters was .88. For clinical purposes, it is probably best to average two independent ratings; the effective interrater reliability using this procedure (ICC_2) was .94. PCL-R diagnoses of psychopathy also have acceptable interrater reliability. Kappa coefficients of agreement between independent raters reported in various studies range between .50 and .80 (e.g., Hart, Forth, & Hare, 1991; Hart & Hare, 1989)[7].

Only one study has looked at the temporal stability of the PCL-R (Alterman et al., 1993). In that study, which looked at 88 adult men attending a methadone maintenance program, the one-month test-retest reliability (r) of total scores was .89. This estimate is similar to that reported for the PCL over a 10-month interval in 42 adult male inmates (Schroeder, Schroeder, & Hare, 1983). There is considerable evidence that PCL-R scores are uncorrelated with subjects' emotional states (state anxiety or dysthymia) at the time of assessment (Hare, 1991).

The PCL-R factors are less reliable than total scores. This unreliability is to be expected, given that the factor scales are shorter in length than the total scale (8 items for Factor 1 and 9 items for Factor 2, versus 20 items for the full scale). Nevertheless, the factor scores are sufficiently reliable for research purposes (Alterman et al., 1993; Hare, 1991).

[7] All the interrater reliability data described here were obtained using the interviewer-observer method.

Norms. The PCL-R presents normative data for total and factor scores from 7 samples of adult male prisoners (N = 1192) and 4 samples of adult male forensic psychiatric patients (N = 440). The distribution of scores varies little within the two settings, despite differences between the samples in principal investigator, country of origin, institution security level, subject's legal status, and sampling technique employed. Demographic variables such as age and race appear to have a small but statistically significant association with PCL-R scores. Similar results have been reported for the PCL (Hare, 1991).

Although the PCL-R has been used with female offenders (e.g., Neary, 1990), young offenders (e.g., Forth, Hart, & Hare, 1990), and noncriminals, no norms were available for these populations when this manual was written.

Validity. No discrimination has been made between research based on the PCL and PCL-R, as evidence indicates that the two scales are highly correlated and can be considered parallel forms (Hare, 1991).

The PCL and PCL-R have good content-related validity, as evidenced by their clear two-facet structures. Perhaps the only weakness is that the items were developed and intended for use in forensic populations. This creates two possible problems for their use with noncriminals. First, the base rate of psychopathy or psychopathic symptoms probably differs greatly from that of the PCL and PCL-R validation samples; consequently, the reliability and validity of the items may be diminished. Second, three items from the PCL and PCL-R are scored on the basis of formal criminal records, making them difficult to score in noncriminals. (Alternatively, these items can be omitted in noncriminals and total scores prorated.) There are preliminary data showing that these problems do not render the PCL-R invalid for use with noncriminals, although they may decrease its utility somewhat (see Hare, 1991).

The concurrent validity of the PCL and PCL-R is good. They are moderately to highly correlated with clinical global ratings of psychopathy, ratings made using Cleckley's 16 criteria, and APD diagnoses and ratings, typically in the range of .55 to .85 (Hare, 1980, 1985, 1991). Their correlations with the MMPI *Pd*, MCMI-II *6A*, and CPI *So* scales are rather low, averaging about r = .30 in magnitude; however, as noted earlier, this probably reflects problems with the self-report measures (Hare, 1985, 1991; Hart, Forth, & Hare, 1991).

The predictive validity of the PCL scales is also good, particularly given the rather poor performance of most psychological tests and diagnoses in the prediction of criminal behavior. More than a dozen studies conducted in Canada and the United States indicate that PCL/PCL-R scores are correlated with antisocial and violent behavior both inside and outside of correctional institutions, including recidivism following conditional release from prison, response to correctional treatments, and institutional misconduct (see Hare, 1991; Hare & Hart, 1993). Psychopaths also have criminal careers — patterns of violent and nonviolent offending across the life span — that are quite different from those of nonpsychopaths (Hare, McPherson, & Forth, 1988; Williamson, Hare, & Wong, 1987). In studies that have compared the ability of various measures to predict criminal behavior, the PCL and PCL-R scales perform as well as, or better than, other measures of psychopathy (such as APD or the MMPI) and actuarial risk assessment scales (Hare, 1991; Rice et al., 1992; Serin, Peters, & Barbaree, 1990; Simourd, Bonta, Andrews, & Hoge, 1990).

The PCL and PCL-R have a clear pattern of convergent and discriminant validities, the interpretation of which is greatly clarified by analysis of the two factors. Like APD, the PCL scales are significantly associated with substance use disorders; however, this association is due entirely to Factor 2 (Hart & Hare, 1989; Hemphill, Hart, & Hare, 1994; Smith & Newman, 1990). Similarly, the PCL and PCL-R correlate positively with DSM-III-R Cluster B personality disorders and negatively with several Cluster C disorders; however the association is due primarily to Factor 1 (except for the correlation with APD, which is due primarily to Factor 2; Hare, 1991; Hart & Hare, 1989). The factors also have distinct patterns of correlations with self-report measures of personality: Factor 1 correlates negatively with anxiety and empathy, and positively with narcissism and dominance; Factor 2 correlates positively with sensation-seeking and impulsivity, and negatively with nurturance (Harpur et al., 1989; Hart, Forth, & Hare, 1991; Hare, 1991). Similar results have been found using projective measures (e.g., Gacono, Meloy, & Heaven, 1990). The PCL-R has good clinical specificity with respect to DSM-III-R Axis I and Axis II Cluster C disorders, both in absolute terms (Hart & Hare, 1989; Raine, 1986) and relative to other measures such as the MMPI (Howard, Bailey, & Newman, 1984; but cf. Howard, 1990).

Finally, there are more than 20 published experimental investigations supporting the construct validity of the PCL and PCL-R. Although psychopaths have no apparent brain damage (at least as measured by standard neuropsychological measures; see Hare, 1984; Hart, Forth, & Hare, 1991), psychopaths have linguistic functions that are abnormal and/or weakly lateralized in the cerebral hemispheres and they give unusual behavioral and physiological responses to affective stimuli (see Hare, Williamson, & Harpur, 1988; Williamson, Harpur, & Hare, 1990). In addition, psychopaths show little physiological arousal in anticipation of noxious stimuli. Together with the results of many studies on learning and attentional processes in psychopaths, this unresponsiveness has been interpreted as evidence of an adaptive coping response. This method of coping helps them to selectively ignore cues of impending punishment but also makes them susceptible to over-focusing on reward cues (for a review, see Harpur & Hare, 1990).

It is worth noting here that the construct validity of psychopathy does not seem to be unduly affected by race (Kosson, Smith, & Newman, 1990; Wong, 1984). Indeed, recent research by Cooke and Michie (1995) using item response theory suggests that the PCL-R has good generalizability across settings (correctional versus forensic psychiatric) and ethnic minorities (e.g., Caucasian versus African-American) within North America, and also has cross-cultural generalizability (e.g., North America versus Scotland).

Summary. The PCL-R has excellent psychometric properties, although there has been relatively little research looking at its temporal stability. It has good normative data for male forensic populations. There is considerable research supporting all facets of the PCL-R's validity.

Like APD, the PCL-R appears to measure a chronic disorder. As a measure that is based in large part on file review, it also appears to be relatively immune to deceitfulness. However, unlike APD, the PCL-R has a clear two-facet structure. In addition, it predicts crime while at the same time its content is not too focused on criminality.

