Aina Sundt Gullhaugen

Redefining psychopathy?

Is there a need for a reformulation of the concept, assessment and treatment of psychopathic traits?

Thesis for the degree of Philosophiae Doctor

Trondheim, March 2012

Norwegian University of Science and Technology
Faculty of Social Sciences and Technology Management
Department of Psychology

NTNU – Trondheim
Norwegian University of
Science and Technology

NTNU
Norwegian University of Science and Technology

Thesis for the degree of Philosophiae Doctor

Faculty of Social Sciences and Technology Management
Department of Psychology

© Aina Sundt Gullhaugen

ISBN 978-82-471-3433-7 (printed ver.)
ISBN 978-82-471-3434-4 (electronic ver.)
ISSN 1503-8181

Doctoral theses at NTNU, 2012:80

Printed by NTNU-trykk

English abstract

Redefining psychopathy? Is there a need for a reformulation of the concept, assessment, and treatment of psychopathic traits?

The concept of psychopathy is unlike most other mental disorders in the lack of observations of vulnerability and pain in those affected. Rather, the psychopath's callous and self-centered ways are known to evoke suffering in others. Measures are developed to identify these characteristics in a reliable way. However, increased accuracy has not led to better treatment. As a consequence, this study aimed to investigate whether the current understanding of psychopathy is changing, or should be changed, and if central changes in the concept and measurement of psychopathy require a modification of the way we handle the problem today? Hallmarks of the current paradigm were challenged through 3 research questions:

1. Are psychopathy and suffering mutually exclusive constructs?
2. Is the psychopath more than the persistent callous, grandiose and ruthless characteristics that we usually see?
3. Is the psychopath deprived of a capacity to change?

The first article of the thesis reviews previously published (1980-2009) cases of offenders with severely psychopathic traits (n=11). Vulnerability and pain in psychopaths were consistent with empirical evidence and concepts associated with object relations theory, Reid (1986) and Martens' (2002) clinical experience of suffering in psychopaths, and comorbid symptom- and personality pathology, as indicated by the authors' assessment and the self-report of individual offenders.

Articles two and three draw from an in-depth investigation of Norwegian high-security and detention prisoners with possible and strong indications of psychopathy (n=16) and controls (n=35). Results indicate important nuances in psychopathic offenders' affective and interpersonal functioning in terms of relational uncertainties and pain, and a greater emotional range than what is previously reported. Results further indicate a link between empirical findings and clinical theory describing structural affective, relational and defensive nuances in pathologically extreme self-states, which should be considered in future treatment of psychopathy.

Results are incongruent with Cleckley's (1941; 1988) recognized description, and the well-established primary-secondary psychopathy distinction (Karpman, 1941), and in agreement with the dimensional model of self- and interpersonal functioning advised in APA's (2010) proposed revision of personality diagnoses. Future work should focus on the vulnerability and suffering, nuances and adjacent treatment of psychopathy. Such an approach would represent a paradigm shift in this field.

Norsk sammendrag

Redefinering av psykopati? Er det behov for en reformulering av begrepet, mål på, og behandlingen av psykopatiske trekk?

Psykopatibegrepet er ulikt de fleste andre psykiske lidelser i egenskap av manglende observasjoner av sårbarhet og smerte hos den det gjelder. Psykopatens selvsentrerte stil og emosjonelle kulde er derimot kjent for å forårsake lidelse hos andre. Psykopatimål har blitt utviklet for å identifisere disse egenskapene på en sikker måte. Økt treffsikkerhet har imidlertid ikke ført til økt behandlingsbarhet. Studien tok derfor sikte på å utrede hvorvidt vår forståelse av psykopati er i ferd med å endre seg eller bør endres, og om sentrale endringer i konsept og målemetode fordrer en forandring av måten vi behandler psykopati på i dag? Sentrale aspekter ved det nåværende paradigmet ble utfordret gjennom 3 forskningsspørsmål:

1. Er psykopati og lidelse gjensidig utelukkende begreper?
2. Er psykopati mer enn de kalde, grandiose, og hensynsløse trekkene vi vanligvis ser?
3. Er psykopaten uten kapasitet for endring?

Avhandlingens første delarbeid gjennomgår tidligere publiserte (1980-2009) kasusstudier av lovbrytere med alvorlig psykopatiske trekk (n=11). Indikasjoner på sårbarhet og smerte hos psykopaten ble tydeliggjort gjennom lovbryternes selvrapportering og artikkelforfatternes vurderinger, og er i overensstemmelse med begrep og empiri tilknyttet objektrelasjonsteori, Reid (1986) og Martens' (2002) publiserte kliniske erfaring med lidelse hos psykopater, og komorbid symptom- og personlighetspatologi.

Delarbeid nummer to og tre utgår fra en dybdeundersøkelse av norske høysikkerhets- og forvaringsinnsatte med mulige og sterke indikasjoner på psykopati (n=16) og kontroller fra en studentpopulasjon (n=35). Resultatene indikerer nyanser i psykopatiske lovovertrederes mellommenneskelige og følelsesmessige fungering i form av en gjennomgripende relasjonell usikkerhet og smerte, samt en større følelsesmessig spennvidde enn det som tidligere er observert og antatt. Resultatene indikerer videre en sammenheng mellom empiri og klinisk teori som beskriver strukturelle affektive, relasjonelle og forsvarsmessige avvik i patologisk ekstreme selvtilstander. Dette til informasjon og bruk i fremtidig behandling av psykopati.

Resultatene utfordrer Cleckleys (1941; 1988) innflytelsesrike beskrivelse, og den veletablerte inndelingen av primær-sekundær psykopati (Karpman, 1941). Resultatene samsvarer med APAs forslag til revisjon av diagnosekriteriene for personlighetsforstyrrelse (2010), og er i overensstemmelse med en dimensjonal tilnærming til psykopatologi. Videre arbeid bør fokusere på sårbarheten, lidelsen, nyansene i, og behandling av psykopati. En slik tilnærming vil representere et paradigmeskifte innenfor dette området.

Preface

This thesis is a product of long held concerns for “the least loved patient”, the psychopath. The unempathic interpersonal predator who ironically excludes him/herself from the much-needed empathy other patients elicit from their therapists.

This project was supported by a grant from "The National Program for Integrated Clinical Specialist and PhD-training for Psychologists", a recruitment program for positions that requires dual competence in psychology funded by “The Ministry of Education and Research and The Ministry of Health and Care Services".

I am grateful to professor Kirsten Rasmussen (NTNU) for giving me the opportunity, to senior scientist Jim Aage Nøttestad (NTNU) for believing in me, and to professor Arne Vikan (NTNU) for thinking with me.

Many thanks to senior psychologist Kåre Nonstad at St. Olavs Hospital, Forensic Department and Research Centre Brøset, for sharing so willingly from an ingenious mind during our many discussions. I would also like to thank clinical psychologist Guro Johansen (Brøset) for her excellent help during the intriguing process of collecting the data, and senior advisor Kyrre Svarva (NTNU) for invaluable support with statistical problems. Last but not least, a sincere thank you to all colleagues and friends who have read and commented on earlier versions of the manuscripts, and to my family for understanding that I needed to write this text.

Trondheim, 30.03.12

Aina Sundt Gullhaugen

Contents

1 List of publications 11
2 Acronyms and abbreviations 13
3 Synopsis 15
4 Introduction 17
4.1 The concept of psychopathy 18
4.2 The assessment of psychopathy 24
4.3 The treatment of psychopathy 29
5 Aims, research questions and hypotheses 36
6 Method 38
6.1 Qualitative approach 39
6.2 Quantitative approach 39
6.2.1 Study population 39
6.2.2 Measures 41
6.2.3 Procedures and statistics 47
6.3 Ethical considerations 48
7 Results 52
7.1 1st article: The suffering of the psychopath 52
7.2 2nd article: Interpersonal and affective nuances 54
7.3 3rd article: Paradoxes and dilemmas 55
8 Discussion of main results 58
8.1 Main findings 58
8.2 Similarities and differences with previous research 59
8.3 Implications 64
8.4 Psychopathy, and the philosophy of science 69
8.5 Strengths and limitations 72
9 Conclusion, implications and further work 76
9.1 Main conclusions and possible implications 76
9.2 Future work 78
10 References 80
11 Appendix 101
11.1 Letters of information and consent 101
11.2 Questionnaires 113
12 Articles I - III 141

1 List of publications

Paper 1:

Gullhaugen, A. S. & Nøttestad, J. A. (2011). Looking for the Hannibal behind the Cannibal: Current Status of Case Research. *International Journal of Offender Therapy and Comparative Criminology, 55, 3,* 350-369.

Paper II:

Gullhaugen, A. S. & Nøttestad, J. A. (In press). Under the surface: The Dynamic Interpersonal and Affective World of Psychopathic High-Security and Detention Prisoners. *International Journal of Offender Therapy and Comparative Criminology.*

Paper III:

Gullhaugen, A. S. & Nøttestad, J. A. (2011). *Treatment of psychopathy? Testing theoretical models for the purpose of future forensic practice.* Manuscript submitted for publication.

2 Acronyms and abbreviations

APA	American Psychiatric Association
APD	Antisocial personality disorder
CAPP-IRS	Comprehensive Assessment of Psychopathic Personality – Institutional Rating Scale
DIP-Q	DSM-IV and ICD-10 personality Questionnaire
DPD	Dissocial personality disorder
ECQ2	Emotional Control Questionnaire 2
IIP-C	Inventory of Interpersonal Problems – Circumplex version
NRK	Norsk rikskringkasting (Norwegian broadcasting)
NTNU	Norwegian University of Science and Technology
PANAS	Positive and Negative Affect Schedule
PCL-R	Psychopathy Checklist – Revised
PCL:SV	Psychopathy Checklist: Screening Version
PPI	Psychopathic Personality Inventory
SCID-I	Structured Clinical Interview for DSM-IV Axis I disorders
SCID-II	Structured Clinical Interview for DSM-IV Axis II disorders
WHO	World Health Organization
YSQ-SF	Young Schema Questionnaire – Short Form

3 Synopsis

The purpose of the thesis was to discuss whether the way we understand psychopathy is changing, or should be changed, and if central changes in the concept and the assessment of psychopathy should influence the way we handle psychopathy today?

In the predominant paradigm, the concept of psychopathy as a mental disorder is different from most such disorders in the absence of observations of vulnerability and pain (Cleckley, 1941; WHO, 1994). Rather than displaying some sort of personal weakness or distress, psychopaths, as we know them, are self-centered and un-empathic interpersonal predators, hallmarked by the tendency to create suffering and pain *in others* (Cleckley, 1941). As a consequence, the clinical concept of psychopathy rests on the psychopath's indifference and harm towards others, rather than any difficulties experienced by the psychopath him/herself.

Research portrays the psychopath as an isolated, antisocial individual without the relations and ruminations (or *inner conflict*; Cleckley, 1941, p. 407) that regulate normal, well-adjusted behavior. A figure maneuvering in an interpersonal landscape, where fields are barren, and the heartland is gone. Psychopathy measures were developed to identify these traits in a reliable way (Hare, 1991, 2003). Measures' sole focus on the psychopath's antisocial propensities is timesaving and facilitates prediction, at the expense of a more fine-meshed understanding of the problem. As a consequence, key characteristics of psychopathic functioning might be lost.

Personality disorder is hallmarked by the stable presence of deviant personality traits and corresponding behavior (APA, 1994; WHO, 1994). With psychopathy, three distinctive features are said to contribute to the conservation of the abnormal state: Lack of comorbid, ego dystonic symptoms (Blair, Mitchell, & Blair, 2005); difficulties with maintaining relationships (Blackburn, 2006); and lack of a

motivation to change (Seto & Quinsey, 2006). These poses serious obstacles in terms of treatment, and early studies demonstrating higher recidivism rates in "treated" psychopaths than in non-psychopathic controls (Hare, Clark, Grann, & Thornton, 2000; Rice, Harris, & Cormier, 1992; Seto & Barbaree, 1999) gave raise to a widespread belief that psychopath's are unable to change, with the consequence that psychopaths have been excluded from treatments with potentially changing effect.

The 1st article of this thesis systematically reviews case descriptions of severely psychopathic offenders published between 1980 and March 2009. In contrast to the prevalent opinion, case material (n=11) demonstrates that severely psychopathic offenders do suffer psychological pain. *The 2nd article* yields an in-depth examination of the interpersonal and affective world of high-security and detention prisoners with possible and strong indications of psychopathy (n=16) and controls (n=35). Results demonstrate important nuances and variations in psychopathic offenders' interpersonal and affective functioning. *The 3rd article* tests Wiggins and Trapnell's (1996) metaconcepts of community and agency and Richard's (1998) description of structural affective, relational, and defensive deviances in pathological extreme self-states in high-security and detention prisoners with possible and strong indications of psychopathy (n=16) and controls (n=35). Results demonstrate a connection between empirical findings and clinical theories, providing the forensic psychologist and related specialists with information that might be essential for treatment of psychopathy.

4 Introduction

This thesis challenges three pillars serving the current concept, assessment, and treatment of psychopathy

1. Psychopaths do not suffer (the concept of psychopathy)
2. Psychopaths are one-dimensional characters (the assessment of psychopathy)
3. Psychopaths are unable to change (the treatment of psychopathy)

by reviewing published case studies of severely psychopathic offenders (PCL-R; Hare, 1991, 2003, ≥ 30), by performing an in-depth investigation of the interpersonal and affective characteristics of high-security and detention prisoners with possible (PCL:SV; Hart, Cox, & Hare, 1995, ≥ 13) and strong (PCL:SV ≥ 18) indications of psychopathy, and by applying the above sample to test theoretical models for the purpose of future treatment of psychopathy.

The rationale for studying the concept, assessment and treatment of psychopathy is the devastating personal and social consequences of a specific blend of affective and interpersonal traits (Cooke, Michie, & Hart, 2006; Frick & Marsee, 2006; Seto & Quinsey, 2006) which etiology is unresolved (Salekin & Lynam, 2010), and which we have no efficient treatment for (Arrigo & Shipley, 2001).

In the following sections, central concepts, theory and research are reviewed to illustrate how the present thesis contributes to the field, both theoretically and empirically. Present controversies, conflicting results, and unanswered questions are highlighted, as well as the grounds for observations.

4.1 The concept of psychopathy

Society has over cultures and time recognized the composite of personality characteristics that we are currently referring to as *psychopathy* (Cook, Michie & Hart, 2006). Despite, or because of, a multidisciplinary approach from the various disciplines of medicine, psychology, philosophy and law, researchers has yet to agree on a concept that is a household word, a disorder (DSM-IV, APA, 1994; ICD-10, WHO, 1994), a legal term (psychopathy is included in the term *dangerous and severe personality disorder*; Howells, Krishnan, & Daffern, 2007), a moral judgment masquerading as a clinical diagnosis (Blackburn, 1988, in Feix, 2006), and a word of abuse (NRK, 2004). Duggan (2008, in abstract) states: “Because forensic mental health is inclusive in its purpose (interacting with the law, social services and the penal system, all of which have different rules and agendas), it is difficult to develop a consensus on fundamentals, this consensus being a hallmark of science”.

A detailed account of the multidisciplinary and historical conceptions of psychopathy is out of range for this thesis (cf. Hare, 1996, for an overview). *Clinical descriptions* of psychopathy saw daylight around 1800 in Pinel and Pritchard’s descriptions of mental disorder in individuals with intact reasoning (Cooke et al., 2006), in which damage to the emotional system were the attributed cause of patients’ exaggerated amounts of anger. The clinical concept of psychopathy was included in early versions of APA’s Diagnostic and Statistical Manual of Mental Disorders, but is now incorporated to the diagnostic manuals under D/APD (WHO, 1994, and APA, 1994, respectively). Table 1 reviews general and specific criteria for D/APD.

Table 1: Diagnostic criteria for dissocial (WHO, 1994) and antisocial (APA, 1994) personality disorder

General D/APD criteria	- There is evidence that the individual's characteristic and enduring patterns of inner experience and behavior as a whole deviate markedly form the culturally expected and accepted range or norm. Such deviation must be manifest in more than one of the following areas: Cognition; affectivity; control over impulses and gratification of needs; manner of relating to others and of handling interpersonal situations - The deviation must manifest itself pervasively as behavior that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations - There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behavior referred to above - The individual is at least age 18 years - There is evidence that the deviations is stable and of long duration, having its onset in late childhood or adolescence - The deviation cannot be explained as a manifestation or consequence of other adult mental disorders, organic brain disease, injury or dysfunction
Specific DPD criteria	At least three of the following must be present: - Callous unconcern for the feelings of others - Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations - Incapacity to maintain enduring relationships, though with no difficulty in establishing them - Very low tolerance to frustration and a low threshold for discharge of aggression, including violence - Incapacity to experience guilt, or to profit from adverse experience, particularly punishment - Marked proneness to blame others, or to offer plausible rationalizations for the behavior that has brought the individual into conflict with society
Specific APD criteria	At least three of the following must be present: - Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest - Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure - Impulsivity, or failure to plan ahead - Irritability and aggressiveness, as indicated by repeated physical fights or assaults - Reckless disregard for safety of self or others - Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations - Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen form another

However, the current clinical concept of psychopathy implies an accentuation of the characteristics presently included in D/APD (Blair, 2008; Boyd, 2003; Cooke, Michie, Hart, & Clark, 2005; Gacono, Loving & Bodholdt, 2001; Ogloff, 2006; Schrum & Salekin, 2006). The concept was explained by Cleckley (1941) and further refined and empirically validated by Hare (1985, 1991; in Arrigo & Shipley, 2001). According to Hare (1996), the lack of psychometrically sound measures hindered the

development of research and society's acceptance of psychopathy as a clinical concept. Hare considered the PCL-R (1991, 2003; Table 2) to be a solution to this problem.

Table 2: PCL – R items (Hare, 1991, 2003)

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

The PCL-R brought a unifying quality to measuring psychopathy, securing that clinicians and researchers in most parts of the world are studying the same problem. The prevalence of psychopathy is found to be a little less that 1 % in the general population (Coid, Yang, Ullrich, Roberts, & Hare, 2009). In the offender population, the base rate for D/APD ranges from 50 – 80 %, whereas the base rate for the more severe psychopathy condition is 15- 25 % (Hare, 2000, in Shipley & Arrigo, 2001).

Although there is considerable agreement regarding the core attributes of psychopathy (a narcissistic and deceitful interpersonal style; defective affective responses; impulsiveness; lack of planned behavior: Cook et. al, 2006; Hare, 1996), researchers and clinicians have different perspectives on the etiology of psychopathy and the disorder's position in the diagnostic landscape (Salekin & Lynam, 2010). Researchers have investigated whether "the individual experiences morality problems

that are solely personality based (e.g., Craft, 1966; Dinges, Atlis, & Vincent, 1998; Millon et al., 1998), exclusively congenitally or biologically derived (Ellard, 1988; Schneider, 1958; Smith, 1978), or principally behaviorally grounded (APA, 1994)" (in Arrigo & Shipley, 2001, p. 326). A small, yet distinct branch has approached the concept from a psychodynamic point of view, focusing on attachment and pathological personality structure, psychological defense, and various psychotherapeutic issues (Meloy, 1998; Meloy & Yakeley, 2010). Others have conceptualized psychopathy as an evolutionary evolved strategy for enhanced reproduction maintained through natural selection (Barr & Quinsey, 2004; Harris & Rice, 2006; Harris, Rice, Hilton, Lalumiere, & Quinsey, 2007; Mealey, 1995; Raine & Venable, 1992), claiming that a climate consisting of stable altruistic bonds creates a niche for alternative strategies involving promiscuousness, manipulation, and deceit. From this perspective, instrumental aggressive behaviors are means for status and resources, and to continue ones genes with minimal effort (Raine & Venable, 1992). However, the most widespread approach to understanding psychopathy has embraced a cognitive neuroscience perspective (cf. Hare, 2006). A central exponent for this view is researcher James Blair in his definition of psychopathy as a neurodevelopmental disorder of genetic origin (Blair, 2003). Blair studied biological brain responses in psychopaths indicating damage to the amygdala (Blair, Morris, Frith, Perret & Dolan, 1999). Damage to the amygdala is hypothesized to entail that the psychopath is not physiologically activated from the suffering of others, which again hinders the development of socialization and empathy (Blair, 2003; Blair, Peschardt, Budhani, Mitchell, & Pine, 2006). According to a review by Woods (2010), research suggests that brain abnormalities, specifically impairment of the emotional learning network, may be a factor in the development of psychopathy.

Also, twin studies have concluded that genetic factors account for at least half of the variance in personality development, and environmental influences are considered limited within this biodeterministic approach (Woods, 2010).

Through it's immersement in the diagnostic manuals under D/APD, psychopathy is currently classified as a *psychiatric* disorder. According to Arrigo and Shipley (2001), a great deal of confusion exists regarding the relationship between D/APD, as specified in the diagnostic manuals, and the modern construct of psychopathy as presented by Cleckley (1941) and Hare (1991). Researchers have debated whether psychopathy and D/APD have a common underlying pathology (Coid, & Ullrich, 2010; Newman, MacCoon, Vaughn, & Sadeh, 2005; Widiger, 2006), but the *primary-secondary psychopathy* distinction of the current paradigm highlights the difference between psychopathy as a genetic/biological predisposition (primary psychopathy) and individuals with similar pathology as an aspect of another psychiatric disorder or as a result of social circumstances (secondary psychopathy, sometimes referred to as *sociopathy*; Karpman, 1948; see also Cleckley, 1988; Lykken, 1995; Mealey, 1995; Newman et al., 2005). Primary psychopaths have been demonstrated to lack attachment capacity (Frodi, Dernevik, Sepa, Philipson, & Bragesjö, 2001) and the natural anxiety associated with possessing this quality (Cleckely, 1988; Harris & Rice, 2006; Newman et al., 2005). With some exceptions (e.g. Coid & Ullrich, 2010), comorbidity with symptom disorders is generally low (Blair et al., 2005), whereas the secondary psychopath appears to be attached to others and to experience various symptoms according to the diagnostic manuals (Goodwin & Hamilton, 2003; Leichsenring, Kunst, & Hoyer, 2003; Harris & Rice, 2006). Observations of psychopathy subtypes distinguishable in terms of personality structure (emotionally stable versus aggressive) are also proposed to reflect different

etiologies for different types of psychopathy (Hicks, Markon, Patrick, Krueger, & Newman, 2004), while research demonstrating comorbidity between psychopathy and other disorders of the personality (Decuyper, De Fruyt, & Buschman, 2008; Hildebrand & de Ruiter, 2004) might indicate a common underlying pathology (Widiger, 2006). Kernberg (2004) proposed that psychopathy, or "antisocial personality disorder proper" (p. 131) belongs at the high end of a spectrum of pathological narcissism.

