PSYCHOPATHY IN A CIVIL PSYCHIATRIC OUTPATIENT SAMPLE

RICARDO DE OLIVEIRA-SOUZA
Hospital Universitário Gaffrée e Guinle, University of Rio de Janeiro, and Rede LABS-D'Or, Rio de Janeiro, Brazil

JORGE MOLL
Rede LABS-D'Or, Rio de Janeiro, Brazil

FÁTIMA AZEVEDO IGNÁCIO
Instituto Philippe Pinel, Rio de Janeiro, Brazil

ROBERT D. HARE
University of British Columbia, and Darkstone Research Group, Vancouver, Canada

Authors' Note: *Correspondence concerning this article should be addressed to Ricardo de Oliveira-Souza, Rua Conde de Bonfim, 232/304, Rio de Janeiro, RJ, 20550-012 – Brazil; e-mail: rdeoliveira@gmail.com; or to Robert D. Hare, Department of Psychology, 2136 West Mall, University of British Columbia, Vancouver, Canada V6T 1Z4; email: rhare@interchange.ubc.ca.*

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Abstract

In this primarily descriptive study we describe a sample of patients referred or brought to a Brazilian civil psychiatric facility for evaluation and consultation because of a chronic pattern of social and behavioral problems. Their PCL: SV scores generally were very high, and half met the DSM-IV criteria for antisocial personality disorder. In addition, about half of the patients reportedly had been charged or convicted of a serious criminal offense. The correlates of the PCL: SV were consistent with the research literature on psychopathy in criminal and forensic psychiatric populations. The results add to the small but growing literature on psychopathy in the community, and are consistent with the view that antisocial dispositions and behaviors are part of the psychopathy construct.

Keywords: community psychopathy, antisocial personality disorder, civil psychiatric patients, criminal behavior

PSYCHOPATHY IN COMMUNITY PSYCHIATRIC PATIENTS IN BRAZIL

Ricardo de Oliveira-Souza, Jorge Moll, Fátima Azevedo Ignácio, and Robert D. Hare

Psychopathy is a personality disorder that includes a cluster of interpersonal, affective, lifestyle and antisocial features, including grandiosity, deception, manipulation, irresponsibility, impulsivity, stimulation-seeking, poor behavioral controls, shallow affect, a lack of empathy, guilt or remorse, and a range of unethical and antisocial behaviors, not necessarily criminal (Hare & Neumann, 2006). Modern conceptions of the disorder are derived from the early investigations and writings of many European and North American clinicians (see historical reviews by Berrios, 1996; Coid, 1993; Hervé, 2007; Millon, Simonsen, Birket-Smith, & Davis, 1998). The clinical descriptions and case studies provided by Cleckley (1941, 1976) have been particularly useful for North American researchers. The patients he described as psychopathic were part of a much larger group of "mental patients" with a variety of psychiatric, behavioral, and neurological disorders admitted or brought to inpatient and outpatient psychiatric facilities, primarily because of persistent and perplexing patterns of problematic and antisocial behaviors. His patients were not representative of the general population, and we do not know to what extent his published case studies were representative of the patients that he considered to be psychopathic (see Hare & Neumann, 2008). Nonetheless, his case studies and theoretical speculations about the nature of the disorder helped to provide a clinical foundation for much of the subsequent empirical and applied research on psychopathy.

The vast majority of this research has been conducted with criminals and forensic psychiatric patients, for several reasons. First, the scientific study of psychopathy is facilitated by the availability of research populations with a reasonably high prevalence of the disorder. Second, the reliable and valid assessment of any personality disorder requires access not only to interviews and self-reports, but to corroborating information from a variety of other sources. It is not surprising, therefore, that the Psychopathy Checklist-Revised (PCL-R; Hare, 1991, 2003) was developed and validated with forensic populations, and that its most common use is with offenders, forensic psychiatric patients, substance abusers, and so forth (see Hare, 2007; Hervé & Yuille, 2007; Patrick, 2006).

