

An analysis of medical and legal flaws in the PCL-R

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Background

The Hare Psychopathy Check List (Revised) (PCL-R) is a twenty question test to determine whether or not an individual is a 'psychopath'. Each item scores up to 2 points, giving a maximum score of 40. It is perhaps the most widespread of such tests, and is used throughout the world. It is frequently used in the UK often just before a prisoner or long term mental patient is about to be released. Any score above 28 in Texas reputedly incurs the death penalty. The bulk of the items scored are historic and cannot change – so to use this test as a predictor of future behaviour rules out the possibility of change, or of emotional maturation, let alone of 'burn out'. Despite its apparently straightforward nature, the test has serious flaws – flaws which are not necessarily apparent to those who know only one side of the story, but which become much clearer if viewed with soundly based common sense. The full 20 questions that make up the test are appended below, preceded by a firsthand account of their impact on a long term prisoner.

A Question of intent

*“The use of the Hare Psychopathy Check List (Revised) (PCL-R) in the criminal justice system . . . sometimes leads to the conclusion that it is primarily **a risk instrument** rather than what it really is, a measure of **a psychological construct.**” [emphasis added]*

The author of the PCL(R), Professor Robert Hare, here highlights the fundamental flaw which leads to his test being widely misapplied, if not actually abused – with dire consequences, not only for those 'tested'. Professor Hare correctly distinguishes between risk assessment on the one hand, and 'a psychological construct' on the other. However, most of those who use the test, or base their decisions on its outcomes, are unlikely to be fully aware of the remarkable implications of this distinction. The above excerpt is taken from page 87, §3 of The Technical Manual for the Hare Psychopathy Check List (Revised) (PCL-R):Second Edition. (July 2005, see www.mhs.com)

Legal authorities and prison personnel, especially parole boards and other tribunals, understandably crave reliable indications that the person under their current scrutiny presents a low risk of re-offending. Indeed so great is the pressure for reassurance in this respect, that corners are routinely cut, and expediciencies deployed which, if given time for cool reflection would be seen to be unacceptable, indeed to be quite illogical and entirely incompatible with any conceivable professional standard.

Risk assessment, as its name implies, sets out to be a measure of what that individual might do in the months and years to come. As such, it is an attempt to foretell the future – never an easy exercise in any context – though, given their statutory duty of protecting the public, society's many tribunals are regularly confronted with precisely this challenge. Not an easy burden. The reader has only to think about what he or she will be doing in say, a year's time, to gain some notion of the size of the problem. This is an important consideration – it will be obvious that all and every future decision will be based on two main factors – the circumstances you then find yourself in, and the plans, intentions or strategies you wished to implement. It takes no great scientific insight to see that all future human activities represent a blend between these two – circumstance and intention.

Now it may come as something of a surprise, especially to members of the legal profession, that the notion of intent currently carries no weight in conventional psychiatric or psychological circles. Certainly the PCL-R omits all mention of it. Nowhere are the intentions of the person being tested given any consideration whatsoever. Quite remarkable really. Indeed this resolute ignoring of anything resembling intent is powerfully confirmed by the astonishing notion that you can assess a person's intent without their consent, by reading what has been written about them, by observing him or her through the hatchway – and at no time engaging him or her in conversation to ask what their intentions might conceivably be. The need to report such intentions to any statutory body simply does not arise.

It therefore inexorably follows that those authorities, legal and otherwise, who base their conclusions on the PCL(R), can only do so by tacitly colluding with Professor Hare, that the faculty of 'intent' plays no part in subsequent human behaviour. Since many legal procedures turn precisely on eliciting the presence of intent ("when you picked up that spade, did you intend to dig, or to kill?"), it seems odd that law officers should so meekly defer to the professor's authority in this matter. Collusion might seem over-strong in this context, but watching legally trained professionals who having first been lead by the nose through a cod-psychology, then base their judgements on a degraded picture of humanity, rinsed of all value and of 'intent' – a picture that would not survive for one second in a court of law – if that isn't collusion, then it's farce.

Indeed such a supine approach to this ubiquitous test and its provenance appears entirely uncharacteristic of the legal profession. Expert witnesses can be subjected to harassment of a painfully detailed nature, as I can testify from my experience – yet here we have a test designed for one purpose – to establish the presence or absence of a ‘construct’ namely ‘psychopathy’ – being used for entirely another, namely to assess the risk of future anti-social behaviour. Could it be, as one barrister assured me, that judges have already decided that ‘once a psychopath always a psychopath’, and that therefore any ‘test’ which supports this view should be accepted without demur. If the question of the relevance or otherwise of intent can be so readily finessed in the legal mind or by others in the criminal justice system, the status of as esoteric a notion as psychological ‘construct’ is yet more parlous.

