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Examining the incremental validity of psychopathy versus antisocial personality disorder in understanding patterns of criminal behavior

par

Erika Braithwaite

Département de Psychologie

Faculté des Arts et Sciences

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Présenté par :

Erika Braithwaite

a été évalué par un jury composé des personnes suivantes :

Joanne-Lucine Rouleau, président-rapporteur

Christopher M. Earls, directeur de recherche

Anne G. Crocker, co-directeur

Ariel Stravynsky, membre du jury

Résumé

La psychopathie et le trouble de personnalité antisociale sont deux syndromes reliés qui ont été identifiés comme prédicteurs importants de comportements violents et de criminalité. Cependant, la recherche indique que les facteurs de la psychopathie centrés sur la personnalité ne sont pas des prédicteurs fiables de récidive violente chez les personnes atteintes de maladies mentales. Toutefois, peu d'études se sont centrées sur l'identification des facteurs associés au patron des antécédents criminels. Les 96 hommes de l'étude ont été déclarés non criminellement responsables en raison de troubles mentaux. Ils ont été évalués quant au trouble de la personnalité antisociale ainsi qu'à la psychopathie. Les dossiers criminels de la Gendarmerie Royale du Canada ont également été consultés afin de reconstituer l'histoire criminelle. Les résultats suggèrent que ni les traits de personnalité antisociaux, ni les facteurs de la psychopathie ne démontrent une validité prédictive incrémentielle les uns sur les autres quant au nombre ou à la sévérité des délits. La présence d'un grand nombre de traits antisociaux est associée à un plus grand nombre et à une plus importante sévérité d'actes criminels non-violents. Les résultats sont discutés en termes de l'utilité d'une classification du trouble de personnalité antisociale, et de la pertinence du construit de la psychopathie pour les personnes atteintes de maladies mentales graves.

Mots-clés : psychopathie, trouble de personnalité antisocial, trouble mental grave, criminalité

Abstract

Psychopathy and antisocial personality disorder are two related yet clinically distinct syndromes both coined as important predictors of violence and criminality. Among the mentally ill, there is increasing evidence that only the behavioral aspects of psychopathy are related to criminality. Studies have shown that the personality-oriented facets of psychopathy add little to the prediction of future violence among the mentally ill. However, few studies have sought to examine whether a lifetime of crime shows the same pattern. A total of 96 men who had been declared not criminally responsible on account of mental disorder participated in this study. Trained interviewers assessed antisocial personality and psychopathy among participants. Official RCMP criminal records were consulted in order to ascertain criminal history. Results suggest that neither antisocial personality disorder traits nor psychopathy facets evidenced incremental validity one over the other regarding a lifetime pattern of offending. A higher number of antisocial traits were related to a greater number and higher severity of non-violent offenses. Results are discussed with regards to the usefulness of the antisocial personality disorder classification, and the applicability of conceptual models of psychopathy to individuals with a severe mental illness.

Keywords: psychopathy, antisocial personality disorder, criminal history, severe mental illness.

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Introduction

The construct of psychopathy is often traced back to the seminal work of Hervey Cleckley. In his book, *The Mask of Sanity* Cleckley (1941) described an individual who appeared to function normally in the outside world but who was irresponsible, callous, grandiose, arrogant and manipulative (Arrigo & Shipley, 2001). To date, the construct of psychopathy has seen a tumultuous evolution (see Arrigo & Shipley, 2001 for a detailed review) with criticisms ranging from its assessment to the validity of the syndrome. The debate continues as to psychopathy's relationship with the Diagnostic and Statistical Manual of mental disorders IV-TR's (American Psychiatric Association, 2000) antisocial personality disorder. The terms 'psychopathy' and 'antisocial personality disorder' are often used interchangeably (Ogloff, 2006) in spite of their important conceptual differences. The present thesis will explore the constructs of psychopathy and antisocial personality disorder, with regards to the criminality of individuals with a severe mental illness.

The history of psychopathy and antisocial personality disorder

Psychopathy was introduced into the first edition of the Diagnostic and Statistical Manual of mental disorders (American Psychiatric Association, 1952) in 1952. Psychopathy was coined under the name "sociopathic personality disturbance" in order to emphasize the psychosocial influences of psychiatric disorders, but whose criteria closely resembled Cleckley's (1941) psychopath. The sociopathic personality encompassed two subtypes: antisocial and dyssocial personalities. The antisocial subtype resembled closely criteria set forth by Cleckley, while the dyssocial subtypes was described as the

professional criminal with loyal ties to similar minded individuals (Arrigo & Shipley, 2001).

It was only until later versions of the Diagnostic and Statistical Manual of mental disorders (American Psychiatric Association, 1980, 1987) that antisocial personality disorder took the place of psychopathy. More noteworthy was the newfound focus on deviant/criminal behavior in the diagnostic criteria and the complete lack of certain core personality traits that had been central to the syndrome. Critics argued that the American Psychiatric Association sacrificed validity for reliability, a phenomena Messick (1995) described as *construct irrelevance variance*. Construct irrelevance variance occurs when "the assessment is too broad, containing excess reliable variance associated with other distinct constructs" (Messick, 1995, p. 742). For some authors, the over inclusive behavioral criteria did not sufficiently describe the psychopath that was intended to be at the heart of the disorder (Hare, 1998; Millon, Simonsen, & Birket-Smith, 1998).

Today antisocial personality disorder is a diagnostic category aimed at describing the persistent and deviant behavior. Psychopathy never made its way back into the Diagnostic and Statistical Manual of mental disorders but it remains one of the most widely studied syndromes, partly due to the ground breaking work of Hare and his development of the Psychopathy Checklist (Hare, 1980) (see also Hare, 1991; Hare, 2003). The Psychopathy Checklist includes 20 items that assess various affective, interpersonal and behavioral characteristics. Psychopathy's overlap with antisocial personality disorder is limited and lies largely in the behavioral items that assess impulsivity, irresponsibility and criminal behavior. The only personality items (beyond the behavioral items) that are shared by psychopathy and antisocial personality disorder are: proneness to lying,

manipulativeness and lack of guilt/remorse. More importantly, there are clinical differences between the two disorders. While antisocial personality disorder has been estimated in between 60 and 80% of incarcerated offenders, only 15% of offenders meet criteria for psychopathy (Hare, 2003).

In contrast to the body of literature that has focused on the differences between the two disorders, some researchers posit that psychopathy is simply a severe form of antisocial personality disorder (Coid & Ullrich, 2010; Widiger, 2007). The argument that psychopathy and antisocial personality disorder lie on the same continuum stems from both methodological and measurement issues. Traditionally, antisocial personality disorder, as outlined in the Diagnostic and Statistical Manual IV, is conceptualized as a dichotomous variable. An individual must meet 3 or 7 adulthood criteria of antisocial behavior, as well as show evidence of conduct disorder by the age of 15 (American Psychiatric Association, 2000). Most studies that measure antisocial personality disorder have treated the disorder as a dichotomous variable, whereby an individual does or does not meet diagnostic criteria.

Skilling and colleagues (Skilling, Harris, Rice, & Quinsey, 2002) operationalized psychopathy and antisocial personality on two continuous scales. Their goal was to compare which disorder more aptly classified participants as persistently antisocial offenders. Using a large sample of individuals from a large maximum-security psychiatric facility, the authors found that the psychopathy and antisocial personality classifications yielded the same results. In other words, both disorders identified the same participants as persistent recidivists. Skilling et al. (2002) argued that previous research has been hampered by the use of a dichotomous antisocial personality category, and that their results

illustrate its relationship with psychopathy increased significantly when antisocial personality scores were used continuously.

The Psychopathy Checklist has garnered a great deal of attention of the domain of risk assessment. While it was initially designed to measure psychopathic traits, research has shown that it had robust ability in predicting risk of aggression and violence in forensic (Heilbrun, et al., 1998; Tengstrom, Grann, Langstrom, & Kullgren, 2000) and general offender populations (Alterman, Cacciola, & Rutherford, 1993). The paradox of an instrument not intended for risk assessment of violent behavior has led many researchers to question the underlying structure of the Psychopathy Checklist-Revised. Examining the factor structure of the Psychopathy Checklist has allowed the exploration of the different facets of psychopathy and its relationship with the aggression and violence (i.e. Patrick, Hicks, Krueger, & Lang, 2005; Walters, Knight, Grann, & Dahle, 2008).

Structure of psychopathy

When initially developed, (Hare, 1980), Hare proposed a two-factor model that underlay the Psychopathy Checklist: factor 1, affective/interpersonal and factor 2, antisocial/impulsive lifestyle. The affective/interpersonal factor contained items describing superficial charm, manipulation and high deceptiveness. The antisocial/impulsive factor contained items relating to past criminal acts, early behavior problems and irresponsibility. This second factor is more conceptually related to antisocial personality than the first factor. The two-factor model was widely accepted for years until Cooke and Michie (2001) reviewed the methodological and statistical advances made in the domain of factor analysis and concluded that the two factor model would no longer be accepted by today's statistical

standards due to its reliance on subjective indices as the sole index of factor structure (Cooke & Michie, 2001; see Davenport, 1990 for a review).

Cooke and Michie (2001) went on to propose a three-factor hierarchical model using item response theory, cluster analysis and confirmatory factor analysis. Their results produced a significantly different portrait of psychopathy, one that completely excluded the antisocial/socially deviant lifestyle items. This model was in keeping with Cleckley's (1941) traditional conceptualization of psychopathy. The original criteria of psychopathy did not require antisocial behavior, but rather focused entirely on the personality traits. Cooke, Michie, Hart and Clark (2004) argued that their statistical findings raised an important question that had not previously been addressed in the psychopathy literature: whether antisocial behavior should be considered a symptom or consequence of psychopathic traits. Cooke et al. (2004) concluded that antisocial behavior was a consequence of psychopathy, and therefore should not be included in its diagnosis. They and others (Hart & Hare, 1997) considered antisocial behavior to be so broad and unspecific that its focus could "lead to [an] over diagnosis of psychopathy in criminal populations, and [an] under diagnosis in non-criminals" (Hart & Hare, 1997, p. 23). While some authors have found the three-factor model to be useful (Hall, Benning, & Patrick, 2004) others have pointed out its flaws. Hare and Neumann (2008) criticized the three-factor model on the basis of its statistical problems. They claimed that ten factors actually existed, that the parameters were unfeasible and argued that there were significant conceptual difficulties [refer to Neumann, Vitacco, Hare and Wupperman (2005) for a detailed account of the problems associated with the three-factor solution].

In the second edition of the Psychopathy Checklist-Revised manual (Hare, 2003) the author presented a two-factor, four-facet model. The two-factor, four-facet solution was later described in detail by Bishopp and Hare (2008). Bishopp and Hare (2008) used multidimensional scaling, a non-linear alternative to factor analysis that allows dimensions to be plotted superimposed on one another in order to visualize factor clustering. Bishopp and Hare concluded that psychopathy was an extreme variant of personality dimensions and behavior manifestations that most likely interact with one another, instead of being conceptualized as parts related to a whole. Hare and Neumann (2008) argued that the four facets of the Psychopathy Checklist-Revised are explained by a superordinate factor, thus indicates that all four facets necessarily make up the construct of psychopathy because the latter accounted for a significant amount of variance in the four facets. The re-inclusion of antisocial behavior in the construct of psychopathy was in sharp contrast with Cooke and Michie's 3-factor model. Salekin and colleagues (2006) sought to validate the four-factor model with the Psychopathy Checklist: Youth Version (Forth, Kosson, & Hare, 2003), a variant of the Psychopathy Checklist. It should be noted that while their four-facet model had adequate fit, the three-factor model still proved to be superior.

Psychopathy and severe mental illness

There are questions as to the overlap between psychopathy and the severe mental illnesses common in forensic settings. The category of severe mental illness usually encompasses schizophrenia spectrum disorders, bipolar disorder, and major depression; it denotes the more severe of the Axis 1 disorders. Research on the prevalence of psychopathy in forensic and civil psychiatric settings has yielded estimates around 10% (Douglas, Ogloff, Nicholls, & Grant, 1999; Hart, Cox, & Hare, 1995; Skeem & Mulvey,

2001) but great variability in prevalence rates can be seen (0-25%) (Côté, Hodgins, & Toupin, 2000).

There was a time when theorists believed that a psychopath could not be psychotic, a so-called *manie sans délire* (Pinel, 1962). The contention that psychopathy and severe mental illness are mutually exclusive was held at one time (Hare, 2003) and some scientific literature has supported this finding with regards to depression (Lovelace & Gannon, 1999). The theorists that posit the exclusivity of psychopathy and severe mental illnesses generally refer to the reciprocal antagonistic relationship between the behavioral inhibition system and the behavioral activation system (Gray, 1976). The behavioral activation and inhibition systems are neural motivational systems that regulate our responses to punishment and rewards (Scholten, van Honk, Aleman, & Kahn, 2006). In short, disorders such as depression schizophrenia are hypothesized to be based in over activation in the behavioral inhibition system. Scholars such as Fowles (1980) suggest that psychopaths suffer from deficits in the behavioral inhibition system, and which in turn, allows the behavioral activation system to become overactive. This theory has been empirically tested, and some results support the contention (Newman, MacCoon, Vaughn, & Sadeh, 2005).