This is not to say that there have not been attempts to study psychopathy in samples from the general population, only that it is difficult to do so. Members of the community understandably are reluctant to volunteer personal details to investigators or to allow them access to the extensive collateral information required to conduct reliable and valid assessments with the PCL-R. Some investigators have attempted to circumvent these problems by using a variety of self-report psychopathy scales or omnibus personality inventories (see Lillienfeld & Fowler, 2006; Lynam & Derefinko, 2006; Widiger, 2006; Williams, Paulhus, & Hare, 2007). Although self-reports broaden the repertoire of tools for the study of psychopathy and allow for large amounts of data to be collected with ease, they are subject to considerable impression management and are only modestly correlated with well-validated construct rating scales such as the PCL-R (Acheson, 2005; Hare, 2003; Lillienfeld & Fowler, 2006).

Other investigators have used newspaper advertisements and posters placed around various locations, such as universities or employment centers, to recruit

potentially psychopathic individuals. The ads and posters typically solicit participants for “a personality study,” using trait descriptors that are less pejorative than those used to describe psychopathy. For example, DeMatteo, Heilbrun, & Marczyk (2006) used this method to induce individuals who see themselves as charming, impulsive, aggressive, adventurous, easily bored, and living life on the edge, to participate in a research project for “easy money.” Many of those who volunteered their services had relatively high PCL-R scores, and more than half had a reported history of criminal arrests. In this and related accounts (e.g., Hall & Benning, 2006; Raine et al., 2004) those with high PCL-R scores and no evidence of criminal arrests often are referred to as “successful psychopaths.” However, it is unlikely that there was sufficient collateral information in these studies to score the PCL-R with confidence. Further, it seems incongruous to refer to psychopaths as successful merely because they manage to avoid prison. Many of these individuals presumably engage in a variety of parasitic, predatory, and socially deviant activities, such as flagrant traffic violations, sexual misconduct, spousal and child abuse, bullying, dishonest business practices, and other behaviors that result in serious psychological, physical, and financial harm to others, including family and friends (Babiak & Hare, 2006; Paulhus & Williams, 2002; Williams et al., 2007). For many of theses individuals, “success” often is ephemeral and defined without recognition of the negative impact on others.

A derivative of the PCL-R, the Psychopathy Checklist: Screening Version (PCL: SV; Hart, Cox, & Hare, 1995), is proving helpful in the study of psychopathy in the community. The PCL: SV was developed for use in the MacArthur Risk Study of violence in patients admitted to acute psychiatric facilities in the United States (Monahan et al., 2001; Steadman et al., 1999). It is strongly related to the PCL-R

(Cooke, Michie, Hart, & Hare, 1999; Guy & Douglas, 2006), but is shorter and requires less collateral information than does the PCL-R. The PCL: SV has been used in several large community studies (Coid, Yang, Ulrich, Roberts, & Hare, 2007; Neumann & Hare, 2007). In each case, the prevalence of psychopathic features was very low but the correlates of the PCL: SV were much the same as those found in PCL-R and PCL: SV studies of forensic populations. The findings are compatible with recent evidence that measures of psychopathy are dimensional in nature (Edens, Marcus, Lillienfeld, & Poythress, 2006; Guay, Ruscio, Knight, & Hare, in press; Marcus, John, & Edens, 2004), and that the construct might be described in terms of extreme manifestations of normal personality traits (Lynam & Derefinko, 2006; Widiger, 2006).

While studies of the sort described above are important for our understanding of psychopathy in the community, they typically do not have enough collateral information to conduct a complete clinical evaluation of the participants. Even the community studies by Coid et al. (2007) and Neumann & Hare (2007) would have benefited from more extensive collateral information.

This was not a problem in the present study, for we had access to sufficient interview and collateral information to conduct reliable PCL: SV and other assessments of these individuals. They were out-patients brought or referred by family or acquaintances to a civil psychiatric facility in Rio de Janeiro for psychiatric and neurological examination and consultation. Like the psychopathic patients described by Cleckley, they had exhibited a variety of externalizing behavioral patterns that caused considerable distress and pain for those who knew them, yet they themselves seldom saw that they had a problem in need of treatment. Most or the patients in our sample could be described as troublesome, aggressive,

irresponsible, deceptive, or parasitic, but many nonetheless had little or no known contact with the criminal justice system. Many were malingerers who misused government and private health and labor insurance systems, and manipulated medical personnel into providing them with prescription drugs.