Whereas most personality disorders' (paranoid-, schizotype-, borderline-, histrionic-, narcissistic-, avoidant-, and dependent personality disorder) specific criteria describe an interpersonal area of vulnerability and pain, this is not explicitly stated in the dissocial/antisocial (schizoid and compulsive) personality disorder. The clinical concept of psychopathy rests on the psychopath's indifference and harm towards others rather than any difficulties experienced by the psychopath him/herself. According to Cleckley (1941, p. 348), psychopathy is a condition where "mature, wholehearted anger, true or consistent indignation, honest solid grief, sustaining pride, deep joy, and genuine despair are reactions not likely to be found". In a clinical paper available from the monthly publication *Psychiatric Times*, Martens (2002) questioned whether all psychopaths show a complete lack of normal emotional capacities and empathy? He refers to several cases (Martens, 1999; Martens & Palermo, 2005, PCL-R score not reported) indicating that psychopaths do suffer emotionally as a consequence of personal loss or dissatisfaction with their own deviant behavior (2002), and that social isolation, loneliness and associated emotional pain may precede violent criminal acts in psychopaths (Martens, 1999, 1997; Martens & Palermo, 2005). Reid (1986, p. X) hypothesized that psychopaths have a mask of sanity that "hides the psychopath's pathology, which is a source not only of

consternation for others but also of pain and sadness for him". This clinical hypothesis by Reid differs markedly from the predominant view of Cleckley (1941) and has never been tested. Potential indications of psychological suffering, vulnerability or pain in psychopaths would mark the advantage of a *dimensional* (psychopathy is on a continuum with normal personality functioning within the general population; Coid & Yang, 2008) rather than a *categorical* (psychopaths are fundamentally different from others and lack basic attributes such as empathy and guilt, which are essential for normal personalities; Coid & Yang, 2008) understanding of psychopathy. The categorical approach (Harris, Rice, & Quinsey, 1994) has been challenged by researchers applying taxometric analyzes on data from interview and self-report measures of psychopathy, indicating a dimensional structure in youths and adults, similar to a diagnosis of depression (Edens, Marcus, & Vaughn, 2011; Marcus, John, & Edens, 2004). This is consistent with APA's new dimensional approach to personality disorders, described in the proposed DSM-V revisions (2010).

The 1st article of the thesis challenges the prevailing concept of psychopathy's focus on the psychopath's indifference and harm towards others, rather than any difficulties experienced by the psychopath him/herself.

4.2 The assessment of psychopathy

Although there is some inconsistency regarding the clinical concept of psychopathy, the assessment of psychopathy is a more integrated affair. Researchers have over the past 20 years developed measures designed to reliably detect and correspond to the core attributes of the psychopath (a narcissistic and deceitful interpersonal style; defective affective responses; impulsiveness; lack of planned behavior: Cook et. al, 2006; Hare, 1996), assessing a one-dimensional character that lack the extent and

depth characterizing the interpersonal and affective capacities of normal personalities. Today's gold standard for measuring psychopathy is the PCL-R, a valid and reliable measure of psychopathy in adult male forensic populations (Hare, 2003). The PCL-R is a clinical rating scale consisting of 20 items scored on a three-point scale (0, 1, 2, the total score ranging from 0 - 40) according to specific criteria, on the basis of file information and a semi-structured interview. Factor analytic research has demonstrated 2, 3 and 4 factors summarizing PCL-R items (Cooke & Michie, 2001; Vittaco, Neuman, & Jackson, 2005). The original two main factors were labeled "selfish, callous, and remorseless use of others" (Factor 1) and "chronically unstable, antisocial and socially deviant lifestyle" (Factor 2; Hare, 1991). The three-factor model extracts an "arrogant and deceitful interpersonal style", a "deficient affective experience", and an "impulsive and irresponsible behavioral style" (Cooke & Michie, 2001; the three-factor model has been criticized by Hare & Neuman, 2008, for several statistical and conceptual problems), whereas the four-factor model reintroduces the antisocial behavior factor by differentiating between interpersonal, affective, behavioral impulsivity, and antisocial behavior dimensions (Vittaco, Neuman, & Jackson, 2005). The PCL-R is based on Cleckley's 16 criteria for psychopathy, which in turn were based on numerous cases of psychopathy from diverse populations (Cleckley, 1941). Research has demonstrated poor treatment response and a high risk of recidivism for individuals with high (PCL-R ≥ 30) scores on the PCL-R (Porter, ten Brinke, & Wilson, 2009). Hare (1991, 2003) recommended a cut-off of 30 for diagnostic purposes. An attempt to equate diagnostic cut-off scores across countries using item response theory analysis resulted in a "European cut-off" of PCL-R ≥ 25 (Cooke & Michie, 1997, in Barrett, n.d.), but was later criticized for being based on false premises (Barrett, n.d.).

Another and more elaborate psychopathy measure, currently under validation, is the CAPP-IRS (Cooke, Hart, Logan, & Michie, 2008). The CAPP-IRS is a clinical rating scale organized according to 6 domains (self, attachment, behavioral, cognitive, dominance, emotional) with corresponding symptoms (Table 3) and adjectival descriptors and behavioral indicators (not in table) providing the basis for a nuanced description over discrete time periods (Cooke, Hart, Logan, & Michie, 2008).

Table 3: CAPP-IRs items (Cooke et al., 2004)

1. Self: Self-centered; self-aggrandizing; sense of uniqueness; sense of entitlement; sense of invulnerability; self-justifying; unstable self-concept
2. Attachment: Detached; uncommitted; unempathic; uncaring
3. Behavioral: Lacks perseverance; unreliable; reckless; restless; disruptive; aggressive
4. Cognitive: Suspicious; lacks concentration; intolerant; inflexible; lacks planfulness
5. Dominance: Antagonistic; domineering; deceitful; manipulative; insincere; garrulous
6. Emotional: Lacks anxiety; lacks pleasure; lacks emotional depth; lacks emotional stability; lacks remorse

The CAPP-IRS was constructed from the authors' review of existing literature and asking clinicians of diverse theoretical backgrounds to rate their opinion of central psychopathic traits. Cooke et al. (2008) reported that both from a theoretical and a clinical perspective, the existing psychopathy measures suffered from significant construct underrepresentation, meaning that they did not include important symptoms of the disorder. Findings were assembled and categorized into the above-mentioned categories according to a lexical approach (Cooke et al., 2008). Assessment procedures include a detailed semi-structured interview structured in terms of life themes rather than a symptom-by-symptom approach. Scoring is supported by an interview rating sheet, a symptom-rating sheet, a staff rating scale and a glossary of definitions (Cooke et al., 2008).

In 1996, Lilienfeld and Andrews published a 187 items self-report measure of psychopathy, the PPI. The PPI assesses 8 categories targeting the psychological functioning of the psychopath: Machiavellian egocentricity, social potency, cold-

heartedness, carefree non-planfulness, fearlessness, blame externalization, impulsive non-conformity, as well as stress immunity. The PPI is a valid and reliable scale that correlates appreciably with the PCL-R (Lilienfeld & Fowler, 2006), with internal consistency measures ranging from .78 to .90 on each subscale (Sadeh & Verona, 2008). Assessment of isolated aspects of psychopathy includes various neurobiological tools (c.f. van Honk & Schutter, 2006, for a review) and projective testing of subjective experiences in psychopathic offenders (Gacono & Meloy, 2009).

The psychiatric assessment of psychopathy is a complicated matter in that we encounter the same theoretical and methodological problems as in the assessment of any other mental disorder as well as the special linkage to areas outside psychiatry, especially law, politics and sociology (Hoff & Herpertz, 2007). Hoff & Herpertz (2007) ask whether antisocial behavior is closer to mental disorder, maladaptive character, or to mere social misconduct, a question reflecting historical changes in the emphasis placed on character versus behavior in diagnostic criteria (Salekin, 2010; Hare, 1996). Despite the fact that psychopathy is formally categorized as a disorder of the *personality* (i.e. the combination of characteristics or qualities that form an individual's distinctive character), the current D/APD diagnoses are to a large degree based on *behavior-oriented* criteria (Hare, 1996a; Salekin, 2010). Further, the present gold standard measure of psychopathy, the PCL-R, is rooted in a categorical approach to understanding psychopathy, suggesting that ("primary") psychopaths are different from others *in some fundamental way* (although Cleckley and Hare never claimed that psychopathy should be constructed as a discrete taxon or class; Hare, 2007; Harris, Rice & Quinsey, 1994). However, recent research (Decuyper et al., 2008) has demonstrated that the characteristics of psychopathy distributes meaningfully on the five-factor model (McCrae & Costa, 2008) of personality (psychopaths are less

agreeable, conscientious, anxious, depressed, vulnerable and warm, and more assertive, hostile and impulsive than most people) and places the main features of psychopathy on a continuum from normality to severe *personality* pathology (Edens et al., 2011; Marcus et al., 2004). This adds construct validity to current measures of psychopathy and indicates that it is the *degree* of specific features and *level of personality functioning* (APA, 2010) that separates personality disorder and psychopathy from the normal personality, and that the D/APD diagnostic criteria could emphasize more character and less behavior, a point put forward by Hare as early as in 1996 (Hare, 1996a).

Even though parts of the current paradigm have incorporated a dimensional understanding of psychopathy, the scientific society has not embraced the full potential or consequences of a dimensional model. If the antisocial traits of the psychopath (ruthless, callous and detached features) are dimensionally distributed (the psychopath is *not* fundamentally different from "the rest of us"), then theoretically, the opposite or more *prosocial* qualities and tendencies (i.e. consideration for others and affiliation needs) could be equally present (like for "the rest of us"). Contemporary psychopathy measures explicitly assess only a limited part of the potential mental and moral qualities distinctive to an individual. Focusing on the target's most salient traits increases the efficiency and accuracy of any measure, but comes with the consequence of loosing potentially important nuances in psychopaths' everyday functioning, which may reduce the possibility of understanding and treatment. Although several studies have examined psychopathy with regard to comorbidity (e.g. Coid & Ullrich, 2010; Decuyper et al., 2008; Hildebrand & de Ruiter, 2004), no published studies that this author knows of have set out to

investigate the full potential of interpersonal and affective qualities in samples of psychopathic offenders.

The 2nd article of the thesis challenges the current categorical approach to the assessment of psychopathy, rather than measuring the full or latent potential of mental and moral qualities implicit in a dimensional understanding.

4.3 The treatment of psychopathy

While there is some optimism regarding treatment of D/APD or secondary psychopathy (Bateman & Fonagy, 2008; Reid & Gacono, 2000), treatment of primary or prototypical psychopathy is associated with considerably darker prospects (Harris & Rice, 2006; Reid & Gacono, 2000; Rice et al., 1992; Salekin, 2002). The categorical approach of the predominant neurobiological paradigm seems to preserve the idea that psychopaths are “a species of their own” (different from others *in fundamental ways*, lacking basic attributes such as empathy and guilt; Coid & Yang, 2008; Harris, Rice, & Quinsey, 1994). Leading researchers argue that a strong case can be made that there is a genetic contribution to the emotional and executive regulatory dysfunction components of psychopathy (cf. Woods, 2010, for a review; Blair et al., 2005) and that traditional psychotherapeutic remedies will only serve to reinforce the already unscrupulous traits associated with psychopathy (Cleckley, 1988; Hare, 1991; Harris & Rice, 2006). Hence, *the fundamental idea* of the dominant paradigm seems to be that the “antisocial personality disorder proper” is neither a traditional psychiatric disorder, even though this is not explicitly stated, nor a product of adverse environmental factors such as childhood psychological and physical abuse (Blair et al, 2005; Harris & Rice, 2006; Woods, 2010). As a consequence, psychopaths are excluded from treatment (Gullhaugen, Nørbech, & Teigset, 2011),

and therapists claiming to have "cured" psychopaths have been met with allegations that their patient was not genuinely psychopathic or criticized for a lack of follow-up (Harris & Rice, 2006). As an example, meta-analytic research by Salekin (2002) indicated that a combination of behavioral- and insight-oriented therapy seemed to be especially helpful in reducing psychopathic traits, whereas therapeutic communities appeared unsuitable in terms of treatment. Salekin study was heavily criticized for including studies without a common measure of psychopathy and studies assessing treatment effect solely on the basis of the therapist's clinical evaluation (Harris & Rice, 2006). However, Harris and Rice (2006) emphasize that until there is *more evidence* that psychopathy subtypes such as primary versus secondary psychopathy have clinical and theoretical significance or matters to prognosis (criminal outcome, response to treatment), the existence of subtypes cannot have much relevance to treatment.

In an attempt to summarize the state in this area, Salekin, Worley & Grimes (2010) argue that there exist strong opinions and potentially ingrained beliefs regarding the potential impact treatment might have on psychopathy. And further, that in the absence of strong research on the topic, it is difficult to ascertain which beliefs are correct (Salekin et al., 2010). With some notable exceptions (Caldwell, Skeem, Salekin, & Van Rybroek, 2006; Chakhssi, de Ruiter, & Bernstein, 2010; Gretton, McBride, Hare, O'Shaughnessy, & Kumka; 2001; Salekin et al., 2010), treatment research in this area is generally deemed as inconclusive due to observations of major methodological weaknesses (c.f. Dolan & Coid, 1993; D'Silva, Duggan, & McCarthy, 2004; and Salekin, 2010, for reviews), or conclude that previous treatment attempts lack success (c.f. Harris & Rice, 2006, and Reid & Gacono, 2000, for reviews).

A few empirical studies have been particularly influential (Hare et al., 2000; Rice et al. 1992; Seto & Barbaree, 1999) in shaping the current negative stance on treatment of psychopathy. In 1992, Rice et al. published what was going to be the most cited study on treatment of psychopathy. The authors presented retrospective ratings of criminal recidivism in a sample of 146 psychopathic prisoners and controls. Prisoners completed 2 years of intensive treatment in a therapeutic community, during the period 1968-1978. Samples were evaluated with regard to general and violent recidivism 10 years after termination of treatment. Results indicated that treatment had a positive impact on non-psychopathic prisoners' general recidivism, but this was not the case for their psychopathic counterparts. Also, violent recidivism was reduced in non-psychopathic prisoners, while "treated psychopaths" recidivated more. Rice et al. concluded that all participants learned new and important interpersonal skills, which contributed to more prosocial and less criminal behavior in non-psychopaths, and in psychopaths, a larger degree of manipulation and exploitation of others. Rice et al.'s study caused considerable debate and was particularly criticized for applying rather unconventional treatment methods (defense disrupting therapy via nude-marathon encounter groups, psychotropic drugs, lack of involvement from medical personnel: D'Silva et al., 2004; Salekin, 2002; and Salekin et al., 2010). Salekin (2002) argues that reports of increased recidivism may be due to a worsening of the patient's conditions, rather than some non-treatable aspects of psychopathy.

Seto and Barbaree (1999) described results similar to Rice et al. (1992). They reported that the probability of general versus serious criminal recidivism were three and five times as likely in incarcerated sexual offenders scoring above the PCL-R median, evaluated to profit from treatment (group-based cognitive- behavioral therapy) from their therapists, than to less psychopathic controls. Looman, Abracen,

Serin and Marquis (2005) replicated the results of this study. However, a later re-analysis of Seto and Barbaree's 1999 findings (Barbaree, Seto, & Langton, 2001), this time on the basis of twice the length of follow-up (5.2 years) and with better data sources, *did not* find a correlation between ratings of successful treatment and elevated recidivism. Finally, Hare et al. (2000) reported that prisoners with high scores on PCL-R Factor 1 (selfish, callous, and remorseless use of others) showed higher ratings of post-treatment recidivism than non-treated controls (85,7 % vs. 58,8 %, $p < 0.01$). Short-time anger-management training and treatment focusing on improving social skills were therapies applied in this study.

A few studies serve as notable exceptions to the notion that psychopathy cannot be treated. Gretton et al. (2001) investigated recidivism rates in psychopathic youths 10 years after completing treatment targeting sexual offending behavior (type of treatment not stated). According to the authors, individuals with high psychopathy scores were characterized with significantly more treatment dropout than youths with low to medium psychopathy scores. However, results demonstrated that among individuals with high psychopathy scores, recidivism rates were almost three times higher in offenders dropping out of treatment, compared to individuals who were in compliance with the program, indicating that the amount of treatment administered may influence the final result. Another study demonstrating the importance of administrational issues in treatment research is Caldwell et al.'s (2006) investigation of recidivism in psychopathic juvenile delinquents. This study indicates that receiving intensive treatment (treatment in special institutions, increased staffing) is more effective (recidivism rates were halved 2 years after treatment completion) than "treatment as usual". Further, a recent review by Salekin et al. (2010) concluded that treatment of adults with psychopathic traits demonstrated low to moderate success (3

out of 8 studies showed a positive effect), whereas treatment of young individuals seemed more promising (6 out of 8 studies showed positive effect). The authors conclude that it would be wrong to maintain the notion that psychopathy cannot be treated. Finally, Chakhssi et al. (2010) demonstrated a lack of significant differences between psychopathic and non-psychopathic violent offenders (n=74) with regard to adaptive social behavior, communications skills, insight, attribution of responsibility, and strategies for self-regulation after treatment. However, the authors report that a subgroup of psychopaths (22 %) developed increased physical aggressiveness, a pattern that was not identified non-psychopathic controls ($p < 0.01$).

Chakhssi et al.'s (2010) study is important as it targets outcome variables other than criminal recidivism. Overall, treatment studies have made an effort to reduce criminal behavior in psychopaths, as "criminal and violent behaviors are clearly the most important outcome *from a social policy perspective*" (Harris & Rice, 2006, in abstract, italics added). Rather than targeting the potential vulnerabilities or problems of the psychopath, treatment programs have focused on preventing harm to others (D'Silva et al., 2004; Salekin, 2002), e.g. through programs teaching empathy and perspective-taking skills (Rice et al., 1992). Avoiding recidivism is a necessary and important approach, but might unintendedly hinder the opportunity to treat psychopathy by selecting a focus that the psychopath does not acclaim or invest any feelings into. The psychopathic offender's *self-centered* and unempathic ways may indicate the presence of strong needs, easily overshadowed by the psychopath's behavior, excluding the psychopath from the empathy other patients elicits from their therapists. From a meta-perspective, assuming the view of the patient and not a social policy perspective, implies that the various conceptualizations of psychopathy (self-centered and unempathic traits as equivalent to strong needs versus genetic

anomalies) may have relevance for treatment responsiveness, and that while a dismantling of psychopathy (e.g. focusing on criminal recidivism) may be important to understand treatment better, it is also important to investigate treatment of psychopathy as a broader construct (Salekin, 2010). In a review of ethical aspects associated with evaluation and treatment of psychopathy, Weinstein, Bath, Ford, Lopez-Leon, and Soloway (2007) underlines that the therapist first and foremost must recognize responsibility to patients, as well as to society, and to other health professionals and to self.

The question of whether psychopathy can be treated arguably depends on factors associated with the psychopathic individual *and* the systems that attend to them. Degree of psychopathy in the patient, the ability to keep a treatment focus, clinicians understanding of the problem, and the willingness of the health-care system to see psychopathy as its concern are important factors in this respect (Gullhaugen, Nørbech, & Teigset, 2011). According to Gunn (1998), the psychopathology of the psychopath is complicated and not fully understood. In therapists, fear, hopelessness, and experiences of being manipulated are common reactions when dealing with these individuals (Strasburger, 2001) who, compared to other lawbreakers, are often threatening and violent, and terminate treatment before it is recommended by the therapist (Forth, Hart & Hare, 1990; Hare et al., 2000; Hare & Jutai, 1983; Hare & McPhearson, 1984; Reid & Gacono, 2000; Salekin, Rogers & Sewell, 1996). However, a logical consequence of the emerging dimensional approach to psychopathy is that if psychopaths are not fundamentally different from most people, then, like most people, psychopaths could be able to change. Rather than questioning *if* psychopathy can be treated, one should ask which therapies might influence the problem of psychopathy?

According to the diagnostic manuals, personality disorder affects the individual's experience of self and others (c.f. the DSM-IV and V; APA, 1994, 1010). By choosing a relational approach, the dominant-hostile characteristics of the psychopath could represent the metaconcepts of *agency* and *community*, or "interpersonal dispositions that communicate concerns about power and status in social hierarchies" and "rejection or avoidance of intimacy" (Wiggins & Trapnell, 1996, in Blackburn, 2006, p. 50). Hence, in the absence of clear-cut signs of (*intra-*) personal distress, focusing on the psychopath's *interpersonal* dispositions could be instrumental in treating psychopathy. According to Richards (1998, p. 88), pathological extremes in self-states (e.g. narcissism) are "modes of experiencing organized around a triad of structural components: (1) problematic primary affects and drives, (2) problematic representations of self and other, and (3) habitual defenses against the catastrophic realization and conscious experience of the painful aspects or consequences of the other two structural components". The dominant self-state determines the perception of and the behavior toward self and environment (Richards, 1998). More specifically, a dominant, aggressive and paranoid self-state will result in temporary self-cohesion, "while undermining the long-term adaptive integration of self and experience" (p. 88). Therapy might circumvent defensiveness and cultivate reflectiveness (Allen, Fonagy, & Bateman, 2008) by addressing factors therapists can influence (e.g. regulation of proximity and affect). The mere observation that psychopaths lack motivation (Seto & Quinsey, 2006) has a pacifying effect.

The 3rd article of the thesis challenges the current emphasis on criminal recidivism in treatment of psychopathy, rather than what therapists usually do: Focusing on the vulnerabilities of the patient.

5 Aims, research questions and hypotheses

In sum, this thesis aims to challenge the current concept, assessment and treatment of psychopathy by opposing central pillars serving the predominant paradigm. More specifically, three research questions, with corresponding hypotheses, are raised:

1. Are psychopathy and suffering mutually exclusive constructs?

Hypotheses: In accordance with object relations theory (St. Claire, 2000), two hypotheses are tested:
[H1] Early interpersonal relations are unstable and insecure.
[H2] Vulnerability and pain can be identified through part-object relations, deviant self- and affect regulation, primitive feelings, and primitive defense.

2. Is the psychopath more than the persistent callous, grandiose and ruthless characteristics that we usually see?

Hypothesis: [H1]Measures targeting a fuller range of interpersonal and affective qualities will demonstrate important nuances in psychopathic functioning.

3. Is the psychopath deprived of a capacity to change?

Hypotheses: In accordance with Wiggins and Trapnell's (1996) metaconcepts of community and agency and Richard's (1998) description of structural affective, relational, and defensive deviances in pathological extreme self-states, two hypotheses are tested:

[H1] The hostile and dominant tendencies of the psychopath correspond to a lack of communion (low parental care) and agency (high parental overprotection/control), indicating areas were the psychopath may be influenced/susceptible to change.