Considering the varying prevalence rates and some evidence of differential neural motivational systems, the possibility that ratings on the Psychopathy Checklist-Revised among individuals with a severe mental illness could be clouded by a confounding, overlapping disorder, such as antisocial personality disorder remains. Elevated levels of antisocial behavior, rather than affective/interpersonal personality traits could explain how previous research has come to find a modest level of psychopathy in forensic samples. Hildebrand and de Ruiter (2004) conducted a study in male forensic psychiatric patients

and the relationship between psychopathy, Axis I and Axis II disorders. The authors found high comorbidity between psychopathy and antisocial personality disorder and low comorbidity between psychopathy and schizophrenia. Skeem and Mulvey (2001) found that not only was there a low prevalence of psychopathy in the MacArthur Community Violence study sample of civil psychiatric patients, but psychopathy's association with violence was significantly reduced when a number of antisocial behavior correlates were controlled for. And finally, the antisocial component of psychopathy is largely responsible for the association between psychopathy and violence (e.g. Crocker, et al., 2005; Hart, et al., 1995).

Antisocial personality disorder and severe mental illness

The role of antisocial personality disorder in violence/aggressive behavior within the severely mentally ill has been well documented. Hodgins and colleagues (2008) found that individuals with severe mental illness who were diagnosed with conduct disorder during adolescence are at an increased risk for aggression and violence. Individuals with schizophrenia are more likely than the general population to receive a diagnosis of antisocial personality disorder (Bland, Newman, & Orn, 1987; Jackson, et al., 1991). Mueser and colleagues (1997) found that schizophrenia patients with antisocial personality disorder represent a high-risk subgroup vulnerable to more severe substance abuse, psychiatric impairment, aggression, and legal problems. These results suggest that a link between antisocial behavior and severe mental illness does exist, whereas the link between antisocial behavior, psychopathy and severe mental illness is less clear. Guy, Anthony, Edens and Douglas (2005) conducted a meta-analysis examining the association between the Psychopathy Checklist-Revised factors and a various forms of institutional misconduct

in civil psychiatric, forensic and correctional settings. Their results were consistent with previous research in that factor 2 (antisocial/impulsive lifestyle) was more strongly associated with misconduct than factor 1 (affective/interpersonal) (Walsh & Kosson, 2008; Walters, 2003). This relates closely to the ongoing debate about the relative importance of the items, factors and most importantly, what the instrument is purportedly measuring.

More recent research has used contemporary models of the Psychopathy Checklist to examine different factor structures predict criminal outcomes. Walters used the 4-factor model to predict violent and general recidivism in forensic and correctional samples (Walters, et al., 2008). Like the 2-factor model, the behavioral items showed incremental validity over the three other facets, but the reverse was not found. This indicates that the 4th facet (relating to antisocial behavior) explained more variance, above and beyond the impact of the other (personality oriented) factors, in recidivism rates.

The problem with many studies that have examined criminality in the severely mentally ill relates to methodology. Often, outcomes are dichotomized into violent versus non-violent offences, or the absence versus presence of an offence and authors seek to predict the occurrence of an event varying follow-up periods. The problem with this approach is that: 1) the definition of violence can differ from one study to the next (Edens & Douglas, 2006); and 2) the occurrence of one event in no way illustrates the association between a personality disorder and a long-standing pattern of criminality. It seems logical that if one wants to look at the impact of a pervasive and longstanding pattern of personality, then it would be useful to look at long-term patterns of behavior. Given the longitudinal prospective studies are rare and costly, the most effective way to examine a life of criminal behavior is to analyze retrospectively.

Goal

Many studies have shown that individuals with a mental illness are at an increased risk of criminality and violence (Hodgins, 1992; Hodgins & Cote, 1993; Link, Stueve, Monahan, & Steadman, 1994; Swanson, Holzer, Ganju, & Tsutomu Jono, 1990; Swanson, Monahan, & Steadman, 1994) compared to the general population with no mental disorder, and that the diagnosis of a personality disorder further increases this risk (Fullam & Dolan, 2006; Hodgins, 2003). But what remains unclear is what aspects of psychopathy, if any, explain the pattern of offending among the mentally ill. There is some evidence that the behavioral aspects of psychopathy are more predictive of criminality in the mentally ill, but to date, most studies have measured antisociality in a very strict fashion using the Psychopathy Checklist. A more comprehensive measure of antisocial behavior, such as a diagnosis of antisocial personality disorder as determined by the Diagnostic and Statistical manual might be better suited to examine this research question. In addition, most studies have examined used psychopathy scores to predict future recidivism, but few have looked retrospectively to examine lifetime patterns of offending among the mentally ill.

The proposed study will examine the relationship between psychopathy and antisocial personality disorder in a sample of individuals declared not criminally responsible on account of mental disorder. More specifically, the goal was to examine whether antisocial personality disorder, versus facets of psychopathy better account for past violence and criminality committed by individuals with a severe mental illness. Examining the incremental validity added by antisocial personality disorder and the 4-facets of the Psychopathy Checklist-Revised will test this hypothesis.

Method

This study was conducted between October 2004 and August 2006 at Philippe Pinel Institute, the only forensic psychiatric hospital in Quebec, and two civil psychiatric hospitals (Douglas Institute and Louis-H Lafontaine Hospital in Montreal). The data collected were part of a larger study on dispositions regarding individuals declared not criminally responsible on account of mental disorder (Crocker & Côté, 2009).

Participants

A total of ninety-six men were recruited for the present study: Seventy nine (82.3%) men had a diagnosis of severe mental illness (either bipolar disorder, schizophrenia or schizo-affective disorder), 5 (5.2%) had an intellectual disability or an organic disorder, 3 (3.1%) had other diagnoses and 9 (9.4%) had no diagnosis mentioned in their files. A total of 38 (39.58%) individuals had a comorbid substance use disorder. Most participants were French speaking (65.6%), followed by English speaking (20.8%) and other languages (12.5%). The most common country of birth was Canada (84.4%). The majority of participants were single (77.1%) or separated/divorced (18.8%), with only 4.2% being married. At the time of the interview, 52.1% were detained in a hospital setting, while 47.9% were living in the community. Age ranged from 18.57 years to 65.91 years, with a mean of 39.02 (SD = 12.89).

Measures

Three types of information were gathered: Sociodemographic, psychopathological, criminological.

Sociodemographic. As described above, sociodemographic data included age, civil status, ethnic origin, language, level of education, main source of income, employment history, parenthood, and residential status prior to the indexed offense. This information was gathered through file consultation, and corroborated during the interview process with a standardized questionnaire (see Appendix A1)

Psychopathological. Psychopathological data consisted of: age at first hospitalization, psychiatric diagnosis, substance use, antisocial personality disorder, and psychopathy. Information regarding hospitalization and diagnoses were gathered through the participant's medical files. The following measures were used to assess antisocial personality disorder and psychopathy.

The *Structured Clinical Interview for DSM-IV axis II personality disorders* (SCID II: First, Spitzer, Gibbon, Williams, & Lorna, 1996) is a personality interview that assesses the 11 personality disorders based on the Diagnostic and Statistical Manual IV-TR {APA, 2000 #2268}. For the purpose of this study, only the antisocial section of the SCID-II was used (see Appendix A2). Maffei and colleagues (1997) reported that the SCID-II had good interrater reliability (kappa = .95). In order to meet diagnostic criteria for antisocial personality disorder, an individual must evidence conduct disorder (before the age of 15), and display antisocial behavior in adulthood (First, et al., 1996).

The *Psychopathy Checklist-Revised* (Hare, 1991, 2003) was used to assess psychopathy (see Appendix A3). A total 20 items are scored on a three point scale: 0= *does not apply*; 1 = *applies to a certain extent or there is uncertainty that it applies*; 2 = *definitely applies*. The items were summed to yield total score. Hare and colleagues (Hare,

1991; 1990) suggest that a score of 30 and above is indicative of psychopathy in North American samples while scores between 20 to 29 are indicative of moderate or 'mixed' cases of psychopathy. Assessments are conducted with the use of a semi- structured interview as well as file review. The Psychopathy Checklist-Revised has well-established psychometric properties with high interrater reliability (r = .82-.93) (Hare, et al., 1990) and high test-retest reliability (r = .84) (Alterman, et al., 1993). In the current study, the PCL-R scores had high interrater reliability (intraclass correlation coefficient = 0.95). Salekin, Rogers and Sewell (1996) conducted a meta-analysis on the predictive validity of the Psychopathy Checklist-Revised. The authors reported that psychopathy was associated with increased risk of violent behavior in male offenders (mean effect d = .79).

Criminological. Criminological data collected included: index offense(s), using Review Board[1] files, and criminal history, based on the Royal Canadian Mounted Police Finger Print Services criminal records. Juvenile records were not available. The index offence was the offence for which the participant was found not criminally responsible on account of mental disorder. Violent offenses were defined in accordance with Webster et al. (1997)'s definition as those including "actual, attempted, or threatened harm to a person" p. 24 and offences "which would be fear-inducing to the average person" p. 24-25. As such, offences involving assault, threats of harm, harassment, any sexual offences, and robbery were coded as violent.

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[1] A Review Board is a quasi-judicial tribunal that is responsible for the annual reviews of individuals declared not criminally responsible on account of mental disorder. For a full review see (Carver & Langlois-Klassen, 2006).

The Cormier-Lang System for Quantifying Criminal History. The Cormier-Lang crime index was first developed by (Akman & Normandeau, 1966, 1967; Akman, Normandeau, Sellin, & Wolfgang, 1968) and later described by (Quinsey, Harris, Rice, & Cormier, 1998). The Cormier-Lang index assigns a numerical severity score to offences whereby a mild offence such as *disturbing the peace* is assigned a 1 and severe offences such as *homicide* is assigned a score of 28 (See Appendix A4).

Procedure

Eligible participants were selected from individuals declared Not Criminally Responsible on account of Mental Disorders up for a Review Board disposition hearing in one of the three aforementioned institutions during the period of the study. Participants must have been able to either understand English or French as well as been capable of giving consent to participate or assent with consent from the legal representative to both have an interview with a research assistant, allow access to personal hospital records and RCMP criminal records.

Participants were recruited from rosters of Provincial Review Board hearings at the three institutions. Prior to the hearing, the research team approached the treating psychiatrist or other case managers to obtain permission to approach their client to take part in the study. When the case manager or psychiatrist agreed, the research team would explain the study to the potential participant, obtain consent (see Appendix A5) and, time permitting, begin the interview process. Most interviews were conducted prior to the Review Board hearing. The research was approved by the Douglas Institute research ethics

board, the Philippe Pinel research ethics committee as well as the Louis-H. Lafontaine research ethics committee.

Statistical treatment of the data

A first set of bivariate analyses was performed on all the variables of interest. Hierarchical regressions were then conducted in order to examine whether psychopathy postdicted criminality above and beyond antisocial personality disorder (i.e. incremental validity). Hierarchical multiple regressions permit a method of entry of predictors as separate 'blocks'. Each block of predictors has its own contribution to the variance explained in the dependent variable (R^2) as well as an associated beta weight for each predictor (Field, 2005). To test incremental validity, known covariates are added in the first block, and the predictors of interest are added into separate blocks. The next step is to reverse the order of entry of the predictors to test if one explains more variance in the outcome variable after controlling for the other.

Because this sample was made of up individuals with a history of psychiatric hospitalization (N = 95, 98.9 %) and/or incarceration (N = 89, 92.7%), which could invariably bias the "opportunity to commit", both these variables, along with age, were used as covariates. Psychopathy was disaggregated into facet scores (see Table 1). The 4-facet model was used for the analyses. The 4-facet model of psychopathy is the most recent model posited by the author of the Psychopathy Checklist (see Hare & Neumann, 2008). The behavioral items of the PCL-R and antisocial personality disorder overlap both conceptually and statistically (Patrick, et al., 2005).

The outcome or dependent variables of interest are criminality and violence. They were operationalized as 1) the number of total lifetime offences, 2) the number of violent lifetime offences, 3) number of lifetime non-violent offences, 4) the severity of lifetime offences, 5) the severity of violent lifetime offences.

Table 1. Facet and item breakdown

	Item
Facet 1	Glibness/Superficial charm
	Grandiose sense of self-worth
	Pathological lying
	Conning/Manipulative
Facet 2	Shallow affect
	Lack of remorse, guilt
	Callous/Lack of empathy
	Irresponsibility
Facet 3	Need for stimulation/Proness to boredom
	Impulsivity
	Failure to accept responsibility for own actions
	Parasitic lifestyle
	Lack of realistic, long-term goals
Facet 4	Poor behavioral control
	Early behavior problems
	Juvenile delinquency
	Revocation of conditional release
	Criminal versatility

N.B. Items that do not load on either the 3- or 4-facet models: Promiscuous lifestyle and Many short-term relationships

Facet 1 = Arrogant and deceitful lifestyle; Facet 2 = Deficient affective experience

Facet 3 = Impulsive and irresponsible lifestyle; F4 = Antisocial behavior

Results

The scores on the Psychopathy Checklist-Revised ranged from 4 to 32, with a mean of 18.28 (*SD* = 5.94). There were only four participants (4.2%) that scored 30 and above on the Psychopathy Checklist Revised, while 35 (36.5%) scored between 20 and 29, and 57 (59.4%) scored 19 and below. Table 2 shows the distribution of Psychopathy Checklist facet scores and the number of antisocial traits. According the Structured Clinical Interview for the Diagnostic Manual IV, to meet criterion for antisocial personality disorder, an individual must meet criteria for both conduct disorder (before the age of 15) and adulthood antisocial behavior (First, et al., 1996). In this sample, only 18.8% met full criteria for antisocial personality disorder, while 65.6% met criteria for adulthood antisocial personality, which is consistent with other studies (Crocker, et al., 2005; Mueser, et al., 2006; Mueser, et al., 1997). The number of conduct disorder traits ranged from 0-10 (*M* = 1.75, *SD* = 2.06). The number of adult antisocial traits ranged from 0-6 (*M* = 3.19, *SD* = 1.52). The average number of previous hospitalizations for the whole sample was 8.18 (*SD* = 7.19) while the number of prior detentions was 3.44 (*SD* = 4.30).