The target population of the PCL-R is adult male offenders. It has been used with female offenders, young offenders, and noncriminals, but no normative data were available for these groups when this manual was released. Also, some of the PCL-R items may not be relevant for use with noncriminals. Additionally, completion of the PCL-R is a rather lengthy process that requires access to collateral information (at least in clinical settings). These factors may decrease the PCL-R's attractiveness to clinicians working in civil psychiatric and other noncriminal settings.

Summary of Evaluations

Several conclusions can be drawn from the review presented above. First, and most general, it appears that none of the existing assessment procedures for psychopathy are without significant limitations with respect to reliability, validity, or clinical utility. This is important, as it suggests that there is a need for new measures that may complement the existing procedures. Second, as Hare (1985) concluded, "clinical-behavioral" procedures (i.e., those that employ expert ratings based on interview and case history data) appear superior to self-report procedures, particularly in terms of validity and ability to control for deceitfulness. Therefore, the development of a new scale may have maximal chance for success if it uses an expert rater format, as opposed to a self-report format. Third, of the procedures reviewed, only the PCL-R has a clear two-facet structure, and this structure has proven extremely useful for clarifying research results. Consequently, any new measure of psychopathy should start with an explicit two-facet structure, taking advantage of research on the PCL-R.

Chapter Three
Development of the PCL:SV

Several key decisions about design were made by the authors of the instrument. First, it was decided that the measure must be developed according to psychometric theory and evaluated according to standard psychometric criteria. Second, it was decided that the PCL:SV must be conceptually and empirically related to the PCL-R. This inclusion would help to maximize the scale's chances for success (as discussed in Chapter 1) and would also allow the scale to tap into the extensive empirical literature supporting the validity of the PCL-R. Third, to maximize its utility, it was decided that the PCL:SV must be suitable for use in a wide range of settings (including civil and forensic psychiatric populations) and require relatively little time, effort, and training to administer and score.

In order to meet the first two requirements, the PCL:SV retains the format that proved so successful with the PCL-R — namely, an expert-rater, symptom-construct rating scale. Like the PCL-R, the PCL:SV yields both dimensional and categorical indexes of psychopathy. It also has an explicit two-facet structure.

Fulfilling part of the third requirement of suitability for use in a wide range of settings did not appear to be problematic. Previous research had indicated that psychopathy, as defined by the PCL-R, could be measured reliably in forensic psychiatric patients (e.g., Harris et al., 1991; Hart & Hare, 1989). However, more of a concern was that all the previous research on the PCL (-R) had been conducted in forensic settings and the content of some items had to be revised to make them appropriate for use with noncriminals. Another requirement — brevity — could be fulfilled relatively easily by decreasing the number of items in the new scale. The high internal consistency of the PCL-R suggested that there was a degree of redundancy among the original items and that it should be possible to reduce the number of items. The main concern was that decreasing the number of items would decrease interrater reliability. The issue of training was not perceived to be a major problem, as experience suggested that even undergraduates could be taught to make reliable PCL-R assessments of psychopathy.

First Draft: The Clinical Version of the PCL-R (CV)

The first attempt to develop a new, shorter version of the PCL-R resulted in the Clinical Version of the PCL (CV; Cox, Hart, & Hare, 1989). One purpose of the CV was for use in screening jail remands. Because initial assessment interviews in a jail typically are very brief (perhaps 20 to 30 minutes) and because there is often limited access to case history information, the CV consisted of items that were rated primarily on the basis of interview (i.e., stylistic or interpersonal) data. Another purpose was for use in treatment outcome studies, which require measures that may be sensitive to changes in symptom severity over time. It was hoped that the time frame for scoring the CV items could be changed from lifetime to a shorter period (i.e., the past month). The CV contained only six items: *Superficial, Grandiose, Deceitful, Lacks Remorse, Lacks Empathy,* and *Doesn't Accept Responsibility.* The content of these items was derived directly from the PCL-R, but the item descriptions were short, presented in point form, and scored on the basis of a brief interview (10 to 20 minutes). As in the PCL-R, items were scored on a 3-point scale; total scores ranged from 0 to 12. The CV was tested in three different studies.

Cox, Hart, and Hare (1989)

Cox, Hart, and Hare tested the CV at the Vancouver Pretrial Services Centre (VPSC), a maximum security jail in Vancouver, Canada. Subjects in this study were 100 males remanded in custody (awaiting trial or a bail hearing) who were referred to staff psychologists for medical, psychological, or security reasons. Systematic data on the demographic characteristics of these men was not collected. It was noted, however, that they ranged in age from 18 to over 60 years, most were Caucasian and English-speaking, and most were charged with violent or other serious offenses. Almost all the men had a previous criminal record. Although the sample was not representative of all inmates at VPSC, it was probably very representative of inmates who are monitored or screened by psychologists after admission.

One of the researchers was employed as a consulting psychologist at the VPSC. He and another researcher conducted a series of 100 joint assessments following the usual institutional procedures. Interviews covered the following areas: current charges and past criminal history; educational, occupational, and marital status; and current medical/psychological complaints. Brief counseling followed some interviews. All available case history information was reviewed. Assessments lasted from 5 to 30 minutes, and averaged about 20 minutes. After each assessment, both raters independently scored the CV and reviewed any scoring differences. All data were kept confidential and were not released to VPSC medical or security staff.

The mean CV score (averaged across the two raters) was 6.24 (*SD* = 2.45). The intraclass correlation coefficient interrater reliability for the single ratings (ICC_1) was .86; the reliability of the averaged ratings (ICC_2) was .92. The interrater reliability (*r*) of the individual items ranged from .52 to .73. Reliability analyses based on the averaged ratings revealed an MIC of .51 (range = .40 to .69); internal consistency, as measured by Cronbach's alpha, was .86.

The MIC and alpha coefficients indicated that the CV could be considered a unidimensional measure. To investigate this issue further, a principal components analysis (PCA) of the averaged ratings was conducted. The PCA yielded one large component (eigenvalue = 3.54) accounting for 59% of the common item variance; all other components were much smaller (eigenvalues $\leq$ .71) and each accounted for less than 12% of the remaining variance. All the CV items had high loadings ($\geq$ .69) on the first principal component; Item 1 (*Superficial*) had the highest loading (.84).

The cutoff score for a research diagnosis of psychopathy on the PCL-R is 30, a score that is approximately 1 *SD* above the mean in most samples of male inmates (Hare, 1991). The comparable cutoff score for the CV was 9. This cutoff score was used to divide the two original sets of CV ratings into two groups: those with a score of $\geq$ 9 were defined as psychopaths, and those with a score of < 9 were considered to be nonpsychopaths. Using these categories, the kappa coefficient of diagnostic agreement between the two raters was .93. Applying the above cutoffs to the averaged CV ratings, the base rate of psychopathy in the sample was 15%.

Roy (1988)

Roy examined the utility of "present-state" CV ratings (those made solely on the basis of an interview and without access to case history information). He determined the concurrent validity of these ratings in a sample of 60 male federal inmates. All subjects previously had been assessed by independent researchers using PCL-R and DSM-III-R criteria. Roy reassessed them between 1 and 24 months later and made CV ratings on the basis of a 30 to 40 minute interview. Subjects ranged in age from 20 to 58 years (*m* = 30.5, *SD* = 8.7) serving aggregate sentences of two years or longer, mostly for violent offenses.

The mean CV score in the sample was 6.7 (*SD* = 2.2), the mean PCL score was 26.6 (*SD* = 7.7), and the mean PCL-R score was 23.6 (*SD* = 8.2). Using DSM-III criteria, 35% of the subjects met the criteria for APD; for DSM-III-R criteria, the figure was 41.7%. Roy (1988) reported that the interrater reliability of the PCL-R in his sample was *r* =.74 but he did not report reliabilities for the other measures.