[H2] The pathology of the psychopath is reflected in comorbid affective and relational disorders, and the presence of habitual, pathological defense, indicating areas were psychopaths may be influenced/susceptible to change.

The combination of theoretically driven and explorative approaches validates the specification of separate hierarchical levels of operationalization in terms of aims, research questions, and hypotheses. Aims, research questions, and hypotheses are inserted into a wider philosophical context and examined by qualitative and quantitative methods, for the purpose of achieving a better understanding of the concept, assessment and treatment of psychopathy. As a result, the thesis may contribute both theoretically and empirically to the field, and could provide forensic psychologists and related specialists with information that may be essential in treatment of psychopathy.

6 Method

This section reviews the methods for investigating the hypotheses of the study. A coherent connection between aims, research questions, hypotheses, and the various methods is strived for and explained. The approach of the present study demands a combination of measures outside and inside the dominant paradigm. Current gold standard measures of psychopathy (PCL-R; Hare, 2003, and PCL:SV; Hart et al., 1995) and symptom- and personality pathology (SCID I; First, Spitzer, Gibbon, & Williams, 1997, and SCID II; First, Spitzer, Gibbon & Williams, 1994) were administered to prepare the ground for a comparison with other studies, as well as valid and reliable measures targeting variables that transcends the traditional focus of research in this area. Measures target individuals' experiences and perceptions "here and now". The author's theoretical stance was decisive in the choice of measures.

The methods of the study include both qualitative and quantitative empirical strategies. Assessment was implemented on an individual level to secure necessary and sufficient details in psychopathic functioning, and on a group level, to demonstrate that potential new knowledge about the individual may be generalized to specific samples or populations. Both inductive (the authors own clinical experience; from special to general observations) and deductive (from general observations to specific claims) thinking form a backdrop for the current investigation.

The broad approach of the study yields large amounts of information but may indirectly reduce the sample sizes of the study. However, with fewer variables, important information could be lost. As a consequence, variable selection is strategic and results may not be generalized to the rest of the population.

6.1 Qualitative approach

As there is a shortage of empirical studies offering detailed descriptions of the everyday functioning of the psychopath prior to March 2009, a qualitatively oriented review of published case studies was conducted to identify possible nuances and dynamic factors in offenders with psychopathic traits.

6.2 Quantitative approach

The literature review prepared the ground for a more quantitative approach to investigate whether potential nuances and dynamic factors in psychopathic functioning can be consistently identified on both individual and group levels. This combination of qualitative and quantitative analysis is particularly helpful when research questions cannot be studied in laboratory settings alone.

6.2.1 Study population

From the 2008 male Norwegian high-security prison and detention population (Ringerike, Ila, and Trondheim prisons; n=225), 189 individuals (84 %) met the language requirements of the study (ability to understand, and make themselves understood in Norwegian, verbally and in writing). From these, a conjoint sample of 30 offenders (15.87 %) volunteered to participate in the study. In this initial sample, 18 offenders (60 %) completed all measures, from which 16 individuals were selected on the basis of scoring ≥ 13 (recommended cut-off for possible psychopathy; n=5) or ≥ 18 (strong indication of psychopathy; n=11) on the Psychopathy Checklist: Screening Version (PCL: SV; Hart, Cox & Hare, 1995).

The participants in this study represent a special selection of prisoners. Ringerike prison is a high-security prison counting 160 inmates. Prisoners represent an elevated risk for violence, criminality and escape, and serve long sentences. Ila and Trondheim prisons accommodate the male detention population (n=65). Detention prisoners are judged by court as dangerous in a way that requires more precaution than normal sentencing. These prisoners are possibly facing lifelong incarceration, and subject to investigation and intervention before being considered for release.

In all prisons, individuals refused participation due to insecurities about confidentiality, health issues, language difficulties, and lack of endurance to the task. In Ringerike prison, individuals also refused participation due to strict procedures for physical examination in connection with visitation.

From the 2007/2008 male undergraduate and graduate psychology student populations at The Norwegian University of Science and Technology (n=250), 46 individuals (18.4 %) volunteered to participate in the study. From this initial sample, 35 non-criminal and non-personality disordered (according to the Structured Clinical Interview for DSM-IV Axis I disorders, SCID-I; First et al., 1997) individuals completed all measures (76.1 %) and were included as controls. Table 1 describes demographic and clinical characteristics of offenders scoring ≥ 13 (n=16, mean age=37.57, SD=10.82) and ≥ 18 (n=11, mean age=34.64, SD=12.21) on the PCL:SV, and controls (n=35, mean age=23.34, SD=5.35).

Table 1: Demographic and clinical characteristics (SCID I & II; F90 Hyperkinetic disorder criteria) in offenders scoring in the range of possible psychopathy (PCL:SV ≥ 13, n=16), offenders with strong indications of psychopathy (PCL:SV ≥ 18, n=11) and non-personality disordered controls (n=35).

	PCL:SV ≥ 13		PCL:SV ≥ 18		Controls	
Variable	N	%	N	%	N	%
Norwegian ethnicity	14	87.50	9	81.82	31	88.57
Intimate relationship	8	50.00	6	54.55	9	25.71
Education						
Elementary school	1	6.25	1	9.09	0	0.00
Junior high school	7	43.75	5	45.45	0	0.00
High school	5	31.25	2	18.18	0	0.00
University/college	3	18.75	3	27.27	35	100.00
Psychiatric record	11	68.75	7	63.63	8	22.86
Medication	8	50.00	5	45.45	1	2.86
Diagnoses						
Psychotic problems	0	0.00	0	0.00	0	0.00
Affective problems	9	56.25	6	54.55	8	22.86
Anxiety problems	6	37.50	4	36.36	2	5.71
Somatic problems	1	6.25	1	9.09	0	0.00
Substance abuse	7	43.75	5	45.45	1	2.86
ADHD	5	32.25	2	18.18	0	0.00
Avoidant PD	3	18.75	1	9.09	0	0.00
Dependent PD	1	6.25	1	9.09	0	0.00
Compulsive PD	5	32.25	5	45.45	0	0.00
Paranoid PD	6	37.50	6	54.55	0	0.00
Schizotypal PD	0	0.00	0	0.00	0	0.00
Schizoid PD	0	0.00	0	0.00	0	0.00
Histrionic PD	0	0.00	0	0.00	0	0.00
Narcissistic PD	2	12.50	2	18.18	0	0.00
Borderline PD	4	25.00	4	36.36	0	0.00
Antisocial PD	13	81.25	8	72.73	0	0.00

Individuals included in the study group (n=16; 8 % of the study population) were non-different from non-completers (n=14) in the initial sample (n=30, 15.87 % of the total study population) with regard to ADHD, substance abuse, and Axis I and II disorders.

6.2.2 Measures

Due to the comprehensiveness of the study, the PCL:SV (Hart et al., 1995), and not the PCL-R (Hare, 1991, 2003), was used to assess psychopathy in the Norwegian male detention and high-security population (whereas the studies included in the review applied the PCL-R, with one exception). The PCL:SV is a 12 items checklist found to be empirically and conceptually related to the current golden standard for

measuring psychopathy, the PCL-R (Cooke et al., 1999; Hare, 1996). The PCL:SV is shorter and requires less collateral information than the PCL-R. The PCL:SV was rated retrospectively (cf. Laurell & Dåderman, 2007) on the basis of information from a diagnostic interview and self-report measures. Each of the 12 criteria was scored numerically for its definitive (2) and possible (1) presence, and absence (0). According to the manual, the recommended cut-off score for possible psychopathy is ≥ 13 (this cut-off has for example been used in epidemiological studies; Coid et al., 2009). Scores ≥ 18 are strong indications of psychopathy. An interrater reliability analysis using the Kappa statistic was performed to determine consistency among raters. The interrater reliability between the first author and another clinical psychologist on the different items was found to have substantial to perfect agreement (Cohen's kappa ranged from .770 to 1.00, $p< .000$).

Diagnostic measures

The Structured Clinical Interview for DSM-IV Axis I and II disorders (SCID-I: First et al., 1997; SCID-II: First et al., 1994) are diagnostic interviews measuring symptom- and personality pathology according to the polythetic diagnostic criteria of the DSM-IV (American Psychiatric Association, APA, 1994). Each criterion is scored numerically for its definitive (3) and possible (2) presence, and absence (1). Cut-off scores are in accordance with the diagnostic manuals. Before examining the study sample, inter-rater reliability between the first author and a graduate student in clinical psychology on *SCID I* and *II* was calculated in controls (n=34), with satisfactory result (Cohen's kappa ranged from 0.93 to 1.00, $p< .001$).

The DSM-IV and ICD-10 Personality Questionnaire (DIP-Q; Ottosson, Bodlund, Ekselius, von Knorring, Kullgren, Lindström, & Soderberg, 1995) is a valid

and reliable self-report measure (Ottosson, Bodlund, Ekselius, Grann, von Knorring, Kullgren, Lindström & Söderberg, 1998; Ottosson, Grann & Kullgren, 2000) of DSM-IV and ICD-10 personality disorders. 135 personality disorder items and 11 items measuring subjective distress are scored as present or not, with cut-off scores according to the diagnostic manuals. Additionally, 5 items measure global assessment of functioning. The overall DIP-Q scale was found to be highly reliable (12 items; α = .848). Figure 1 displays correspondence between SCID-II and DIP-Q ratings of psychopathic offenders. Personality disorder symptoms were non-existent in controls.

Attention Deficit Hyperactivity Disorder (ADHD) was rated with the research criteria for F90 Hyperkinetic disorder (WHO, 1993). The F90 criteria assess attention deficit (9 items), hyperactivity (5 items) and impulsivity (4 items), as well as four general criteria. Each item is scored as present or not. Cut-off scores are in accordance with the diagnostic manuals. Before examining the study sample, raters agreed on all ADHD evaluations in controls.

Interpersonal measures

The Inventory of Interpersonal Problems-Circumplex scales (IIP-C, Soldz, Budman, Demby, & Merry, 1995) is a valid and reliable (Monsen, Hagtvet, Havik & Eilertsen, 2006) self-report measure of interpersonal problems. Each of the 64 items is scored according to a 5-points Likert-scale. Subscales are: Vengefulness, callousness, socially avoidance, low self-assertance, easy to exploit, exaggerated care, invading, and dominance. Subscales were computed as the arithmetic mean of all data points contributing to each scale. The overall scale was highly reliable (8 items; α = .886).

Young Schema Questionnaire-Short Form (YSC-SF; Young, 1998) is a valid and reliable (Lee, Taylor & Dunn, 1999; Schmidt, Joiner, Young & Telch, 1995) 75

items self-report measure of early maladaptive schemas, or “broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood, elaborated throughout one's lifetime, and dysfunctional to a significant degree." Subscales are: Emotional deprivation; abandonment/instability; mistrust/abuse; social isolation/alienation; defectiveness/shame; failure; dependence/incompetence; vulnerability to harm or illness; enmeshment/undeveloped self; subjugation; self-sacrifice; emotional inhibition; unrelenting standards/hyper criticalness; entitlement/grandiosity; and insufficient self-control/self-discipline. Each item is scored according to a 6-points Likert-scale. Scores for each schema are found by counting the total number of items within each schema rated either 5 or 6. The YSC-SF overall scale was found to be highly reliable (15 items; α = .924).

The Parental Bonding Instrument (Parker, Tupling & Brown, 1979) is a 25-items questionnaire measuring fundamental parental styles, with the subscales *care* and *overprotection*/*control*. The measure is retrospective in that adults (over 16 years) complete the measure for how they remember their parents during their first 16 years. The measure is to be completed for both mothers and fathers separately. The PBI has been found to have good reliability and validity based on several studies (Black dog institute, n.d.). In the present study, all subscales were found to have acceptable reliability (Cronbach’s α ranged from .786 to .945).

Measures of affect

The Positive and Negative Affect Schedule (PANAS; Watson, Clark & Tellegen, 1988) is a valid and reliable (Crawford & Henry, 2004; Watson et al. 1988) self-report measure of 20 distinct emotions forming a positive and a negative experiences subscale. Emotions are scored according to a 5-points Likert-scale, ”usually” and ”last

week”. Subscales were computed by adding items belonging to each scale. The PANAS negative experience subscales demonstrated high internal consistency (10 items; α = .884 “usually”, and .871 “last week”). The positive experience subscales were equally good (10 items; α = .879 “usually”, and .866 “last week”).

The Emotion Control Questionnaire 2 (ECQ2; Roger & Nesshoever, 1987) is a 56-items valid and reliable (Roger & Najarian, 1989; Roger & Nesshoever, 1987) self-report measure of four subtypes of affective control: Affective rehearsal (degree of pondering over emotional activating events); emotional inhibition (the tendency to suppress expression of emotions); aggression control (inhibition of aggression, independent of general emotional constraints); and benign control. Each item is scored as present or not. Consistent with Roger & Nesshoever (1987) who constructed and validated the ECQ2 scale for measuring emotion control on university students, Cronbach’s alpha for the overall scale was low (4 items; α = .249, and α = .323 in controls), which according to the authors is to be expected in a scale with a multi-dimensional orthogonal (or statistically independent) structure. Unlike Roger and Nesshoever (1987) and Roger and Najarian (1989) who reported satisfactory alpha coefficient for all subscales (in university students), we found that Cronbach’s alphas for the four subscales in offenders were: Affective rehearsal (14 items, α = .835), emotional inhibition (14 items, α = .783), aggression control (14 items, α = .258), and benign control (14 items, α = .335). Alpha levels in controls were .745, .551, .494, and 419, respectively.

Measure of defense

The Defense Style Questionnaire – 40 (DSQ-40; Bond, Gardner, Christian, & Sigal, 1983) is a 40-items questionnaire measuring three principal categories of

psychological defense. *Immature defense* includes acting out, denial, devaluation, displacement, dissociation, autistic fantasy, isolation, passive aggressiveness, projection, rationalization, somatization, and splitting. *Neurotic defense* includes pseudo-altruism, idealization, reaction formation, and undoing. *Mature defense* includes anticipation, humor, suppression, and sublimation. Each item is scored according to at 9-points Likert-scale. The DSQ-40 has been found to have good reliability and validity (Andrews, Singh & Bond, 1993). In the present study the internal reliability of the three subscales ranged from good to poor (immature-, 24 items, $\alpha = .852$; neurotic-, 8 items, $\alpha = .553$; and mature defense, 8 items, $\alpha = .680$).

Translation of measures

To secure the validity of the content of two previously non-translated measures, these instruments were translated from English into Norwegian, and back translated into English. This work was partly undertaken by the author of this thesis, and partly by a professional translating service, the “English-Norwegian Database of Interdisciplinary Translation” (”EDIT”), located at the Department of Modern Foreign Languages at NTNU. The translated measures were the PANAS (Watson et al., 1988) and the ECQ2 (Roger & Nesshoever, 1987). Authors were contacted for permission and permission was granted.

Excluding measures from the thesis

Due to the small sample sizes (n=16, n=35), two measures included in this study’s research protocol, and also administered to all subjects, are not included in the thesis. The excluded measures were four subtests from the Wechsler Adult Intelligence Scale-3 (comprehension, block design, similarities, and matrix reasoning; The

Psychological Corporation, 1997), and the Delis-Kaplan Color-Word Interference Test (Delis, Kaplan, & Kramer, 2001). Measures were originally included as control against potential confounding variables (verbal and perceptual intellectual abilities, and the subject's ability to suppress dominant responses).

6.2.3 Procedures and statistics

Procedure

Prior to the collection of data, all prisoners and relevant staff were given a verbal and written orientation about the study and the methods employed (see Appendix). After having received the information, prisoners were given one week to consider participating in the study, whereas students had the opportunity to register immediately after the presentation. Clinical interview and testing lasted from a little over 1 hour to approximately 5 hours, depending on "the clinical picture" (progression under testing; number of diagnoses, etc.) and how much the individual was able or willing to reveal. Questionnaires estimated to require an effort of about 2 hours were handed out for independent work.

Of importance, interviewers had no access to previous reports of psychopathy or other study variables in the study sample. One of the raters knew the objectives of the study, but not the groupings of the subjects at the time of collecting and rating the data. PCL:SV ratings were based on clinical interview *and* self-report measures, to minimize subjective interpretation and evaluate the correspondence between self-report measures and diagnostic interview (cf. article 2). Study variables (interpersonal and affective measures) were questionnaires, and hence not confounded by the evaluation of raters.

Offenders scoring above the cut-off for possible psychopathy (PCL: SV ≥ 13, range=13-23, n=16) were compared to non-personality disordered and non-criminal controls (n=35) on measures targeting affective and interpersonal functioning. Additionally, a sub-sample of offenders with strong indications of psychopathy (PCL: SV ≥ 18, range=18-23, n=11) was also compared to the above-mentioned controls.

Data analysis

Data analysis was conducted in PASW18. Non-parametric statistics (Independent samples Mann-Whitney U-Test) was used on nominal and ordinal variables. On some variables, possible between groups difference was additionally explored with parametric statistics (Independent-sample t test). Due to the small sample sizes, descriptive statistic was applied to describe patterns in data. Inter-rater reliability was calculated with Cohen's kappa, whereas Cronbach's alpha was computed to control the internal consistency of self-report measures. Correlation was used to describe trends in variables targeting past (last week) and continued (usual) characteristics.

6.3 Ethical considerations

The study was developed in accordance with the profession's standards for ethical practice (the *Meta-code of ethics* from the European Federation of Psychology Associations, 1995, and *Ethical principles for medical research involving human subjects* from the World Medical Association Declaration of Helsinki, 2000), and approved by NTNU's Institutional Board and Mid-Norway's "Regional Committee for Ethics in Medical and Health Research". Of importance, two concrete principles were strived for in the study: A duty to act in the patient's best interest (beneficence),

that is to conduct the study in a way that benefits the patient; A duty not to harm (nonmaleficence), that is an obligation not to inflict harm intentionally or apply procedures with potentially harmful side effects.

In accordance with the two principles, individual results were kept from prison- and university management (minimal risk, confidentiality and anonymity). Importantly, this aspect touches the interface between society's need for protection and the individual's right to privacy and confidentiality with respect to personal needs. Further, prison inmates can be defined as a vulnerable group, and an important premise for the study was to secure that no prisoners (nor students) were obliged to, or coerced into participation (study information handed out in advance of voluntary and informed consent; entitlement to withdraw consent). The overall goal of the study was not further stigmatization but rather to identify information that may contribute to the “humanization” of individuals with psychopathic traits.

Prisoners were informed that one potential benefit from the study was the opportunity to get visitation and to contribute information about personal needs. Information that can contribute to improved conditions for prisoners in the future. Other than this, there was no reward for participating in the study. As a consequence, there was no opportunity for further follow-up or treatment organized by the project, and information that could potentially benefit individual prisoners and the systems that attend to them remained untold. If special circumstances were revealed, one would assist the individual, with his consent, in contacting psychiatric personnel (one individual received the appropriate diagnostic labels, as he planned to seek help for his problems). However, prisoners’ access to psychiatric treatment seemed rather limited (information retrieved from prisoners and available treatment personnel), and the debate about the individual’s right to service is hampered by the lack of treatment

programs with demonstrated effect in individuals with psychopathic traits. When this is said, a more frequent problem is probably the challenge of getting psychopaths into treatment. The current political and clinical climate does not favor compulsory treatment for personality disorders or psychopathy, but have implemented a hybrid: Individuals with severe personality disorders may be sentenced to detention, which gives the possibility of lifetime sentencing. In this system it is imperative to prove that a given person has changed for the individual to be considered for release. The risk of producing false positives and false negatives with regard to treatment outcome constitutes a serious problem. False positives (deciding that the psychopath is cured when he/she is not) represent a problem for the society whereas the risk of generating false negatives (erroneously deciding that the psychopath is not cured) poses a problem for the rights of the individual. There should be a fair balance between the legal rights and needs of the individual and society's right to protection. It is not so much for or against treatment as what should be the focus of treatment. Health professionals probably contribute to the problem by focusing on symptoms, not cause, which makes it difficult to be certain of the type of problem that must be resolved.

"Overarching the many ethics concerns in regard to the evaluation or treatment of individuals with psychopathic personality disorder is the principle of respect for person (Stanford Encyclopedia of Philosophy, 2006)" (in Weinstein et al., 2007, p. 456). Weinstein et al. (2007, p. 445) ask: "How does the setting of the evaluation or treatment affect the resolution of these issues", and further: "How are the conflicts between what may be in the best interest of the patient and the needs of society and the justice process to be reconciled?" The authors place particular emphasis on the importance of competence (that no professionals go beyond their qualifications), the problem of labeling (the negative connotations with the term "psychopath"), the

significance of the patient's trust in confidentiality given the sensitive legal and psychological situations commonly confronted in treating psychopathic patients, and the counter-transference involving psychopathic individuals that can "impact the psychiatric treatment in myriad ways" (p. 452).

7 Results

In this section, results are presented in accordance with, and in the order of the overreaching aims, research questions, and hypotheses of the study.

7.1 1st article: The suffering of the psychopath

In the 1st article, “Looking for the Hannibal behind the Cannibal: Current status of case research”, we asked whether psychopathy and suffering are mutually exclusive constructs? Through the lens of object relations theory (St. Claire, 2000), this article systematically reviewed case descriptions of severely psychopathic offenders (PCL-R ≥ 30) published between 1980 and March 2009 (n=11). Two hypotheses were tested:

H1 Early interpersonal relations are unstable and insecure.

H2 Vulnerability and pain can be identified through part-object relations, deviant self- and affect regulation, primitive feelings, and primitive defense.

Results demonstrated early experiences of instability, neglect, and/or abuse in offenders’ family of origin. All cases demonstrated part–object relations, in that the offenders ruthlessly used other individuals to satisfy their needs. The interpersonal relationships of the psychopaths were further characterized as unstable and intense (studies 1, 3, 5, 6, 7, 8, 9, and 11). As regards self- and affect regulation, case descriptions included individuals who are always on edge (studies 5 and 9), with intense mood swings (studies 2, 4, 5, 9, 10, and 11), a deficiency in the ability to set or maintain long-term goals (study 3), and recurrent self-mutilation, suicidal, and impulsive behavior acted out while experiencing intense feelings (studies 6, 2, 9, and 10). Several offenders were characterized with primitive feelings such as anxiety,

sadism, and especially rage (studies 1, 3, 4, 8, 9, 10, and 11), and some reportedly relied on the primitive mechanisms of splitting, projection, dissociation, and denial as psychological defense (studies 4, 5, and 8). Oddities of thoughts, cognitive and perceptual distortion, identity disturbance, and poor reality testing under stress were also reported (studies 4, 5, 8, 9, 10, and 11).