Criminal history.

Of the 96 participants in the sample, 72.6% (*N* = 82) had criminal charges brought against them prior to their index verdict of non-criminal responsibility. The average number of lifetime offenses (including the index offenses) was 8.78 (*SD* = 11.17) and ranged from 1 to 59. Only 7 of the 82 men with a criminal history committed exclusively non-violent offenses, which indicates that 91.5% of individuals with a criminal history, or 78.1% of the entire sample, had a committed a violent offense. The number of prior offenses ranged from 0-60, with a mean of 7.50 (*SD* = 10.72). The number of prior violent offenses ranged

from 0-24, with a mean of 2.89 (*SD* = 3.66). Table 3 contains all offenses in the participants' criminal histories, excluding those related to the present NCRMD verdict.

NCRMD offenses.

Table B1 (in Appendix B) illustrates the breakdown of the most severe index offense for the NCRMD verdict. Murder and manslaughter made up almost one fifth of the sample's index offense while assaults were the most common. Similarly, assaults also made up the most common offenses committed in over the participants' lifetimes, followed by threats and criminal harassment. For the purpose of the analyses, criminal history constituted all offenses, including the index offense(s) that led to the current verdict of non-criminal responsibility.

Psychopathology.

Table 4 shows the distribution of comorbid disorders. The most common comorbid disorders combination was schizophrenia and substance use disorders as evidenced in over one third of the sample. Only one individual met full criteria for both antisocial personality disorder and psychopathy, while three met criteria for psychopathy but not antisocial personality disorder. This would suggest that three individuals most likely scored high on the personality facets and lower on the behavioral facets of the Psychopathy Checklist, but did not evidence the deviant behaviors of antisocial personality disorder.

Preliminary analyses.

For multiple regressions, as with all parametric tests, it is crucial to ensure that the assumptions of each statistical test are respected.

Table 2
PCL-R facet scores and SCID Antisocial scores

PCL-R	*M*	*SD*
4-facet model		
Facet 1	1.64	1.65
Facet 2	5.6	2.14
Facet 3	5.73	2.07
Facet 4	4.63	2.44
ASPD	*N*	%
No traits	3	3.13
1 trait	9	9.38
2 traits	22	22.92
ASPD (3 traits)	23	23.96
ASPD (4 traits)	18	18.75
ASPD (5 traits)	14	14.58
ASPD (6 traits)	7	7.29
ASPD (3 traits coded 3)	63	65.6
ASPD + CD	18	18.8

Note. PCL-R = Psychopathy Checklist-Revised; Facet 1 = Arrogant and deceitful lifestyle; Facet 2 = Deficient affective experience; Facet 3 = Impulsive and irresponsible lifestyle; F4 = Antisocial behavior; ASPD = Antisocial personality disorder; CD = Conduct disorder.

Table 3
Frequency of offenses in criminal history N = 82

Offense	Frequency	%
Assault	139	20.4
Theft	137	20.1
Administration of justice	132	19.3
Mischief	55	8.06
Threats, intimidation	53	7.8
Weapon related	35	5.1
Breaking and entering	34	5.0
Drug related	21	3.1
Driving under the influence	19	2.8
Murder, manslaughter	15	2.2
Fraud	10	1.5
Conspire to commit crime	9	1.3
Gross indecency	8	1.2
Attempted Murder	6	0.9
Sexual assault	5	0.7
Confinement, sequestering	2	0.3
Arson	2	0.3

Table 4
Frequency table of dichotomous variables

	1		2		3		4	
	n	%	*n*	%	*n*	%	*n*	%
ASPD	-							
Schizophrenia	15	15.6%	-					
Mood disorder	2	2.1%	2	2.1%	-			
Substance use	8	8.3%	33	34.4%	4	4.1%	-	
Mix psychopathy	12	12.5%	28	29.2%	3	3.1%	22	22.9%
Full psychopathy	1	1.04%	1	1.04%	1	1.04%	1	1.04%
No psychopathy	5	5.2%	50	52.1%	5	5.2%	15	15.6%

Note. ASPD = Antisocial personality disorder

The Psychopathy Checklist total scores were normally distributed: both the skew (.12) and kurtosis (.28) statistics was well under the acceptable threshold of 1 (Tabachnick & Fidell, 2007). The number of conduct disorder traits not was normally distributed (skewness = 1.72, kurtosis = 3.44) however the adult antisocial traits were in the acceptable range (skewness = 0.06, kurtosis = -0.65). A square root transformation was applied to the conduct traits, and the distribution became normal (skew = 0.25, kurtosis = 0.50).

Bivariate analyses were conducted on all variables. Table 5 illustrates the phi correlations between the dichotomous disorders. Both the presence (r = .30) and absence (r = .31) of psychopathy was positively correlated with antisocial personality disorder. Mixed psychopathy, was correlated with substance disorders (r = .33). This would suggest a bimodal distribution of psychopathy scores that are higher among those with antisocial personality disorders with an over lap of behavioral items and another peak in psychopathy scores on the personality facets among those without antisocial personality disorder.

Pearson correlations were computed for all continuous variables (Table 6). The severity of violent offenses was not significantly correlated with the psychopathy facet scores, or with antisocial or conduct disorder traits. Facet 4 (antisocial behavior) significantly correlated with the number (r = .45, p < .05) and severity of lifetime offenses (r = .25, p < .05) and the number of violent (r = .32, p < .05) and non-violent offenses (r = .41, p < .05). Facets 1 (arrogant and deceitful lifestyle), 2 (deficient affective experience) and 3 (impulsive and irresponsible lifestyle) were all significantly, albeit weakly, correlated with the number of lifetime offenses.

With regards to antisocial personality, the number of adult antisocial traits was positively correlated with the number of lifetime offenses (r = .33, p < .05), number of violent offenses (r = .27, p < .05), and the number of non-violent offenses (r = .28, p < .05). Neither the severity of violent, nor of non-violent or lifetime offences were associated with the antisocial traits. The number of conduct disorder traits was not associated with the number or severity of violent, non-violent or lifetime offenses.

To examine the issue of overlap between antisocial personality disorder and psychopathy, point-biserial and pearson correlations were computed. When antisocial personality disorder was dichotomized, its association with Psychopathy Checklist scores was r = .43 (p < .05). However, when the number of antisocial traits was considered, this relationship increased to r = .68 (p < .05). The number of antisocial traits and facet 4 of the Psychopathy Checklist were significantly correlated r = .39 (p < .05). Despite their conceptual similarity, this correlation was not a cause for concern in terms of collinearity, and therefore both variables could be entered into the model.

Hierarchical regressions

Severity of violent offenses.

Table B2 contains the estimates from the first set of hierarchical regressions, with the severity of violent offenses as the outcome. Neither the addition of the psychopathy facet scores, nor the presence of adult antisocial traits or conduct disorder traits explained a significant proportion of variance in the severity of past violent offenses. When psychopathy facet scores were entered into the final step of the regression model, R^2 increased from .14 to .22 [F(4, 73) = 1.66, p >.05]; this change was not significant.

Similarly, when antisocial and conduct disorder traits were entered into the final step of the model, R^2 increased from .19 to .22 [$F(2, 73) = 1.06$, $p > .05$]. In terms of predictors of the severity of prior violent offenses, age at interview, and facet 2 scores were both significant. While age was positively associated with severity of violent offenses $\beta = .34$ ($p < .05$), Facet 2 was negatively associated with the outcome $\beta = -.30$ ($p < .05$).

Severity of non-violent offenses.

Table B3 contains the results from the hierarchical multiple regressions predicting the severity of non-violent offenses. Neither the addition of antisocial personality traits, conduct disorder traits nor psychopathy facet scores explained a significant proportion of the variance in the severity of non-violent offenses. The addition of psychopathy facet scores in the final step of the model resulted in a non-significant increase of R^2 from .47 to .48 [$F(2, 73) = 0.77$, $p > .05$]. Similarly, the addition of antisocial and conduct disorder traits resulted in a non-significant increase in R^2 from .42 to .48 [$F(4, 73) = 2.14$, $p > .05$]. In terms of individual predictors, the number of prior detentions was significantly associated with the severity of non-violent offenses [$\beta = .59$ ($p < .05$)], as were facet 4 scores of the PCL-R [$\beta = .24$ ($p < .05$)]. Facet 2 demonstrated a trend towards significance [$\beta = .18$ ($p < .05$)].

Severity of all offenses.

Table B4 contains the results from the hierarchical multiple regressions predicting the severity of non-violent offenses. Neither the addition of antisocial personality traits, conduct disorder traits nor psychopathy facet scores explained a significant proportion of

Table 5.
Phi correlations of dichotomous variables

	1	2	3	4	5	6	7
ASPD	1						
Schizophrenia	.06	1					
Mood disorder	.05	-.54*	1				
Substance use	.05	.06	.03	1			
Mix psychopathy	.30*	-.14	-.03	.33*	1		
Full psychopathy	.07	-.14	.2	.03	-	1	
No psychopathy	.31*	.17	-.03	-.34*	-	-	1

Note. ASPD = Antisocial personality disorder
* $p < .05$. ** $p < .01$

Table 6.
Correlations of all continuous variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Age	1														
Num. detentions	.10	1													
F1	-.08	.08	1												
F2	.14	.12	.29**	1											
F3	-.03	.30**	.26*	.29**	1										
F4	-.17	.40**	.18	.17	.40**	1									
PCL-R	-.006	.37**	.39**	.45**	.59**	.67**	1								
Conduct traits	-.19	0.19	.21*	.03	.25*	.51**	.33**	1							
Antisocial traits	-.01	.32**	.30**	.52**	.62**	.39**	.52**	.29**	1						
Num. lifetime offenses	.03	.66**	.22*	.21*	.24*	.45**	.41**	.11	.33**	1					
Num. violent offenses	.10	.33**	.24*	.18	.19	.32**	.28**	.08	.27**	.62**	1				
Num. non-violent offenses	-.02	.63**	.17	.17	.21*	.41**	.38**	.11	.28**	.94**	.32**	1			
Lifetime offense severity	.16	.47**	.12	.06	.07	.25*	.29**	.11	.12	.69**	.65**	.55**	1		
Violent offense severity	.18	.21*	.09	-.06	.001	.09	.12	.12	.05	.29**	.63**	.09	.83**	1	
Non-violentoffense severity	.04	.54**	.10	.19	.12	.33**	.35**	.04	.16	.83**	.31**	.87**	.65**	.12	1

Note. Num. of detention = number of lifetime detentions; F1 = Arrogant and deceitful lifestyle, F2 = Deficient affective experience; F3 = Impulsive and irresponsible lifestyle; F4 = antisocial behavior; PCL-R = total score of the Psychopathy Checklist-Revised; Conduct traits of the Structured Clinical Interview for the Diagnostic and Statistical Manual II - Antisocial personality disorder module; Antisocial traits of the Structured Clinical Interview for the Diagnostic and Statistical Manual II - Antisocial personality disorder module.

**. Correlation is significant at the 0.01 level

*. Correlation is significant at the 0.05 level

the variance in the severity of lifetime offenses. The addition of psychopathy facet scores in the final step of the model resulted in a non-significant increase of R^2 from .40 to .43 [$F(4, 73) = 1.03$, $p > .05$]. Similarly, the addition of antisocial and conduct disorder traits resulted in a non-significant increase in R^2 from .43 to .432 [$F(2, 73) = 0.11$, $p > .05$]. With regards to individual predictors, only the number of prior detentions [$\beta = .51$, ($p < .05$)] and age [$\beta = .28$, ($p < .05$)] were significantly associated with the severity of lifetime offenses.

Number of violent offenses.

Table B5 contains the results from the hierarchical multiple regressions predicting the number of violent offenses. Neither the addition of antisocial personality traits, conduct disorder traits nor psychopathy facet scores explained a significant proportion of the variance in the severity of lifetime offenses. The addition of psychopathy facet scores in the final step of the model resulted in a non-significant increase of R^2 from .24 to .30 [$F(4, 73) = 1.65$, $p > .05$]. Similarly, the addition of antisocial and conduct disorder traits resulted in a non-significant increase in R^2 from .20 to .23 [$F(2, 73) = 2.18$, $p > .05$]. With regards to individual predictors, only the number of prior detentions [$\beta = .32$, ($p < .05$)] and age [$\beta = .24$, ($p < .05$)] were significantly associated with the severity of lifetime offenses. Facet 3 was negatively associated with the number of violent offenses [$\beta = -.30$, ($p < .05$)], while the number of antisocial traits was positively associated with the number of violent offenses [$\beta = .29$, ($p < .05$)].