CV scores were correlated *r* = .42 with PCL Total scores and *r* = .38 with PCL-R Total scores. Correlations with Factor 1 scores on the PCL and PCL-R were somewhat higher (*r* = .54 and .47, respectively), whereas correlations with Factor 2 were lower (*r* = .23 and .22, respectively). Interestingly, the CV was uncorrelated with DSM-III and DSM-III-R diagnoses of APD (*r* = -.08 and -.09, respectively). Multiple regression analyses indicated that CV scores in combination with APD diagnoses predicted PCL and PCL-R Total scores significantly better than did either CV scores or APD diagnoses alone (multiple R^2s ranging between .38 and .51)[8].

Roesch (in press)

Roesch used the CV in another study of pretrial remands at VPSC. The random sample consisted of 861 men admitted to the jail over a 12-month period. The subjects ranged from 18 to 71 years of age (*M* = 30.4, *SD* = 9.2), and most (82.3%) had a prior criminal record as an adult. Of these subjects, 684 (79.4%) completed an interview-based mental health screening battery that included, in addition to the CV, the following instruments: a 19-item symptom construct rating scale of general psychopathology called the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962; a brief structured interview for major mental disorders called the Referral Decision Scale (RDS; Teplin & Swartz, 1989); and a 7-item syndrome construct rating scale called the Diagnostic Profile (DP — Hart & Hemphill, 1989). Standard cutoffs were applied to the BPRS and the DP: Subjects with an elevation on at least one scale were classified as mentally disordered offenders (MDOs) and subjects with no hits were designated as non-MDOs. A random subsample of 192 subjects, stratified according to MDO status, were subsequently administered the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981). Also, conjoint screening interviews were conducted with 45 subjects to determine the interrater reliability of the rating scales.

Complete CV ratings were available for 651 subjects. The mean CV total score was 4.58 (SD = 3.16); using a cutoff of $\geq$ 9, the base rate of psychopathy was 13.1%. These figures are similar to, although slightly lower than, those reported by Cox et al. (1989). The internal consistency and item homogeneity of the CV were high (alpha = .88; MIC = .56). In the subsample of 45 subjects, the interrater reliability of the CV was acceptable (ICC_1 = .80, ICC_2 = .90), as was interrater agreement for psychopathy diagnoses (kappa = .73).

A principal components analysis of the CV items once again yielded a single large component (eigenvalue = 3.79) accounting for 63.2% of the common item variance; all other components were much smaller (eigenvalues $\leq$ .72) and accounted for 12% or less of the remaining variance each. All the CV items had high

[8] It should be noted that none of the above correlations was disattenuated for the unreliability of the various measures across time or raters.

loadings (≥ .74) on the first principal component; Item 4 (*Lacks Remorse*) had the highest loading (.83).

With respect to validity, CV scores had a small but significant negative correlation with status as a MDO (r = -.11, p = .004). Looking at the DP, the CV also had a small negative correlation with scores on the Depressed and Organic syndrome scales (r = -.13 and -.12, respectively, both $p \leq .002$). On the BPRS, the CV was correlated positively with factors related to grandiosity (r = .43, $p <$ .001) and hostility (r = .30, $p < .001$), and negatively correlated with factors of dysthymia (r = -.30, $p < .001$) and psychomotor retardation (r = -.12, $p < .002$). In the subsample assessed with the DIS, CV scores had small positive correlations with APD diagnoses (made ignoring the exclusion criterion) (r = .16, p = .032) and small negative correlations with diagnoses of sexual disorders (r = -.19, p = .008).

Summary

The results of these three studies were encouraging, and suggested that it was indeed possible to shorten the PCL assessment procedure. However, two major problems were apparent with the CV. First, factor analyses of the PCL and PCL-R conducted subsequent to the construction of the CV (Harpur et al., 1988; Hare et al., 1990) revealed that all six CV items reflected only Factor 1 of the PCL scales. That is, the CV neglected the social deviance component of psychopathy. The CV's relatively low correlations with PCL(-R) Factor 2 (Roy, 1988) and APD diagnoses (Roesch, in press; Roy, 1988) support this view. The second problem was that the CV allowed ratings to be made in the absence of case history information. There was some evidence that such a procedure might result in a drop in reliability or validity (Roy, 1988); in addition, it might make the CV unduly susceptible to deceitfulness. Given these arguments, it is clear that the CV must be considered flawed as a measure of psychopathy.

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Rather than develop a second scale *de novo*, it was decided to retain the CV's format and expand its content. The six CV items were relabeled **Part 1**, analogous to Factor 1 of the PCL-R. Six new items were then added to tap Factor 2 symptoms: *Impulsivity*, *Poor Behavioral Controls*, *Lacks Goals*, *Irresponsibility*, *Adolescent Antisocial Behavior*, and *Adult Antisocial Behavior*. These were labeled **Part 2**. In order to make the last two items more suitable for use outside of forensic settings, their content was significantly altered from the original PCL-R descriptions to include actions that did not result in formal contact with the criminal justice system. It was also decided to make the use of case history information a requirement for scoring (at least for clinical purposes). The result of these efforts was a 12-item scale, the Screening Version of the Psychopathy Checklist (PCL:SV).

The PCL:SV's name is an explicit recognition of its derivation from the PCL-R with respect to content and format. Items are scored using the same 3-point scale as in the PCL-R. Also, raters have the option of omitting as many as two items if they feel there is insufficient information with which to score the items; scores are prorated to adjust for the missing items.

The PCL:SV yields three dimensional scores. **Total** scores (the sum of Items 1 through 12) can range from 0 to 24, and reflect the degree of overall psychopathic symptomatology exhibited by the individual. **Part 1** scores (sum of Items 1 through 6) can range from 0 to 12 and reflect the severity of the interpersonal and affective symptoms of psychopathy (i.e., PCL-R Factor 1). **Part 2** scores (sum of Items 7 through 12) can also range from 0 to 12, and reflect the severity of the social deviance symptoms of psychopathy (i.e., PCL-R Factor 2).

Research regarding use of the PCL:SV for classification is ongoing, but at the present time some approximate cutoff scores can be suggested. Scores of 18 and above on the PCL:SV (roughly equivalent to a score of 30 on the PCL-R) are usually only obtained by psychopaths and this cutoff will be of use in diagnostic situations. On the other hand, scores of 12 or below on the PCL:SV (roughly equivalent to 20 on the PCL-R) are usually only obtained by non-psychopaths. This lower cutoff is more appropriate in non-forensic settings or for screening purposes. In practice, those scoring 12 or lower on the PCL:SV can be considered non-psychopathic. Those scoring 13 through 17 may be psychopathic and should be further evaluated, including an administration of the full PCL-R. Scores of 18 or more offer a strong indication of psychopathy and warrant an administration of the full PCL-R. It is important to recognize that no single cut-off score will be perfect for all applications and situations.

With respect to ease of administration, scoring, and training, note that the 12-item PCL:SV represents a 40% reduction in length relative to the 20-item PCL-R. In addition, the PCL:SV excludes PCL-R items that are scored on the basis of detailed, highly specific, or difficult-to-confirm information (e.g., marital or sexual history). Pilot testing revealed that the PCL:SV interview could be completed in 30 to 60 minutes, with the case history review and scoring requiring a further 20 to 30 minutes — a 50% reduction in administration time relative to the PCL-R. Also, raters with varied educational and professional backgrounds, from undergraduates to clinical psychologists, were easily trained with a program consisting of a 3-hour lecture and 10 practice ratings; the usual training program for the PCL-R involves 8 to 16 hours of lecture plus the practice ratings.