Indications of psychological pain in severely psychopathic offenders were evident in offenders' *self-report* of auditory hallucinations; mood swings and tension which were relieved by acting out; a desire to exact revenge for the pain endured throughout life; derealization; powerful feelings of isolation; "edginess" and anger; depression and suicidal thoughts and plans: perceptions of being unfairly treated; a tendency to compare oneself negatively to others; and uncomfortableness with care. *Authors* of the reviewed articles reported frantic efforts to avoid real or imagined abandonment; feelings of emptiness and longings for love; dysphoria; fear; self-mutilation; abnormally undervalued sense of self, seeing persecution and abandonment where there is none; unstable and intense interpersonal relations; intense mood swings; recurrent suicidal behavior; identity disturbance with unstable self-image; reality-testing deficits; a tendency toward both isolation and dependency on others; defensiveness against own affect; and a deeply felt sense of being injured and damaged in severely psychopathic offenders.

The diagnostic profiles of the reviewed offenders demonstrated ego dystonic and ego syntonic problems that can be conceptualized as mental disorders according to the diagnostic manuals. All but one offender (study 7) were diagnosed with symptom- and/or character disorders according to the diagnostic manuals. The majority of the offenders were diagnosed with a substance and/or drug disorder (studies 1, 3, 5, 8, 10, and 11), and some with comorbid personality disorders (studies

2, 4, 5, and 10). Three offenders were diagnosed with symptom disorders, including diagnosable anxiety, depression, and schizophreniform disorder (studies 2, 5, and 9).

7.2 2nd article: Interpersonal and affective nuances

In the second article, "Under the surface: The Dynamic Interpersonal and Affective World of Psychopathic High-Security and Detention Prisoners", we asked whether psychopathy is adequately measured or described by the current standard measures (is the psychopath more than the persistent callous, grandiose and ruthless characteristics that we usually see)? By administering measures targeting a wide range of interpersonal and affective qualities, one hypothesis was tested in moderate and severely psychopathic (PCL:SV ≥ 13 and 18) high-security and detention prisoners (N=16) and non-personality disordered controls (n=35):

H1 Measures targeting a fuller range of interpersonal and affective qualities will demonstrate important nuances in psychopathic functioning.

Results confirmed the established grandiose, dominant and callous characteristics of the psychopath (traditional measures), while simultaneously demonstrating nuances in psychopathic offenders' appreciation of self and other, feelings and defense (non-traditional measures in the psychopathy population). Scores on the YSQ-SF (Young, 1998) revealed that offenders scoring in the range of possible *and* strong indications of psychopathy were significantly more disconnected and rejected (emotional deprivation; mistrust/abuse; social alienation/isolation; defectiveness/shame), had more impaired autonomy and performance (dependence/incompetence; vulnerability to harm/illness; enmeshment/undeveloped self), overvigilance and inhibition (emotional inhibition), and impaired limits (entitlement/grandiosity) than non-

personality disordered and non-criminal controls. Offenders scoring ≥ 13 on the PCL:SV scored significantly higher than offenders with strong indications of psychopathy on abandonment and failure, whereas offenders scoring ≥ 18 were characterized with more subjugation of needs and insufficient self-control.

Results further revealed that offenders scoring in the range of possible and strong indications of psychopathy reported significantly higher levels of usual negative feelings, hostility, irritability and shame (PANAS; Watson et al., 1988) than non-personality disordered and non-criminal controls. However, with most positive and negative emotions, no significant differences existed between the offenders and controls. Compared to controls, offenders scoring ≥ 13 on the PCL:SV were characterized with significantly more negative emotions last week, feeling upset, and being interested usually, than offenders scoring ≥ 18 on the PCL:SV. Offenders with strong indications of psychopathy scored significantly higher on being "in need" usually, general positive emotions, and being interested, enthusiastic and alert last week. Offenders scoring in the range of possible and strong indications of psychopathy experienced about the same amount of negative emotions over time (usually/last week; $r = .597$, $p = .05$, 2-tailed). A correlation of the subscales positive feelings usually and last week was non-significant, indicating variance in positive emotions. Finally, offenders scoring ≥ 13 on the PCL:SV were characterized with rumination as a strategy for emotional control.

7.3 3rd article: Paradoxes and dilemmas

In the 3rd article, "Treatment of psychopathy? Testing theoretical models for the purpose of future forensic practice", we asked whether the psychopath is deprived of

a capacity to change? Wiggins and Trapnell's (1996) metaconcepts of community and agency and Richard's (1998) description of structural affective, relational, and defensive deviances in pathological extreme self-states were tested in psychopathic high-security and detention prisoners (n= 16) and controls (n=35), for the purpose of identifying areas were psychopaths might be susceptible to change. Two hypotheses were tested:

H1 The hostile and dominant tendencies of the psychopath correspond to a lack of communion (low parental care) and agency (high parental overprotection/control), indicating areas were the psychopath may be influenced/susceptible to change.

H2 The pathology of the psychopath is reflected in comorbid affective and relational disorders, and the presence of habitual, pathological defense, indicating areas were psychopaths may be susceptible to change.

Results can be categorized according to Wiggins and Trapnell's (1996) metaconcepts of community and agency in that scores on the PBI (Parker et al., 1979) revealed a tendency towards parental *overprotection* or *control* in the parents of offenders scoring in the range of possible and strong indications of psychopathy. Additionally, offenders scoring ≥ 13 on the PCL:SV report less *care* from fathers, when compared to controls. Scores on the PBI (Parker et al., 1979) further revealed attachment patterns characterized with neglect (low care/low protection; 7 fathers, 2 mothers) and affectionless control (high protection/low care; 6 mothers, 2 fathers) in 53.13 % of the study's parental population. A parental style of affectionate constraint (high care/high protection) was reported in 3 mothers and 2 fathers (15.62 %), whereas 3 fathers (APD and PCL:SV = 14, 18 and 20 in offenders) and 4 mothers (APD and PCL:SV = 14, 16, 16, 18 in offenders) were reported as having exercised optimal parenting (high

care/low overprotection; 21.87 %). Scores were missing for 2 fathers and 1 mother (9.38 %).

In accordance with Richard's (1998) description of structural affective, relational, and defensive deviances in pathological extreme self-states, results further demonstrate mood (unipolar depression; bipolar II), anxiety (panic; social phobia; specific phobia; agoraphobia; obsessive-compulsive, and posttraumatic stress-), and somatoform (somatization; pain-) disorders in half of the initial sample (scoring in the range of possible *and* strong indications of psychopathy), and high prevalence of personality disorders (mainly cluster B, but also compulsive, avoidant, dependent, and paranoid personality disorders) and primitive defense (DSQ-40; Bond et al., 1983). A clinical paradox was identified in offenders reporting optimal psychological functioning *in relation to the current diagnostic system* (two of these offenders reported a depressive reaction as a response to incarceration only), *and* psychological, physical and/or social stressors with adverse effect (DIP-Q GAF and Difficulties/impact scales; Ottosson et al., 1995). Inadequate bonding and primitive defense also signalized high levels of stress in these offenders. In the last half (n=8) of the initial sample (n=16), symptom disorders were frequent and GAF scores in accordance with the observed symptoms and scores on the Difficulties/impact scale.

8 Discussion of main results

In the following text the main findings of the study will be discussed with regard to pertinent research, potential implications for the current concept, measurement and treatment of psychopathy, and according to a scientific-philosophical framework of understanding. The general discussion of the thesis ends with an evaluation of the qualities of the study.

8.1 Main findings

The different works of the present thesis point in the same direction by challenging the main premises of the current understanding of psychopathy, maintaining that:

1. Psychopaths do not suffer (the concept of psychopathy)
2. Psychopaths are one-dimensional characters (the assessment of psychopathy)
3. Psychopaths are unable to change (the treatment of psychopathy)

The 1st article of the thesis systematically reviews case descriptions of severely psychopathic offenders published between 1980 and March 2009. In contrast to the prevalent opinion, case material (n=11) demonstrates that severely psychopathic offenders do suffer psychological pain. *The 2nd article* yields an in-depth examination of the interpersonal and affective world of high-security and detention prisoners with possible and strong indications of psychopathy (n=16) and controls (n=35). Results demonstrate important nuances and variations in psychopathic offenders' interpersonal and affective functioning. *The 3rd article* tests Wiggins and Trapnell's (1996) metaconcepts of community and agency and Richard's (1998) description of structural affective, relational, and defensive deviances in pathological extreme self-

states in high-security and detention prisoners with possible and strong indications of psychopathy (n=16) and controls (n=35). Results indicate a link between empirical findings and clinical theories, providing the forensic psychologist and related specialists with material that may be essential in treatment of psychopathy.

8.2 Similarities and differences with previous research

The suffering of the psychopath

The present thesis challenges the current concept of psychopathy as a mental disorder resting on the psychopath's indifference and harm towards others, rather than any difficulties experienced by the psychopath him/herself (Cleckley, 1941; WHO, 1994).

The results of the present thesis demonstrate self- and author (of the reviewed articles) reported psychological suffering; vulnerability and pain according to the hallmarks of object relations theory; Martens (2002) and Reid's (1986) clinical experiences of sadness and pain in psychopathy; and the personal distress defined by observations of comorbid symptom- and personality pathology. Results are further in accordance with empirical studies demonstrating primitive object relations (Gacono, Meloy, & Berg, 1992); regulatory deficits; primitive affect (Meloy & Gacono, 1998); and primitive defense (Gacono, 1990; Gacono & Meloy, 1992; Meloy, 2002) in severely psychopathic offenders. The author of the present thesis was not able to identify any other studies with the explicit intent of reviewing or searching for observations of suffering, vulnerability or pain in psychopathic offenders.

Results are incongruent with Cleckley's (1941; 1988) recognized description of general poverty in major affective reactions and empirical studies demonstrating lack of anxiety (Newman et al. 2005), callous lack of emotion (Stanford, Houston, & Barrat, 2007), and the absence of comorbid symptom disorders (cf. Blair et al., 2005)

in psychopathic offenders. Results further challenge the well-established primary versus secondary psychopathy distinction (Karpman, 1941; in Poythress & Skeem, 2006) by demonstrating similar symptom- and personality pathology, as well as other variants of personal distress or psychological suffering, vulnerability and pain, in offenders with low *and* high levels of psychopathy.

Interpersonal and affective nuances

The present thesis challenges the prevailing focus on a limited and undesirable set of characteristics (callous and detached traits: Cleckley, 1941; WHO, 1994) in current assessment of psychopathy, rather than examining the potential full range of an individual's interpersonal and affective dispositions. The results of the present thesis confirm the callous, grandiose and dominant characteristics of the psychopathic offender, consistent with the contemporary concept and measures of psychopathy. Comorbid personality disorder ratings were comparable to results reported in other studies (Decuyper et al., 2008; Hildebrand & de Ruiter, 2004). However, the academic or conceptual implications of parallel observations of psychopathy and comorbid personality disorder have perhaps not been thoroughly discussed. The DSM-IV (APA, 1994) and the ICD-10 (WHO, 1994) specific criteria for most personality disorders describe various types of *personal distress* (e.g. "excessive efforts to avoid abandonment", "persistent and pervasive feelings of tension and apprehension"). Psychopaths' lack of the kind of personal distress that typically drives treatment engagement (Galietta, Fineran, Fava, & Rosenfeld, 2010) has been a hallmark in clinical descriptions of psychopathy (cf. Cleckley, 1941). If psychopaths can be diagnosed with comorbid personality disorders normally associated with personal distress (e.g. avoidant, paranoid and emotionally unstable traits), then we can

conclude that unless the investigation is flawed, the psychological functioning of the psychopath is not purely shallow or cold.

The results of the present thesis further demonstrate the occurrence of positive and negative emotions, diagnosable affective- and anxiety disorders, affective rehearsal strategies, and various concerns with regard to the appraisal of self and other (mistrust, defectiveness, shame, dependency, incompetence, vulnerability to harm, and subjugation of needs), challenging the traditional portrayal of the psychopath and Cleckley's (1941; 1988) descriptions of the psychopath's general poverty in major affective reactions. Results are in accordance with recent studies demonstrating poor emotional modulation and low attachment capacity in male prison inmates scoring above the cut-off for severe psychopathy (Young, Justice, & Edberg, 2010; Franks, Sreenivasan, Spray, & Kirkish, 2009). Results are thus in agreement with the deviant self- and affect regulation accompanying pathologically developed "object relations" or "internal working models" described in object relations (St. Claire, 2000) and attachment theory (Arrigo & Griffin, 2004). Results are both inconsistent and consistent with research applying the five-factor model of personality (McCrae & Costa, 2008) to psychopathy, finding that psychopaths are less agreeable, conscientious, anxious, depressed, vulnerable and warm, and with more assertiveness, angry hostility and impulsiveness than most people (Decuyper et al., 2008). Results are in accordance with Coid & Ullrich's (2010) reports of similar demography, Axis I comorbidity, and treatment-seeking behavior in subgroups of prisoners with APD above and below the cut-off for psychopathy. Also, on some variables in the present study (e.g. "guilt", "subjugation of needs", and "being in need usually"), offenders with strong indications of psychopathy scored *higher* than the sample including individuals scoring in the range of possible psychopathy, challenging the concept of

primary versus secondary psychopathy (Karpman, 1941; in Poythress & Skeem, 2006). However, results also support the concept of primary and secondary psychopathy, as offenders scoring ≥ 13 on the PCL:SV confessed to significantly more feelings of being abandoned, upset and a failure, and rumination as a means for affective control, than offenders scoring in the range of strong indications of psychopathy. Finally, results tangent the dimensional model of self- and interpersonal functioning advised in APA's (2010) proposed revision of personality diagnoses.

Paradoxes and dilemmas

The present thesis challenges the long-held belief that psychopaths are unable to change (Cleckley, 1988; Hare, 1991; Harris & Rice, 2006) and the concurrent focus on the psychopath's lack of motivation and reduction of criminal recidivism, rather than testing clinical theories to identify areas were psychopaths might be susceptible to change. Results tangent Wiggins and Trapnell's (1996) metaconcepts of community and agency with regard to the high rate of offenders having experienced the effects of inadequate parenting (specifically rejection or avoidance of intimacy and lack of power and status in social hierarchies), and research demonstrating early experiences of neglect and abuse in moderate and severely psychopathic male and female offenders (Frodi, Dernevik, Sepa, Philipson, & Bragesjö, 2001; Gao et al., 2010; Shipley, 2002; Taylor, 1998; also cf. the first article of this thesis). The observed variation in the number of individuals reporting deficient or insufficient parenting in the first and third article of the thesis may reflect a lack of comparative information (e.g. from therapists, relatives and criminal records) with regard to offenders' background in the third article, rather than a non-problematic childhood.

Results further challenge the primary-secondary psychopathy distinction of the current paradigm (Karpman, 1948; Cleckley, 1988; Lykken, 1995; Mealey, 1995; Newman et al., 2005) by indicating a connection between early aversive experiences and high scores on the behavioral, affective, and interpersonal dimensions characterizing severe or primary psychopathy. Results are in accordance with the hallmarks of developmental psychology, describing how the child is molded by consecutive psychosocial *dilemmas* through its interaction with caregivers. The individual develops basic trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, and industry versus inferiority (Erikson, 1968, 1974, in Carver & Scheier, 2000. Hence, paranoid (mistrust), shallow (lack of autonomy) and ruthless (initiative, no guilt) traits correspond theoretically with experiences of an uncaring and controlling environment (also, offenders scoring above possible and strong indications of psychopathy admitted to experience feelings of *shame;* cf. Article 2).

Results further demonstrated that about 50 % of the offenders scoring in the range of possible *and* strong indications of psychopathy were diagnosed with affective- and anxiety problems, high levels of personality disorders, inadequate bonding, and elevated levels of immature defense. This is in accordance with Richard's (1998) description of structural affective, relational, and defensive deviances in pathological extreme self-states. In these individuals, GAF scores were in accordance with the observed symptoms and scores on the Difficulties/impact scale. Observations of ego dystonic conditions in severely or prototypical psychopathic offenders challenges the primary-secondary psychopathy distinction of the current paradigm, indicating the advantage of a dimensional rather than a categorical understanding of psychopathy. A *clinical paradox* was identified in offenders reporting optimal psychological functioning (and lack of formal diagnoses)

and psychological, physical and/or social stressors with negative personal effect. Inadequate bonding and primitive defense also signalized high levels of stress in these offenders. Lack of formal diagnoses and giving the impression that one is doing well is in accordance with conventional portrayals of the psychopath (Cleckley, 1941; Galietta et al., 2010), based on conventional measures, whereas the simultaneous presence of observations of optimal psychological functioning *and* psychological, physical and/or social stressors with negative personal effect is previously unreported.

8.3 Implications

There is a need to question today's concept, assessment and treatment of psychopathy

The included cases form a heterogeneous group, but share similar characteristics with regard to the observed relational vulnerabilities (unstable and intense self-other relations), (primitive) emotions and defense. The current concept of psychopathy emphasizes *some* of the psychopaths' interpersonal and affective qualities (the callous-unemotional and ruthless traits), but fails to integrate other aspects of the self-other dimension (relational insecurity and attachment-oriented behavior), the suffering, and normal qualities of the psychopath, thus providing an incomplete picture of psychopathic individuals. What this thesis adds to the field is a solid contribution to further debate about the validity of today's concept of psychopathy.

In this context it should be noted that the work group behind APA's (2010) proposed DSM-V revision has recommended a significant reformulation of the *assessment* and *diagnosis* of personality psychopathology, including measures of the severity of disturbances in self and interpersonal functioning. APA (2010, webpage) describes *impairments in self-functioning* according to dimensions of:

1) Identity; the “experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience”, and:
2) Self-directedness; the “pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively”.

Interpersonal impairments affect an individual’s capacities for:

1) Empathy; the “comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding of the effects of own behavior on others”), and:
2) Intimacy; the “depth and duration of positive connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior”.

According to APA (2010, webpage), observations of impairment in self- and interpersonal functioning are “consistent with multiple theories of personality disorder and their research bases, including cognitive/behavioral, interpersonal, psychodynamic, attachment, developmental, social cognitive, and evolutionary theories, and to be key aspects of personality pathology in need of clinical attention (Clarkin & Huprich, 2011; Pincus, 2011)”.

A beginning consensus on fundamentals may influence related disciplines (law, social services and the penal system), and may eventually lead to more effective treatment strategies. APA’s new emphasis on dimensions of identity and self-direction and individual capacities for intimacy and empathy are consistent with the interpersonal and affective pathology revealed in the offenders included in the present

thesis, and supports this thesis' conclusion regarding the future *clinical* concept (as opposed to biological and social approaches) and assessment of psychopathy.

The in-depth examination of the cases included in the present thesis reveals a greater range of interpersonal and affective difficulties than can be derived from standard psychopathy measures alone, indicating a need for a more comprehensive assessment of psychopathy. What this thesis adds to the field is a basis for questioning the usefulness of current gold-standard measures of psychopathy. Repeated findings with similar results should inspire a discussion about the validity of the current measures. The CAPP-IRS (Cooke et al., 2008) marks a further development of the categorical "Hare psychopath" and the PCL-R (Hare, 1991, 2003) and holds significant clinical utility as regards identifying the presence and degree of personality psychopathology. However, and despite its dimensional nature, CAPP-IRS items do not incorporate the full range of the psychopath's potential interpersonal and affective qualities, as presented in this thesis. Hence, a more throughout assessment is recommended before proceeding with individual treatment.

The included cases reveal paradoxes, inconsistencies and dilemmas in the psychopath's pathology (detachment versus attachments efforts; callousness versus emotions and defense; GAF=100 versus symptom- and character diagnoses) and psychiatric symptoms consistent with clinical theory (St. Claire, 2000; Richard, 1998; Wiggins & Trapnell, 1996), indicating areas where psychopaths can be influenced to change. Historically, treatment of psychopathy has focused on making the psychopath aware of the needs of others. What this thesis adds to the field is a link between empirical findings and clinical theories, providing the forensic psychologist and related specialists with information about the vulnerabilities of the psychopath. This would lead us away from "demonology" towards working with more clinical entities.

Besides working with factors outside individual therapy (the political climate; clinicians understanding of the disorder; aspects with regard to security and housing), a general rule would be that the “degree of antisocial tendencies and the quality of object relations determine the prognosis for any psychotherapeutic treatment” (Kernberg, 1984, 2004, p. 131). Kernberg (2004) states that one must interpret the persistent *deceptiveness* of the patient that usually leads to the unmasking of a psychopathic transference (the patient’s basic assumption that the treatment consists of mutual manipulation and exploitation of the two persons in the relationship). Following Kernberg, the transference implications of such a fantasy enactment should be fully elaborated and worked through to transform psychopathic into paranoid transferences, which may then be explored in more leisurely fashion.

What are the findings telling us about the situation today?

The results of the present thesis indicate that current and past attitudes towards aspects of psychopathy appear inadequate, and may have contributed to the observed stagnation with regard to treatment. The concept of psychopathy is still very much a moral diagnosis, and not a real clinical concept, by its current implementation under predominantly behavioral-focused diagnostic categories, explaining at least parts of the difficulties with treating the disorder. Theoretically, high levels of psychopathology, as in severe psychopathy, correspond to high and not low levels of personal distress, difficulties or suffering, indicating that the psychopath should be included in treatment, and not excluded as he or she often is today.

The present thesis indicates that the problems of the psychopath are personality based and that the individual’s difficulty with self and other (identity and self-direction; capacity for intimacy and empathy; APA, 2010) is accompanied with

suffering, and is developed, at least partly, from experiences in early attachment relationships. The question of whether psychopathy can be treated or not has a long history characterized with strong opposites (Salekin et al., 2010). Examining the history of psychotherapy in general may help put in context current views on the psychopathy-treatment relation (Salekin et al., 2010), as new research and clinical practice have proved its effect in a number of areas. However, to be effective, treatment programs will have to take into account the full nature of the psychopathic offender (Hare, 2007), beyond the current focus on callous and ruthless traits.

What are the findings telling us about "reality"?

Results indicate that severely psychopathic offenders endure personal afflictions and inclinations similar to their less psychopathic counterparts and individuals in the normal- and other patient populations. The observation of different measurement levels, or finding psychological correlates to psychopathic behavior, is consistent with the clinical hypothesis by Reid (1986), and opens up for discussion of what kind of problem psychopathy really is.

Results indicate that behind dissocial behaviors and callous traits lay affective experiences and expectations about self and other that seem to interfere with the maintenance of an individual's personal and professional relationships. On the surface, psychopathy is a social problem that fills our prisons. Beneath the surface, psychopathy may be the struggle to find a place in the world. Therapists must be close enough to touch but far enough to think to be able to relate to these extremes.