The number of non-violent offenses

Table B6 contains the results from the hierarchical multiple regressions predicting the number of non-violent offenses. Neither the addition of antisocial personality traits, conduct disorder traits nor psychopathy facet scores explained a significant proportion of the variance in the severity of lifetime offenses. The addition of psychopathy facet scores in the final step of the model resulted in a non-significant increase of R^2 from .45 to .49 [$F(4, 73) = 1.53$, $p > .05$]. Similarly, the addition of antisocial and conduct disorder traits resulted in a non-significant increase in R^2 from .48 to .49 [$F(2, 73) = 0.70$, $p > .05$]. With regards to individual predictors, only the number of prior detentions [$\beta = .59$, ($p < .05$)] and Facet 4 [$\beta = .25$, ($p < .05$)] were significantly associated with the number of non-violent offenses.

Total number of lifetime offenses

Table B7 contains the results from the hierarchical multiple regressions predicting the number of lifetime offenses. Again, neither the addition of antisocial personality traits, conduct disorder traits nor psychopathy facet scores explained a significant proportion of the variance in the number of lifetime offenses. The addition of psychopathy facet scores in the final step of the model resulted in a non-significant increase of R^2 from .53 to .58 [$F(4, 73) = 2.20$, $p > .05$]. Similarly, the addition of antisocial and conduct disorder traits resulted in a non-significant increase in R^2 from .57 to .48 [$F(2, 73) = 0.96$, $p > .05$]. With regards to individual predictors, the number of prior detentions [$\beta = .63$, ($p < .05$)], Facet 3 [$\beta = -19$, ($p < .05$)] and Facet 4 [$\beta = .24$, ($p < .05$)] were significantly associated with the number of lifetime offenses.

Discussion

The goal of the present thesis was to examine the association and overlap of antisocial personality disorder and psychopathy on criminal history in a sample of individuals with severe mental illness. More specifically, using the 4-facet model of psychopathy, it was hypothesized that antisocial personality disorder would be a stronger predictor of the number, and severity of lifetime, violent and non-violent offences than psychopathy scores. The results indicated that antisocial personality disorder did not show incremental validity over psychopathy. In the current sample, neither psychopathy nor antisocial personality disorder evidenced a unique contribution in the explanation of criminal history among the severely mentally ill.

A longstanding debate exists regarding the overlap between psychopathy and the Diagnostic and Statistical Manual's (American Psychiatric Association, 2000) antisocial personality disorder. While the two disorders share their roots, they evolved quite differently over the past 40 years. One of the main points of contention in the literature touches upon the degree to which antisocial personality disorder and psychopathy overlap. Discordant methodologies and operationalizations have yielded varying results. In the present study, as in others (Skilling, et al., 2002), the association between these two personality syndromes appears to increase when antisocial personality disorder is used on a continuous scale. This makes intuitive sense given that a continuous measure of antisocial personality might be a better indicator of the severity of the syndrome. Furthermore, the criteria for antisocial personality disorder, as it is currently defined in the Diagnostic and Statistical Manual IV, may be applicable to too many individuals in an offender population.

Indeed, even in this sample of mentally ill offenders, 65% had three or more adult antisocial traits. A combination of any 3 traits suffices for a diagnosis (coupled with the presence of conduct disorder). Clearly the discriminatory power of the Diagnostic and Statistical manual's antisocial personality disorder, as it is defined now, is not strong in a sample of individuals who have a criminal history. Goldstein (2006) examined the discriminatory power of the antisocial trait "lack of remorse" in a large sample of individuals all meeting criteria for antisocial personality disorder. Goldstein found that men and women with antisocial personality disorder who endorsed this item versus those with antisocial personality disorder who did not committed more violent and aggressive acts. Incidentally, this item is the most personality oriented traits of the possible seven antisocial personality disorder criteria and is an item of the Psychopathy Checklist.

Relation between psychopathy scores and antisocial personality and criminal history

When predicting the number of violent and non-violent, as well as the severity of violent and non-violent offences, the number of prior incarcerations was consistently associated with the aforementioned outcomes. It is not surprising that the more offences an individual commits, the odds of incarceration increase. Age and number of incarcerations consistently explained a large proportion of the variance in the number and severity of offenses (between 10-25% of the variance in the outcome). Only in the case of the severity and number of violent offenses did the number of prior incarcerations and age appear to play a minimal role (R^2 = .12 and .21 respectively). This might suggest that general

criminality may be more associated with demographic variables such as age, and less with personality traits.

In the current study, criminality was analyzed in different ways: frequency and severity, and then offenses were further broken down into violent, non-violent and lifetime. Many studies look primarily at the incidence and rate of recidivism following release. These studies have their uses (such as looking at post-treatment, incarceration or hospitalization outcomes), but say very little about the lifelong pattern of behavior that an individual exhibits. Furthermore, not all offenses have the same repercussions. A longstanding pattern of non-violent offenses is a known risk factor for future reoffending (Quinsey, et al., 1998), but these types of crimes may not have the same consequences at the societal level as violent crimes, certainly in terms of potential public safety.

A different pattern of association seemed to emerge when criminal history was operationalized as the severity versus the frequency. Consistent with prior research, the antisocial facet of the Psychopathy Checklist was associated with a higher number of non-violent and lifetime offenses (not surprisingly, given that non-violent offenses made up a large proportion of lifetime offenses). The finding that non-violent offenses were only associated with antisocial items of the Psychopathy Checklist may suggest that this instrument is not very useful for postdicting these types of offenses. Non-violent offenses, which include theft, breaching of conditions and property offenses may be so common among the mentally ill offenders, that psychopathy has no predictive power.

With regards to violent offenses, results also went contrary to past literature. Lower scores on facet 3, which relates to lifestyle irresponsibility and impulsivity, were related to

the number, but not severity of violent offenses. Impulsivity is one of 7 possible traits of antisocial personality disorder and has traditionally been considered one of the classic manifestations of the syndrome (Swann, Lijffijt, Lane, Steinberg, & Moeller, 2009). Impulsivity has also been linked to severity of the index offense in forensic patients (Haden & Shiva, 2008). However, it is difficult to generalize various measures of impulsivity to the Psychopathy Checklist facets. The Psychopathy Checklist's measure of impulsivity refers to a pervasive pattern of irresponsible lifestyle and not the attention, motor or planning abilities tapped by measures such as the Barratt Impulsivessness Scale (Patton, Stanford, & Barratt, 2008). With regards to facet 3 of the Psychopathy Checklist (irresponsible and impulsive lifestyle), Hall, Benning and Patrick (Hall, et al., 2004) found that it is related to aggression linked to poor behavioral control and high reactivity, and not instrumental, goal-directed violence.

Antisocial personality disorder may not be a significant predictor of criminal history in a homogeneous sample. Roughly two thirds of the sample met adult criteria for antisocial personality traits. Using criminal behavior to make statements about personality is questionable at best, and raises important issues regarding the validity of the Diagnostic and Statistical Manual-IV's criteria. Many of traits of antisocial personality disorder, and the antisocial facet of the Psychopathy Checklist relate directly to observable behaviors, more specifically, criminal acts. Several authors have now come to question the utility of using behaviors to describe psychopathy, and suggest that personality traits be the focus. In the present study, it was the antisocial items from the Psychopathy Checklist that related directly to criminal history thus leading us to question the usefulness of this measure for

this particular population. Antisocial attitudes or behaviors might offer more discriminatory power in the general population where criminal behavior is uncommon. However, antisociality appears much less useful predictor of behavior in population with elevated rates of criminal involvement.

The second important theoretical issue that may be important to consider is the heterogeneity of individuals suffering from schizophrenia. The inconsistencies found across the literature with regards to the prevalence and manifestation of psychopathy in the severely mentally ill, from 8% in community (Skeem & Mulvey, 2001) and 31.4% in homicide offenders (Laurell & Daderman, 2007) suggests that psychopathy is not distributed similarly in all psychiatric settings. However, some research suggests that there may be profiles, or subgroups, for which psychopathy is relevant. For instance, Tengstrom and colleagues (2004) conducted a study on pretrial detainees undergoing psychiatric evaluations. A subgroup of individuals diagnosed with schizophrenia and high scores of psychopathy had consistent criminal histories, beginning at a young age; this subgroup was similar to the men with high psychopathy scores, and no schizophrenia. Despite Tengstrom's results, it is difficult to apply Hare's Psychopathy Checklist in a mentally disordered sample when: 1) a large proportion has long-standing criminal histories, and 2) the facets may be confounded by other factors, such as the mental illness. There are traits of psychopathy that are shared with schizophrenia (e.g. shallow affect, lack of remorse, lack of empathy and irresponsibility), while facet 3 of the Psychopathy Checklist could overlap with symptoms of mania (need for stimulation, impulsivity, lack of realistic goals, failure to take responsibility for one's own actions).

Limitations

In the current study, criminality was operationalized with the severity and frequency of offences. However, there is other research suggesting that conceptualizing aggression as reactive and instrumental can be useful when studying psychopathy (Cornell, et al., 1996). This conceptualization was not possible in the current study given that criminal history information was gathered retrospectively through administrative databases. Failure to distinguish between two subtypes of violence may have clouted these results.

Another limitation was that, due to the reliance on archival data, dynamic variables such as symptoms or substance use at the time of the offense were not examined. Substance use has been found to be an important predictor of criminal behavior in both the general population and among the severely mentally ill (Cohen, 1980). However, a prospective birth cohort study conducted in Denmark found that individuals with psychotic disorders were responsible for a disproportional number of violent offences compared to individuals who had never been hospitalized even after controlling for the impact of substance use and personality disorders (Brennan, Mednick, & Hodgins, 2000). Another study conducted by Tengstrom et al. (2004) examined violent offenders receiving psychiatric evaluations. Offenders with schizophrenia and high levels of psychopathy committed more violent offenders than men with schizophrenia and low psychopathy scores. An additional diagnosis of substance use disorder did not differentiate the two groups on number of violent offenses. Furthermore, when comparing the two groups of high psychopathy levels (and no mental illness), again substance use did not differentiate the two groups on the number of violent offenses.

At a practical level, substance abuse poses an interesting challenge as a risk factor, because it can be considered either as historically stable [such as in the Violence Risk Appraisal Guide (Quinsey, et al., 1998)], or acutely variable [such as in the Short-Term Assessment of Risk and Treatability (Webster, Martin, Brink, Nicholls, & Middleton, 2004)]. In the present study, the goal was to examine how two personality syndromes, that are believed to be relatively stable over the lifetime correlate with criminal history. In that vein, substance abuse is, according to this author, a dynamic and changing variable that should be used to short-term prediction rather than long-term. Therefore, omitting substance abuse from the analyses was not considered to be a major shortcoming.

A theory of offending among the mentally that has received increasing attention posited by Hodgins (Hodgins, 1998) is that of *early versus late starters*. Hodgins and colleagues suggested that mentally ill offenders can be classified into two broad categories: those who start their criminal careers early on, before the onset of the mental illness, and those who start their commit criminal acts after the onset of the illness. Early starters have been found to engage in more antisocial behavior, have higher psychopathy scores, and commit more instrumental violence (Tengstrom, Hodgins, & Kullgren, 2001). Late starters commit more reactive aggression and score lower on measures of antisocial personality and psychopathy (Tengstrom, et al., 2001). The present results could not provide support for or against Hodgins's work due to the fact that juvenile records could not be accessed, and we did not have information regarding the etiology of the mental illness. However, the prevalence of antisocial personality disorder among early starters (26.6%) from these

previous studies was not far from the prevalence found in the present study (18.8%) in comparison that of late starters (2%) (Tengstrom, et al., 2001).

Finally, severity of the mental illness was not taken into account. All individuals in the sample had been declared not criminally responsible on account of mental disorder, and therefore suffer from an illness severe enough to receive such a disposition. However, malingering is a potential confounding problem, especially if high psychopathy traits are present. However, we did not estimate that malingerers posed a significant issue because of low estimated base rates of malingering due to the inherent difficulty to malinger a severe mental illness.

Future directions

Explaining how psychopathy and antisocial behavior is manifested in the severely mentally ill is a complex process. Traditionally, the antisocial behavior seen in the mentally ill has been attributed to the illness, without consideration for personality disorders. Given the under-recording of comorbid personality disorders in this population (Blackburn, Logan, Donnelly, & Renwick, 2003), it is not surprising that individuals are often classified based upon the most salient (and easily diagnosed) condition, i.e. the axis 1 disorders.

This study lends to the line of thinking that a major review of the Diagnostic and Statistical Manual's antisocial personality disorder was sorely needed. Not only does antisocial personality disorder overlap more closely with psychopathy when conceptualized on a continuum as opposed to a categorical diagnosis, but perhaps it would become a more useful predictor of criminal outcomes if it incorporated more personality oriented

indicators. Presently, the Diagnostic and Statistical Manual is considering making significant changes to the antisocial personality criteria towards one based on the severity (rather than presence or absence of a trait), and the inclusion of more personality oriented (e.g. psychopathic) traits such as narcissism and callousness (Amercian Psychiatric Association).

Conclusion

Decades of research have shown that the mentally ill are at an increased probability to come into contact with the criminal justice system, compared to the general public. Violence and criminality are some of the many possible outcomes related to psychopathy and antisocial personality. Disentangling the relationship between mental illness, personality disorders and crime is no simple feat. Future studies should explore the temporal appearance of various correlates of psychopathy and mental illness to understand the factors that contribute to the criminality of the mentally ill.