In summary, the PCL:SV provides a cost-effective way to assess both the interpersonal/affective as well as the social deviance symptoms of psychopathy within and outside of forensic settings.

Chapter Four
Administration of the PCL:SV

This chapter describes appropriate uses for the PCL:SV, methods for administration, scoring procedures and examples, and item descriptions.

Uses and Users

The PCL:SV can be used in both applied and research settings, provided that users have appropriate training and expertise in the areas of psychopathology and psychometric assessment.

Applied Settings

In applied settings, the PCL:SV is administered to men and women over the age of 16 for psychodiagnostic purposes. In a forensic context, the primary use of the PCL:SV is to screen for psychopathy — individuals who receive high scores may be referred for follow-up assessment using the PCL-R. In a civil psychiatric or community (e.g., pre-employment screening) context, the PCL:SV is used to assess and diagnose psychopathy. Because an individual's scores may have important consequences for his or her future in such settings, it is critically important to ensure that the scores are accurate.

The potential for harm is considerable if the PCL:SV is used incorrectly, or if the user is not familiar with the clinical and empirical literature pertaining to psychopathy.

Users should:

- Possess an advanced degree in the social, medical, or behavioral sciences, such as a Ph.D., D.Ed., or M.D.;
- Have expertise (graduate education, supervised training, and clinical experience) in psychopathology and psychometric assessment;
- Be registered with a state or provincial professional body that regulates the assessment and diagnosis of a mental disorder (e.g., psychological or psychiatric association) or working under the direct supervision of a registered professional;
- Be familiar with the clinical and empirical literature pertaining to psychopathy, specifically with the research described in the manual for the Hare Psychopathy Checklist - Revised (Hare, 1991);
- Avoid administering the PCL:SV using non-standard procedures or in populations where it has not been validated (e.g., children, adolescents aged 15 or younger);
- Ensure that they have adequate training and experience in the use of the PCL:SV. See the section describing appropriate training (this page).

Wherever possible, it is recommended that the PCL:SV scores of two independent raters should be averaged to increase the reliability of the assessment results.

Research Settings

In research settings where PCL:SV scores are kept confidential and thus have little or no potential for harming the individual, user qualifications are less stringent.

Researchers or (if currently enrolled in a graduate training program or medical school) their supervisors should:

- Possess an advanced degree in the social, medical, or behavioral sciences, such as a Ph.D., D.Ed., or M.D.;
- Have expertise (graduate education, supervised training, and clinical experience) in psychopathology and psychometric assessment;
- Be responsible for the supervision of raters with lesser qualifications (e.g., research assistants with undergraduate degrees in the social or behavioral sciences).

Researchers should provide formal training to raters and evaluate the reliability of the raters' assessments before they begin actual data collection. There is no restriction on the type of research setting in which the PCL:SV may be used. The usual PCL:SV administration procedures can be changed according to the requirements of the research; however, such changes should be noted in any formal communications or published reports based on the research.

Training

Formal training in the use of the PCL:SV helps to increase the reliability of ratings, although it is neither necessary nor sufficient to ensure reliability. It is recommended that training programs cover three major topics:

- **The nature and assessment of psychopathy.** A review of the concept of psychopathy, problems in assessing the disorder, research on the PCL and PCL-R, and the psychometric properties and validity of the PCL:SV.
- **The PCL:SV assessment procedure.** A discussion of interviewing techniques, chart reviews, and collateral informants.

- **PCL:SV scoring.** Raters should have a chance to watch several videotapes of assessment interviews to help them establish a set of "internal norms" for scoring individual PCL:SV items. It is recommended that ratings on five to ten practice cases be completed before users administer the PCL:SV for clinical purposes.

The time required to train raters depends on their level of clinical and/or forensic experience. Experienced clinicians have been trained to make reliable ratings using a brief, 2˙ hour training program. Less experienced raters may require a 1- or 2-day training program. A large group format often is as effective as a small group or individual format for training and much more economical. Users have been known to form small groups to review their own case materials and get feedback on their ratings.

A package of materials (case histories plus accompanying videotaped interview clips) is being developed for training groups or individuals. Contact Multi-Health Systems Inc. for information.

The PCL:SV Assessment Procedure

The PCL:SV assessment procedure, among other things discussed in this chapter, involves interviewing, confirming claims made by the subject, and handling conflicts between sources of information. These tasks are discussed below.

Interviewing

An interview is one of the two key data sources on which the PCL:SV is rated, the other being charts or collateral informants. The interview is used to collect historio-demographic data and to sample the individual's interpersonal style. The former is used primarily to score items in Part 2 of the PCL:SV, whereas the latter is used primarily to score Part 1 items.

The use of semi-structured, rather than structured interviews, is recommended. Some structure aids the interviewer in collecting necessary content-related information, but too much structure can hinder rapport-building and obscure interactional style. For example, with a semi-strutured interview, interviewers can use their clinical skills to elicit evidence of emotional bonds, or they can permit an individual to "ramble" and tell stories. The interview should cover the following areas:

- presenting problem/current legal status
- educational history and goals
- vocational history and goals
- medical and psychiatric history
- family background, marital history
- juvenile conduct problems
- adult antisocial behavior (including substance use)

Within each area, recommended general questions and follow-up probes are listed; however, interviewers are free to rephrase or even omit questions, or to ask additional questions as they see fit. It is not necessary to complete the interview in one sitting; in fact, multiple interviews may actually be an asset, as they help to ensure that the rater obtains a representative sample of the individual's interpersonal style. *Interview and Information Schedules* have been developed to assist in the administration of the PCL:SV in forensic, civil psychiatric, and community settings.

It should be apparent from the above description that the semi-structured interview is very similar in structure to any reasonably comprehensive clinical interview. Consequently, if the individual has already completed a clinical interview, it may be unnecessary to re-interview that person in order to make PCL:SV ratings. If the clinical interview administered was not sufficiently comprehensive, the rater may wish to ask only selected questions from the PCL:SV interview guide.

In rare instances, it may be impossible to complete an interview due to mental illness, discharge, or elopement from the institution, and so forth. If there is adequate collateral information (e.g., criminal record, presentence report, and correctional progress notes; or previous mental health evaluation, interview with a family member, and hospital ward notes) and behavioral observations of the individual, it may be possible to complete the PCL:SV without an interview. However, to be consistent with professional ethics, it is important that when the PCL:SV is administered under non-standard conditions, this fact, and any resulting limitations on the validity of the assessment should be noted in clinical reports.

Charts and Collateral Informants

The second major source of data for scoring the PCL:SV is charts and collateral informants. For clinical purposes, data obtained in the interview should not be taken at face value. Rather, an attempt should be made to confirm or deny important claims made by the individual. Hospital charts, correctional files, and criminal records may all be used for this purpose as can interviews with friends, relatives, past employers, and so forth. This information should be summarized and recorded in Part II of the PCL:SV *Interview and Information Schedule*.

In rare cases, there may be absolutely no file or collateral information available. **The PCL:SV should NOT be completed in the absence of file or collateral information**. Every attempt should be made to collect at least some file information (e.g., requesting a criminal record for the individual or interviewing a family member, friend, or previous employer). If this is not possible, then PCL:SV ratings should be delayed until collateral information in the form of progress notes, consultant reports, and so forth, becomes available.