The results of the present thesis indicate that the traditional concept of psychopathy does not measure up by demonstrating new characteristics (suffering, and nuances in affective and interpersonal functioning) consistent with a dimensional

latent structure, and that future research should investigate its aetiology. In 2004, Marcus et al. argued that a dimensional approach does not call into question either the ontological status of the concept or its efficacy for predicting violent and criminal behavior, but that such findings have clear implications for the assessment and study of psychopathy, and for the manner in which clinicians and researchers communicate with the general public and the legal system when discussing psychopathy. Specifically, if psychopathy is dimensional it seems unlikely that it can be attributable to a single underlying deficit, and there is little theoretical justification for extreme group designs as psychopathy might be most fruitfully investigated as a continuous measure (Marcus et al., 2004). This may result in less stigmatization of those affected.

As far as this author is concerned, the best alternative is not to reject the concept, but a redefinition or reformulation according to newfound clinical variables. Attempts at redefining psychopathy would have to include a discussion of the concept according to observations of comorbid disorders/whether the concept qualifies as a separate condition, and the suitability of a medical versus a psychological tradition or approach (number of symptoms versus experienced problems).

8.4 Psychopathy, and the philosophy of science

Through the years, various transitions and philosophical and scientific perspectives has influenced and contributed to changes in the nomenclature, meaning, degree of social condemnation, and the prognosis of psychopathy (Arrigo & Shipley, 2001). This multidisciplinary approach has made it difficult to develop a consensus on fundamentals, this consensus being a hallmark of science (Duggan, 2008). Nevertheless, the dominant paradigm of the last decades has been a cognitive neuroscience perspective (Hare, 2006), in which psychopathy is constructed as a

neurodevelopmental disorder of genetic origin (Blair, 2003). Inside this paradigm, studies have demonstrated that genetic factors account for at least half of the variance in personality development, and environmental influences are considered limited (Woods, 2010). An important concept within the current paradigm is the primary-secondary psychopathy distinction in which *primary psychopathy* represents the disorder in it's purest form, based on a genetic/biological predisposition (Karpman, 1941, in Poythress & Skeem, 2006), categorically different from the comparable, but milder version that is *secondary psychopath*.

In keeping with the principles or mindset of the current paradigm, neuroscientific research into mental health has commended generous funding; suggesting neuroscience is understood by a variety of actors and institutions as having significant potential to enhance therapeutic practice (Pickersgill, 2011). Pickersgill (2011) advocates that the large material and symbolic investments in neuroscience should, perhaps, be reflected upon more critically (but also that analytic approaches must keep in mind it's at times surprising commitment to the realms of the social and the psychological), which is the purpose of the present thesis.

The title "Redefining psychopathy? Is there a need for a reformulation of the concept, assessment and treatment of psychopathic traits?" invites a discussion of whether the way we approach psychopathy is changing or should be changed, and if central changes in the concept, assessment, and treatment of psychopathy would result in a paradigm entirely different from how we understand psychopathy today? Past and present uncertainties about the concept of psychopathy have brought about a high production of papers, while researchers have tended to withdraw from real, human contact with the psychopath (Seabrook, 2008). The current zeitgeist seems to encourage meticulous research with a "biological and experimental touch", rather

than asking the big questions. Latour (1987, in Table of contents) put this condition into words by illustrating how doubts about a given problem can result in a sense of immersion in details ("when controversies flare up the literature becomes technical").

The current state may also be described through the eyes of Thomas Kuhn. In 1962, Kuhn wrote "The structure of scientific revolutions", an analysis of the history of science. Kuhn was interested in which ideas, options and strategies were available to people at a particular time (Kuhn, 2002), and argued that scientific progress does not emerge from straightforward accumulation of facts, but rather when the current understanding fails to incorporate new observations. According to Kuhn (2002), the majority of the scientific community will oppose any conceptual change, but once a challenging paradigm is solidified, a paradigm shift will have occurred.

However, a paradigm is also influence by factors outside the scientific realm. According to Kuhn (2002), on the surface, science is a witness of method, structure, and continuous knowledge transfer, but science is also largely influenced by social and non-rational factors such as coincidences, mistakes, superstitions and myths. As previously outlined, the concept of psychopathy is a household word, a disorder, a legal term, and a word of abuse. Further, psychopaths tend to strongly influence their surroundings, and can evoke a sense of fear, hopelessness, and experiences of being manipulated in therapists (Strasburger, 2001). Finally, because treatment of individuals with dangerous and severe personality disorder is an interpersonal extreme situation, it increases the risk of acting-out in both patients and the therapists (Gullhaugen, Nørbech, & Teigset, 2011), which in therapists may result in thinking about psychopathy as an inherent or untreatable disease. Because of the above-mentioned and possibly other factors, innovative or alternative thinking outside the current paradigm is often met with loud, and not always fair criticism.

In 1963, Popper wrote that the most interesting research comes from hypotheses that challenge what we believe today. More than 30 years later, Isabelle Stengers argued that each time in the name of science, a person ensures that specific interests, requirements, and questions that could have discussed a proposed relevance is silenced, we are facing a double circuit (Stengers, 1999): A short circuit of democratic demands, and a short circuit of the risk-taking that gives knowledge its reliability (p. 70). As a consequence, it is of utmost importance that we seek to challenge all aspects of the concept, assessment, and treatment of psychopathy.

It can be argued that APA's (2010) revision of the diagnostic criteria for personality disorders mark the official beginning of a dimensional rather than a categorical understanding of personality pathology. The initiation of a dimensional approach (e.g. as indicated by the development of the CAPP-IRS) challenges the well-established primary-secondary distinction, indicating that some of the ideas of the prevailing paradigm are incorrect. The results of the present thesis go beyond, and are in agreement with this.

The existing disagreements in understanding psychopathy are at least partly due to differences in the various approaches to the problem. Biological research must be integrated with studies focusing on psychological process and social aspects to achieve a future consensus on fundamentals, this consensus being a hallmark of science. A few studies are already doing this (cf. APA, 2010).

8.5 Strengths and limitations

The strengths of the present study

Following Popper (1963), the present study has a courageous aim to challenge the leading principles of the current paradigm. This pioneering effort is accomplished by

using well-known clinical measures often applied in other patient populations, to investigate clinical characteristics beyond the established measurement of psychopathy. To control for potential pitfalls with relying on self-report and interview measures only, self-report data was compared to information derived from a diagnostic interview. Further, the scoring of the PCL:SV on the basis of diagnostic interview and self-report data is, as far as this author knows, a new approach to administering the PCL:SV, but follows in the tradition of exploring new ways to collect PCL-data (Laurell & Dåderman, 2007).

For ethical reasons, the potentially impulsive offenders were given one week to consider contributing in the study, after receiving written and oral information. This was done to ensure that all subjects had the time to reflect upon various aspects in connection with participating in the study. The author is not aware of any other study applying a similar time limit, which may in part explain the limited participation. Further, with a narrower study scope, samples sizes would probably have been higher, but then important information would be lost.

Despite the small number of participants, the broad approach of the study (several time-consuming measures) secures a nuanced portrayal of individuals that are most often described according to their most salient traits. Also, the initial design was constructed to control for more variables (verbal and perceptual intellectual abilities and the subject's ability to suppress dominant responses) than what was actually achievable because of the low sample sizes. However, the observed agreement between clinical theory and empirically demonstrated features of psychopathy strengthens the results of the present study. Results were also generally consistent for subjects with possible and strong indications of psychopathy, indicating common qualities in psychopathy and comorbid disorders of the personality. Finally, the link

between clinical theories and empirically demonstrated features of psychopathy informs the therapist about potential areas or mechanisms for change.

Limitations

The small sample sizes complicate generalization and are apparent limitations to the present study. Larger samples could have equated or reduced the data, and identified patterns not visible in small samples. Further, the study sample consists of incarcerated psychopathic offenders, which means that results cannot necessarily be generalized to other samples (e.g. non-incarcerated or "successful", and non-criminal psychopaths). Hence, the study sample might only be representative of "disadvantaged groups". Most of the research on psychopathy has, however, focused on this particular group.

Applying university students as controls is common and is sometimes referred to as a "convenience sample". A comparison of psychopathic offenders with non-psychopathic personality- or symptom-disordered controls could have provided additional information about the concept of psychopathy in contrast to symptom- and personality pathology in general. Likewise, a comparison with non-psychopathic offenders will be necessary to control for offender-related features. As a consequence, results are preliminary and need to be compared with further research.

Another potential limitation of the study is the possibility that offenders fake responses for the thrill of it, or to be portrayed in a more flattering, or even worse way. The present study did not include a "lie" scale, but different instruments measuring aspects of the same concept were correlated, ruling out the possibility of random response sets. Responses were further coherent and systematic. Further, subjects were informed that the correctional system would not receive any

information regarding participating offenders' psychological health (as far as no danger to life or health existed; no cases), securing that respondents had little to lose from giving an honest response. Results were further in agreement with earlier reports of object relation's deficits in psychopathic offenders (Brody & Rosenfeld, 2002; Gacono, Meloy & Berg, 1992), which the subjects cannot possibly be aware of.

The less rigorous PCL:SV measure was preferred over the full PCL-R in two of the studies of the present thesis, at the expense of collateral information and a complete criminal record. Subjects were, however, detention- and high-security prisoners, which guarantees the presence of severely dissocial behavior. The PCL:SV was initially preferred due to expectations about considerably larger samples, as well as the administration of several time-consuming tests/measures. A collection of relevant collateral information would have strengthened the study, e.g. by gauging the accuracy of the offender's reports of early relationships. However, the results of the present study portray subjects' *mental representations* of early attachment relationships, which may serve as independent treatment targets.

Measures were reliable except for the low α levels of two DSQ-40 (Bond et al., 1983) subscales and ECQ2's (Roger & Nesshoever, 1987) aggression control and benign control subscales, which could be a result of the low sample sizes or highly antisocial sample, as high alpha levels are reported elsewhere (Andrews et al., 1993; Roger & Nesshoever, 1987; Roger & Najarian, 1989).

9 Conclusion, implications and further work

The present thesis: “Redefining psychopathy? Is there a need for a reformulation of the concept, assessment and treatment of psychopathic traits?” questions whether the way we approach psychopathy is changing, or should be changed, and if central changes in the concept and the assessment of psychopathy will represent the start of a paradigm shift and change the way we look at psychopathy today?

9.1 Main conclusions and possible implications

The results of the present thesis are preliminary, given the small sample sizes and lack of “perfect controls”. Nevertheless, certain insights are gained through the studies of the present thesis:

Psychopathy and suffering are mutually inclusive *constructs*

Preliminary results demonstrate self- and author (of the reviewed articles) reported psychological suffering; vulnerability and pain according to the hallmarks of object relations theory; support the clinical experiences of sadness and pain in psychopaths by Martens (2002) and Reid (1986); and personal distress according to comorbid symptom- and personality disorders in psychopathic offenders. If replicated in larger samples, results implies a need for a reformulation of the concept of psychopathy.

Psychopathy is more than the persistent callous, grandiose and ruthless characteristics that we usually see

Preliminary results support, expand, and challenge the ordinary portrayal of the psychopath by confirming the established callous, grandiose and dominant

characteristics, by adding construct validity to the PCL from a psychodynamic point of view, and by demonstrating personal distress and affective and interpersonal dynamics and dilemmas, which identification depends on measures that are able to calibrate a fuller range of interpersonal and affective qualities. If replicated in larger samples, this will indicate a need for a reformulation of current measures of psychopathy.

Theoretically, psychopaths have a capacity for change

Preliminary results give an in-depth representation of the psychopath's pathology by supporting Wiggins and Trapnell's (1996) metaconcepts of community and agency and Richard's (1998) description of the structural affective, relational, and defensive deviances behind the extreme self-states of psychopathy. Theoretically, these are clinical variables that can be instrumental in treatment of psychopathy. If replicated in larger samples, results indicate a need for a reformulation of the current stance on treatment of psychopathy.

The way we approach psychopathy is rightfully changing

The results of the present thesis expand existing thinking, assessment and attitudes towards treatment of psychopathy, indicating the need for a reformulation of the way we approach the problem. In contrast to the professional climate during this study's early creation in 2003/2004, the study is completed in a time where more researchers and clinicians has started to question the credibility of some of the hallmarks of the dominating neurobiological paradigm. APA's newfound emphasis on dimensions of identity and self-direction and individual capacities for intimacy and empathy in personality disorders touches the interpersonal and affective pathology identified in

this study's psychopathic offenders, and supports this thesis' conclusion about the future clinical concept, assessment, and treatment of psychopathy:

Central changes to the concept, assessment and treatment of psychopathy represent the start of a paradigm shift that will influence the way we look at psychopathy today
If replicated, the results of the present thesis have implications for theory, practice and research in the field of psychopathy. Researchers and clinicians will have to immerse themselves into clinical variables, and further research and theory should focus on the vulnerability and suffering, nuances, and adjacent treatment of psychopathy. This approach would represent a paradigm shift in the field of psychopathy.

9.2 Future work

The preliminary results and conclusions of the present thesis need to be modified according to further research. Future research must compare psychopathic offenders with non-psychopathic personality- or symptom-disordered controls, as well as with non-psychopathic offenders. Studies should also concentrate on separate parts of the contents included in the present thesis, to ensure a sufficient number of subjects. To gain a sufficient number of subjects, it would be beneficial to carry out the assessment once the subjects are informed about the objectives of the study and permission is obtained, given the often-impulsive approach of the psychopath. However, this would require a discussion of the ethics involved in taking advantage of the characteristics of the subjects to raise the number of participants.

The outlined implications of the present thesis must be kept within the bounds and limitations of the current ethical, professional, political, social, economical, administrative, and physical consequences. This has particular relevance for the

treatment of psychopathy. Future research and clinical practice should not embark on "treatment adventures" without securing a necessary and sufficient basis with regard to the above-mentioned parameters. That being said, clinicians and researchers should immediately pay attention to clinical variables such as dimensions of identity and self-directedness and individual capacity for empathy and intimacy in understanding and working with psychopathy. Further work should focus on the vulnerability, suffering and nuances in psychopathy.

10 References

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. Arlington, VA: American Psychiatric Publishing Inc.

Andrews, G., Singh, M., & Bond, M. (1993). The defense style questionnaire. *Journal of nervous and mental disease, 181,* 246-256.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental health disorders (4th ed).* Washington DC: Author.

American Psychiatric Association (2010). *American Psychiatric Association DSM-5 development.* Retrieved July 20, 2011, from http://www.dsm5.org/ProposedRevision/Pages/PersonalityDisorders.aspx

Arrigo, B. A., & Shipley, S. (2001). The Confusion Over Psychopathy (I): Historical Considerations. *International journal of offender therapy and comparative criminology, 45, 3, 325-344.*

Barbaree, H. E., Seto, M. C., & Langton, C. M. (2001). *Psychopathy, treatment behavior and sex offender recidivism: Extended follow-up.* Paper presented at the 20th annual conference of the Association for the Treatment of Sexual Abusers (ATSA), San Antonio, Texas.

Barr, K. N., & Quinsey, V. L. (2004). Is psychopathy pathology or a life strategy? Implications for social policy. In C. Crawford & C. Salmon (Eds.), *Evolutionary*

psychology, public policy and personal decisions, (pp. 239-317). New Jersey: Lawrence Erlbaum Associates Publishers.

Barrett, P. (n.d.). Test-equating based upon false premises. Retrieved August 1, 2011, from http://www.rasch.org/rmt/rmt141c.htm

Bateman, A., & Fonagy, P. (2008). Comorbid antisocial and borderline personality disorders: Mentalization-based treatment. *Journal of Clinical Psychology: In Session, 64,* 181–194.

Bond, M., Gardner, S. T., Christian, J., & Sigal, J. J. (1983). Empirical study of self-rated defense styles. *Archives of general psychiatry, 40,* 333-338.

Blackburn, R. (2006). Other theoretical models of psychopathy. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 35-57). New York: Guilford.

Black dog institute (n.d.). Parental bonding instrument. Retrieved August 29, 2011, from http://www.blackdoginstitute.org.au/docs/ParentalBondingInstrument.pdf

Blair, R. J. R. (2003). Neurobiological basis of psychopathy. *British journal of psychiatry, 182,* 5-7.

Blair, R. J. R. (2008). The amygdala and ventromedial prefrontal cortex: functional contributions and dysfunction in psychopathy. *Philosophical transactions of the royal society, 363, 1503,* 2485-2489.

Blair, J., Mitchell, D., & Blair, K. (2005). *The psychopath. Emotion and the brain.* Malden, MA: Blackwell publishing.

Blair, R. J. R., Morris, J. S., Frith, C. D., Perret, D. I., & Dolan, R. J. (1999). Dissociable neural responses to facial expressions of sadness and anger. *Brain, 122,* 883-893.

Blair, R. J. R., Peschardt, K. S., Budhani, S., Mitchell, D. G. V., & Pine, D. S. (2006). The development of psychopathy. *Journal of child psychology and psychiatry, 7,* 15-25.

Boyd, A. R. (2003). *Psychopathy and sex offender treatment. PCL-R total and factor scores and their relation to treatment completion and admission of offense behavior.* Dissertation-Abstracts-International: Section B: The-Sciences-and-Engineering, Vol. 64(5-B), 2379.

Caldwell, M., Skeem, J., Salekin, R., & Van Rybroek, G. (2006). Treatment response of adolescent offenders with psychopathy features: A 2-year follow-up. *Criminal Justice and Behavior, 33, 5,* 571-596.

Chakhssi, F., De Ruiter, C., & Bernstein, D. (2010). Change during forensic treatment in psychopathic versus nonpsychopathic offenders. *Journal of Forensic Psychiatry & Psychology, 21, 5,* 660-682.

Cleckley, H. M. (1941). *The mask of sanity. An attempt to clarify some issues about the so-called psychopathic personality* (1st ed.). St. Louis, MO: Mosby

Cleckely, H. M. (1988). *The mask of sanity. An attempt to clarify some issues about the so-called psychopathic personality.* Fifth edition: Private printing for non-profit educational use.

Coid, J., & Ullrich, S. (2010). Antisocial personality disorder is on a continuum with psychopathy. *Comprehensive Psychiatry, 51, 4,* 426-433.

Coid, J., & Yang, M. (2008). The distribution of psychopathy among a household population: Categorical or dimensional? *Social psychiatry and psychiatric epidemiology, 43, 10,* 773-781.

Coid, J., Yang, M., Ullrich, S., Roberts, A., & Hare, R. D. (2009). Prevalence and correlates of psychopathic traits in the household population of Great Britain. *International journal of law and psychiatry, 32, 2, 65-73.*

Cooke, D. J., Hart, S D., Logan, C., & Michie, C. (2008). *Comprehensive assessment of psychopathic personality.* Retrieved July 17, 2011, from Glasgow Caledonian University Web site: http://www.gcu.ac.uk/capp/

Cooke, D. J., & Michie, C. (2001). Refining the construct of psychopath: Towards a hierarchical model. *Psychological Assessment, 13, 2,* 171–88.

Cooke, D., Michie, C., & Hart, S. D. (2006). Facets of clinical psychopathy. Toward clearer measurement. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 91-106). New York: Guilford.

Cook, D., Michie, C., Hart, S. D. & Clark, D. (2005). Searching for the pan-cultural core of psychopathic personality disorder. *Personality and Individual Differences, 39, 2,* 283-295.

Cooke, D. J., Michie, C., Hart, S. D., & Hare, R. D. (1999). Evaluating the screening version of the Hare Psychopathy Checklist-Revised (PCL:SV): An item response theory analysis. *Psychological Assessment, 11*,*1,* 3-13.

Crawford, J. R., & Henry, J. D. (2004). The Positive and Negative Affect Schedule (PANAS): Construct validity, measurement properties and normative data in a large non-clinical sample. *British Journal of Clinical Psychology, 43, 245-265.*

Decuyper, M., Fruyt, F., & Bushman, J. (2008). A five-factor model perspective on psychopathy and comorbid Axis-I disorders in a forensic-psychiatric sample. *International journal of law and psychiatry, 31, 5,* 394-406.

Delis, D. C., Kaplan, E., & Kramer, J. H. (2001a). *Delis-Kaplan Executive Function System (D-KEFS).* San Antonio, TX: The Psychological Corporation.

Dolan, M., & Coid, J. (1993). *Psychopathic and antisocial personality disorders. Treatment and research issues.* London: Gaskill.

D'Silva, K., Duggan, C. & McCarthy, L. (2004) Does treatment really make psychopaths worse? A review of the evidence, Journal of Personality Disorders, 18 (2), 163–177.

Duggan, C. (2008). Why are programs for offenders with personality disorder not informed by the relevant scientific findings? *Philosophical transactions of the royal society B, 363, 1503, 2599-2612.*

Edens, J. F., Marcus, D. K., & Vaughn, M. G. (2011). Exploring the taxometric status of psychopathy among youthful offenders: Is there a juvenile psychopath taxon? *Law and Human Behavior, 35, 1,* 13-24.

European Federation of Psychology Associations (1995). *Meta-code of ethics.* Brussels, Belgium: Author.

Feix, J. (2006). [Review of the book *The handbook of psychopathy*]. *The journal of the American academy of psychiatry and the law, 34, 3,* 428-430.

First, M. B, Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1994). *Structured Clinical Interview for DSM-IV Axis II personality disorders (SCID-II).* New York: New York State Psychiatric Institute, Biometrics Research Department.

First, M. B, Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1997). *Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I/P).* New York: New York State Psychiatric Institute, Biometrics Research Department.

Forth, A. E., Hart, S., & Hare, R. D. (1990). Assessment of psychopathy in male young offenders. *Psychological assessment: A journal of consulting and clinical psychology, 2,* 342-344.

Frick, P. J. & Marsee, M. A. (2006). Psychopathy and developmental pathways to antisocial behavior in youth. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 355-374). New York: Guilford.

Frodi, A., Dernevik, M., Sepa, A., Philipson, J. & Bragesjø, M. (2001). Current attachment representations of incarcerated offenders varying in degree of psychopathy. *Attachment and Human Development, 3, 3,* 269-283.

Gacono, C. B. (1990). An empirical study of object relations and defensive operations in antisocial personality disorder. *Journal of Personality Assessment, 54*, 589-600.

Gacono, C. B., Loving, J. L. Jr., & Bodholdt, R. B. (2001). The Rorschach and psychopathy: Toward a more accurate understanding of the research findings. *Journal of personality assessment, 77,* 16-38.

Gacono, C. B., & Meloy, J. R. (1992). The Rorschach and the DSM-III-R antisocial personality: A tribute to Robert Lindner. *Journal of Clinical Psychology, 48*, 393-406.