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Appendix A1

Sociodemographic information

Données sociodémographiques

Date d'aujourd'hui : ☐☐ / ☐☐ / ☐☐☐☐ (JJ / MM / AAAA)

ID participant : ☐☐☐☐☐

ID évaluateur : ☐☐

---

1. Quelle est votre date de naissance? ☐☐ / ☐☐ / ☐☐☐☐ (JJ / MM / AAAA)

2. Quel est votre pays de naissance?

   ☐ Canada ☐ Autre (spécifiez : _____)

3. Quelle est votre langue maternelle?

   ☐ Français

   ☐ Anglais

   ☐ Autre (Spécifiez : _____)

4. Êtes-vous sous un régime de protection?

   ☐ Oui ☐ Non

   Si oui :

   4a. Sous quel régime de protection?

   ☐ Public ☐ Privé

   4b. De quel type?

   ☐ Curatelle biens et personne ☐ Tutelle biens et personne

   ☐ Curatelle biens ☐ Tutelle biens

   ☐ Curatelle personne ☐ Tutelle personne

5. Quel est votre état civil?

Seul :

☐ Célibataire (aucune union de fait)

☐ Divorcé légalement

☐ Séparé d'une union de fait ou d'un mariage

☐ Veuf

En couple :

☐ Marié / remarié

☐ Union de fait (Spécifiez la durée : _____)

6. Avez-vous des enfants?

   ☐ Oui ☐ Non

   Si oui :

   Combien? ☐☐

Données sociodémographiques (suite)

7. Nombre d'unions (vie en commun) ? ☐☐

8. Milieu de vie

a) Résidence actuelle

☐ Famille d'origine (père/mère)
☐ Famille élargie (frère/soeur/oncle/tante)
☐ Vit avec son épouse
☐ Union de fait
☐ Vit chez un de ses enfants
☐ Partage un appartement avec une (des) connaissance(s)
☐ Vit seul en appartement
☐ Hôpital
☐ Vit seul dans une maison de chambres
☐ Itinérant/sans domicile fixe
☐ Appartement supervisé
☐ Famille d'accueil
☐ Foyer de groupe
☐ Centre d'accueil
☐ Autre (Spécifiez : _____)

Si en détention (hôpital) :

b) Résidence prévue (à la sortie de l'hôpital)

☐ Ressource approuvée par l'hôpital
☐ Famille d'origine (père/mère)
☐ Famille élargie (frère/soeur/oncle/tante)
☐ Vit avec son épouse
☐ Union de fait
☐ Vit chez un de ses enfants
☐ Partage un appartement avec une (des) connaissance(s)
☐ Vit seul en appartement
☐ Vit seul dans une maison de chambres
☐ Itinérant/sans domicile fixe
☐ Appartement supervisé
☐ Famille d'accueil
☐ Foyer de groupe
☐ Centre d'accueil
☐ Autre (Spécifiez : _____)

9. Quel est votre source principale de revenu actuellement?

☐ Emploi du participant
☐ Emploi du conjoint
☐ Pension
☐ Assurance-emploi
☐ Aide sociale
☐ Aumône (itinérance)
☐ Travail non déclaré (au noir)
☐ Produit de la criminalité
☐ Autre (Spécifiez : _____)

10. Travaillez-vous actuellement?

☐ Emploi régulier à temps plein
☐ Emploi régulier à temps partiel
☐ Étudiant
☐ Centre de travail adapté (externe)
☐ Atelier thérapeutique (interne)
☐ Autre (spécifiez : _____)
☐ Ne travaille pas

Données sociodémographiques (suite)

11. Quel est votre plus haut niveau de scolarité complété?

☐ Aucune scolarité régulière
☐ Secondaire non complété
☐ Secondaire complété (D.E.S., D.E.S.P.)
☐ Cégep non complété ou en cours
☐ Cégep complété (D.E.C., D.E.P.)
☐ Universitaire non complété ou en cours
☐ Universitaire complété (B.Sc., B.A.)
☐ Universitaire cycles supérieurs (maîtrise, doctorat) non complété ou en cours
☐ Universitaire cycles supérieurs complété (M.Sc., M.A., Ph.D., M.D.)

12. Receviez-vous des services avant l'hospitalisation?

☐ Oui ☐ Non
Si oui :

Type de suivi : *(Cochez toutes les réponses qui s'appliquent)* Nom de l'organisme *(Selon le participant)*

☐ Équipe psychiatrique (C.H.) _____
☐ Bureau privé _____
☐ C.L.S.C. _____
☐ Centre de services sociaux _____
☐ Agent de probation / de libération conditionnelle _____
☐ Autre (Spécifiez type : _____) _____

Motif du suivi :

☐ Psychiatrique
☐ Probation / libération conditionnelle
☐ Toxicomanie
☐ Autre (Spécifiez : _____)

13. Avez-vous déjà eu un des comportements suivants?

a) Pincer ou gratter votre peau, arracher vos cheveux, vous frapper (sans blessure) :
☐ Oui ☐ Non

b) Frapper votre tête, donner des coups de poing dans les murs, vous jetter par terre :
☐ Oui ☐ Non

c) Infliger des coupures, des ecchymoses, des brûlures ou des marques mineures sur vous-même :
☐ Oui ☐ Non

d) Infliger des blessures importantes sur vous même ou faire une tentative de suicide :
☐ Oui ☐ Non

Données sociodémographiques (suite)

14. Si vous avez déjà fait une tentative de suicide (essayé de vous enlever la vie) :

A- Combien de fois : ☐☐

B- Cela s'est-il passé au cours des 12 derniers mois? ☐ Oui ☐ Non

15. Avez-vous déjà été hospitalisé en psychiatrie?

☐ Oui ☐ Non

Si oui :

A- Combien de fois : ☐☐

B- Âge à la première hospitalisation : ☐☐

C- Y a-t-il eu un diagnostic posé?

☐ Oui ☐ Non ☐ Ne sait pas

Si oui, quel est le dernier diagnostic posé selon le participant? _____

_____

16. Avez-vous déjà été traité pour abus de substance?

☐ Oui ☐ Non

Si oui :

A- Combien de fois : ☐☐

B- Âge au premier traitement : ☐☐

17. Avez-vous déjà été en prison?

☐ Oui ☐ Non

Si oui :

A- Combien de fois : ☐☐

B- Âge à la première détention : ☐☐

C- En prison, avez-vous reçu des traitements pour des problèmes de santé mentale?

☐ Oui ☐ Non

D- Combien de mois avez-vous été incarcéré AU COURS DE VOTRE VIE? ☐☐☐

N.B. Comptez seulement les incarcérations de plus de 2 semaines. Pour les incarcérations entre 2 et 4 semaines, arrondissez à 1 mois)

18. Au cours de la dernière année, à quelle fréquence avez-vous été victime de:

a) Crime violent (ex. agression, viol, attaque, vol qualifié)?

☐ Jamais ☐ Une fois ☐ Deux fois ou plus

b) Crime non violent (ex. vol)?

☐ Jamais ☐ Une fois ☐ Deux fois ou plus

Données sociodémographiques (suite)

19. Est-ce qu'un membre de votre famille immédiate a déjà été condamné et/ou incarcéré pour un délit criminel?
    ☐ Oui ☐ Non

20. Numéro de SED : ☐☐☐☐☐☐☐-☐

21. Numéro TAQ : ☐☐☐-☐-☐☐☐☐☐☐-☐☐☐☐

22. Date d'hospitalisation (jj/mm/aaaa) : ☐☐ / ☐☐ / ☐☐☐☐

23. Date de sortie de l'hôpital (jj/mm/aaaa) : ☐☐ / ☐☐ / ☐☐☐☐

    Si en détention : ☐ Ne s'applique pas

24. Nom de l'hôpital : Numéro de dossier :

    ☐ Hôpital Douglas _____

    ☐ Hôpital Louis-H.-Lafontaine _____

    ☐ Institut Philippe Pinel de Montréal _____

25. Médication actuelle (voir dossier) : _____

_____

_____

_____

_____

_____

_____

_____

_____

Durée de l'entrevue (en minutes) : ☐☐☐☐

Appendix A2

Structured Clinical Interview for the Diagnostic and Statistical Manual II

Antisocial personality disorder module

Entrevue clinique structurée pour l'axe II du DSM-IV: Troubles de la personnalité

SCID-II

Michael B. First, M.D.; Robert L. Spitzer, M.D.;
Miriam Gibbon, M.S.W.; Janet B.W. Williams, D.S.W.;
and Lorna Benjamin, Ph.D.

Étude : _____ Étude N° : ___ ___ ___ ___ **1**

Sujet : _____ N° ID : ___ ___ ___ ___ **2**

Évaluateur : _____ Éva luateur N° :___ ___ ___ ___ **3**

Date de l'entrevue : ____ ____ ____ **4**
Jour mois année

Sources d'information (cochez toutes celles qui s'appliquent)

___ sujet **5**
___ f amille/amis/associés **6**
___ professionnel de la santé **7**
dossier/note de référence
___ questionn aire SCID-II **8**

Édité et révisé par : M. Lapalme & S. Hodgins, Groupe de Recherche sur le Développement des Troubles Affectifs, Département de Psychologie, Université de Montréal (novembre 1998).

Édité et révisé par : Division de recherche psychosociale, Centre de recherche de l'hôpital Douglas (Montréal, septembre 2004) avec la participation financière du Réseau en santé mentale et en neurosciences du Québec (FRSQ).

PERSONNALITÉ ANTISOCIALE	**CRITÈRES DX DE LA PERSONNALITÉ ANTISOCIALE**					
Note : le comportement ne survient pas exclusivement au cours de la schizophrénie ou d'un épisode maniaque	B. Âge courant : 18 ans et plus C. Évidence d'un trouble de conduite trouble qui apparaît avant l'âge de 15 ans tel qu'indiqué par 3 ou plus des manifestations suivantes :	1			3	**122**
105. Vous avez dit qu'avant l'âge de 15 ans vous avez [*Avant l'âge de 15 ans, avez-vous*] souvent malmené, menacé ou intimidé d'autres enfants. Parlez -m'en.	(1) a souvent malmené, menacé ou intimidé les autres avant l'âge de 15 ans	?	1	2	3	**123**
106. Vous avez dit qu'avant l'âge de 15 ans il vous est [*Avant l'âge de 15 ans, vous est-il*] arrivé souvent de commencer des bagarres. Combien de fois est-ce arrivé?	(2) initiation fréquente de batailles avant l'âge de 15 ans	?	1	2	3	**124**
107. Vous avez dit qu'avant l'âge de 15 ans, vous avez déjà [*Avant l'âge de 15 ans, avez-vous*] blessé ou menacé quelqu'un avec un bâton, une brique, une bouteille cassée, un couteau ou un fusil. Parlez -m'en.	(3) a utilisé une arme pouvant causer des dommages physiques sérieux avant l'âge de 15 ans (p. ex., bâton, brique, bouteille cassée, couteau, fusil)	?	1	2	3	**125ix**

108. Vous avez dit qu'avant l'âge de 15 ans, vous avez [*Avant l'âge de 15 ans, avez-vous*] délibérément maltraité ou infligé une souffrance physique à quelqu'un. Qu'avez-vous fait?	(4) cruauté physique envers les personnes avant l'âge de 15 ans	?	1	2	3	**126**
109. Vous avez dit qu'avant l'âge de 15 ans, vous avez [*Avant l'âge de 15 ans, avez-vous*] maltraité ou blessé des animaux de façon intentionnelle. Qu'avez-vous fait?	(5) cruauté physique envers les animaux avant l'âge de 15 ans	?	1	2	3	**127**
110. Vous avez dit qu'avant l'âge de 15 ans, vous avez [*Avant l'âge de 15 ans, avez-vous*] volé, dévalisé ou pris par la force des choses en menaçant quelqu'un. Parlez -m'en.	(6) a volé en confrontant une victime avant l'âge de 15 ans (p. ex., assaut, extorsion, vol de sac à main, attaque à main armée)	?	1	2	3	**128**
111. Vous avez dit qu'avant l'âge de 15 ans, vous avez [*Avant l'âge de 15 ans, avez-vous*] forcé quelqu'un à avoir des relations sexuelles, à se dévêtir ou à vous faire des attouchements sexuels. Parlez -m'en.	(7) a forcé quelqu'un à avoir des activités sexuelles avant l'âge de 15 ans	?	1	2	3	**129**

112. Vous avez dit qu'avant l'âge de 15 ans, vous avez [*Avant l'âge de 15 ans, avez-vous*] allumé intentionnellement un incendie. Parlez -m'en.	(8) a délibérément allumé un incendie avec l'intention de causer des dommages sérieux, avant l'âge de 15 ans	?	1	2	3	**130**
113. Vous avez dit qu'avant l'âge de 15 ans, vous avez [Avant l'âge de 15 ans, avez-vous] délibérément endommagé des choses qui ne vous appartenaient pas. Qu'avez-vous fait?	(9) a délibérément détruit le bien d'autrui avant l'âge de 15 ans (autrement qu'en allumant un incendie)	?	1	2	3	**131**
114. Vous avez dit qu'avant l'âge de 15 ans, vous vous êtes [*Avant l'âge de 15ans, vous êtes-vous*] introduit par effraction dans une maison, un immeuble ou une voiture. Parlez -m'en.	(10) s'est déjà introduit par infraction dans un immeuble, une maison, ou une voiture avant l'âge de 15 ans	?	1	2	3	**132**
115. Vous avez dit qu'avant l'âge de 15 ans, vous mentiez [*Avant l'âge de 15 ans, mentiez-vous*] beaucoup. À quel sujet mentiez-vous?	(11) mensonges répétés afin d'obtenir des faveurs ou de se soustraire à des obligations avant l'âge de 15 ans	?	1	2	3	**133**
116. Vous avez dit qu'avant l'âge de 15 ans, il vous est arrivé [*Avant l'âge de 15 ans, vous est-il arrivé*] de voler à l'étalage, de falsifier une signature, ou de dérober des choses qui ne vous appartenaient pas. Parlez -m'en.	(12) a volé des objets de valeur sans confrontation avec une victime avant l'âge de 15 ans (p. ex., vol à l'étalage, contrefaçon, etc.)	?	1	2	3	**13**