The purpose of the present article was to describe and summarize the psychological and psychiatric work-ups on the patients in our sample. We emphasize that the study is descriptive, not inferential, and that it is based on a sample that is not representative of the general population. It is, however, reasonably representative of Brazilian out-patients brought to psychiatric facilities because of their patterns of disruptive or antisocial behaviors. Such patients frequently are encountered in most urban psychiatric facilities (Barry, Fleming, & Maxwell, 1997; Mesulam, 1981.

Method

Participants[1]

The participants in this study were obtained from a pool of adult out-patients in Rio de Janeiro who had received neurological or psychiatric consultation over the past decade from one of the authors (ROS) in private practice or at the Instituto Philippe Pinel, a civil psychiatric facility. Among these patients, the subject of this study, were 63 who came or were brought by relatives and acquaintances in search of a diagnosis, explanation, treatment or counseling for a variety of emotional and behavioral problems, generally characterized by patterns of chronic and recurrent antisocial acts and attitudes, often not criminal in nature. They represented close to 20% of all the patients seen by ROS over a 10-year period.

Because of inadequate or incomplete PCL: SV data 13 patients were dropped from the study. The primary analyses in this study therefore were based on 50 patients, 19 males and 31 females. Age varied from 18 to 72, with most being in their 30s or 40s (M = 36.1, SD = 16.3). Education varied from 4 to 17 years of schooling (M = 11.2, SD = 3.1); many (28%) had attended or graduated from university. Each patient satisfied the DSM-IV (American Psychiatric Association, 1994, 2000) adult criterion for antisocial personality disorder (ASPD). However, only 25 patients (12/19 males, 13/31 females) met the full criteria for a diagnosis of ASPD. None had a DSM-IV Axis I disorder. Most (91%) saw no need for a medical or treatment referral, at least not for the reasons that brought them to medical or psychotherapeutic attention.

The sample consisted of private civil psychiatric patients and it therefore was not feasible to obtain information concerning formal criminal records. Instead, we relied on information provided by the patient and corroborated by collateral sources (family, friends, etc.). About half (53%) of the males and 7% of the females reportedly had been charged with, or convicted of, at least one criminal offense.

Measures

Formal interviews and available collateral information (from at least one relative or acquaintance) were used to complete a battery of psychological and psychiatric instruments and to obtain information on substance abuse and criminal behaviors.

Psychopathy Checklist: Screening Version (PCL: SV*).* The PCL: SV is a 12-item derivative of the PCL-R developed for use in the MacArthur Risk Assessment study (Steadman et al., 1999). The PCL: SV is conceptually and empirically related to the PCL-R (Cooke, Michie, Hart, & Hare, 1999; Guy & Douglas, 2006). It is widely used in non-

forensic contexts, both as a screen for psychopathy (e.g., Guy & Douglas, 2006) and as a reliable and valid "stand-alone" instrument, particularly in countries outside of North America (e.g., Douglas, Strand, Belfrage, Fransson, & Levander, 2005). The PCL: SV consists of 12 items grouped into two correlated (around .5) sets of six items each. Part 1 measures interpersonal and affective traits, whereas Part 2 measures Lifestyle and Antisocial features. In the present sample, the correlation between Parts 1 and 2 was .57.

Recent analyses indicate that Parts 1 and 2 each can be split in two, producing a 4-factor solution (e.g., Vitacco, Neumann, & Jackson, 2005) consistent with the factor structure of the PCL-R (Hare, 2003; Neumann, Hare, & Newman, 2007). The items in these PCL: SV factors are as follows: *Interpersonal* (Superficial, Grandiose, Deceitful); *Affective* (Lacks remorse, Lacks empathy, Doesn't accept responsibility); *Lifestyle* (Impulsive, Lacks goals, Irresponsible); and *Antisocial* (Poor behavioral controls, Adolescent antisocial behavior, Adult antisocial behavior).