Gacono, C. B., & Meloy, J. R. (2009). Assessing antisocial and psychopathic personalities. In J. N. Butcher (Ed.), *Oxford handbook of personality assessment*, (pp. 567-581). New York, NY: Oxford University Press.

Gacono, C. B., Meloy, J. R. & Berg, J. L. (1992). Object relations, defensive operations, and affective states on narcissistic, borderline, and antisocial personality disorder. *Journal of Personality Assessment, 59, 1,* 32-49.

Galietta, M., Fineran, V., Fava, J., & Rosenberg, B. (2010). Antisocial and psychopathic individuals. In McKay, D., Abramowitz, J. S., & Taylor, S. (Eds.), *Cognitive-behavioral therapy for refractory cases: Turning failure into success (385-405).* Washington, DC: The American Psychological Association.

Goodwin, R. D., & Hamilton, S. P. (2003). Lifetime comorbidity of antisocial personality disorder and anxiety disorders among adults in the community. *Psychiatry research, 117*, 159-166.

Gretton, H. M., McBride, M., Hare, R. D., O'Shaughnessy, R., & Kumka, G. (2001). Psychopathy and recidivism in adolescent sex offenders. *Criminal Justice and Behavior, 28,* 427-449.

Gullhaugen, A. S., Nørbech, P., & Teigset, I. A. (2011). *For the better or for the worse? On treatment of psychopathy.* Manuscript submitted for publication.

Gullhaugen, A. S. & Nøttestad, J. A. (2011). Looking for the Hannibal behind the Cannibal: Current Status of Case Research. *International Journal of Offender Therapy and Comparative Criminology, 55, 3,* 350-369.

Gullhaugen, A. S. & Nøttestad, J. A. (In press). Under the surface: The Dynamic Interpersonal and Affective World of Psychopathic High-Security and Detention Prisoners. *International Journal of Offender Therapy and Comparative Criminology.*

Gunn, J. (1998). Psychopathy: An elusive concept with moral overtones. In T. Millon, E. Simonsen, M. Birket-Smith, & R. Davis, (Eds.), *Psychopthy: Antisocial, criminal, and violent behaviour,* (pp. 32-49). New York: The Guilford Press.

Hare, R. D. (1991). *Manual for the Hare Psychopathy Checklist – Revised.* Toronto, ON, Canada: Multi-Health Systems.

Hare, R. D. (1996). Psychopathy: A clinical construct whose time has come. *Criminal Justice & Behavior, 23, 1,* 25-54.

Hare, R. D. (1996a). Psychopathy and antisocial personality disorder: A case of diagnostic confusion. *Psychiatric times, 13, 2,* 39-40.

Hare, R. D. (2003). Manual for the Revised Psychopathy Check List (2nd ed.). Toronto, ON, Canada: Multi-Health Systems.

Hare, R. D. (2006). Psychopathy: a clinical and forensic overview. *Psychiatric Clinics of North America. 29, 3,* 709-24.

Hare, R. D. (2007). Psychological instruments in the assessment of psychopathy. In: A. R. Felthous, & H. Saß, (Eds), *International handbook on psychopathic disorders and the law, Volume I* (pp. 41-67). West Sussex: John Wiley & Sons, Ltd.

Hare, R. D., Clark, D., Grann, M., & Thornton, D. (2000). Psychopathy and the predictive validity of the PCL-R: An international perspective. *Behavioral science and the law, 18,* 623-645.

Hare, R. D., & Jutai, J. W. (1983). Criminal history of the male psychopath: Some preliminary data. In K. T. Van Dusen, & S. A. Mednick (Eds.), *Perspective studies of crime and delinquency* (pp. 225-236). Boston; Kluwer-Nijhoff.

Hare, R. D., & McPhearson, L. M. (1984). Violent and aggressive behavior by criminal psychopaths. *International Journal of Law and Psychiatry, 7,* 35-59.

Hare, R. D., Neumann, C. S. (2008). "Psychopathy as a Clinical and Empirical Construct". *Annual Review of Clinical Psychology, 4,* 217–46.

Harris, G. T., & Rice, M. E. (2006). Treatment of psychopathy. A review of empirical finding. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 555-572). New York: Guilford.

Harris, G. T., Rice, M. E., Hilton, N. Z., Lalumiere, M. L., & Quinsey, V. L. (2007). Coercive and precocious sexuality as a fundamental aspect of psychopathy. *Journal of personality disorders, 21, 1,* 1-27.

Harris, G. T., Rice, M. L., & Quinsey, V. L. (1994). Psychopathy as a taxon: Evidence that psychopaths are a discrete class. *Journal of consulting and clinical psychology, 62, 2,* 387-397.

Hart, S. D., Cox, D. N., & Hare, R. D. (1995). *The Hare Psychopathy Checklist Screening Version (PCL:SV).* New York: Multi-Healthe Systems Inc.

Hicks, B. M., Markon, K. E. Patrick, C. J., Krueger, R. F., & Newman, J. P. (2004). Identifying psychopathy subtypes on the basis of personality structure. *Psychological assessment, 16, 3,* 276-288.

Hildebrand, M., & de Ruiter, C. (2004). PCL-R psychopathy and its relation to DSM-IV Axis I and II disorders in a sample of male forensic psychiatric patients in the Netherlands. *International journal of law and psychiatry, 27, 3,* 233-248.

Hoff, P., & Herpertz, S. C. (2007). Psychiatric assessment. In Felthous, A. R. & Saß, H. (Eds.). *International handbook on psychopathic disorders and the law. Volum I* (pp. 33-40). West Sussex, England: John Wiley & Sons Ltd.

Howells, K., Krishnan, G., & Daffern, M. (2007). Challenges in the treatment of dangerous and severe personality disorder. *Advances in psychiatric treatment, 13, 325-332.*

Karpman, B. (1948). The myth of the psychopathic personality. *American journal of psychiatry, 104, 9,* 523–34.

Kernberg, O. F. (2004). *Aggressivity, narcissism, and self-desctructiveness in the psychotherapeutic relationship: New developments in the psychopathology and psychotherapy of severe personality disorders.* New Haven: Yale University Press.

Kuhn, T. S. (2002). *Vitenskapelige revolusjoners struktur.* Oslo: Spartacus forlag.

Latour, B. (1987). *Science in action.* Cambridge, MA: Harvard University Press

Laurell, J., & Dåderman, A. M. (2007). Psychopathy (PCL-R) in a forensic psychiatric sample of homicide offenders: Some reliability issues. *International journal of law and psychiatry, 30, 2,* 127-135.

Lee, C.W., Taylor, G., & Dunn, J. (1999). Factor structure of the schema questionnaire in a large clinical sample. *Cognitive Therapy and Research, 23, 4,* 441-451.

Leichsenring, F., Kunst, H., & Hoyer, J. (2003). Borderline personality organization in violent offenders: Correlations of identity diffusion and primitive defense mechanisms with antisocial features, neuroticism, and interpersonal problems. *Bulletin of the Menninger Clinic, 67, 4,* 314-327.

Lilenfeld, S. O., & Andrews, B. R. (1996). Development and preliminary validation of a self-report measure of psychopathic personality traits in noncriminal populations. *Journal of Personality Assessment, 66,* 488-524.

Lilienfeld, S.O., & Fowler, K.A. (2006). The self-report assessment of psychopathy: Promises, problems, and solutions. In C. Patrick (Ed.), *Handbook of psychopathy* (pp. 107-132). New York: Guilford Books.

Lykken, D. (1995). *The antisocial personalities.* Hillsdale, NJ, England: Lawrence Erlbaum Associates, Inc.

Marcus, D. K., John, S. L., & Edens, J. F. (2004). A taxometric analysis of psychopathic personality. *Journal of abnormal psychology, 113, 4,* 626-635.

Martens, W. H. J. (1997). *Psychopathie en narijping: Een theoretische terreinverkenning aangevuld met een kwalitatief onderzoek naar het verschijnsel narijping* [Psychopathy and maturation: A theoretical and qualitative forensic psychiatric investigation]. Maastricht, the Netherlands: Shaker.

Martens, W. H. J. (1999). Marcel: A case report of a violent sexual psychopath in remission. *International journal of offender therapy and comparative criminology, 143,* 391-399.

Martens, W. H. J. (2002). The hidden suffering of the psychopath. *Psychiatric times, 19, 1,* 1-17.

Martens, W. H. J., & Palermo, G. B. (2005). Loneliness and associated violent antisocial behavior: Analysis of the case reports of Jeffrey Dahmer and Dennis Nilsen. *International journal of offender therapy and comparative criminology, 49,* 298-307.

McCrae, R. R., & Costa Jr., P. T. (2008). The five-factor theory of personality. In O. P. John, R. W. Robins & L. A. Pervin (Eds.), *Handbook of personality. Theory and research. Third edition* (pp. 159-181). New York: The Guilford Press.

Mealey, L. (1995). The sociobiology of sociopathy: An integrated evolutionary model. *Behavioral and Brain Sciences, 18,* 523-540.

Meloy, J. R. (1998). *The psychopathic mind: Origins, dynamics and treatment.* Lanham, Maryland: Jason Aronson.

Meloy, J. R. (2002). *Violent attachments*. Lanham, MD: Rowman & Littlefield.

Meloy, J. R., & Gacono, C. B. (1998). The internal world of the psychopath. In T. Millon, E. Simonsen, M. Birket-Smith, & R. D. Davis (Eds.), *Psychopathy: Antisocial, criminal, and violent behavior* (pp. 95-109). New York: Guilford.

Meloy, J. R., & Yakeley, J. (2010). Psychodynamic treatment of antisocial personality disorder. In J. F. Clarkin, P. Fonagy, & G. O. Gabbard (Eds.), *Psychodynamic psychotherapies for personality disorder: A clinical handbook* (pp. 311-336). Arlington, VA: American Psychiatric Publishing, Inc.

Monsen, J. T., Hagtvet, K. A., Havik, O. E., & Eilertsen, D. E. (2006). Circumplex structure and personality disorder correlates of the Interpersonal Problems Model (IIP-C): Construct validity and clinical implications. *Psychological Assessment, 18, 2,* 165-173.

Newman, J. P. MacCoon, D. G., Vaughn, L. J. & Sadeh, N. (2005). Validating a distinction between primary and secondary psychopathy with measures of Gray's BIS and BAS constructs. *Journal of abnormal psychology, 114, 2,* 319-323.

Norsk rikskringkasting (2004, March 12). Psychopath who's ex-husband. Retrieved July 21, 2011, from http://www.nrk.no/helse-forbruk-og-livsstil/1.1317690

Ogloff, J. R. P. (2006). Psychopathy/antisocial personality disorder conundrum. *Australian and New Zealand journal of psychiatry, 40,* 519-528.

Ottosson, H., Bodlund, O., Ekselius, L., Grann, M., von Knorring, L., Kullgren, G., Lindström, E., & Söderberg, S. (1998). DSM-IV and ICD-10 personality disorders: A comparison of a self-report questionnaire (DIP-Q) with a structured interview. *European psychiatry, 13, 5,* 246-253.

Ottosson, H., Bodlund, O., Ekselius, L., von Knorring, L., Kullgren, G., Lindström, E., & Soderberg, S. (1995). The DSM-IV and ICD-10 personality questionnaire (DIP-Q): Construction and preliminary validation. *Nordic journal of psychiatry, 49, 4*, 285-291.

Ottosson, H., Grann, M., & Kullgren, G. (2000). Test-retest reliability of a self-report questionnaire for DSM-IV and ICD-10 personality disorders. *European Journal of Psychological Assessment, 16, 1,* 53-58.

Parker, G., Tupling, H., & Brown, L. B. (1979) A Parental Bonding Instrument. *British Journal of Medical Psychology, 52,* 1-10.

Pickersgill, M. (2011). "Promising" therapies: Neuroscience, clinical practice, and the treatment of psychopathy. *Sociology of Health & Illness, 33, 3,* 448-464.

Popper, K. (1963). *Conjectures and refutations*. London: Routledge.

Porter, S., ten Brinke, L., & Wilson, K. (2009). Crime profiles and conditional release performance of psychopathic and non-psychopathic sexual offenders. *Legal and Criminological Psychology, 14,* 109–118.

Psychological Corporation, the (1997). *Wechsler Adult Intelligence Scale-Third Edition*. San Antonio, TX: Harcourt Brace & Company.

Raine, A., & Venable, P. H. (1992). Antisocial behavior: Evolution, genetics, neuropsychology, and psychophysiology. In A. Gale & M. W. Eysenck (Eds.), *Handbook of individual differences: Biological perspectives* (pp. 287-321). Oxford, England: John Wiley & Sons.

Reid, W. H. (1986). Introduction: Assaulting the mask. In Reid, W. H., Dorr, D., Walker, J. I., & Bonner III, J. W. (Eds.), *Unmasking the psychopath. Antisocial personality and related syndromes* (pp. 159-190). New York: W. W. Norton & Company.

Reid, W., & Gacono, C. (2000). Treatment of antisocial personality, psychopathy, and other characterologic antisocial syndromes. *Behavioral Science and the Law, 18,* 647-662.

Rice, M. E., Harris, G. T., & Cormier, C. A. (1992). An evaluation of a maximum-security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior, 16,* 399-412.

Richards, H. (1998). Evil intent: Violence and disorders of the will. In Millon, T., Simonsen, E., Birket-Smith, M. & Davis, R. D. (Eds.), *Psychopathy, antisocial, criminal, and violent behavior* (pp. 69-94). New York: The Guilford Press.

Roger, D., & Najarian, B. (1989). The construction and calidation of a new scale for measuring emotion control. *Personality and Individual Differences, 10, 8, 845-853.*

Roger, D., & Nesshoever, W. (1987). The construction and preliminary validation of a scale for measuring emotional control. *Personality and Individual Differences, 8, 4, 527-534.*

Roth, A. & Fonagy, P. (1996). *What works for whom? A critical review of psychotherapy research.* New York: The Guilford Press.

Sadeh, N., & Verona, E. (2008). Psychopathic traits associated with abnormal selective attention and impaired cognitive control. *Neuropsychology, 22, 5,* 669-680.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism: Clinical lore or clinical reality. *Clinical psychology review, 22,* 79-112.

Salekin, R. (2010). Treatment of child an adolescent psychopathy: Focusing on change. In R. T. Salekin, & D. R. Lynam (Eds.), *Handbook of child and adolescent psychopathy,* (pp. 343-373). New York, NY: Guilford Press.

Salekin, R. T., & Lynam, D. R. (2010). Child and adolescent psychopathy: The road ahead. In R. T. Salekin, & D. R. Lynam (Eds.), *Handbook of child and adolescent psychopathy* (pp.401-419). New York: Guilford Press.

Salekin, R. T., Rogers, R., & Sewell, K. W. (1996). A review and meta-analysis of the Psychopathy Checklist and Psychopathy Checklist – Revised. Predictive validity of dangerousness. *Clinical psychology: Science & practice, 3,* 203-215.

Salekin, R. T., Worley, C., & Grimes, R. D. (2010). Treatment of Psychopathy: A Review and Brief Introduction to the Mental Model Approach for Psychopathy. *Behavioral sciences and the law, 28,* 235-266.

Schrum, C. L., & Salekin, R. T. (2006). Psychopathy in Adolescent Female Offenders: An Item Response Theory Analysis of the Psychopathy Checklist: Youth Version. *Behavioral sciences and the law, 24, 1,* 39-63.

Seabrook, J. (2008). *Suffering souls. The search for the roots of psychopathy.* Retrieved July 21, 2011, from

http://www.newyorker.com/reporting/2008/11/10/081110fa_fact_seabrook

Seto, M. C., & Barbaree, H. E. (1999). Psychopathy, treatment behavior, and sexual offender recidivism. *Journal of interpersonal violence, 14,* 1235-48.

Seto, M. C., & Quinsey, V. L. (2006). Toward the future: Translating basic research into prevention and treatment strategies. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 589-604). New York: Guilford.

Schmidt, N. B., Joiner, T. E., Young, J. E., & Telch, M. J. (1995). The Schema Questionnaire: Investigation of psychometric properties and the hierarchical structure of a measure of maladaptive schemata. *Cognitive Therapy and Research, 19, 3,* 295-321.

Shipley, S., & Arrigo, B. (2001). The confusion over psychopathy (II): Implications for forensic (correctional) practice. *International journal of offender therapy and comparative criminology, 45, 4,* 407-420.

Soldz, S., Budman, S., Demby, A., & Merry, J. (1995). A short form of the Inventory of Interpersonal problems circumplex scales. *Assessment 2,* 53-63.

Stanford, M. S., Houston, R. J., & Barrat, E. S. (2007). Psychophysiological correlates of psychopathic disorders. In A. R. Felthous & H. Sass (Eds.), *International handbook on psychopathic disorders and the law* (pp. 83-102). West Sussex, UK: Wiley.

St. Claire, M. (2000). *Object relations and self-psychology: An introduction* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Stengers, I. (1999). *For en demokratisering av vitenskapene.* Oslo: Spartacus forlag.

Strasburger, L. H. (2001). The treatment of antisocial syndromes. In J. R. Meloy (Ed.), *The Mark of Cain, The psychoanalytic Insight and The Psychopath* (pp. 297-314). Hillsdale: The Analytic Press.

van Honk, J., & Schutter, D. J. L. G. (2006). Unmasking feigned sanity: A neurobiological model of emotional processing in primary psychopathy. *Cognitive neuropsychiatry, 11, 3,* 285-306.

Vittaco, M. J. Neuman, C. S., & Jackson, R. L. (2005). Testing a four-factor model of psychopathy and its association with ethnicity, gender, intelligence, and violence. *Journal of consulting and clinical psychology, 73, 3,* 466-476.

Watson, D. Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of Positive and Negative Affect: The PANAS scales. *Journal of personality and social psychology, 54,* 1063-1070.

Weinstein, H. C., Bath, E., Ford, E. B., Lopez-Leon, M., & Soloway, S. M. (2007). Ethical considerations involving psychopathic disorders. In A. R. Felthous, & H. Saß (Eds.), *International handbook of psychopathic disorders and the law, Volume II* (pp. 445-459). Chichester, West Sussesx: John Wiley & Sons, Ltd.

Westen, D., Gabbard, G. O., & Ortigo, K. M. (2008). Psychoanalytic approaches to personality. In O. P. John, R. W. Robins, & L. A. Pervin (Eds.), *Handbook of personality. Theory and research. Third edition* (pp. 61-113). New York: Guilford.

World Health Organization (1994). *International Statistical Classification of Diseases and Related Health Problems, 10th Revision.* Geneva: World Health Organization

World Medical Association Declaration of Helsinki (2000). *Ethical Principles for Medical Research Involving Human Subjects.* Adopted by the 18th WMA General Assembly, Helsinki, Finland June 1964, and amended by the 52nd WMA General Assembly, Edinburgh, Scotland, October 2000.

Widiger, T. A. (2006). Psychopathy and the DSM-IV psychopathology. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 156-171). New York: Guilford.

Wiggins, J. S., & Trapnell, P. D. (1996). A dyadic-interactional perspective on the five-factor model. In J. S. Wiggins (Ed.), *The five-factor model of personality: Theoretical perspectives* (pp. 88-162). New York: Guilford Press.

Woods, R. L. (2010). Etiological factors in the development of psychopathy: Gender-based and cross-cultural variations. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 71 (1-B), pp. 701.*

Young, J. E. (1998). The Young Schema Questionnaire Short Form. Download from http://home.sprynet.com/sprynet/schema/ysql.htm

11 Appendix

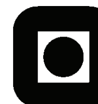
This section presents the initially distributed letters of information (prison- and university faculties; prisoners and students) and consent (prisoners and students), and the 7 questionnaires handed out to participating subjects after interview and testing.

11.1 Letters of information and consent

Letter of information, prison faculty

NTNU
Norges teknisk-naturvitenskapelige universitet

Fakultet for samfunnsvitenskap og teknologiledelse
Psykologisk institutt



Kriminalomsorgen region sør
Postboks 2166
3103 Tønsberg

Stipendiat
Aina Sundt Gullhaugen
Telefon 7355086
E-post aina.gullhaugen@svt.ntnu.no

Vår dato: 07.06.2007	Vår ref.: asg	Deres dato:	Deres ref.

Henvendelse vedrørende forskningsprosjekt

"Tanker, følelser, impulsivitet og mellommenneskelig stil blant fengselsinnsatte og pasienter i sikkerhetspsykiatri"

Jeg viser til retningslinjer for behandling av søknader om forskning i Kriminalomsorgen, og søker med dette om tillatelse til å samle inn data ved Ringerike Fengsel (og Ila Fengsel, forvarings- og sikringsanstalt).

Datainnsamlingen er del av undertegnedes doktorgradsstudie og tar sikte på å kartlegge forhold vedrørende personlighetsforstyrrelse hos mennesker som vurderes som farlige for seg selv/andre.

Personlighetsforstyrrelse defineres som en varig avvikende måte å tenke, føle og forholde seg til andre mennesker på, og forskning har vist at forekomsten av personlighetsforstyrrelse er svært høy blant fengselsinnsatte og pasienter i sikkerhetspsykiatrien. Sammenlignet med andre grupper er forekomsten av alvorlig ustabil og dyssosial personlighetsforstyrrelse særlig høy, og disse personlighetsforstyrrelsene er blant de typer lidelser som vi pr dags dato har minst behandling for.

Prosjektet søker å kartlegge på hvilken måte innsatte og pasienter med personlighetsforstyrrelse og farlighetsproblematikk skiller seg fra pasienter uten farlighetsproblematikk samt et utvalg studenter, med implikasjoner for fremtidig behandling og risikovurdering.

Undersøkelsen er godkjent av Regional Komité for Medisinsk Forskningsetikk Midt-Norge og Norsk Samfunnsvitenskapelig Datatjeneste, ved Personvernombudet for forskning.

Vedlagt er prosjektbeskrivelse, bekreftelse fra faglig veileder, informasjonsbrev til potensielle deltakere, og samtykkeerklæring.

Med vennlig hilsen

Aina S. Gullhaugen
Stipendiat/Cand. Psychol.

Prosjekt: Tanker, følelser, impulsivitet og mellommenneskelig stil hos fengselsinnsatte og pasienter i sikkerhetspsykiatri

Undersøkelsens formål, problemstilling og metode
Internasjonal og nasjonal forskning viser at opp mot 80 % av pasienter og innsatte i fengsels- og sikkerhetspopulasjonen fyller de diagnostiske kriteriene for personlighetsforstyrrelse.

Formålet med studien er ny kunnskap om denne gruppen, med tanke på fremtidig behandling og risikovurdering. Man ønsker å gå under diagnosemanualenes grove beskrivelsesnivå, og kartlegge pasienters og innsattes tanker, følelser, impulsivitet og mellommenneskelig stil.