The ‘construct’ problem

“Psychopathy is a well-validated clinical construct . . . arguably the single most important clinical construct in the criminal justice system” [op cit p 9 §4, emphasis added]

Professor Hare is a firm believer in the notion that the apparently endlessly fluid nature of the human mind is a illusion – that there are rigid structures just below the surface which he terms ‘constructs’. As the above excerpt testifies, he has little doubt that such things exist, and indeed that detecting their presence represents a worthy and highly successful pursuit. He confidently dismisses those who raise doubts as to the viability of this approach, mentioning that *“in some cases – usually on the basis of a single study or doctoral dissertation – an investigator confidently concludes that his or her particular findings raise serious questions about the construct of psychopathy or about the ability of the PCL-R to measure the construct” [loc cit]*. He counters this by arguing, basically, that all the published work on the PCL-R confirms its validity – overlooking the fact that such a literature must do so, since essentially it presupposes it.

Clearly those who question the validity of ‘constructs’ can expect only limited support from Professor Hare in the advancement of their careers. However, since the word ‘clinical’ appears twice in the above excerpt, it is germane to look at how the PCL-R would fare in a strictly clinical context. Having now worked for almost 5 decades as a clinician, a closer look at what constitutes clinical practice might assist.

Two points are relevant. The be-all and end-all of clinical practice is benefit to the patient – just as the fundamental objective of the criminal justice system is to protect the public safety and ensure fairness and justice for all. In clinical terms therefore, any concepts, constructs or nostrums you elect to deploy may be as eccentric, esoteric or eclectic as you wish – if they fulfil the essential criteria of benefiting the patient to whom they are applied, then however far they depart from the established orthodoxy, they should be given space to justify themselves.

The same criterion applies to the wider society – if a clinical concept can afford wider social benefit, then however outlandish it might at first appear, it nevertheless should be given sufficient room to grow. Now if the ‘construct’ of psychopathy were as fixed and realistic as Professor Hare maintains, then it is relevant to ask how this has benefited society. Also it should benefit the criminal justice system – by increasing social protection, and by ensuring greater justice and fairness all round. Sadly these benefits have not been forthcoming even from the widespread use of the PCL-R, indeed are unlikely ever to be so from such a rigid source. Ergo there is a prime facie case for doubting the very existence of such ‘constructs’, indeed their stability, and reliability are far from established – and where clinical results based upon them have borne fruit, it tends to be negative, unjust and destructive. Not only are legal professionals lulled into a false sense of security by the persuasive Professor Hare, but so too, and most regrettably, are too many psychiatrists.

The second point to raise in this clinical context relates to the durability of the ‘construct of psychopathy’ in clinical practice. There is simply no point in having a ‘construct’ which evaporates after a few years. In other words, for the ‘construct of psychopathy’ to be maintained as a valid clinical item, it should be fixed and established once and for all. Indeed this is precisely the thinking behind the PCL-R in the first place – there is little doubt that that is precisely how Professor Hare sees the situation. It is therefore doubly detrimental to then propose using the PCL-R, not at the start of a prison sentence or hospital incarceration, but at the end, to assess risk. Were the ‘construct’ to be valid, then there is no point – no change would be expected, nor should one be looked for – and those who insist that ‘once a psychopath always a psychopath’ would be fully justified in their prejudice.

However, there is startlingly clear objective clinical evidence that psychopathy is not fixed, rigid, nor solid, as the ‘construct’ notion demands. And this evidence is recorded in the HM Prison Inspector’s report into Parkhurst Prison in 1994, where it is clearly recorded that no alarm bells were rung in a two-year period in a maximum security wing, indeed in a Special Unit for especially dangerous, unstable, violent lifers. In fact, as the prison records show, there were, on average 20 alarm bells rung a year in that Unit, except in the final three years, when none were. This is a unique record for any maximum security wing anywhere in the world – and since it is based on objective evidence it cannot, in logic, be wished away. In technical terms the first 7 years of the Unit act as an earlier ‘control’, and the last 3 show a radical change for the better, that is more than statistically significant.

It follows therefore that where Professor Hare appeals to the clinical nature of the PCL-R, and to it being the ‘single most important’ clinical item in the criminal justice system – there is evidence that

the stability of the very construct itself is in doubt. So whether the basis of the PCL-R falls on the grounds of lack of obvious benefit either to the individuals or to the society and prison system in which it is deployed, or on the basis that a group of some 50 of the UK prison systems most violent, recalcitrant and dangerous individuals did in fact respond, and were objectively proven to respond to an approach which failed to endorse the 'construct' – either way, there are serious reasons to doubt the validity of this test, and indeed to appeal for a more benign approach. In particular, the notion of treatability gains particularly harsh disdain from Professor Hare's approach, and to this we now turn.