Using information provided by semi-structured interview and available collateral sources, each item is scored on a 3-point scale, ranging from 2 (*item is consistent with the individual's behavior*) through 1 (*item applies in some respects*) to 0 (*item is not at all descriptive of the individual*). Total scores, can vary from 0 to 24, with scores of 13 and 18 being indicative of possible and probable psychopathy, respectively.

In the present study, PCL: SV assessments were based on detailed interviews with the patient and information provided by at least one collateral source acquainted with the patient, usually a spouse or close relative. The interviews and collateral information were in Portuguese, and the items were scored from a Portuguese translation of the PCL: SV items (de Oliveira-Souza & Passman, 1996). The first author (a psychiatrist) rated all the patients, while the third author (a psychologist) rated 43 of the patients. Both raters are fluent in English and experienced in psychological assessment. The intraclass correlation (average

measure reliability) was 92, .86, and .96 respectively for Total, Part 1, and Part 2 scores, and greater than .80 for each of the four PCL: SV factor scores. Analyses involving the PCL: SV were based on averaged ratings in all but seven cases.

Hollingshead Index of Social Position (ISP). Occupational level was coded with the ISP (Hollingshead, 1957). Scores on this scale can vary from 1 ("higher executives of large concerns, proprietors, and major professionals"), through 4 (Clerical and sales workers, technicians, and owners of little businesses), to 7 ("unskilled employees"). A given score was based on the average occupational level attained by a patient, although this level was not always maintained.

Mini-Mental State Exam (MMSE). The MMSE (Folstein, Folstein, and McHugh, 1975, 2000) is a widely-used scale for the detection and tracking of cognitive impairment associated with neurodegenerative disorders. It consists of 30 items that measure orientation to place and time, ability to repeat words, attention and concentration, recall of words, language ability, and ability to copy a design. The MMSE has good reliability and validity. The score can range from 0 to 30, with scores below 24-27 (depending on age and education) being suggestive of cognitive dysfunction (Crum, Anthony, & Bassett, & Folstein, 1993; Folstein et al., 2000).

Global Assessment of Functioning (GAF). The GAF (Spitzer, Gibbon, & Endicott, 2000) is a measure of overall psychological, social, and occupational functioning. It constitutes Axis V of the DSM-IV multi-axial system (American Psychiatric Association, 1994, pp. 30-32). Scores can range from 1 to 100, with the higher scores being associated with good global functioning.

Criminal Offenses. Because the sample consisted of private civil psychiatric patients it was not feasible to obtain information concerning formal criminal records. Instead, we relied on information provided by the patient and corroborated by

collateral sources (family, friends, etc.). We excluded minor offenses such as traffic violations, possession of drugs, disorderly conduct, and so forth. For statistical analyses, cases with and those without a report of at least one charge or conviction were coded 1 and 0, respectively.

We also attempted to identify those patients whose pattern of interpersonal relations included substantial evidence of aggressive behavior, such as threats, intimidation, coercion, or violence, that was predatory or instrumental in nature (c.f., Cornell et al., 1996; Woodworth & Porter, 2002). Inter-observer agreement (between the first and third authors) for coding the presence (1) or absence (0) of this pattern of instrumental/aggressive behavior was good (kappa = 0.80, $p < 0.01$).

Results and Discussion

Because of the selective nature of the sample and the relatively small number of participants, the results largely are descriptive, with statistical analyses only where deemed appropriate.

The reasons for the relatively high proportion of female patients in the sample are unclear, but may be a reflection of sex-role expectations in which the community considers aggressive and antisocial behaviors to be less acceptable, and therefore more in need of explanation, among females than among males (e.g., Maccoby & Jacklin, 1974; but also see Richardson, 2005).