117. Vous avez dit qu'avant l'âge de 15 ans, vous vous êtes [*Avant l'âge de 15 ans, vous êtes-vous*] déjà sauvé de la maison et avez passé la nuit à l'extérieur. Est-ce arrivé plus d'une fois? (Avec qui habitiez-vous à cette époque?)	(13) s'est sauvé de la maison parentale la nuit à au moins deux reprises ou une seule fois sans y retourner pour une longue période avant l'âge de 15 ans	?	1	2	3	**135**
118. Vous avez dit qu'avant l'âge de **13 ans,** il vous arrivait [*Avant l'âge de **13 ans**, vous arrivait-il*] souvent de rentrer à la maison à des heures tardives, bien après l'heure convenue par vos parents. À combien de reprises?	(14) est souvent rentré à la maison à des heures tardives en dépit de l'interdiction parentale, avant l'âge de **13 ans**	?	1	2	3	**136**
119. Vous avez dit qu'avant l'âge de **13 ans,** il vous arrivait [*Avant l'âge de **13 ans**, vous arrivait-il*] souvent de faire l'école buissonnière	(15) absences injustifiées et répétées de l'école avant l'âge de **13 ans**	?	1	2	3	**137**
	AU MOINS 3 ITEMS SONT COTÉS « 3 » (p. ex., certaine manifestation du trouble des conduites)	1			3	**138**

CRITÈRE C DE LA PERSONNALITÉ ANTISOCIALE REMPLI

Depuis l'âge de 15 ans... Avez-vous fait des choses qui sont contre la loi, même si vous n'avez pas été pris, comme voler, consommer ou vendre des drogues, faire de faux chèques, ou vous prostituer? **SI NON :** avez-vous déjà été arrêté?	A. Caractéristiques dominées par le non-respect et la violation des droits d'autrui depuis l'âge de 15 ans tel qu'indiqué par 3 ou plus des manifestations suivantes :					
	(1) défaut de se conformer à des normes sociales en regard d'un comportement respectant la loi tel qu'indiqué par la commission d'actes motivant une arrestation 3 = plusieurs exemples	?	1	2	3	**139**
Avez-vous souvent à mentir pour obtenir ce que vous voulez? (Avez-vous déjà utilisé un faux nom ou prétendu être quelqu'un d'autre?) (Avez-vous souvent utilisé de faux prétextes pour obtenir des autres ce que vous vouliez (p. ex., arnaqué ou escroqué des gens?)	(2) peu de considération pour la vérité tel qu'indiqué par des mensonges répétés, l'usage de faux noms ou escroqueries pour son profit personnel ou par plaisir 3 = plusieurs exemples	?	1	2	3	**140**
Faites-vous souvent des choses sur l'impulsion du moment sans penser aux conséquences que cela pourrait avoir sur vous ou sur les autres? Quel genre de choses? Y a-t-il déjà eu une période dans votre vie où vous n'aviez pas d'endroit fixe pour demeurer? (Combien de temps?)	(3) impulsivité ou défaut de prévoir 3 = plusieurs exemples	?	1	2	3	**141**

(Depuis l'âge de 15 ans) Avez-vous été impliqué dans des batailles? (Combien de fois?) Avez-vous déjà frappé un enfant, le vôtre ou celui d'un autre, au point où il a eu des marques, a dû garder le lit ou voir un médecin? Parlez -m'en. Avez-vous menacé ou blessé physiquement quelqu'un d'autre? Parlez-m'en. (Combien de fois?)	(4) irritabilité et agressivité tel qu'indiqué par des assauts ou des batailles répétées 3 = plusieurs exemples	?	1	2	3	**142**
Vous arrive t-il de conduire votre voiture lorsque vous avez bu ou consommé des drogues? Combien de contraventions pour excès de vitesse ou d'accidents d'automobile avez-vous eus? (Est-ce que quelqu'un vous a déjà dit que vous aviez placé en situation dangereuse un enfant dont vous aviez la responsabilité?)	(5) conduite imprudente, peu de considération pour sa propre sécurité ou celle des autres 3 = plusieurs exemples	?	1	2	3	**143**

Combien de temps au cours des 5 dernières années avez-vous été sans emploi?

SI POUR UNE PÉRIODE PROLONGÉE : pourquoi?

(Est-ce qu'il y avait du travail disponible?)

Lorsque vous aviez un emploi, étiez-vous souvent absent?

SI OUI : pourquoi?

Avez-vous déjà quitté un emploi sans en avoir un autre de prévu?

SI OUI : combien de fois est-ce arrivé?

Avez-vous déjà emprunté de l'argent à des gens sans les rembourser par la suite?

(Combien de fois?)

Vous est-il arrivé de ne pas payer la pension alimentaire ou de ne pas donner l'argent pour un enfant ou quelqu'un d'autre qui dépendait de vous?

(6) irresponsabilité constante tel qu'indiqué par une incapacité à conserver un emploi stable ou à honorer ses obligations financières 3 = plusieurs exemples	?	1	2	3	**144**

SI ÉVIDENCE D'ACTES ANTISOCIAUX ET QUE L'ABSENCE DE REMORDS N'A PAS ÉTÉ ÉTABLIE :

Comment vous sentez-vous par rapport aux choses que vous avez faites? (liste des comportements antisociaux)

(Pensez-vous que ce que vous avez fait n'était pas correct?)

(7) absence de remords tel qu'indiqué par de l'indifférence ou de la rationalisation face aux actes antisociaux commis

3 = absence de remords

? 1 2 3 **145**

AU MOINS 3 ITEMS SONT COTÉS « 3 » 1 3 **146**

Critère A du trouble de la personnalité antisociale rempli

LES CRITÈRES A, B et C SONT COTÉS « 3 » 1 3 **147**

PERSONNALITÉ ANTISOCIALE

Appendix A3

Psychopathy Checklist-Revised

Hare PCL-R: 2e Édition

Robert D. Hare, Ph.D.

Date d'aujour'hui : ☐☐ / ☐☐ / ☐☐☐☐ (JJ MM AAAA)

ID participant : ☐☐☐☐☐

ID évaluateur : ☐☐

Les cotes devraient être attribuées en révisant les critères énoncés dans le Rating Booklet (Guide de cotation) ou le Technical Manual (Manuel technique) du PCL-R : 2e édition. Encerclez la cote appropriée à gauche de chaque item. Pour les items 17 à 20, consultez les notes ci-dessous. **On trouvera la marche à suivre pour remplir le présent questionnaire au chapitre 2 du Technical Manual (Manuel technique) du PCL-R : 2e édition.**

Non	Peut-être	Oui	Omettre	
(0)	(1)	(2)	(X)	01. Loquacité / charme superficiel
(0)	(1)	(2)	(X)	02. Surestimation de soi
(0)	(1)	(2)	(X)	03. Besoin de stimulation / tendance à s'ennuyer
(0)	(1)	(2)	(X)	04. Tendance au mensonge pathologique
(0)	(1)	(2)	(X)	05. Duperie / manipulation
(0)	(1)	(2)	(X)	06. Absence de remords ou de culpabilité
(0)	(1)	(2)	(X)	07. Affect superficiel
(0)	(1)	(2)	(X)	08. Insensibilité / Manque d'empathie
(0)	(1)	(2)	(X)	09. Tendance au parasitisme
(0)	(1)	(2)	(X)	10. Faible maîtrise de soi
(0)	(1)	(2)	(X)	11. Sexualité débridée
(0)	(1)	(2)	(X)	12. Apparition précoce de problèmes de comportement
(0)	(1)	(2)	(X)	13. Incapacité de planifier à long terme et de façon réaliste
(0)	(1)	(2)	(X)	14. Impulsivité
(0)	(1)	(2)	(X)	15. Irresponsabilité
(0)	(1)	(2)	(X)	16. Incapacité d'assumer la responsabilité de ses faits et gestes
(0)	(1)	(2)	(X)	17. Nombreuses cohabitations de courte durée*
(0)	(1)	(2)	(X)	18. Délinquance juvénile**
(0)	(1)	(2)	(X)	19. Violation des conditions de mise en liberté conditionnelle**
(0)	(1)	(2)	(X)	20. Diversité des types de délits commis par le sujet***

* Si âgé de moins de 30 ans: 0 = 0-1, 1 = 2, 2 = 3 ou plus, X = Omettre.
Si âgé de 30 ans ou plus: 0 = 0-2, 1 = 3, 2 = 4 ou plus, X = Omettre.

** 0 = pas de délits, 1 = délit mineur, 2 = délit majeur, X = Omettre.

*** 0 = 0-3, 1 = 4-5, 2 = 6 ou plus, X= Omettre.

Appendix A4

Cormier-Lang Severity Scale

Délit	Côte Cormier-Lang
meurtre premier degré	28
meurtre au deuxième degré	28
meurtre qualifié	28
meurtre non qualifié	28
meurtre	28
homicide involontaire	28
négligence criminelle causant la mort	28
agression sexuelle armée	12
viol	10
agression sexuelle	10
tentative de meurtre	7
voies de fait avec intention de mutiler	7
frapper avec intention de blesser	7
tentative de viol	6
voies de faits graves	6
grossière indécence	6
inceste	6
blesser	6
enlèvement	6
tentative d'enlèvement	6
détention forcée, séquestration	6
administrer substances nocives	6
inflictions lésions corporelles, voies de fait causant lési	5
incendiat, incendie criminel	5
voies de fait avec intention de voler, vol avec violence	5
prendre un véhicule à moteur, vol auto	5
extorsion (tentative)	5
Vol de plus de XXX $	5
vol qualifié	4
tentative de vol à main armée, de vol qualifié	4
agression armée	3
voies de fait	2
voies de fait simples	2
attentat à la pudeur	2
attentat à la pudeur d'une personne de sexe féminin	2
attentat à la pudeur d'une personne de sexe masculin	2
voies de fait envers policier	2
proférer des menaces, intimidation	2
relations sexuelles anales, sodomie	2
exploitation sexuelle (contacts sexuels avec adol. 14-18	2
possession arme	1
usage illégal d'une arme	1

Délit	Côte Cormier-Lang
usage négligent d'une arme à feu	1
arme dissimulée	1
braquer une arme à feu	1
possession arme lors de la perpétration d'un acte crimin	1
usage arme à feu (lors d'un délit criminel)	1
négligence criminelle	1
mettre le feu à des substances	1
tentative de vol, vol	1
possession biens volés, recel	1
introduction par effraction	1
introduction par effraction avec intention ou commettre	1
tentative introduction par effraction	1
dommages, fausse alerte, méfait	1
méfait aux biens publics	1
méfait à des biens privés	1
troubler la paix	1
entraver la justice (agent de la paix)	1
faux prétextes	1
défaut de se conformer à un ordre de probation	1
évasion garde légale, illégalement en liberté	1
bris condition, caution, omis. comparaître, omis. confor	1
possession drogue à usage restreint, de stupéfiants	1
nuisance publique	1
possession explosifs	1
harcèlement téléphonique, criminel, faux messages	1
faux, usages de faux	1
se donner faussement, supposition intentionnelle de per	1
possessin carte de crédit volée, vol carte de crédit	1
entrée non autorisée, intrusion	1
vol par effraction	1
fraude, mise en circulation de fausse monnaie	1
vagabondage	1
protistution juvénile, proxénitisme	1
conduite dangereuse	1
conduire avec un permis suspendu, retiré, suspendu	1
complot, conspiration, conseiller de commettre un acte	1
conduite avec facultés affaiblies ou + 80 mg alcool/sang	1
possession stupéfiants en vue d'en faire le trafic, trafic	1
délit de fuite	1
bris de prison	1
maison de débauche	1
évasion	1

Délit	Côte Cormier-Lang
refus de fournir un échantillon d'haleine	1
possession instruments d'infraction, d'outils de cambrio	1
faire d'un enfant un délinquant	1
déguisement	1
Autre	1
prétendre faussement être un agent de la paix	1
infraction à la loi des chemins de fer	1
défaut d'arrêter lors d'un accident	1
acquisition d'arme à feu sans autorisation	1
faire souffrir inutilement un animal	1
production de substances (drogues et subst.)	1
contact sexuel	1
sollicitation	1
arme prohibée dans véhicule moteur	1
méfait public	1
gangstérisme	1
présence illégale dans habitation	1
Vol de moins de XXX $	1
Méfait de plus ou de moins de XXX $	1
Obtention frauduleuse de transport	1

Appendix A5

Consent forms

CENTRE DE RECHERCHE Hôpital Douglas Hospital RESEARCH CENTRE

FORMULAIRE DE CONSENTEMENT À LA RECHERCHE

Il est important que vous compreniez bien toutes les informations contenues dans ce formulaire de consentement. N'hésitez pas à poser des questions s'il y a un mot ou une phrase que vous ne comprenez pas.