Conflicts Between Sources of Information

Occasionally, there are numerous or major discrepancies between the interview and collateral information. In general, conflicting reports concerning an individual's personality or behavior should alert the user to the possibility that the individual is engaging in

impression management. However, the rater first should assess the credibility of the sources of information. If a source is considered by the rater to be totally noncredible, it can be ignored. If a source is seen as less credible than others, information obtained from it can be given less weight. If the sources are equally credible, then the rater should consider seeking out new information or giving the individual a score of 1 on the relevant item(s); otherwise, greater weight should be given to the information source most suggestive of psychopathology, on the assumption that most people tend to under-report or minimize psychopathic symptomatology. Finally, if all information pertaining to an item comes from sources that lack credibility, the item can be omitted.

Scoring

According to a pilot study, the PCL:SV can be scored by a trained professional (with the case history within reach) in as little as 20-30 minutes. There are several issues to consider when scoring (time frame, item scores, and omitting items) and they are covered below.

Time Frame

The PCL:SV items are rated on the basis of the person's lifetime functioning as revealed by the assessment data: What the individual is like most of the time, in most situations, and with most people. **Items should not be rated solely on the basis of the individual's present state.** The present state may be atypical of his or her usual functioning because of extreme situational factors, an exacerbation of acute psychopathology (e.g., depression or psychosis), and so forth.

Novice raters sometimes are unsure of what to do if a person's behavior is erratic or inconsistent or if there has been a dramatic and lasting change in behavior at some point during his/her life. For example, people who suffer from bipolar mood disorders or psychoses may have dramatically different presentations at different times. In such cases, raters should score the PCL:SV items according to the individual's usual functioning; that is, how he/she functioned, on average, throughout his/her life.

Note that because psychopathy is a personality disorder, it is chronic by definition and should remain relatively stable across the lifespan. Also, note that the PCL:SV is scored on the basis of the individual's lifetime functioning. **For these reasons, the PCL:SV cannot be used to make "present state" assessments of psychopathy (e.g., severity in past week, past month, or past year) or to assess changes in psychopathic symptomatology over brief periods of time (less than a year).**

Item Scores

Each of the PCL:SV items is scored using a 3-point ordinal scale based on the degree to which the personality and behavior of the individual matches the item description in this Manual. The scoring of the items is subjective and requires considerable inference and judgment; however, research indicates that experienced raters can be highly reliable when making judgments of this kind. Scores of 2, 1, and 0 are defined as follows:

2 The item applies to the individual; a reasonably good match in most essential respects; his/her behavior is generally consistent with the flavor and intent of the item.

1 The item applies to a certain extent but not to the degree required for a score of 2; a match in some respects but with too many exceptions or doubts to warrant a score of 2; uncertain about whether or not the item applies; conflicts between interview and file information that cannot be resolved in favor of a score of 2 or 0.

0 The item does not apply to the individual; he/she does not exhibit the trait or behavior in question, or he/she exhibits characteristics that are the opposite of, or inconsistent with, the intent of the item.

The individual item descriptions should be read carefully prior to making the ratings. Item definitions appear later in this chapter. Raters should use the item definition to create a prototype, or ideal image, of the item then decide how closely the individual matches the prototype. Although the item definitions contain a list of characteristics, they are ostensional (as opposed to extensional or intensional) in nature. That is, the characteristics are merely examples of the types of characteristics associated with a trait; raters should not use the characteristics as a simple checklist. An individual could receive a score of 2 on an item by displaying one or two of the characteristics to a great degree, or by displaying several of the characteristics to a moderate degree. It is even possible that a rater could give a score of 2 to someone who exhibits none of the characteristics in the item definition, as long as that rater noted other characteristics that obviously are consistent with the item definition. Raters should take into account the intensity, frequency, and duration of the individual's symptoms when scoring the item. Also, raters should keep in mind that the time frame for scoring the PCL:SV is the individual's entire life; each item is supposed to reflect a personality trait rather than a symptom that is present only briefly or rarely.

Omitting Items

Sometimes there is insufficient information to score an item. At other times, the interview and collateral information may be totally divergent, and it may be impossible to determine if either of the sources is credible. In such instances an item may be omitted. **Items should**

be omitted only when absolutely necessary; they should not be omitted simply because the rater is uncertain about which score to assign.

Only 1 of 6 Part 1 or Part 2 items can be omitted without invalidating the corresponding score. If an acceptable number of items were omitted, then scores should be prorated using Tables 4 and 5. (These tables also appear on the PCL:SV QuikScore™ form.) If too many items are omitted, the individual should be re-interviewed or reassessed when more collateral information is available.

Using the QuikScore™ Form for the PCL:SV

The QuikScore™ form for the PCL:SV is a self-scoring form that is used to administer the PCL:SV. The rater should begin by writing his or her name, the date of the assessment, and the name of the individual being assessed in the appropriate places at the top of the QuikScore™ form. After careful review of the rating criteria for each item, the rater notes the score given for each item where indicated on the front of the QuikScore™ form.

After all 12 items are rated, the rater should separate the QuikScore™ form at the perforation at the top of the form. The scores recorded on the front page of the form will have transferred to the scoring grid on the second page. Next, the numbers under the "Total Score" column should be copied to the appropriate scoring box on the left-hand side of the page, under one of the columns labelled "Part 1" and "Part 2." For example, the score given for Item 1, "Superficial," should be copied to the box on the column under "Part 1". Each item is connected by a dotted line to the appropriate box in the columns labelled "Part 1" or "Part 2."

Once every item in the first column has been copied to a corresponding box in the second or third columns, the rater should sum the items in each of the three columns (Total, Part 1, and Part 2). The user should write the sum of the items at the bottom of the column in the row labelled, "Raw Sum." Total score can range from 0 to 24; Part 1 and 2 scores can range from 0 to 12.

Missing items. If no items are missing, simply transfer the Raw Sums for the Total, Part 1, and Part 2 scores to the last row on the grid to obtain the Adjusted Score. If any items were omitted, the Total, Part 1, and Part 2 scores should be prorated using the tables on the back of the top sheet of the QuikScore™ form. First, write the number of missing items for the Total, Part 1, and Part 2 scores in the row at the bottom of the scoring grid labelled "Number of Missing Items." Next, refer to the Prorated PCL:SV Total Scores and Prorated PCL:SV

Table 4
Prorated PCL:SV Total Scores

Raw Score	Prorated total score if X items are omitted: X=1	X=2
22	24	—
21	23	—
19	21	23
17	19	20
15	16	18
13	14	16
11	12	13
9	10	11
7	8	8
5	5	6
3	3	4
1	1	1

Table 5
Prorated PCL:SV Part 1 and Part 2 Scores

Raw Score	Prorated score for Part 1 or 2 when an item is omitted
10	12
9	11
8	10
7	8
6	7
5	6
4	5
3	4
2	2
1	1
0	0

Part 1 and Part 2 Scores on the back of the top page of the QuikScore™ form to obtain the Adjusted Sums. Table 4 provides the adjusted sums for Total scores, and Table 5 provides the Adjusted Sums for Part 1 and 2 scores. For the Total score, the rater should look up the Raw Sum on the left side of Table 4. Then, he/she should follow the row across to the column that corresponds to the number of missing items for the Total score to obtain the Adjusted Sum. This number should be written in the last row of the scoring grid under the column labelled, "Total." A similar procedure is used with Table 5 to prorate for missing items on Parts 1 and 2.

Percentile ranks. The percentile ranks for Total, Part 1, and Part 2 scores can be obtained from tables on the back of the bottom page of the QuikScore™ form. Separate tables of percentile ranks are available for correctional offenders, forensic patients, civil psychiatric patients, and university students.