The PCL-R test and treatability

One of the all too human reactions to a splendidly firm and authoritative approach, especially in an area so bedevilled by emotional irrationalities as the criminal justice system, is to grasp the whole concept with an unseemly enthusiasm. The same tendency can be seen in Professor Hare himself with respect to treatability. If you once decide, as Professor Hare clearly did, that this clinical problem is a fixity, then your energy for searching for a clinical remedy for it, must necessarily wane. Untreatability is an inevitable consequence of any 'construct' – indeed evidence for treatability such as that cited above, will tend to undermine the very purity of the whole edifice – theory, construct, test and all. As such, if Professor Hare has any say, it is unlikely to be warmly welcomed. As Professor Hare clearly notes in the manual cited, a whole literature, almost an industry is now founded on this 'construct' – no member of which can readily afford to check the authenticity of what happened in a remote wing in Parkhurst Prison. What if it were authenticated?

Now in clinical medicine in general, the key to treatability is the aetiology, or cloud of causative factors which precede the medical condition. If you can understand where a medical disease comes from, then you can begin to put a stop to it – indeed can approach achieving a cure for it. And as in any clinical text, Professor Hare has the obligatory section on 'etiology' [op cit p 7], in which he is perfectly happy to conclude that the *'factors responsible for . . . psychopathy are not well understood'*. Now from a clinical viewpoint, such vagueness is not helpful. Far more to the point, though unemphasised in the manual for the PCL-R, is the notion that violence shown to a child tends to lead to violence being shown when adulthood is reached. Naturally there is a vast literature that confirms this rather common-sensical supposition, notably by Dr Felicity de Zulueta in her book 'From pain to violence'. Further, the dramatic abolition of violence in the Special Unit in Parkhurst Prison cited above was brought about by the careful analysis and support for the ubiquitous childhood traumas those prisoners had suffered. Once this could be addressed, thereby allowing emotional maturation to occur – the violence evaporated. Not an easy notion to propagate in our current ethos.

One final point in this section follows directly from the lack of emphasis Professor Hare places on childhood traumas. In the 'Interview Guide' which accompanies the test, Question 56 recommends posing the following question –

Q56 Were you ever physically, sexually, or emotionally abused ? [by whom? What happened?]

If a student on my course posed such a question, without any concern for support, for follow up, for gross re-traumatisation – I would ensure they were severely reprimanded – the risks inflicted by such inexpert handling are huge. Disastrous 'acting out' would be inevitable in the vast majority of cases. Childhood abuse is protected against by 'denial' – 'this isn't happening to me.' The severity of the abuse is the key determinant as to the strength of the denial – there is no way a severely abused individual will 'open up' without enormous quantities of reassurance and support, nor should they be expected to. The link between childhood trauma and violent adult behaviour may not feature in the background to the PCL-R – but clinical experience alone should ensure that such matters are more expertly handled.

Finale

In sum, the PCL-R has negative clinical value – it signally fails to benefit the actual patient. It derives from a legal view that would grace the worst dictatorships, generating positively Kafkaesque conundrums. And it propagates a covert political agenda which is both degrading and unworthy of any civilised society.

In terms of clinical value, far from assisting the patient to conquer her or his disease, it reduces her or his self-esteem and self-confidence (universally in short supply in this particular population) by 'proving' they have a fixed and incurable (and entirely shame-worthy) disease. As far as the clinicians who deploy it, the PCL-R impacts upon them by positively obstructing therapeutic endeavour, by blocking potential leads to better treatment, and thereby adding further to the overall negative impact of this regrettable test.

Legally, it has taken several centuries to establish that humans are best credited with intent, for which they should be held accountable. How can legally trained minds tacitly accept that such basic legal principles can safely be withdrawn from the most troubled members of our society? The society the law is charged with protecting is hereby degraded – a degradation that no ignorance of the background of the PCL-R can possibly justify.

Such clinical and legal irresponsibility does not go without penalty – politicians, especially legislators, have rushed to fill the void thus exposed, with populist and expedient legal millstones which portrays this humane degradation, writ large.

The human spirit deserves better. Despite the current inclement climate in established psychiatric, psychological, legal and political circles, it behoves every citizen to agitate for a more enlightened view, to seek better, more reliable, and more civilised means to deal with these antisocial problems, and to assert that humanity does have values, it can use its intent creatively, and that when it does so, we can all flourish.

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Next follows a prisoner's account of how the PCL-R is currently deployed; following which the 20 questions themselves are listed.