Titre de la recherche :

Troubles mentaux graves et criminalité : une analyse des décisions de prise en charge des individus déclarés non criminellement responsables pour troubles mentaux (NCRTM).

Chercheurs :

Anne Crocker, Ph. D., Université McGill et Centre de recherche de l'hôpital Douglas, Gilles Côté, Ph.D., Université du Québec à Trois-Rivières et Centre de Recherche de l'Institut Philippe Pinel de Montréal, Alain Lessage, MD, Université de Montréal et Centre de recherche Fernand-Séguin.

Financement :

Ce projet est financé par une subvention de recherche des Fonds de recherche en santé du Québec (FRSQ).

Description de la recherche :

Le but de cette recherche est de comprendre comment les cliniciens et la Commission d'Examen font leurs évaluations et prennent leurs décisions concernant la détention ou la libération de personnes déclarées non criminellement responsables pour cause de troubles mentaux.

Votre rôle :

1) Vous aurez une rencontre d'environ 2 heures avec un assistant de recherche du projet. Lors de cette rencontre, l'assistant de recherche vous posera des questions sur vos habitudes de vie, sur comment vous vous sentez et sur les services que vous recevez.

2) L'assistant de recherche vous demandera s'il peut consulter vos dossiers institutionnels, médicaux et judiciaires au cours des trois prochaines années.

Inconvénients possibles :

Il n'existe pas de risques prévisibles à participer à la présente étude. Il est possible que vous trouviez l'entrevue longue ou certaines questions difficiles.

Bienfaits possibles :

Les avantages directs de votre participation à la recherche sont limités. Il est possible que vous aimiez parler avec quelqu'un qui est intéressé à connaître ce que vous vivez. L'étude permettra d'aider d'autres personnes

comme vous dans l'avenir et de cerner les facteurs associés aux décisions de prise en charge d'individus déclarés NCRTM.

Confidentialité :

Les informations recueillies ne seront pas partagées avec qui que ce soit en dehors des membres de l'équipe de recherche sauf si ces informations laissent croire que votre santé ou sécurité ou celle de quelqu'un d'autre pourrait être menacée. Les informations seront utilisées pour fins de recherche seulement, de sorte que personne ne pourra vous identifier quand les résultats de l'étude seront discutés. Votre nom n'apparaîtra sur aucun questionnaire et les informations que vous allez partager seront gardées secrètes et conservées dans un classeur barré.

Participation :

Votre participation à cette étude est tout à fait volontaire. Vous avez le droit d'accepter ou de refuser de participer. Vous pouvez décider d'arrêter de participer n'importe quand et vous avez le droit de refuser de répondre à des questions qui vous mettent mal à l'aise. Peu importe votre choix, cela ne changera pas les services que vous recevez actuellement ou que vous allez recevoir dans l'avenir.

Compensation :

Si vous participez à l'étude, vous recevrez une compensation monétaire de 20$ pour votre participation à l'entrevue.

Questions :

Pour toutes questions à propos de cette recherche, n'hésitez pas à parler à l'assistant de recherche ou à joindre Anne Crocker, Ph.D. au (514) 761-6131, poste 3361 ou Gilles Côté, Ph.D. au (514) 881-3764. Si vous avez des questions concernant vos droits à titre de participant à une étude, communiquez avec l'ombudsman de l'hôpital Douglas au (514) 761-6131 poste 3287.

Si vous décidez de participer à cette étude, une copie de ce document vous sera remise. Pour faciliter les échanges d'informations entre cliniciens lors de visites à l'urgence et autres services de l'hôpital, une copie de votre formulaire de consentement sera placée dans une section de votre dossier de l'hôpital.

Consentement :

Votre signature signifie que vous avez lu (ou que l'assistant de recherche vous a lu et expliqué) les informations ci-dessus, que vous les comprenez et que vous consentez librement à participer au projet sur la base des renseignements qui vous ont été transmis.

Nom du participant en lettre moulées:_____

Signature du participant :_____ Date : _____

Nom du curateur en lettres moulées:_____

Signature du curateur:_____ Date : _____

Merci d'accepter de participer à ce projet de recherche!

Hôpital Douglas Hospital

6875, boulevard LaSalle, Verdun (Québec), Canada H4H 1R3 • Tél. : (514) 761-6131 • Téléc: (514)-762-3049

AUTORISATION POUR LA CONSULTATION DES DOSSIERS MÉDICAL, INSTITUTIONNEL ET JUDICIAIRE

Nom:_____ Dossier_____

Date de naissance :_____/_____/_____ (jj/mm/aaaa)

Je, soussigné(e), _____, autorise un assistant de recherche chargé de l'évaluation des dossiers dans l'équipe de recherche de Dr Anne Crocker à consulter mes dossiers médical, institutionnel et judiciaire dans le cadre de ma participation à la recherche intitulée **« Troubles mentaux graves et criminalité : une analyse des décisions de prise en charge des individus déclarés non criminellement responsables pour troubles mentaux (NCRTM)»**.

Les membres de l'équipe de recherche vérifieront :

1) Si je peux participer à la recherche.
2) Mon utilisation des services en santé mentale.
3) L'histoire de ma vie.
4) Mon histoire médicale.
5) Mes contacts avec le système de justice.

J'autorise l'assistant de recherche de l'équipe de Dr Anne Crocker à consulter mes dossiers médical, institutionnel et judiciaire dans le cadre du projet ci-haut mentionné.

Signature du participant : _____

Signature du curateur : _____

Signé le _____ (date), À_____ (ville)

Hôpital Douglas Hospital

6875, LaSalle Boulevard, Verdun (Quebec), Canada H4H 1R3 • Tel.: (514) 761-6131 • Fax: (514)-762-3049

AUTHORIZATION TO CONSULT MY MEDICAL, INSTITUTIONAL AND LEGAL FILES

Name:_____ File #:_____

Date of Birth:___/____/____ (dd/mm/yyyy)

I, the undersigned, _____, authorize a research assistant responsible for the evaluation of files from Dr Anne Crocker's research team to consult my medical, institutional and criminal files within the context of my participation in the research study entitled **"Severe mental illness and criminality: An analysis of dispositions regarding individuals declared non criminally responsible on account of mental disorders (NCRMD)"**.

The members of the research team will verify:

1) If I can participate in the research.
2) My utilization of services and resources in mental health.
3) My life story.
4) My medical history.
5) My contacts with the justice system.

I authorize the research assistant from Dr Anne Crocker's research team to consult my medical, institutional and legal files in the context of the study mentioned above.

Signature of participant: _____

Signature of curator: _____

Signed the _____ (date), at_____ (city)

Hôpital Louis-H. Lafontaine
AFFILIÉ À Université de Montréal
7401, rue Hochelaga • Montréal (Québec) • H1N 3M5 • Téléphone : (514) 251-4000

FORMULAIRE DE CONSENTEMENT À LA RECHERCHE

Il est important que vous compreniez bien toutes les informations contenues dans ce formulaire de consentement. N'hésitez pas à poser des questions s'il y a un mot ou une phrase que vous ne comprenez pas.

Titre de l'étude

Troubles mentaux graves et criminalité : une analyse des décisions de prise en charge des individus déclarés non criminellement responsables pour cause de troubles mentaux.

Chercheurs

Anne Crocker, Ph. D., Université McGill et Centre de recherche de l'hôpital Douglas, Gilles Côté, Ph.D., Université du Québec à Trois-Rivières et Centre de Recherche de l'Institut Philippe Pinel de Montréal, Alain Lesage, MD, Université de Montréal et Centre de recherche Fernand-Séguin.

Description de la recherche :

Le but de cette recherche est de comprendre comment les psychiatres et les membres de la Commission d'Examen font leurs évaluations et prennent leurs décisions concernant la détention ou la libération de personnes déclarées non criminellement responsables pour cause de troubles mentaux.

Votre rôle :

1) Vous aurez une rencontre d'environ 2 heures avec un assistant de recherche du projet. Lors de cette rencontre, l'assistant de recherche vous posera des questions sur vos habitudes de vie, sur comment vous vous sentez et sur les services que vous recevez.

2) L'assistant de recherche vous demandera s'il peut consulter vos dossiers institutionnels, médicaux et judiciaires au cours des trois prochaines années.

Préjudices et inconvénients possibles :

Il n'existe pas de risques prévisibles à participer à la présente étude. Il est toutefois possible que vous trouviez l'entrevue longue ou certaines questions difficiles

Bienfaits possibles :

Les avantages directs de votre participation à la recherche sont limités. Il est possible que vous aimiez parler avec quelqu'un qui est intéressé à connaître ce que vous vivez. L'étude permettra d'aider d'autres personnes comme vous dans l'avenir et de cerner les facteurs associés aux décisions de prise en charge d'individus déclarés non criminellement responsables pour cause de troubles mentaux.

Confidentialité

Les informations recueillies ne seront pas partagées avec qui que ce soit en dehors des membres de l'équipe de recherche sauf si ces informations laissent croire que votre santé ou sécurité ou celle de quelqu'un d'autre pourrait être menacée. Les informations seront utilisées pour fins de recherche seulement, de sorte que

personne ne pourra vous identifier quand les résultats de l'étude seront discutés. Votre nom n'apparaîtra sur aucun questionnaire et les informations que vous allez partager seront gardées secrètes et conservées dans un classeur verrouillé.

Destruction des informations :

Toutes les informations confidentielles recueillies dans le cadre de ce projet de recherche seront détruites cinq ans suivant la publication des résultats de recherche.

Participation

Votre participation à cette étude est tout à fait volontaire. Vous avez le droit d'accepter ou de refuser de participer. Vous pouvez décider d'arrêter de participer n'importe quand et vous avez le droit de refuser de répondre à des questions qui vous mettent mal à l'aise. Peu importe votre choix, cela ne changera pas les services que vous recevez actuellement ou que vous allez recevoir dans l'avenir.

Compensation :

Si vous participez à l'étude, vous recevrez une compensation monétaire de 20$ pour votre participation à l'entrevue.

Questions :

Pour toute question relative à la présente étude, n'hésitez pas à poser des questions à la personne qui vous demande de participer ou à joindre Anne Crocker, Ph.D. (Centre de recherche de l'hôpital Douglas) au (514) 761-6131, poste 3361 ou Alain Lesage, MD, co-chercheur (Centre de Recherche Fernand-Séguin) au (514) 251-4015, poste 2365. Pour toute question sur vos droits à titre de sujet de recherche ou pour tout problème éthique concernant les conditions dans lesquelles se déroule votre participation à ce projet, vous pouvez contacter M^{me} Elise St-Amant, Commissaire local à la qualité des services - Hôpital Louis-H. Lafontaine - 7401, rue Hochelaga - Montréal (Québec) H1N 3M5 - téléphone : (514) 251-4000 poste 2920.

En acceptant de participer à cette étude, vous ne renoncez à aucun de vos droits ni ne libérez nommément les chercheurs, les organismes, les entreprises ou les institutions impliqués de leurs responsabilités légales et professionnelles.

Si vous décidez de participer à cette étude, une copie de ce document vous sera remise et une copie sera déposée à votre dossier.

Consentement :

Par la présente, je _____confirme mon consentement à participer au projet de recherche portant sur les décisions de détention et de libération des individus déclarés non criminellement responsables pour cause de troubles mentaux.

Nom du participant (du curateur ou du tuteur) :_____

Signature du participant (du curateur ou du tuteur) :_____

Date : _____

Monsieur..... a pu poser toutes les questions qui lui paraissaient importantes et j'ai répondu à toutes ses questions en toute bonne foi et honnêteté.

Nom en lettres moulées de l'interviewer

Signature de l'interviewer Date

Nom en lettres moulées de l'investigateur

Signature de l'investigateur Date

Mister..... was given the opportunity to ask all questions that were important to him and I answered all of his questions in good faith and honesty.

Name in capital letters of interviewer

Signature of interviewer Date

Name in capital letters of investigator

Signature of investigator Date

Hôpital Louis-H. Lafontaine
AFFILIÉ À Université de Montréal
7401, rue Hochelaga • Montréal (Québec) • H1N 3M5 • Téléphone : (514) 251-4000

AUTORISATION POUR LA CONSULTATION DU DOSSIER MÉDICAL, INSTITUTIONNEL ET JUDICIAIRE

Nom:_____ Dossier_____

Date de naissance :_____/_____/_____ (jj/mm/aaaa)

Je, soussigné(e), _____, autorise un assistant de recherche chargé de l'évaluation des dossiers dans l'équipe de recherche de Dr Anne Crocker à consulter mon dossier médical, institutionnel et judiciaire dans le cadre de ma participation à la recherche intitulée **« Troubles mentaux graves et criminalité : une analyse des décisions de prise en charge des individus déclarés non criminellement responsables pour troubles mentaux»**.

Les membres de l'équipe de recherche vérifieront :

1) Si je peux participer à la recherche.
2) Mon utilisation des services en santé mentale.
3) Mon histoire psychosociale.
4) Mon histoire médicale.
5) Mes contacts avec le système de justice.