Disse hovedkomponentene deles igjen inn i underkomponenter:

1. Tanker: fleksibilitet, perspektivtaking, kontroll, oppfattelsesmønstre, og selvbilde
2. Følelser: grad og retning av følelser, regulering og uttrykking av følelser, lidelse, og forsvarsmekanismer
3. Impulsivitet: evne til å kontrollere seg, bipolar lidelse, ADHD
4. Mellommenneskelig stil: tilknytning, mellommenneskelige mønstre, og krenkelsesberedskap

I tillegg ønsker vi å kartlegge pasienters og innsattes generelle evnenivå og fungering i hverdagen, samt psykologiske behov og en eventuell tilstedeværelse av akutt psykososialt stress som kan føre til lidelse og påvirke fungeringsnivået.

Vi er ute etter økt kunnskap om hva personlighetsforstyrrelse dreier seg om på et mer psykologisk nivå, da mye av forskningen frem til i dag har dreid seg om diagnosekriterier som i stor grad fokuserer på faktiske handlinger.

Vi ønsker videre å kartlegge hvorvidt enkeltkomponenter i den psykologiske fungeringen er representert på en systematisk måte i de ulike personutvalgene, og om mulig knytte slike komponenter til eventuelle undergrupper av personer og/eller farlighet.

Med bakgrunn i dette har følgende problemstillingen blitt formulert:

”*Er det systematiske forskjeller i tanker, følelser, impulsivitet, og sosialt samspill hos mennesker med personlighetsforstyrrelse i høyrisiko fengsler og på sikkerhetsavdelinger, og personer i andre pasient- og normalutvalg?*”

I tillegg er følgende forskningsspørsmål definert:
1) Hva kjennetegner det kliniske bildet?
2) Kan ulike psykologiske komponenter kobles til undergrupper eller farlighet?
3) Hva er personenes psykologiske behov?
4) Hva vil være god behandling?

Vi ønsker å samle inn data ved følgende institusjoner:
1. NTNU: et studentutvalg på 100 personer. Innsamlingen er i gang.
2. Ila fengsel, forvarings- og sikringsanstalt (forvaringsdømte): 55/60 plasser
3. Ringerike fengsel (landets høyeste sikkerhetsnivå): 160 plasser
4. Regional sikkerhetsavdeling Brøset, Trondheim: 18 plasser.
5. Regional sikkerhetsavdeling i Sandviken, Bergen: Regional post har 10 plasser. Fylkeskommunal post har 10 plasser.
6. Regional sikkerhetsavdeling Dikemark, Oslo: 16 plasser.

I tillegg ønsker vi å sammenligne nevnte data med data fra den norske ”Multisenterstudien”. Dette utvalget består av pasienter med personlighetsforstyrrelse uten farlighetsproblematikk, som er undersøkt med enkelte av instrumentene som benyttes i denne studien.
Prosjektet tar sikte på å kartlegge alle pasienter og innsatte som gir et skriftlig informert samtykke til dette. Eksklusjonskriterier er aktiv psykose eller annen alvorlig sinnslidelse, og språk og lesevansker som vanskeliggjør datainnsamlingen i betydelig grad.

Studien gjennomføres ved de ulike institusjonene. Det gis ingen belønning for deltagelse.

Beskrivelse av instrumentene: intervju, tester og spørreskjemaer
Man vil benytte følgende instrumenter i kartleggingen:

1. "Strukturert klinisk intervju for DSM-IV akse I & II-forstyrrelser" (SCID I, Vogel, et al., 1996, og Friis et al., 1995)

Intervjuet kartlegger en eventuell tilstedeværelse av psykiske lidelser beskrevet i diagnosemanualen DSM-IV (APA, 1994).

2. "F90-intervju" (World Health Organization, 1993)

"Intervjuet" er et skjema som dekker forskningskriteriene for F90 diagnosen "hyperaktivitet og oppmerksomhetssvikt", og består av 22 spørsmål hvor man krysser av ut fra en utspørring av pasienten.

3. The DSM-IV and ICD-10 Personality Questionnaire (DIP-Q, Ottosson, et al., 1995)

Instrumentet er et spørreskjema for selvutfylling bestående av 135 spørsmål som til sammen danner skalaene: Paranoid-, schizoid-, schizotyp-, antisosial-, borderline-, histrionisk-, narsissistisk-, unnvikende-, avhengig-, og tvangsmessig personlighetsforstyrrelse. Instrumentet kartlegger i tillegg grad av subjektivt ubehag/stress (11 spørsmål) og funksjonalitet (GAF, 5 spørsmål).

4. Young Schema Questionnaire – Short Form (YSC-SF; Young,1998)

Instrumentet er et spørresskjema for selvutfylling bestående av 75 spørsmål som til sammen danner skalaene: emosjonell deprivasjon; redsel for å bli forlatt/ustabilitet; mistro/misbruk; sosial isolasjon/fremmedgjøring; opplevelse av at noe er galt med deg/skam; mislykkethet; avhengighet/inkompetanse; sårbarhet for skade/sykdom; overinvolvering/underutviklet selv; underdanighet; selvoppofrelse; emosjonell inhibering; uoppnåelige standarder/hyperkritisisme; selvberettigelse/grandiositet; og utilstrekkelig selvkontroll/selvdisiplin.

5. The Inventory of Interpersonal Problems – Circumplex Scales (IIP-C; Soldz, Budman, Demby, & Merry, 1995)

Instrumentet er et spørreskjema for selvutfylling bestående av 64 spørsmål som til sammen danner skalaene: hevngjerrig, kald, sosialt unnvikende, lite selvhevdende, lett å utnytte, overdrevent omsorgsfull, invaderende, og dominerende.

6. Defence Style Questionnaire – 40 (DSQ-40; Bond, Gardner, Christian, & Sigal, 1983)

Instrumentet er et spørreskjema for selvutfylling bestående av 40 spørsmål som til sammen danner skalaene: umodent forsvar (utagering, benekting, devaluering, forskyvning, dissosiering, autistisk fantasi, isolasjon, passiv aggressivitet, projeksjon, rasjonalisering, somatisering, splitting), modent forsvar (forventning, humor, undertrykking, sublimering), og nevrotisk forsvar (pseudo-altruisme, idealisering, reaksjonsdannelse, omgjøring).

7. Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979)

Instrumentet er et spørreskjema for selvutfylling bestående av 50 ledd som til sammen danner skalaene omsorg og overbeskyttelse. Fem mulige tilknytningsmønstre er identifisert: mye omsorg/høy overbeskyttelse (følelsesmessig begrensende /kontrollerende); mye omsorg/lite overbeskyttelse (optimale bånd); lite omsorg/mye overbeskyttelse (følelsesløs kontroll); lite omsorg/lite overbeskyttelse (neglisjerende oppdragelse); gjennomsnittlig (statistisk definert ved normer).

8. The Positive and Negative Affect Schedule (PANAS; Watson, Clark & Tellegen, 1988)

Instrumentet er et spørreskjema for selvutfylling bestående av 20 spørsmål som til sammen danner skalaene: positiv affekt (i hvilken grad personen føler seg entusiastisk, aktiv og våken) og negativ affekt (reflekterer personens subjektive opplevelse av negativt stress og ubehag).

9. Emotion Control Questionnaire (ECQ2; Roger, & Nesshoever, 1987)

Instrumentet er et spørreskjema for selvutfylling bestående av 56 ledd som til sammen danner skalaene: øvelse (grad av fundering over emosjonelt aktiverende hendelser), emosjonell inhibisjon (tendens til å undertrykke emosjonsuttrykk), aggresjonskontroll (inhibering av aggresjon uavhengig av mer generelle emosjonelle begrensninger), og benign kontroll.

10. Delis-Kaplan Executive Function System (D-KEFS) color-word interference test (Ellis et al., 2001)

Instrumentet er en nevropsykologisk funksjonstest som måler evnen til å kontrollere/holde igjen naturlige responser.

11. Deltester fra Wechsler Adult Intelligence Scale-3 (WAIS-3; The Psychological Corporation, 1997

Instrumentene er utvalgte deltester fra en omfattende evnetest. Hver deltest består av ulike oppgaver, og man oppnår poeng etter antall riktige svar. Deltestene er: Ordforståelse (ordkunnskap og verbal flyt), terningmønster (spatial persepsjon, visuell
abstrakt prosessering og problemløsning), likheter (verbal abstrakt resonnering, kategorier og relasjoner), og matriser (visuell analyse og spatial resonnering).

Prosjektet er godkjent i Regional komité for medisinsk forskningsetikk, avdeling Midt-Norge, samt Norsk Samfunnsvitenskapelig datatjeneste AS, personvernombudet for forskning.

Personer som skal gjennomfører undersøkelsen og deres faglige bakgrunn
Prosjektets leder er Aina Sundt Gullhaugen. Innsamlingen skjer som ledd i Gullhaugens doktorgradsarbeid med tittel:

"Kognisjon, emosjonalitet, impulsivitet og interpersonlig stil; en klinisk differensiell studie av utvalg fra den norske fengsels- og sikkerhetspopulasjonen."

Gullhaugen var ferdigutdannet psykolog fra NTNU i 2004. Hun har tidligere arbeidet ved St. Olavs hospital, Regional sikkerhetsavdeling Brøset, og har gjennomført ett år av Norsk Psykologforenings spesialistkurs innenfor området klinisk voksenpsykologi.
Gullhaugen faglige veileder i doktorgradsprosjektet er Professor i rettspsykologi, NTNU, Kirsten Rasmussen. Rasmussen er spesialist i nevropsykologi og psykologisk habilitering, og har vært faglig ansvarlig for en rekke studier av fengsels- og sikkerhetspopulasjonen.

Gullhaugens forskningsassistent er psykologstudent og prosjektmedarbeider Guro Mari Johansen. Johansen har fullført 5 av 6 år ved profesjonsstudiet i psykologi ved NTNU, og arbeider ved siden av studiene i Trondheim fengsel samt St. Olavs hospital, Regional sikkerhetsavdeling Brøset.

Plan for gjennomføring
Studien gjennomføres etter følgende plan:

1. Innsamling av studentdata fra NTNU ferdigstilles ved utgangen av september 2007.
2. Innsamling av data fra Ila fengsel, forvarings- og sikringsanstalt ønskes gjennomført i løpet av oktober/november 2007.
3. Innsamling av data fra Regional sikkerhetsavdeling i Sandviken, Bergen og Regional sikkerhetsavdeling Dikemark, Oslo, ønskes gjennomført i perioden desember 2007 til januar 2008.
4. Innsamling av data fra Ringerike fengsel ønskes gjennomført i perioden januar-mars 2008.
5. Innsamling av data ved St. Olavs hospital Regional sikkerhetsavdeling Brøset ønskes gjennomført i siste halvdel av mars måned, 2008.

Letter of information, university faculty

NTNU
Norges teknisk-naturvitenskapelige universitet

Fakultet for samfunnsvitenskap og teknologiledelse
Psykologisk institutt

Psykologisk institutt

Stipendiat
Aina Sundt Gullhaugen
Telefon 73550864
E-post aina.gullhaugen@svt.ntnu.no

Vår dato:	Vår ref.:	Deres dato:	Deres ref.
11.10.2006			

Innsamling av data ved psykologisk institutt

Jeg ønsker med dette å orientere om at jeg i perioden medio november 2006 til utgangen av januar 2007 kommer til å samle inn data fra psykologistudenter på ulike nivåer.

Prosjektet er godkjent i Regional komité for medisinsk forskningsetikk, avdeling Midt-Norge, og søknad er sendt Norsk Samfunnsvitenskapelig datatjeneste AS, personvernombudet for forskning.

Innsamlingen skjer som ledd i mitt doktorgradsarbeid med tittel:

Kognisjon, emosjonalitet, impulsivitet og interpersonlig stil; en klinisk differensiell studie av utvalg fra den norske fengsels- og sikkerhetspopulasjonen

Formålet med studien er økt kunnskap om personlighetsforstyrrelse i fengsels- og sikkerhetspopulasjonen. Man ønsker å gå under diagnosemanualenes grove beskrivelsesnivå, og kartlegge en utvidet personlighetsprofil, definert som "klinisk relevante variabler med tanke på psykologisk behandling", bestående av hovedkomponentene kognisjon, emosjonalitet, impulsivitet og interpersonlig stil, som igjen operasjonaliseres i underkomponenter. I tillegg ønsker man mål på funksjonalitet i hverdagen.

Følgende forskningsspørsmål er definert:

5) Hva kjennetegner det kliniske bildet?
6) Kan komponenter i personligheten kobles til antisosial atferd og/eller farlighet?
7) Hva er personenes psykologiske behov? (Mål på psykologiske behov er indirekte og eksemplifiseres med f eks "indre representasjoner av selv og andre" og tilknytningsstil.)
8) Hva vil være god behandling? (Man vil her se nærmere på profilene resultatene viser samt eventuelle psykiske plager, og sammenholde dette med faktorer som empiri og klinisk erfaring tilsier kan behandles.)

Studentutvalget, på ca 100 personer, anses i studien som et normalutvalg, og jeg ønsker å sammenligne dette utvalget med fengsels- og sikkerhetspopulasjonen.

Jeg vil benytte følgende instrumenter i kartleggingen:

Diagnostisk intervju som kartlegger en eventuell tilstedeværelse av psykisk lidelse:

- ”Strukturert klinisk intervju for DSM-IV akse I & II-forstyrrelser” (SCID I, Vogel, et al., 1996, og Friis et al., 1995)
- ”Mini Internasjonalt Nevropsykiatrisk Intervju” (M.I.N.I, Pedersen, 1996).
- ”F90-intervju” (World Health Organization, 1993)

Spørreskjemaer med diagnostisk profil:

- The DSM-IV and ICD-10 Personality Questionnaire (DIP-Q, Ottosson, et al., 1995)
- SCID-screen (Ekselius et al, 1994)

Spørreskjemaer som kartlegger kognisjon, emosjonalitet, impulsivitet og interpersonlig stil:

- Young Schema Questionnaire – Short Form (YSC-SF; Young,1998)
- The Inventory of Interpersonal Problems – Circumplex Scales (IIP-C; Soldz, Budman, Demby, & Merry, 1995)
- Defence Style Questionnaire – 40 (DSQ-40; Bond, Gardner, Christian, & Sigal, 1983)
- Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979)
- The Positive and Negative Affect Schedule (PANAS; Watson, Clark & Tellegen, 1988)
- Emotion Control Questionnaire (ECQ2; Roger, & Nesshoever, 1987)

Psykologiske tester som kartlegger grad av impulsivitet/eksekutiv kontroll:

- Delis-Kaplan Executive Function System (D-KEFS) color-word interference test (Ellis et al., 2001)
- Deltester fra Wechsler Adult Intelligence Scale-3 (WAIS-3; The Psychological Corporation, 1997

Jeg vil også samle inn data ved:

- Regional sikkerhetsavdeling Brøset, Trondheim
- Regional sikkerhetsavdeling Sandviken, Bergen
- Regional sikkerhetsavdeling Dikemark, Oslo
- Trondheim fengsel
- Ringerike fengsel
- Ila fengsel, forvarings- og sikringsanstalt
- Bredvedt kvinnefengsel

Dette til orientering.

Mvh

Aina Sundt Gullhaugen
Stipendiat/Cand. Psychol

Letter of information, prisoners

Forespørsel om å delta i en vitenskapelig undersøkelse:

Kognisjon, emosjoner, impulsivitet og interpersonlig stil: En klinisk differensiell studie av utvalg fra den norske fengsels- og sikkerhetspopulasjonen.

Du inviteres med dette til å delta i en undersøkelse av personlighetsmessige forhold hos pasienter og innsatte i norske sikkerhetsavdelinger og fengsler.

Bakgrunnen for denne undersøkelsen er at:

1) Vi vet lite om pasienter og innsatte ved norske sikkerhetsavdelinger og fengsler. Man ønsker større kunnskap om personlighetsmessige forhold, noe som kan bidra til at pasienter og domfelte i fremtiden vil kunne få et tilbud som er mer tilpasset deres individuelle behov.
2) Mange pasienter og innsatte kan ha utilfredsstilte personlige behov. Dette kan forklare hvorfor mange innsatte og pasienter fra tid til annen opplever vanskelige og slitsomme tanker og følelser, noe som kan føre til at forholdet til andre mennesker kan bli både konfliktfulle og lite tilfredsstillende
3) Mange pasienter og innsatte får ikke den forståelsen og hjelpen de har behov for og krav på, noe som kan føre til en negativ spiral som det er vanskelig å komme ut av

Vår undersøkelse omfatter:

1) Et intervju laget for å fange opp ulike psykiske vansker man kan ha
2) Spørreskjemaer som kartlegger ulike aspekter av personligheten (tanker, følelser, grad av impulsivitet, og forholdet til andre) og ulike behov
3) Testing av oppmerksomhet og problemløsningsstrategier

Målsetting for undersøkelsen:
Større kunnskap om personlighetsmessige kjennetegn og behov hos innsatte og pasienter

Hvor mye arbeid innebærer dette for deg?
Hvis du bestemmer deg for å hjelpe til vil undertegnede eller prosjektmedarbeider Guro Marie Johansen sette av en halv arbeidsdag til intervju/samtale og noen kortvarige tester. Avslutningsvis får du utdelt 7 spørreskjemaer. Vi har beregnet at man vil trenge omtrent 1-1.5 timer på å fylle ut disse skjemaene, men du kan bruke så lang tid du vil.

Vil det påvirke behandlingen din?
Ingen behandling forandres på grunn av undersøkelsen, og du vil motta den samme behandlingen som du hadde fått hvis du ikke hadde deltatt.

Hvilken nytte får jeg av å delta?
Dersom du ønsker tilbakemelding på egne testresultater får du dette. På sikt kan man tenke seg at undersøkelsen kan føre til endringer i måten å tenke på og å behandle innsatte og pasienter.

Vil det være negative konsekvenser for deg?
Nei. De ansatte ved ditt nåværende oppholdssted får ikke tilgang til de opplysninger du gir, og den behandling du for tiden mottar endres ikke.

Frivillig deltagelse?
Deltakelse er frivillig, og en kan trekke seg på ethvert tidspunkt uten å oppgi grunn.

Betenkningstid?
Du får god tid til å tenke deg om. Du har fått en muntlig orientering, og du får dette informasjonsbrevet nå. Jeg kontakter deg om 1 uke, og spør om du vil signere avtalen, men bare hvis du selv ønsker det. I mellomtiden har du god tid til å tenke gjennom saken.

Hvis jeg sier ja til å delta, kan jeg da i ettertid forandre mening og trekke meg fra undersøkelsen?
Ja, når som helst, og uten begrunnelse.

Hvis jeg sier ja til å delta, hvem vil få tilgang til opplysninger om meg?
All personlig informasjon om deg vil bli behandlet konfidensielt og ingen utenfor forskningsgruppen vil ha tilgang til de konfidensielle dataene. Eksempelvis vil ikke ansatte ved fengselet eller sykehuset ha tilgang på disse opplysningene. Prosjektleder Aina Sundt Gullhaugen har taushetsplikt. Prosjektmedarbeider Guro Marie Johansen, som skal hjelpe til under innsamlingen av data, har også taushetsplikt.
Opplysninger som publiseres vil ikke kunne tilbakeføres til enkeltpersoner. Datamaterialet anonymiseres innen utgangen av 2009.

Institusjonell forankring, finansiering og forsikring

Studien er tilknyttet Norges Teknisk Naturvitenskaplige Universitet (NTNU) i Trondheim, hvor prosjektleder og undertegnede er ansatt som doktorgradsstipendiat. Materialet som fremkommer av undersøkelsen vil bli benyttet i undertegnedes doktorgrad.

Studien finansieres av Prosjekt dobbeltkompetanse i psykologi. Dobbelkompetanseprosjektet er et samarbeid mellom universiteter, helseforetak og Norsk psykologforening etter oppdrag og finansiering fra Utdannings- og forskningsdepartementet og Helsedepartementet. Deltagende pasienter er forsikret gjennom pasientskadeerstatningsordningen.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste og av Regional komité for medisinsk forskningsetikk.

Dersom du har spørsmål om denne undersøkelsen, er du velkommen til å ringe meg på telefon nummer 73 55 08 64.

Med hilsen

Aina Sundt Gullhaugen
Prosjektleder
Psykolog/Stipendiat

Letter of information, students

Forespørsel om å delta i en vitenskapelig undersøkelse:

Kognisjon, emosjoner, impulsivitet og interpersonlig stil: En klinisk differensiell studie av utvalg fra den norske fengsels- og sikkerhetspopulasjonen.

Du inviteres med dette til å delta i en undersøkelse av personlighetsmessige forhold hos pasienter og innsatte i norske sikkerhetsavdelinger og fengsler, og i en kontrollgruppe av norske psykologistudenter.

Bakgrunnen for denne undersøkelsen er at:

1) Vi vet lite om personlighetsmessige forhold hos pasienter og innsatte ved norske sikkerhetsavdelinger og fengsler. Man ønsker større kunnskap om dette, noe som kan bidra til at pasienter og innsatte i fremtiden vil kunne få et tilbud som er mer tilpasset deres individuelle behov.
2) Mange pasienter og innsatte kan ha utilfredsstilte personlige behov. Dette kan forklare eventuelle vanskelige og slitsomme tanker og følelser, noe som igjen kan føre til at forholdet til andre mennesker kan bli både konfliktfulle og lite tilfredsstillende
3) Mange pasienter og innsatte får ikke den forståelsen og hjelpen de har behov for og krav på, noe som kan føre til en negativ spiral som det er vanskelig å komme ut av

Vår undersøkelse omfatter:

1) Et intervju laget for å fange opp ulike psykiske vansker man kan ha
2) Spørreskjemaer som kartlegger ulike aspekter av personligheten (tanker, følelser, grad av impulsivitet, og forholdet til andre) og ulike behov
3) Testing av oppmerksomhet og problemløsningsstrategier

Målsetting for undersøkelsen:
Større kunnskap om personlighetsmessige kjennetegn og behov hos innsatte og pasienter, med implikasjoner for behandling.

Hvor mye arbeid innebærer dette for deg?
Hvis du bestemmer deg for å hjelpe til vil undertegnede eller prosjektmedarbeider Guro Marie Johansen sette av tid et til intervju og noen kortvarige tester. Det har vist seg at det i gjennomsnitt tar 1.5 timer å gjennomføre intervju og tester. Avslutningsvis får du utdelt 7 spørreskjemaer. Vi har beregnet at man vil trenge omtrent 1 time på å fylle ut disse skjemaene, men du kan bruke så lang tid du vil.