MMSE scores (Table 2) were consistent with normal cognitive functioning. However, GAF scores (Table 2) generally were very low (10 – 45), a reflection of the serious social and occupational problems that brought them to the psychiatric facility for consultation. In spite of the low GAF scores, occupational level was relatively high, with a mean score on the ISP of 3.1 (SD = 1.9, Mdn = 3). Although

many of the patients held, at one time or another, skilled or professional positions, their work history was erratic and unstable.

Many in the sample (52% overall, 76% of the males, 39% of the females) had alcohol or drug use problems serious enough to warrant a DSM-IV diagnosis of Substance Abuse. Perhaps most noteworthy is that about half (53%) of the males and 7% of the females reportedly had been charged or convicted of a criminal offense. Interestingly, very few of those charged or convicted of an offense actually served time in prison.

For almost half (47%) of the male patients, and 10% of the female patients, there was evidence for a pattern of interpersonal behavior that was aggressive and instrumental in nature.

PCL: SV Scores

The PCL: SV scores for the sample varied from 10 to 24 (10 to 23 for females; 10-24 for males). The scores for the entire sample, and for males and females considered separately, are presented in Table 1. The PCL:SV Total and Part 1 scores were significantly lower ($p < .05$) for female than for male patients. Interestingly, the highest overall scores tended to be on the Affective and Lifestyle factors, suggesting that as a group these patients were particularly callous, uncaring, impulsive, and irresponsible. A score of 18 or higher, often used for a research diagnosis of psychopathy, was obtained by 60% of the total sample (79% of the males, and 48% of the females).

Table 1 about here

Correlates of the PCL: SV

The PCL: SV generally was uncorrelated with age, education, or scores on the MMSE or GAF. The correlation between PCL: SV total scores and Substance Abuse (coded 0, 1) was .33 ($p < .05$) for the entire sample of patients, .15 (ns) for the males and .34 (ns) for the females.

The adult criterion for ASPD requires that 3 of 7 symptoms be evident. The number of symptoms exhibited varied from 3 to 7. This symptom count was correlated ($p < .01$ in each case) .70 with the PCL: SV total score, .54 with Part 1, and .70 with Part 2. The pattern was similar for male and female patients. The results are consistent with those obtained in forensic populations (Hare, 2003); ASPD is more strongly associated with the social deviance components of psychopathy than with the interpersonal/affective components.

The correlation between PCL: SV total scores and a reported criminal offense (coded 0 or 1) was .49 ($p < .01$) for the entire sample, .47 ($p < .05$) for the males, and .37 ($p < .05$) for the females. For the entire sample the correlations with a criminal offense were much the same for PCL: SV Part 1 (.40, $p < .01$) and Part 2 (.45, $p < .01$). Among the male patients, 6 of 9 *without* a criminal offense had a PCL: SV score of 18 or higher. Among females, 13 of the 29 patients *without* a criminal offense had a PCL: SV score of 18 or higher. The two female patients with a criminal offense had a very high PCL: SV score (21 and 23).

The correlation between PCL: SV total scores and instrumental aggression (coded 0 or 1) was .52 ($p < .01$) for the entire sample, .63 ($p < .01$) for the males, and .27 (ns) for the females. For the entire sample the correlation with instrumental aggression was .40 ($p < .01$) for Part 1 and .52 ($p < .01$) for Part 2. Among the male patients, all 9 in the instrumental aggression group had a PCL: SV score of 18 or

higher (4 had a score of 24, and 8 had a score of 20 or higher). Among the other patients, 6 of 10 males had a score of 18 or higher. Among female patients, 2 of 3 in the instrumental aggression group had a PCL: SV score of 18 or higher, while 13 of 28 of the other patients had a score of 18 or higher.

Although there generally was a modest positive association between the PCL: SV and reported evidence of a criminal offense, the finding must be interpreted with caution, given the small sample size, lack of official criminal records, low base rate for crime among female patients, and the possibility that the PCL: SV scores for some items may have been influenced by the rater's knowledge about a patient's criminal activities.

General Clinical Impressions

Space limitations do not allow for detailed clinical descriptions of the attitudes and behaviors of the patients in this sample. However, we are able to provide some general clinical impressions, with emphasis on those who received high scores on the PCL: SV.