ERRORS, MISTAKES AND MURKY WATERS

Prison therapy and accompanying assessments, have improved a lot since the early 1990's. Yet, as courses have been modified, altered and in some cases named anew, the assessments have also been refined. But when it comes to the 'Psychopathy Checklist – Revised' or 'PCL-R', many professionals find this assessment tool to be decidedly dubious and in need of renewed attention.

The use of the PCL-R test has increased in recent years to include long-term prisoners as well as lifers. And it is a tool used to identify which prisoners are said to be suffering from a 'Dangerous, Severe Personality Disorder' or 'DSPD'. The test is centred around a battery of questions, which fall into 20 different headings, and then a score of 1 or 2 is given. The end result is produced by adding up the scores. Pre 2002, if one scored over 30, one was labelled as 'Psychopathic', suffering from 'DSPD'.

Post 2002, the end score was lowered to 25, so any lifer or long-term prisoner scoring over 25 was automatically called 'High Risk' and having DSPD. To any lifer who has already served over 20 years, having already completed 8–10 years prison therapy, to score over 25 on the PCL-R, is like throwing him back to the start of his sentence again. The consequences for scoring high, for any lifer, is horrendous, and yet when a lifer does score high and he challenges the high score via other professionals, the Home Office fail to admit that mistakes could have been made, or via errors, a man may have been scored highly.

Most of the PCL-R tests are conducted by Psychology trainees, rubber stamped later by a senior Psychologist. Trainees often make mistakes and when rushed, mistakes can easily be missed by their seniors.

Errors, mistakes and confusion from a trainee, can cost a lifer 5-10 years on top of the time already served. Yet, this situation goes from bad to worse, as there's 2 other key factors as to why a PCL-R score can be miscalculated.

- 1) It fails to detect and deduct points from the overall score if one has a 'Milder 'Personality Disorder'.
- 2) It scores high on 'Historical Factors', which no inmate can change, no matter how long he serves.

Yet, the Home Office argue that the PCL-R is purely designed to detect DSPD – but I argue, that if one already has a 'Milder personality Disorder', the PCL-R already has the bulk of it's scores long before adding on the scores for the 'Historical Factors'.

As the question headings are the same in all 'Psychological assessments', it is no wonder then, that when converted to a 'Score System' most lifers will score highly?

This amounts to a misdiagnosis – had lifers not had a 'Personality Disorder' in the first place, their crimes would not have been committed. Some 20–30 years ago, they may have suffered from DSPD, but with aging, maturing, becoming educated and doing years of prison therapy, DSPD would have lessened into a 'Milder Personality Disorder'.

And it's that 'aging process' which the PCL-R fails to acknowledge in any way or form. To have any Personality Disorder, the PCL-R will always score it as high. Thus, it is an incorrect diagnosis/score.

Having undertaken all the other Psychological assessments open to me – having shown I'm 'Medium Risk', I fail to see how a PCL-R test can rule me as 'High Risk', especially after 25 years in prison, changing from decade to decade for the better.

Again, after the last 6 years, the Home Office deny the result of a PCL-R test is a diagnosis. That in identifying DSPD, which they now offer treatment for, DSPD is not a diagnosis gained from the use of a PCL-R assessment.

In truth, the use of the PCL-R on inmates, is not only flawed, but it's also devised in such a way that it cannot be successfully challenged, not by inmates or other professionals.

Therefore, after a long 6 year battle to bring this assessment to peoples' attention, I write this in the hope that somebody, somewhere, will pick up on this challenge and investigate the present format and usage of the PCL-R, before others, like myself, are wrongly scored and forced to spend years more in prison with no light at the end of the tunnel.

This assessment is about assessing one's personality of today, therefore, when it comes to 'Historical Factors' from 2-3 decades ago, the scores should be excluded. And were that the case, my score of today would fall below 25.

And I'm not the only lifer now being detained because of a high PCL-R score – a test that should be fully investigated, revised or banned completely.

Terry Leggatt.

THE HARE PSYCHOPATHY CHECK LIST(Revised) (PCL-R)

1	Glibness/superficial charm
2	Grandiose sense of self-worth
3	Need for stimulation/proneness to boredom
4	Pathological lying
5	Cunning/manipulative
6	Lack of remorse or guilt
7	Shallow affect [i.e. superficial experience and expression of emotions]
8	Callous/lack of empathy
9	Parasitic lifestyle
10	Poor behavioural controls
11	Promiscuous sexual behaviour
12	Early behaviour problems
13	Lack of realistic long-term goals
14	Impulsivity
15	Irresponsibility
16	Failure to accept responsibility for own actions
17	Many short term marital relationships
18	Juvenile delinquency
19	Revocation of conditional release
20	Criminal versatility

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