To obtain percentile ranks for an individual, first choose the appropriate set of norms for comparison. For the Total score, find the individual's Adjusted Total score on the left side of the corresponding table. Then, follow the row across to the column labelled, "Total" to obtain the percentile rank associated with that Adjusted Total score. A similar procedure is used to obtain the percentile ranks associated with Part 1 and 2 scores.

The percentile ranks for the Total and Factor scores can be circled and joined by solid lines for a visual display of the individual's PCL:SV profile.

Scoring Examples

Two scoring examples have been included to illustrate proper scoring technique. The first example is a form completed for an individual in the forensic/psychiatric population and the other form has one item missing for an individual of the civil/psychiatric population.

Example A shows a completed PCL:SV QuikScore™ form with no missing items. The individual comes from a forensic/psychiatric population. Items have been scored according to the rating criteria found later in this manual. For each of the twelve items, a score has been assigned and written on the boxes on the front of the QuikScore™ form. Figure 1 shows the front of the QuikScore™ form for Example A.

Figure 2 shows the scoring grid that corresponds to the scores shown in Figure 1. Scores pertaining to Part 1 and Part 2 of the PCL:SV have been transferred to the appropriate boxes. The sum of the numbers in the boxes is calculated to obtain raw scores for Part 1, Part 2, and the Total Score. The raw scores have been recorded in the row marked Raw Sum. Since there are no missing items, the Raw Sum is the same as the Adjusted Sum.

Figure 3 shows the scores plotted in relation to the appropriate comparison group. The individual for Example A was said to have come from a forensic/psychiatric population; therefore, the upper right quadrant, which pertains to this reference group has been used in this case. As indicated in Figure 3, the Total Score of 17 corresponds to a percentile rank of 70.8. This individual's Total Score is somewhat elevated relative to others in the forensic/psychiatric population. The Part 1 score of 10 converts to a percentile of 93.3. Therefore this individual's Part 1 score should be considered very high relative to others in the forensic/psychiatric population. Finally, this individual's Part 2 score of 7 converts to a percentile rank of 30.8. This means that this individual's score on Part 2 of the PCL:SV was lower than the average of those individuals in the forensic/psychiatric comparison group.

Example B shows a completed PCL:SV QuikScore™ form for a civil/psychiatric person where one item is missing from each part of the PCL:SV. Insufficient information was available to make ratings for these items. The front page of the QuikScore™ form is shown in Figure 4. Note that had there been two or more items missing on either part, it would not be possible to obtain valid scores for the part with the missing items, and it would not be

possible to obtain a valid total score. In such a case, use of the PCL:SV should be deferred until enough information is available to obtain valid scores. However, for Example B, only 1 item is missing for each part and the charts shown in Figure 5 can be used to obtain prorated PCL:SV scores. For Part 1, the Raw Score of 2 remains 2 after being prorated. For Part 2, the Raw Score of 5 becomes 6 after being prorated. Finally, the Total Score of 7 converts to 8 after being prorated. These prorated scores are put in the row marked Adjusted Sum on the scoring page of the QuikScore™ form (see Figure 6). The Adjusted Sum scores are the ones that should be used. These adjusted scores are examined relative to the appropriate comparison group. In this case the civil/psychiatric comparison group, appearing in the bottom right quadrant of Figure 7, was used. In comparison to this group, the PCL:SV adjusted Total Score of 8 converts to a percentile of 47.0, the adjusted Part 1 score of 2 converts to a percentile of 44.7, and the adjusted Part 2 score of 6 is equivalent to a percentile of 54.4. All of these scores are about average relative to the civil/psychiatric comparison group. Although the PCL:SV allows for the calculation of prorated scores where no more than one item is missing from each part, users should always make an effort to obtain sufficient information to score all items of the PCL:SV. The PCL:SV is most valid when full and accurate information is available and all of the items are scored.

Cutoff Scores

The PCL:SV Total Score is a dimensional measure of the degree to which a given individual matches the prototypical psychopath. These dimensional ratings are more useful than categorical diagnoses in several respects. For example, they have superior psychometric properties, they do not require assumptions about whether the underlying construct is continuous or categorical, and they permit users to make distinctions among individuals even in a setting where the base rate of psychopathy is very high or very low. Despite this, it is recognized that for some research and clinical applications, a categorical diagnosis of psychopathy is required.

It is impossible to specify a single "best" cutoff score for the PCL:SV, one that maximizes every facet of predictive efficiency with respect to every criterion. For diagnostic purposes, a cutoff score of ≥ 18 is recommended. This cutoff corresponds to a sensitivity of 100% but a specificity of only 82% when PCL-R diagnoses of psychopathy are considered to be the criterion. The overall chance-corrected rate of diagnostic agreement is fair to good (about = .49). A cutoff of ≤ 12 corresponds to near 100% specificity. Taking the information regarding these two cutoffs together leads to the following suggestions. In practice, those scoring 12 or lower on the PCL:SV can be considered non-psychopathic. Those scoring 13 through 17 may be psychopathic and should be further evaluated with the PCL-R. Scores of 18 or higher offer a strong indication of psychopathy and warrant further evaluation with the full PCL-R.

This research is based on data pooled across several relatively small samples; thus, the statistics on the diagnostic efficiency of the PCL:SV should be considered preliminary. More data, and data from large samples, are necessary to confirm the utility of the cutoff scores. Also, users who work in applied settings should read the material on standard errors of measurement presented in Chapter 5, which provides information necessary to estimate the probability of making diagnostic errors for individuals with Total scores near the cutoff scores.

Item Descriptions

The PCL:SV items are defined below. These definitions are brief, comprising a number of simple statements ordered roughly in descending order of importance and frequency (prototypicality). However, as discussed earlier, raters should not use the item definitions as a simple checklist. Instead, they should use the entire item description to form an impression (prototype) in their minds, then compare the individual being rated to the prototype. Once raters have assessed someone who matches an item description very well, that individual can serve as an exemplar for the item; it may be helpful to conjure up a mental image of that person while rating the item in question. Also, because PCL:SV items are derived from the twenty-item PCL-R, the user would benefit from familiarization with the scoring criteria from the PCL-R items.

Item 1: Superficial

This item describes an individual whose interactional style appears superficial (i.e., glib) to others. Usually, the individual tries to make a favorable impression on others by "shamming" emotions, telling stories that portray him/her in a good light, and making unlikely excuses for undesirable behaviors. He/she may use unnecessary — frequently inappropriate — jargon. Despite its superficiality, the individual's style may be considered engaging. Alternatively, the individual may try to impress others by appearing sullen, hostile, or "macho." Still, the key aspect is that this presentation appears affected and superficial. Both types of individuals are "slippery" in conversation; when challenged with facts that contradict their statements or with inconsistencies in their statements, they simply change their stories.

Item 2: Grandiose

Individuals who score high on this item are often described as grandiose or as braggarts. They have an inflated view of themselves and their abilities. They appear self-assured and opinionated in the interview (a situation

Figure 1
Front Page of the PCL:SV QuikScore™ Form — Example A

The HARE PCL:SV

S.D. Hart, D.N. Cox, & R.D. Hare

Rater: DR. JONES Date: / / Name: SAMPLE

Part 1	0 = no; 1 = maybe; 2 = yes; X = omit	1	1.	*Superficial*
	0 = no; 1 = maybe; 2 = yes; X = omit	1	2.	*Grandiose*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	3.	*Deceitful*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	4.	*Lacks Remorse*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	5.	*Lacks Empathy*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	6.	*Doesn't Accept Responsibility*
Part 2	0 = no; 1 = maybe; 2 = yes; X = omit	1	7.	*Impulsive*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	8.	*Poor Behavioral Controls*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	9.	*Lacks Goals*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	10.	*Irresponsible*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	11.	*Adolescent Antisocial Behavior*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	12.	*Adult Antisocial Behavior*

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Ratings should be made while reviewing the criteria in the PCL:SV Rating Booklet.