Confidentialité :
Les informations recueillies dans les dossiers seront gardées strictement confidentielles au même titre que les informations colligées lors des entrevues. Les informations seront comptabilisées pour fins de recherche seulement ce qui veut dire que l'on ne pourra pas vous identifier personnellement lors de la diffusion des résultats de recherche. Les informations seront détruites 5 ans suivant la publication des résultats de recherche.

J'autorise la consultation de mon dossier médical, institutionnel et judiciaire par une personne chargée de l'évaluation des dossiers de l'équipe de recherche de Dr Anne Crocker.

Signature du participant : _____

Signature du curateur : _____

Signé le _____ (date), À_____ (ville)

Centre de recherche
Institut
Philippe-Pinel
de Montréal
AFFILIÉ À
Université de Montréal

FORMULAIRE DE CONSENTEMENT À LA RECHERCHE

Participant

Il est important que vous compreniez bien toutes les informations contenues dans ce formulaire de consentement. N'hésitez pas à poser des questions s'il y a un mot ou une phrase que vous ne comprenez pas ou si une information n'est pas claire.

Titre de l'étude

Troubles mentaux graves et criminalité : une analyse des décisions de prise en charge des individus déclarés non criminellement responsables pour troubles mentaux.

Chercheurs

Anne Crocker, Ph. D., Département de psychiatrie de l'Université McGill, Centre de recherche de l'hôpital Douglas, Gilles Côté, Ph.D., Université du Québec à Trois-Rivières et Centre de Recherche de l'Institut Philippe Pinel de Montréal, Alain Lesage, Ph. D., Université de Montréal et Centre de recherche Fernand-Séguin.

Description de la recherche et de votre rôle

Vous êtes invité à participer à une recherche dont le but est de cerner les facteurs associés aux décisions de prise en charge d'individus déclarés NCRTM. Les objectifs de la recherche sont de :1) cerner les facteurs identifiés par les cliniciens lors de la présentation de leur rapport devant la Commission d'Examen ; 2) identifier les critères de prise en charge retenus par les membres de la Commission d'Examen; 3) établir la correspondance entre les facteurs observés et ce que l'on connaît des recherches antérieures; 4) explorer la rechute (hospitalisations ou comportement criminel ou violent) après une libération inconditionnelle.

L'échantillon total sera composé de 150 hommes âgés de 18 à 65 ans recrutés pour participer à l'étude à partir de l'Institut Philippe Pinel de Montréal, de l'hôpital Douglas et de l'hôpital Louis-H. Lafontaine.

Si vous acceptez de participer à cette étude :
1) Vous aurez une rencontre d'environ deux heures avec un agent de recherche du projet. Lors de cette rencontre, l'agent de recherche vous posera des questions sur vos habitudes de vie, vos comportements, vos symptômes, les services que vous recevez, les choses que vous vivez et les difficultés personnelles que vous pouvez avoir.

2) Nous vous demanderons également l'autorisation de consulter vos dossiers institutionnels, médicaux et judiciaires.

Préjudices et inconvénients possibles

Il n'existe pas de risques prévisibles à participer à la présente étude. Il est toutefois possible que vous trouviez l'entrevue longue ou certaines questions difficiles

Bienfaits possibles :

Il est possible que votre participation à la recherche ne vous soit pas directement bénéfique. Il est possible que vous appréciiez de parler avec quelqu'un qui est intéressé à connaître ce que vous vivez. L'étude aura des retombées cliniques, organisationnelles et scientifiques importantes pour d'autres personnes comme vous dans l'avenir. Les informations recueillies permettront, entre autres, de cerner les facteurs associés aux décisions de prise en charge d'individus déclarés NCRTM.

Confidentialité

Les informations recueillies ne seront partagées d'aucune façon avec les membres du personnel d'un service de santé ou judiciaire sauf dans le cas où l'agent de recherche considère que ces informations laissent fortement à supposer que votre santé ou sécurité ou celle de quelqu'un d'autre puisse être menacée. Les informations seront comptabilisées pour fin de recherche seulement, de sorte qu'on ne pourra vous identifier personnellement lors de la diffusion des résultats de l'étude. Votre nom n'apparaîtra sur aucun questionnaire et les informations que vous donnerez à l'agent de recherche seront secrètes et gardées sous clé dans un classeur.

Participation

Votre participation à cette étude est tout à fait volontaire. Que vous décidiez de participer ou non ne changera en rien les services que vous recevez actuellement ou que vous allez recevoir dans l'avenir. De plus, vous pouvez mettre fin à votre participation n'importe quand et cela n'affectera en rien les services que vous recevez d'habitude. En tout temps, vous avez le droit de refuser de répondre à des questions qui vous mettent mal à l'aise.

Compensation :

Si vous participez à l'étude, vous recevrez une compensation monétaire de 20$ pour votre participation à l'entrevue.

Pour toute question relative à la présente étude, n'hésitez pas à poser des questions à la personne qui vous demande de participer ou à joindre Anne Crocker, Ph.D., au (514) 761-6131, poste 3361 ou Gilles Côté, Ph.D., au (514) 881-3764. Si vous avez des questions concernant vos droits à titre de participant à une étude, veuillez communiquer avec Dre France Proulx, (514) 648-8461 poste 574.

Si vous décidez de participer à cette étude, une copie de ce document vous sera remise et une copie sera déposée à votre dossier.

Consentement :

Par la présente, je _____confirme mon consentement à participer au projet de recherche portant sur les décisions de prise en charge des individus déclarés non criminellement responsables pour cause de troubles mentaux. Ma participation consiste :

- En une rencontre de deux heures pour votre entrevue;
- À fournir l'autorisation de consulter mes divers dossiers au cours des trois prochaines années.

Ma participation est absolument volontaire et je peux y mettre fin en tout temps. Les informations recueillies ne seront partagées d'aucune façon avec les membres du personnel d'un service de santé ou d'un service judiciaire sauf si elles laissent fortement supposer que ma santé ou sécurité ou celle d'autrui puisse être menacées. Les données seront comptabilisées pour fin de recherche seulement.

Je donne également l'autorisation à l'équipe de recherche de consulter mes dossiers pendant une période de trois ans (dossiers hospitaliers, dossiers judiciaires, dossiers institutionnels, dossier de l'assurance maladie, selon le cas).

J'ai été assuré(e) que mon refus de participer à ce projet n'aura aucune répercussion sur la nature et la durée des services que je reçois ou que je pourrais recevoir.

Nom du participant (du curateur ou du tuteur) :_____

Signature du participant (du curateur ou du tuteur) :_____

Date : _____

J'atteste avoir lu et expliqué en des termes compréhensibles pour le sujet le contenu du formulaire de consentement.

Nom du témoin en lettres moulées:_____

Signature du témoin:_____

Date : _____

Merci d'accepter de participer à ce projet de recherche!

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AUTORISATION POUR LA CONSULTATION DES DOSSIERS MÉDICAL, INSTITUTIONNEL ET JUDICIAIRE

Nom:_____ Dossier_____

Date de naissance :_____/_____/_____ (jj/mm/aaaa)

Je, soussigné(e), _____, autorise un assistant de recherche chargé de l'évaluation des dossiers dans l'équipe de recherche de Dr Anne Crocker à consulter mes dossiers médical, institutionnel et judiciaire dans le cadre de ma participation à la recherche intitulée **« Troubles mentaux graves et criminalité : une analyse des décisions de prise en charge des individus déclarés non criminellement responsables pour troubles mentaux (NCRTM)»**.

Les membres de l'équipe de recherche vérifieront :

1) Si je peux participer à la recherche.
2) Mon utilisation des services en santé mentale.
3) L'histoire de ma vie.
4) Mon histoire médicale.
5) Mes contacts avec le système de justice.

J'autorise l'assistant de recherche de l'équipe de Dr Anne Crocker à consulter mes dossiers médical, institutionnel et judiciaire dans le cadre du projet ci-haut mentionné.

Signature du participant : _____

Signature du curateur : _____

Signé le _____ (date), À_____ (ville)

Appendix B1

Number of NCRMD index offences (total and most severe)

Table B1
Number of NCRMD index offences (total and most severe)

	Total		Most severe	
Offences	N	%	N	%
Assaults (level 1, 2, 3)	66	31.88	43	44.79
Threats, harassment	44	21.26	13	13.54
Administration of justice	20	9.66	4	4.17
Murder, Manslaughter	18	8.7	17	17.71
Weapons related	14	6.76	0	0
Attempted murder	9	4.35	7	7.29
Mischief	8	3.86	0	0
Sexual offences	4	1.93	3	3.13
Armed robbery	4	1.93	1	1.04
Break and entering	4	1.93	3	3.13
Arson	4	1.93	4	4.17
Disturbing the peace, nuisance	4	1.93	0	0
Theft	2	0.97	1	1.04
Drug related offences	2	0.97	0	0
Other	2	0.97	0	0
Offences involving hostages	1	0.48	0	0
Fraud	1	0.48	0	0
Total	207	100	96	100

Appendix B2

Results from hierarchical multiple regressions: predicting the severity of violent offenses

Table B2

Results from hierarchical multiple regressions: predicting the severity of violent offenses

	B	SE	β
Step 1			
Constant	1.91	9.93	
Age	0.50	0.17	.30**
Number of lifetime incarcerations	2.71	0.53	.51***
Step 2			
Conduct traits	0.26	1.21	.02
Adult antisocial traits	0.78	2.05	.05
Step 3			
Arrogant and deceitful lifestyle	0.42	1.44	.03
Deficient affective experience	-1.21	1.23	-.11
Impulsive and irresponsible lifestyle	-1.78	1.26	-.15
Antisocial behavior	1.69	1.15	.18

* $p < .05$ ** $p < .01$ *** $p < .001$

Appendix B3

Results from hierarchical multiple regressions: predicting the severity of prior non-violent offences

Table B3

Results from hierarchical multiple regressions: predicting the severity of prior non-violent offences

	B	SE	β
Step 1			
Constant	-6.17	5.87	
Age	0.03	0.10	.03
Number of lifetime incarcerations	1.95	0.31	.59***
Step 2			
Conduct traits	-0.53	0.71	-.08
Adult antisocial traits	-1.07	1.21	-.11
Step 3			
Arrogant and deceitful lifestyle	0.22	0.85	.02
Deficient affective experience	1.22	0.72	.18
Impulsive and irresponsible lifestyle	-0.55	0.74	-.08
Antisocial behavior	1.41	0.68	.24*

* $p < .05$ ** $p < .01$ *** $p < .001$

Appendix B4

Results from hierarchical multiple regressions: predicting the severity of prior offenses

Table B4

Results from hierarchical multiple regressions: predicting the severity of prior offenses

	B	SE	β
Step 1			
Constant	1.91	9.93	
Age	0.50	0.17	.30**
Number of lifetime incarcerations	2.71	0.53	.51***
Step 2			
Conduct traits	0.26	1.21	.02
Adult antisocial traits	0.78	2.05	.05
Step 3			
Arrogant and deceitful lifestyle	0.42	1.44	.03
Deficient affective experience	-1.21	1.23	-.11
Impulsive and irresponsible lifestyle	-1.78	1.26	-.15
Antisocial behavior	1.69	1.15	.18

* $p < .05$ ** $p < .01$ *** $p < .001$

Appendix B5

Results from hierarchical multiple regressions: predicting the number of prior violent offenses

Table B5

Results from hierarchical multiple regressions: predicting the number of prior violent offenses

	B	SE	β
Step 1			
Constant	-0.07	2.07	
Age	0.08	0.03	.24*
Number of lifetime incarcerations	0.34	0.11	.32**
Step 2			
Conduct traits	0.09	0.25	.04
Adult antisocial traits	0.85	0.43	.29*
Step 3			
Arrogant and deceitful lifestyle	0.23	0.30	.08
Deficient affective experience	-0.16	0.25	-.07
Impulsive and irresponsible lifestyle	-0.64	0.26	-.30*
Antisocial behavior	0.23	0.24	.13

* $p < .05$ ** $p < .01$ *** $p < .001$

Appendix B6

Results from hierarchical multiple regressions: predicting the number of prior non-violent offences

Table B6

Results from hierarchical multiple regressions: predicting the number of prior non-violent offences

	B	SE	β
Step 1			
Constant	-1.27	4.53	
Age	-0.02	0.07	-.03
Number of lifetime incarcerations	1.53	0.24	.60***
Step 2			
Conduct traits	-0.65	0.55	-.12
Adult antisocial traits	0.28	0.93	.04
Step 3			
Arrogant and deceitful lifestyle	0.25	0.66	.03
Deficient affective experience	0.31	0.56	.06
Impulsive and irresponsible lifestyle	-0.65	0.58	-.12
Antisocial behavior	1.13	0.52	.25*

* $p < .05$ ** $p < .01$ *** $p < .001$

Appendix B7

Results from hierarchical multiple regressions: predicting the number of prior offenses

Table B7

Results from hierarchical multiple regressions: predicting the number of prior offenses

	B	SE	β
Step 1			
Constant	-1.67	4.88	
Age	0.07	0.08	.07
Number of lifetime incarcerations	1.92	0.26	.63***
Step 2			
Conduct traits	-0.59	0.59	-.09
Adult antisocial traits	1.10	1.01	.12
Step 3			
Arrogant and deceitful lifestyle	0.44	0.71	.05
Deficient affective experience	0.15	0.60	.02
Impulsive and irresponsible lifestyle	-1.26	0.62	-.19*
Antisocial behavior	1.32	0.56	.24*

* $p < .05$ ** $p < .01$ *** $p < .001$