In general, the patients in this Brazilian population looked very much like those with high PCL: SV scores described in North American (Neumann & Hare, 2007) and UK (Coid et al., 2007) samples. Typically, the patients were seen as "troublesome" because of chronic disruptive behaviors that were emotionally and financially costly to those with whom they lived or were associated in any significant way. Their antisocial behaviors consisted of recurrent and frequent violations of the rights of others for their own gain. In some cases, such violations consisted of minor infractions, such as truancy, lies, or robbery of small amounts of money that, if infrequent, might cause no serious harm. In other cases, particularly

among the males, there was evidence of criminal and aggressive behavior, frequently instrumental in nature. The recurrent nature of these violations ultimately resulted in major losses for others, usually a family member or relative. The patients did not seem to care if they were causing harm to their supporters, nor did they appear to be moved by the suffering inflicted on others. Indeed, they seldom acknowledged their roles as agents of that suffering. Even if they did admit culpability their behavior did not change accordingly—they would say they were sorry one day only to repeat the same transgressions on the next. They clearly understood that what they did was wrong, and when asked to judge situations involving explicit moral conflicts they did not hesitate to criticize and condemn the characters of the *vignettes* as "guilty" or "utterly wrong." When they themselves were portrayed as the violators they disapproved of their own conduct and even offered apologies. However, the knowledge of how to behave appropriately was expressed only rhetorically and had little, if any, connection with their behaviors in real-life contexts.

There were differences among our patients in their interpersonal style, but each individual's style seemed quite stable from adolescence into adulthood. Many appeared warm and outgoing, excelling in social encounters because of their charm and wit. They often appeared genuinely concerned with the misfortunes of people unrelated to them, such as homeless children or victims of warfare and famine. This way of relating to others did not easily fit the picture of callousness and selfishness usually brought to mind by words like "antisocial" or "psychopath." In every case, however, this apparent paradox vanished whenever the individuals found themselves in situations that conflicted with their own self-interest. In such cases, apparently sincere verbal expressions of empathy and concern for others quickly gave way to a

familiar pattern of selfish and callous attitudes and actions in which the feelings and rights of others, including family, were easily brushed aside.

Many of these patients used manipulation, intimidation, threats, and verbal abuse to get what they wanted, but apparently not all engaged in physical aggression. Many followed a parasitic, aimless, and unproductive lifestyle in which gambling, partying, and alcohol and drug use were common. Their self-indulgence typically placed excessive demands on parents and friends for money, loans, and other privileges. In some cases their actions might have led to arrest and criminal charges were it not for the help and support of family and friends who paid their debts or otherwise "bailed them out" of trouble. There is no doubt that these individuals caused enormous emotional and financial harm to those around them, but the essence of this harm was not necessarily physical violence. While these individuals managed to remain out of prison it would be inappropriate to refer to them as "successful," given their unstable and antisocial lifestyle, and the distress they caused others. Their high PCL: SV scores suggest that we might describe them as "noncriminal psychopaths," but what separates them from "criminal psychopaths" sometimes seems rather fuzzy, more a matter of circumstances and opportunities than of differences in personality and behavioral dispositions. Interestingly, these groups differed primarily in terms of the Lifestyle and Antisocial components of psychopathy.

The association between PCL: SV scores and criminal behavior is consistent with the findings from other community samples (Coid et al., 2007; Neumann & Hare, 2007; Steadman et al., 1999). Similarly, as in other studies of community psychopathy (e.g., DeMatteo et al., 2005), a significant proportion of the males in our sample had been in contact with the criminal justice system, but managed to

avoid prison. Their behaviors were sufficiently problematic for others that family or friends thought it necessary to seek professional consultation and advice. Consistent with evidence from community (Coid et al., 2007) and criminal samples (e.g., Hare, 2003; Vitale & Newman, 2001) psychopathy was less strongly related to reported criminality among females than among males.