Figure 2
Scoring Grid — Example A

The HARE PCL:SV

S.D. Hart, D.N. Cox, & R.D. Hare

Rater: DR. JONES Date: / / Name: SAMPLE

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Part 1	Part 2	Score		
1		1	1.	*Superficial*
1		1	2.	*Grandiose*
2		2	3.	*Deceitful*
2		2	4.	*Lacks Remorse*
2		2	5.	*Lacks Empathy*
2		2	6.	*Doesn't Accept Responsibility*
	1	1	7.	*Impulsive*
	2	2	8.	*Poor Behavioral Controls*
	0	0	9.	*Lacks Goals*
	2	2	10.	*Irresponsible*
	0	0	11.	*Adolescent Antisocial Behavior*
	2	2	12.	*Adult Antisocial Behavior*
10	7	17		**Raw Sum**
—	—	—		*Number of Missing Items*
10	7	17		*Adjusted Sum (from Tables 1 and 2)*
Part 1	Part 2	Total Score		

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Figure 3
Profile Form — Example A

The HARE PCL:SV

S.D. Hart, D.N. Cox, & R.D. Hare

Percentile Ranks for PCL:SV Total and Factor Scores

Forensic/Non Psychiatric (N = 149)

Total	Percentile	Part 1	Part 2
24	100.0		
23	99.3		
22	98.0		
21	96.0		
20	89.9		
19	81.9		
18	75.8		
17	69.8		
16	58.4		
15	51.7		
14	38.9		
13	35.6		
12	29.5	100.0	100.0
11	24.8	96.0	91.9
10	20.1	92.6	73.8
9	16.1	84.6	52.3
8	11.4	74.5	40.3
7	8.1	63.1	28.9
6	6.7	49.7	19.5
5	4.7	36.2	14.1
4	3.4	26.2	10.1
3	0.7	17.4	6.7
2	0.0	13.4	3.4
1	0.0	6.7	1.3
0	0.0	1.3	0.7

Forensic/Psychiatric (N = 120)

Total	Percentile	Part 1	Part 2
24	100.0		
23	100.0		
22	100.0		
21	96.7		
20	91.7		
19	83.3		
18	78.3		
17	70.8		
16	62.5		
15	54.2		
14	42.5		
13	31.7		
12	29.2	100.0	100.0
11	20.0	96.3	95.8
10	15.0	93.3	83.3
9	10.8	83.3	65.0
8	5.8	72.5	45.8
7	4.7	60.0	30.8
6	0.8	48.3	22.5
5	0.8	30.0	10.0
4	0.0	17.5	4.2
3	0.0	10.8	0.0
2	0.0	3.3	0.0
1	0.0	0.0	0.0
0	0.0	0.0	0.0

Non Criminal/Non Psychiatric Undergrads (N = 100)

Total	Percentile	Part 1	Part 2
24	100.0		
23	100.0		
22	100.0		
21	100.0		
20	100.0		
19	100.0		
18	100.0		
17	100.0		
16	100.0		
15	100.0		
14	99.0		
13	98.0		
12	98.0	100.0	100.0
11	98.0	100.0	100.0
10	97.0	100.0	100.0
9	95.0	100.0	100.0
8	95.0	99.0	98.0
7	90.0	99.0	98.0
6	86.0	99.0	98.0
5	81.0	97.0	96.0
4	75.0	94.0	91.0
3	62.0	89.0	79.0
2	53.0	82.0	70.0
1	34.0	65.0	52.0
0	17.0	41.0	22.0

Civil/Psychiatric (N = 217)

Total	Percentile	Part 1	Part 2
24	100.0		
23	100.0		
22	99.5		
21	96.8		
20	94.9		
19	92.2		
18	90.8		
17	88.0		
16	84.3		
15	77.4		
14	74.7		
13	70.0		
12	66.4	100.0	100.0
11	62.7	99.1	94.9
10	57.1	97.7	88.5
9	51.2	92.6	82.9
8	47.0	88.5	72.8
7	41.5	84.3	63.6
6	34.1	79.3	54.4
5	27.7	71.0	44.2
4	24.0	61.3	35.9
3	16.8	53.5	28.1
2	12.9	44.7	19.4
1	6.5	30.0	11.1
0	4.1	13.8	6.5

Figure 4
Front Page of the PCL:SV QuikScore™ Form — Example B

The HARE PCL:SV

S.D. Hart, D.N. Cox, & R.D. Hare

Rater: DR. SMITH Date: / / Name: SAMPLE

Part 1	0 = no; 1 = maybe; 2 = yes; X = omit	1	1.	*Superficial*
	0 = no; 1 = maybe; 2 = yes; X = omit	1	2.	*Grandiose*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	3.	*Deceitful*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	4.	*Lacks Remorse*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	5.	*Lacks Empathy*
	0 = no; 1 = maybe; 2 = yes; X = omit	X	6.	*Doesn't Accept Responsibility*
Part 2	0 = no; 1 = maybe; 2 = yes; X = omit	2	7.	*Impulsive*
	0 = no; 1 = maybe; 2 = yes; X = omit	2	8.	*Poor Behavioral Controls*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	9.	*Lacks Goals*
	0 = no; 1 = maybe; 2 = yes; X = omit	0	10.	*Irresponsible*
	0 = no; 1 = maybe; 2 = yes; X = omit	X	11.	*Adolescent Antisocial Behavior*
	0 = no; 1 = maybe; 2 = yes; X = omit	1	12.	*Adult Antisocial Behavior*

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Ratings should be made while reviewing the criteria in the PCL:SV Rating Booklet.

Figure 5
Prorated PCL:SV Total Scores — Example B

Table 1
Prorated PCL:SV Total Scores

Raw Score	Prorated score if 1 or 2 items are omitted: 1 item omitted	2 items omitted
22	24	—
21	23	—
20	22	24
19	21	23
18	20	22
17	19	20
16	17	19
15	16	18
14	15	17
13	14	16
12	13	14
11	12	13
10	11	12
9	10	11
8	9	10
7	8	8
6	7	7
5	5	6
4	4	5
3	3	4
2	2	2
1	1	1
0	0	0

Table 2
Prorated PCL:SV Part 1 and Part 2 Scores

Raw Score	Prorated score if 1 item is omitted:
10	12
9	10
8	9
7	8
6	7
5	6
4	5
3	4
2	2
1	1
0	0

Figure 6
Scoring Grid — Example B

The HARE PCL:SV

S.D. Hart, D.N. Cox, & R.D. Hare

Rater: DR. SMITH Date: / / Name: SAMPLE

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Part 1	Part 2	Score		
1		1	1.	*Superficial*
1		1	2.	*Grandiose*
0		0	3.	*Deceitful*
0		0	4.	*Lacks Remorse*
0		0	5.	*Lacks Empathy*
X		X	6.	*Doesn't Accept Responsibility*
	2	2	7.	*Impulsive*
	2	2	8.	*Poor Behavioral Controls*
	0	0	9.	*Lacks Goals*
	0	0	10.	*Irresponsible*
	X	X	11.	*Adolescent Antisocial Behavior*
	1	1	12.	*Adult Antisocial Behavior*
2	5	7		***Raw Sum***
1	1	2		*Number of Missing Items*
2	6	8		*Adjusted Sum (from Tables 1 and 2)*
Part 1	Part 2	Total Score		