The lack of a significant association between age of assessment and ratings of psychopathy in our patients is similar to findings from criminal and community samples (Coid et al., 2007; Hare, 2003). Although the data in these cases are cross-sectional, it is possible that some of the key features of psychopathy are relatively stable across much of the lifespan (Hare, 2003; Lynam, Caspi, Moffitt, Loeber, & Stouthamer-Loeber, 2007; Lynam & Gudonis, 2005). Several of our oldest patients, a 66 year-old man and a 69 year-old women, had a PCL: SV score of 24 and 23, respectively. Certainly, age did little to increase their capacity for empathy or to reduce their deceptiveness, impulsivity, and irresponsibility.

Our experiences in this study revealed an interesting diagnostic anomaly. Most of the patients previously had been in contact with a psychiatrist, medical doctor, or counselor at one time or another, yet their symptoms and behaviors seldom resulted in a diagnosis of ASPD or psychopathy. It is possible that in-depth psychiatric examinations were not conducted and that the collateral information needed for a reliable diagnosis was unavailable. It also is possible that many clinicians do not include ASPD or psychopathy among their diagnostic alternatives when dealing with patients from the general community. This would be more understandable with respect to psychopathy than to ASPD. The latter is well-known to clinicians but it is only recently that instruments, such as the PCL: SV, have been used for the assessment of psychopathy and its traits in non-forensic populations.

Conclusions

Recent community studies indicate that psychopathy and the traits that define it are distributed throughout the general population (Coid et al., 2006; Neumann & Hare, 2007). Many of these individuals will come to the attention of the authorities, but many others will not. Some will function reasonably well in various occupations and endeavors, while others will create continual social, economic, and personal distress to those around them. This study described a sample of those individuals whose behaviors were so disruptive and perplexing to family, friends, and acquaintances that clinical evaluation and intervention were required.

The findings are consistent with the view that antisocial dispositions and behaviors, *not necessarily criminal in nature*, form an integral part of the psychopathy construct (Hare & Neumann, 2008). Although some observers (e.g., Cooke & Michie, 2001) have asserted that antisocial behaviors are not part of the Cleckley conception of psychopathy, Cleckley himself (1976, p. 370) noted that he was "in complete accord" with the description of the psychopath as "…*simply a basically asocial or antisocial individual*…(italics ours). As put by Patrick (2006, p. 608), "There is no question that Cleckley considered persistent antisocial deviance to be characteristic of psychopaths. Without exception, all the individuals represented in his case histories engage in repeated violations of the law–including truancy, vandalism, theft, fraud, forgery, fire-setting, drunkenness and disorderly conduct, assault, reckless driving, drug offenses, prostitution, and escape."

Note

1. As part of a neuroimaging research program psychological and psychiatric data, including PCL: SV assessments, also were collected for 53 productive members of the community: caregivers, students from various academic programs, and relatives and acquaintances of the research team who volunteered to take part in a research program. This volunteer sample could not be construed as appropriate control or comparison groups for the present study. However, it is worth noting that most of the volunteers had a PCL: SV score below 3 and none had a score greater than 5.

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Table 1: Scores on Psychological Instruments

Instruments	**Total** *N* = 50		**Males** *N* = 19		**Females** *N* = 31	
PCL: SV	*M*	*SD*	*M*	*SD*	*M*	*SD*
Total	18.1	3.9	19.5	4.2	17.2	3.5
Part 1	9.1	2.5	10.5	2.2	8.2	2.2
Interpersonal	3.7	1.9	4.8	1.7	3.1	1.7
Affective	5.4	1.1	5.7	0.8	5.1	1.1
Part 2	9.0	2.0	8.9	2.5	9.0	1.7
Lifestyle	5.4	1.0	5.1	1.1	5.6	0.8
Antisocial	3.6	1.5	3.8	1.8	3.4	1.4
GAF	29.3	11.1	25.5	11.6	31.7	10.3
MMSE	27.8	2.1	27.9	1.6	27.7	2.3

Note: PCL: SV = Psychopathy Checklist: Screening Version; GAF = Global Assessment of Functioning; MMSE = Mini-Mental State Exam.

1.