Figure 7
Percentile Ranks — Example B

The HARE PCL:SV

S.D. Hart, D.N. Cox, & R.D. Hare

Percentile Ranks for PCL:SV Total and Factor Scores

Forensic/Non Psychiatric (N = 149)

Total	Percentile	Part 1	Part 2
24	100.0		
23	99.3		
22	98.0		
21	96.0		
20	89.9		
19	81.9		
18	75.8		
17	69.8		
16	58.4		
15	51.7		
14	38.9		
13	35.8		
12	29.5	100.0	100.0
11	24.8	96.0	91.9
10	20.1	92.6	73.8
9	16.1	84.6	52.3
8	11.4	74.5	40.3
7	8.1	63.1	28.9
6	6.7	49.7	19.5
5	4.7	36.2	14.1
4	3.4	26.2	10.1
3	0.7	17.4	6.7
2	0.0	13.4	3.4
1	0.0	6.7	1.3
0	0.0	1.3	0.7

Forensic/Psychiatric (N = 120)

Total	Percentile	Part 1	Part 2
24	100.0		
23	100.0		
22	100.0		
21	96.7		
20	91.7		
19	83.3		
18	78.3		
17	70.8		
16	62.5		
15	54.2		
14	42.5		
13	31.7		0
12	29.2	100.0	100.0
11	20.0	96.3	95.8
10	15.0	93.3	83.3
9	10.8	83.3	66.0
8	5.8	72.5	45.8
7	1.7	60.0	30.8
6	0.8	48.3	22.5
5	0.8	30.0	10.0
4	0.0	17.5	4.2
3	0.0	10.8	0.0
2	0.0	3.3	0.0
1	0.0	0.0	0.0
0	0.0	0.0	0.0

Non Criminal/Non Psychiatric Undergrads (N = 100)

Total	Percentile	Part 1	Part 2
24	100.0		
23	100.0		
22	100.0		
21	100.0		
20	100.0		
19	100.0		
18	100.0		
17	100.0		
16	100.0		
15	100.0		
14	99.0		
13	98.0		
12	98.0	100.0	100.0
11	98.0	100.0	100.0
10	97.0	100.0	100.0
9	95.0	100.0	100.0
8	95.0	99.0	98.0
7	90.0	99.0	98.0
6	86.0	99.0	98.0
5	81.0	97.0	96.0
4	75.0	94.0	91.0
3	62.0	89.0	79.0
2	53.0	82.0	70.0
1	34.0	65.0	52.0
0	17.0	41.0	22.0

Civil/Psychiatric (N = 217)

Total	Percentile	Part 1	Part 2
24	100.0		
23	100.0		
22	99.5		
21	96.8		
20	94.9		
19	92.2		
18	90.8		
17	88.0		
16	84.3		
15	77.4		
14	74.7		
13	70.0		
12	66.4	100.0	100.0
11	62.7	99.1	94.9
10	57.1	97.7	88.5
9	51.2	92.6	82.9
8	47.0	88.5	72.8
7	41.5	84.3	63.6
6	34.4	79.3	54.4
5	27.7	71.0	44.2
4	24.0	61.3	35.9
3	16.6	53.5	28.1
2	12.9	44.7	19.4
1	6.5	30.0	11.1
0	4.1	13.8	6.5

where most people are somewhat reticent or deferential). If they are in hospital or prison, they attribute their unfortunate circumstances to external forces (bad luck, the "system") rather than to themselves. Consequently, they are relatively concerned about their present circumstances and worry little about the future. (Note that psychotic delusions are irrelevant to the scoring of this item, unless they are accompanied by the other characteristics listed.)

Item 3: Deceitful

People with this characteristic commonly engage in lying, deception, and other manipulations in order to achieve their own personal goals (money, sex, power, etc.). They lie and deceive with self-assurance and no apparent anxiety. They may admit that they enjoy conning and deceiving others; they may even label themselves "fraud artists."

Item 4: Lacks Remorse

High scores on this item are given to individuals who appear to lack the capacity for guilt. It is normal to feel justified in having hurt someone on at least a few occasions; however, high scorers on this item appear to have no conscience whatsoever. Some of these latter individuals will verbalize remorse but in an insincere manner; others will display little emotion about their own actions or the impact they had on others and will focus instead on their own suffering. (In scoring this item, it is necessary to take the nature of the individual's harmful behaviors into account. Clearly, a lack of remorse concerning relatively trivial acts may not be pathological.)

Item 5: Lacks Empathy

This item describes individuals who have little affective bonding with others and are unable to appreciate the emotional consequences (positive or negative) of their actions. As a result, they may appear cold and callous, unable to experience strong emotions, and indifferent to feelings of others. Alternatively, they may express their emotions, but these emotional expressions are shallow and labile. The verbal and nonverbal aspects of their emotion may appear inconsistent.

Item 6: Doesn't Accept Responsibility

People who score high on this item avoid taking personal responsibility for their harmful actions by rationalizing their behavior, greatly minimizing the consequences for others, or even denying the actions altogether. Most of their rationalizations involve the projection of blame (or at least partial blame) onto the victim or onto circumstances. Minimizations usually involve denying that the victim suffered any serious or direct physical, emotional, or financial consequences. Denial usually involves claiming innocence, that is, that the victim lied or the individual was framed; alternatively, he/she may claim amnesia due to substance use or to physical or mental illness.

Item 7: Impulsive

This item describes people who act without considering the consequences of their actions. They act on the spur of the moment, often as the result of a desire for risk and excitement. They may be easily bored and have a short attention span. Consequently, they lead a lifestyle characterized by instability in school, relationships, employment, and place of residence.

Item 8: Poor Behavioral Controls

This item describes people who are easily angered or frustrated; this may be exacerbated by the use of alcohol or drugs. They are frequently verbally abusive (e.g., they swear, insult, or make threats) and physically abusive (e.g., they break or throw things; push, slap, or punch others). The abuse may appear to be sudden and unprovoked. These angry outbursts are often short-lived.

Item 9: Lacks Goals

High scores on this item are given to those who do not have realistic long-term plans and commitments. Such people tend to live their lives "day-to-day," not thinking of the future. They may have relied excessively on family, friends, and social assistance for financial support. They often have poor academic and employment records. When asked about their goals for the future, they may describe far-fetched plans or schemes.

Item 10: Irresponsible

This item describes people who exhibit behavior that frequently causes hardship to others or puts others at risk. They tend to be unreliable as a spouse or parent; they lack commitment to relationships, fail to care adequately for their children, and so forth. Also, their job performance is inadequate; they are frequently late or absent without good reason, etc. Finally, they are untrustworthy with money; they have been in trouble for such things as defaulting on loans, not paying bills, or not paying child support.

Item 11: Adolescent Antisocial Behavior

People who score high on this item had serious conduct problems as an adolescent. These problems were not limited to only one setting (i.e., occurred at home, at school, and in the community) and were not simply the result of childhood abuse or neglect (e.g., running away to avoid beatings, stealing food when it wasn't available at home). Such people frequently were in trouble with the law as a youth or minor, and their antisocial activities were varied, frequent, and persistent.

Item 12: Adult Antisocial Behavior

This item describes people who frequently violate formal, explicit rules and regulations. They have had legal problems as an adult, including charges or convictions for criminal offenses. Their antisocial activities are varied, frequent, and persistent.