Hvilken nytte får jeg av å delta?
Dersom du velger å delta i undersøkelsen vil du få et godt innblikk i psykologfaglig utredning og kartlegging på et tidlig stadium av studiet, hvor man ellers ikke har særlig mye konkret erfaring. Som blivende psykolog eller master i psykologi vil en opplevelse av å ha sittet på "den andre siden av bordet" også kunne være en nyttig erfaring å ta med seg videre. Det vil bli gitt en tilbakemelding av undersøkelsens resultater på gruppenivå, på prosjektets hjemmeside.

Vil det være negative konsekvenser for deg?
Nei. Undersøkelsen er ikke forbundet med spesielle risikoer av noen art.
Frivillig deltagelse?
Deltakelse er frivillig, og en kan trekke seg på ethvert tidspunkt uten å oppgi grunn.

Hvis jeg sier ja til å delta, kan jeg da i ettertid forandre mening og trekke meg fra undersøkelsen?
Ja, når som helst, og uten begrunnelse.

Hvis jeg sier ja til å delta, hvem vil få tilgang til opplysninger om meg?
Alt rundt denne undersøkelsen er *absolutt konfidensielt*. All personlig informasjon om deg vil bli behandlet konfidensielt, og ingen utenfor forskningsgruppen vil ha tilgang til de konfidensielle dataene.

Eksempelvis vil ikke ansatte ved universitetet ha tilgang på disse opplysningene. Prosjektleder Aina Sundt Gullhaugen har taushetsplikt. Prosjektmedarbeider Guro Marie Johansen, som skal hjelpe til under innsamlingen av data, har også taushetsplikt. Opplysninger som publiseres vil ikke kunne tilbakeføres til enkeltpersoner. Datamaterialet anonymiseres innen utgangen av 2009.

Institusjonell forankring og finansiering

Studien er tilknyttet Norges Teknisk Naturvitenskaplige Universitet (NTNU) i Trondheim, hvor prosjektleder og undertegnede er ansatt som doktorgradsstipendiat. Materialet som fremkommer av undersøkelsen vil bli benyttet i undertegnedes doktorgrad.

Studien finansieres av Prosjekt dobbeltkompetanse i psykologi. Dobbelkompetanseprosjektet er et samarbeid mellom universiteter, helseforetak og Norsk psykologforening etter oppdrag og finansiering fra Utdannings- og forskningsdepartementet og Helsedepartementet. Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste og av Regional komité for medisinsk forskningsetikk.

Hvis du har spørsmål om denne undersøkelsen, er du velkommen til å ringe meg på telefon nr 73 55 08 64, eller eventuelt sende en e-mail til aina.gullhaugen@svt.ntnu.no. Informasjon om prosjektet vil også være tilgjengelig på http://www.svt.ntnu.no/psy/aina.sundt.gullhaugen/

Med hilsen

Aina Sundt Gullhaugen
Prosjektleder
Psykolog/Stipendiat

Letter of consent, prisoners and students

Samtykkeerklæring

Tanker, følelser, impulsivitet og mellommenneskelig stil hos fengselsinnsatte og pasienter i sikkerhetspsykiatri.

Jeg har lest informasjonsskrivet og har hatt anledning til å stille spørsmål. Jeg samtykker i å delta i prosjektet.

Sted, dato, underskrift:………………………………………………………………..

11.2 Questionnaires

The positive and negative affect schedule (PANAS)

Her kommer noen ord som beskriver ulike følelser og stemninger. Les hvert ord og skriv det tallet som best viser hvor mye du har følt på denne måten *den siste uken*, og hvor mye du *vanligvis* føler slik (hvordan du føler det gjennomsnittlig).

1 = Veldig lite eller ikke i det hele tatt
2 = Litt
3 = Moderat
4 = En god del
5 = Ekstremt

Følelse/stemning	**Den siste uken**	**Vanligvis**
Interessert		
I nød		
Opprømt		
Opprørt		
Sterk		
Skyldig		
Skremt		
Fiendtlig		
Entusiastisk		
Stolt		
Irritabel		
Våken		
Skamfull		
Inspirert		
Nervøs		
Besluttsom		
Oppmerksom		
”Skvetten”		
Aktiv		
Redd		

Emotional control questionnaire 2 (ECQ2)

Vennligst svar hva du føler mht hvert punkt ved å sette ring rundt *enten* RIKTIG eller GALT. Dersom du føler at et punkt verken er helt riktig eller galt, vennligst velg det svaret som er *mest* likt det du føler. Hvis du ikke har vært i en av de beskrevne situasjonene, vennligst oppgi hva du tror du ville ha gjort i en slik situasjon.

1. Når noen gjør meg opprørt, forsøker jeg å skjule følelsene mine. **RIKTIG GALT**
2. Hvis noen dyttet meg, ville jeg dytte tilbake. **RIKTIG GALT**
3. Jeg husker ting som gjør meg opprørt eller sint i lang tid etterpå. **RIKTIG GALT**
4. Jeg føler meg sjelden irritabel. **RIKTIG GALT**
5. Jeg tar ofte sjanser når jeg krysser veien. **RIKTIG GALT**
6. Folk synes det er vanskelig å si om jeg er begeistret for noe eller ikke. **RIKTIG GALT**
7. Jeg gjør eller sier ofte ting som jeg senere angrer på. **RIKTIG GALT**
8. Jeg synes det er vanskelig å trøste folk som har blitt opprørt. **RIKTIG GALT**
9. Jeg bærer vanligvis ikke nag – når noe er over, så er det over, og jeg tenker ikke på det igjen. **RIKTIG GALT**
10. Ingen får utnytte meg – jeg lar meg ikke pille på nesen. **RIKTIG GALT**
11. Når noe gjør meg opprørt foretrekker jeg å snakke med noen heller enn å stenge det inne. **RIKTIG GALT**
12. Jeg har vært involvert i mange kamper eller krangler. **RIKTIG GALT**
13. Jeg blir opphisset bare av å tenke på ting som har gjort meg opprørt på et tidligere tidspunkt. **RIKTIG GALT**
14. Jeg blir ikke så lett distrahert. **RIKTIG GALT**
15. Dersom jeg får dårlig service i en butikk eller på en restaurant lager jeg vanligvis ikke noe oppstyr. **RIKTIG GALT**
16. Dersom jeg mottar dårlige nyheter foran andre mennesker forsøker jeg vanligvis å skjule hvordan jeg føler meg. **RIKTIG GALT**
17. Jeg ombestemmer meg ofte. **RIKTIG GALT**
18. Dersom jeg blir sprutet på av en passerende bil, roper jeg til sjåføren. **RIKTIG GALT**
19. Dersom noen skulle slå meg ville jeg slå tilbake. **RIKTIG GALT**
20. Jeg viser sjelden hva jeg føler om ting. **RIKTIG GALT**
21. Jeg sier ofte ting uten å tenke på om jeg forulemper andre. **RIKTIG GALT**
22. Jeg tenker ofte igjen og igjen på ting som har gjort meg sint. **RIKTIG GALT**
23. Dersom jeg blir gledelig overrasket viser jeg umiddelbart hvor glad jeg blir. **RIKTIG GALT**

24. Jeg har en tendens til å glefse til andre. **RIKTIG GALT**

25. Dersom jeg blir sint eller opprørt sier jeg vanligvis hvordan jeg føler det. **RIKTIG GALT**

26. Dersom noen sier noe dumt, forteller jeg dem det. **RIKTIG GALT**

27. Dersom jeg ser noen snike i køen foran meg ignorerer jeg det vanligvis. **RIKTIG GALT**

28. Jeg kan vanligvis gjøre opp ting raskt og bli vennlig igjen etter en krangel. **RIKTIG GALT**

29. Mine interesser skifter raskt. **RIKTIG GALT**

30. Jeg blir ikke flau av å gi uttrykk for mine følelser. **RIKTIG GALT**

31. Hvis jeg ser heller hører om en ulykke, tenker jeg på noe lignende som skjer meg selv eller mennesker som står meg nært. **RIKTIG GALT**

32. Jeg tenker på hvordan jeg kan hevne meg på folk som har gjort meg sint i lang tid etter at episoden fant sted. **RIKTIG GALT**

33. Jeg vil heller innrømme nederlag på et område enn å gå inn i en diskusjon. **RIKTIG GALT**

34. Jeg glemmer aldri folk som gjør meg sint eller opprørt, selv ikke når det handler om småting. **RIKTIG GALT**

35. Jeg tråkker sjelden i salaten. **RIKTIG GALT**

36. Jeg mister raskt beherskelsen. **RIKTIG GALT**

37. Jeg synes folk viser sine følelser for lett. **RIKTIG GALT**

38. Jeg synes det er vanskelig å slutte å tenke på ting som har opprørt meg. **RIKTIG GALT**

39. Nesten alt jeg gjør er nøye gjennomtenkt. **RIKTIG GALT**

40. Jeg tror ikke at jeg noen gang vil være i stand til å ”vende det andre kinnet til”. **RIKTIG GALT**

41. Jeg dagdrømmer ofte om situasjoner hvor jeg hevner meg på folk. **RIKTIG GALT**

42. Jeg synes det er kjedelig med lange reiser – alt jeg vil er å komme frem så raskt som mulig. **RIKTIG GALT**

43. Å gi uttrykk for mine følelser gjør meg veldig sårbar og engstelig. **RIKTIG GALT**

44. Hvis en venn låner noe og leverer det tilbake i skitten eller skadet stand, sier jeg vanligvis ikke noe om det. **RIKTIG GALT**

45. Jeg holder ikke ut å måtte vente på noe. **RIKTIG GALT**

46. Dersom jeg ser noe som gjør meg skremt eller opprørt, ser jeg bildet av det inni meg i lang tid etterpå. **RIKTIG GALT**

47. Jeg hater å ikke kunne komme forbi en som kjører sakte. **RIKTIG GALT**

48. Dersom noen fornærmer meg forsøker jeg å forbli så rolig som mulig. **RIKTIG GALT**

49. Å tenke på opprørende ting ser bare ut til å gjøre at tankene fortsetter, så jeg prøver å ikke tenke på dem. **RIKTIG GALT**

50. Jeg klarer som regel å fremstå som rolig på utsiden, til tross for at jeg er opprørt på innsiden. **RIKTIG GALT**

51. Dersom jeg går glipp av noe, kommer jeg raskt over det. **RIKTIG GALT**

52. Jeg kan ikke la være å vise hva jeg føler, selv ikke på et upassende tidspunkt. **RIKTIG GALT**

53. Dersom jeg må konfrontere noen, forsøker jeg å ikke tenke så mye på det på forhånd. **RIKTIG GALT**

54. Jeg liker å planlegge heller enn å ta ting som de kommer. **RIKTIG GALT**

55. Noen ganger buser jeg ut meg ting som setter de jeg er sammen med i forlegenhet. **RIKTIG GALT**

56. Noen ganger kan jeg bare ikke kontrollere følelsene mine. **RIKTIG GALT**

The parental bonding instrument (PBI)

Her ser du en liste over ulike holdninger foreldre har og måter de er på. Vennligst angi *hvordan du husker at din mor var* frem til du fylte 16 år ved å sette et kryss i en av parentesene under hvert utsagn.

1. Snakket til meg med en varm og vennlig stemme.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

2. Hjalp meg så mye som jeg hadde behov for.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

3. Lot meg gjøre de tingene jeg likte å gjøre.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

4. Virket følelsesmessig kald mot meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

5. Syntes å forstå mine problemer og bekymringer.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

6. Var kjærlig mot meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

7. Likte at jeg tok mine egne beslutninger.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

8. Ønsket at jeg skulle vokse opp.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

9. Prøvde å kontroller alt jeg gjorde.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

10. Invaderte mitt privatliv.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

11. Likte å diskutere ting med meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

12. Smilte ofte til meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

13. Hadde en tendens til å behandle meg som en liten unge.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

14. Syntes å forstå hva jeg ønsket eller hadde behov for.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

15. Lot meg bestemme ting selv.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

16. Fikk meg til å føle meg uønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

17. Kunne få meg til å føle meg bedre når jeg var opprørt.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

18. Snakket ofte til meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

19. Prøvde å gjøre meg avhengig av henne.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

20. Følte at jeg ikke kunne passe på meg selv uten at hun var i nærheten.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

21. Gav meg så mye frihet som jeg ønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

22. Lot meg gå ut så ofte som jeg ønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

23. Overbeskyttet meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

24. Gav meg ros.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

25. Lot meg kle meg akkurat slik jeg ønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

Her ser du den samme listen over ulike holdninger foreldre har og måter de er på. Vennligst angi hvordan du husker at din *far* var inntil du fylte 16 år ved å sette et kryss i en av parentesene under hvert utsagn

1. Snakket til meg med en varm og vennlig stemme.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

2. Hjalp meg så mye som jeg hadde behov for.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

3. Lot meg gjøre de tingene jeg likte å gjøre.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

4. Virket følelsesmessig kald mot meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

5. Syntes å forstå mine problemer og bekymringer.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

6. Var kjærlig mot meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

7. Likte at jeg tok mine egne beslutninger.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

8. Ønsket at jeg skulle vokse opp.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

9. Prøvde å kontroller alt jeg gjorde.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

10. Invaderte mitt privatliv.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

11. Likte å diskutere ting med meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

12. Smilte ofte til meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

13. Hadde en tendens til å behandle meg som en liten unge.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

14. Syntes å forstå hva jeg ønsket eller hadde behov for.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

15. Lot meg bestemme ting selv.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

16. Fikk meg til å føle meg uønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

17. Kunne få meg til å føle meg bedre når jeg var opprørt.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

18. Snakket ofte til meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

19. Prøvde å gjøre meg avhengig av han.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

20. Følte at jeg ikke kunne passe på meg selv uten at han var i nærheten.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

21. Gav meg så mye frihet som jeg ønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

22. Lot meg gå ut så ofte som jeg ønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

23. Overbeskyttet meg.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

24. Gav meg ros.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

25. Lot meg kle meg akkurat slik jeg ønsket.

Veldig lik ( ) Relativt lik ( ) Relativt ulik ( ) Veldig ulik ( )

The defense style questionnaire – 40 (DSQ-40)

Utsagnene nedenfor beskriver personlige holdninger. Det er ikke noen rette eller gale svar. Benytt 9 punkts skalaen under hvert utsagn til å indikere *hvor mye du er enig eller uenig* ved å sette ring rundt en verdi for hvert utsagn. For eksempel vil det å sette ring rundt 5 si at du verken er enig eller uenig i utsagnet, en ring rundt 3 at du er moderat uenig, og en ring rundt 9 at du er helt enig.

1. Jeg liker å hjelpe andre og ville blitt lei meg hvis dette ble tatt fra meg.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

2. Jeg er i stand til å utsette og tenke på et problem til jeg har tid til å håndtere det.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

3. Jeg håndterer uro ved å gjøre noe konstruktivt og kreativt.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

4. Jeg er i stand til å begrunne alt jeg gjør.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

5. Jeg har lett for å le av meg selv.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

6. Andre har en tendens til å behandle meg dårlig.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

7. Hvis noen overfalt meg og stjal pengene mine ville jeg heller at de fikk hjelp enn straff.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

8. Andre sier jeg har en tendens til å overse ubehagelige ting som om de ikke eksisterer.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

9. Jeg overser farer som om jeg er usårlig.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

10. Jeg er stolt av min evne til å sette andre på plass.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

11. Jeg handler ofte impulsivt når noe plager meg.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

12. Jeg får fysisk ubehag når ting ikke går bra for meg.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

13. Jeg er en veldig tilbakeholden person.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

14. Jeg har mer glede av fantasiene mine enn mitt virkelige liv.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

15. Jeg har spesielle evner som gjør det mulig for meg å gå i gjennom livet uten problemer.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

16. Når ting ikke ordner seg for meg, er det alltid gode grunner til det.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

17. Jeg ordner opp i flere ting i dagdrømmer enn i det virkelige liv.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

18. Jeg er ikke redd for noe.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

19. Noen ganger føler jeg meg som en engel, og andre ganger som en djevel.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

20. Jeg blir aggressiv når jeg føler meg såret.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

21. Jeg føler jeg alltid har noen som beskytter meg.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

22. Slik jeg ser det er folk enten gode eller dårlige.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

23. Hvis sjefen min plager meg, kan jeg bli pinlig korrekt eller arbeide langsomt for å ta igjen.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

24. Jeg kjenner noen som får til alt og som alltid er ærlig og rettferdig.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

25. Jeg kan legge lokk på følelsene mine, dersom de vil forstyrre det jeg holder på med.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

26. Jeg kan vanligvis se de morsomme sidene ved en ellers vanskelig sak.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

27. Jeg får fysisk ubehag hvis jeg må gjøre noe jeg ikke liker.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

28. Jeg er ofte veldig hyggelig mot folk som jeg med god grunn burde være sint på.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

29. Jeg er sikker på at livet behandler meg urettferdig.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

30. Når jeg vet jeg skal møte en vanskelig situasjon, prøver jeg å se for meg hvordan den vil bli og planlegger måter å mestre den på.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

31. Legene forstår aldri helt hva som feiler meg.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

32. Etter å ha kjempet for mine rettigheter, pleier jeg å be om unnskyldning for min pågåenhet.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

33. Når jeg er nedfor eller engstelig føler jeg meg bedre ved å spise.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

34. Jeg blir ofte fortalt at jeg ikke viser følelsene mine.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

35. Hvis jeg på forhånd vet jeg kommer til å bli skuffet, kan jeg mestre det bedre.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

36. Uansett hvor mye jeg ber om det, får jeg aldri god nok tilbakemelding.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

37. Jeg opplever ofte at jeg ikke føler noe i situasjoner som burde vekke sterke følelser.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

38. Å konsentrere meg om det jeg holder på med hjelper meg til å takle vanskelige følelser.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

39. Dersom jeg var i krise, ville jeg oppsøke en annen person med samme problem.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

40. Dersom jeg har dårlige tanker om andre, har jeg behov for å gjøre noe for å lette min dårlige samvittighet.

Helt uenig 1 2 3 4 5 6 7 8 9 Helt enig

The inventory of interpersonal problems – circumplex scaøes (IIP-C)

Her er en liste med problemer som folk har i omgang med andre mennesker. Vennligst les hvert av disse og vurder *om du har opplevd dette problemet* med hensyn til en eller annen betydningsfull person i ditt liv. Sett en sirkel rundt det ordet som beskriver hvor plagsomt det har vært. Det følgende er ting du synes det er vanskelig å gjøre i forhold til andre mennesker. Det er vanskelig for meg å:

1. Stole på andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

2. Si "nei" til andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

3. Delta i grupper.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

4. Holde ting hemmelig for andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

5. La andre mennesker få vite hva jeg har bruk for.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

6. Be en person om å slutte å plage meg.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

7. Presentere meg for nye mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

8. Konfrontere folk med problemer som oppstår.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

9. Hevde mine egne meninger overfor en annen person.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

10. La andre mennesker få vite når jeg er sint.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

11. Forplikte meg over lang tid i forhold til en annen person.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

12. Være sjef over en annen person.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

13. Være sint på andre når situasjonen gjør det nødvendig.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

14. Omgås andre mennesker på en selskapelig måte.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

15. Vise andre mennesker at jeg er glad i dem.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

16. Komme overens med folk.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

17. Forstå andres synspunkter.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

18. Uttrykke mine følelser overfor andre direkte.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

19. Være bestemt når jeg trenger å være det.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

20. Oppleve kjærlighet i forhold til en annen person.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

21. Sette grenser for andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

22. Støtte en annen persons mål med livet.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

23. Føle nærhet til andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

24. Virkelig bry seg om problemer andre har.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

25. Krangle med en annen person.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

26. Tilbringe tid alene.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

27. Gi en annen person en gave.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

28. Tillate meg å føle sinne overfor noen jeg liker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

29. Sette en annens behov framfor mine egne.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

30. Ikke bry meg med andres saker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

31. Ta imot råd og ordrer fra folk som har myndighet over meg.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

32. Glede meg over et annet menneskes lykke.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

33. Be andre mennesker om å omgås meg sosialt.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

34. Være sint på andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

35. Åpne meg å snakke om følelsene mine til andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

36. Tilgi en annen person etter at jeg har vært sint.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

37. Ta hensyn til mitt eget beste når en annen blir krevende.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

38. Si mine egne meninger uten å bekymre meg for at jeg sårer en annen persons følelser.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

39. Være trygg på meg selv når jeg er sammen med andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

Følgende er ting du gjør for mye:

40. Jeg krangler for mye med andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

41. Jeg føler meg for ansvarlig for å løse andres problemer.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

42. Jeg lar meg alt for lett overtale av andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

43. Jeg er for åpen overfor andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

44. Jeg er altfor selvstendig.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

45. Jeg er altfor aggressiv i forhold til andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

46. Jeg prøver for sterkt å tekkes andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

47. Jeg klovner for mye.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

48. Jeg ønsker for mye å bli lagt merke til.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

49. Jeg stoler for mye på andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

50. Jeg prøver for mye å kontrollere andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

51. Jeg lar for ofte andres behov gå foran mine egne.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

52. Jeg prøver altfor mye å forandre andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

53. Jeg er for godtroende.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

54. Jeg er overdrevent sjenerøs overfor andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

55. Jeg er redd for andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

56. Jeg er for mistenksom overfor andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

57. Jeg manipulerer andre for mye for å oppnå det jeg vil.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

58. Jeg forteller alt for lett personlige ting til andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

59. Jeg er for ofte uenig med andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

60. Jeg holder andre altfor mye på avstand.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

61. Jeg lar altfor lett andre mennesker utnytte meg.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

62. Jeg føler meg for ofte flau overfor andre mennesker.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

63. Jeg lar en annen persons elendighet for lett gå inn på meg.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

64. Jeg ønsker for ofte hevn over andre.

Ikke i det hele tatt Litt Moderat Ganske mye Veldig

Young schema questionnaire – short form (YSQ-SF)

Nedenfor følger en liste med utsagn som folk ofte bruker for å beskrive seg selv. Vennligst les hvert utsagn og avgjør *hvor godt det beskriver deg*. Dersom du er i tvil så svar på grunnlag av hva du føler og ikke på grunnlag av hva du tror er riktig. Velg det tallet som best beskriver deg ved å skrive tallet på linjen etter utsagnet.

1 = Beskriver meg ikke, 2 = Beskriver meg stort sett ikke, 3 = Beskriver meg litt, 4 = Beskriver meg ganske godt, 5 = Beskriver meg stort sett slik jeg er, 6 = Beskriver meg helt presis

1. I mesteparten av tiden, har jeg ikke hatt noen som har gitt meg omsorg eller som har brydd seg skikkelig om alt som har hendt meg ___

2. Generelt kan jeg si at det ikke er noen som har gitt meg varme, kos, og kjærlighet ___

3. I stort sett hele mitt liv har jeg følt at jeg ikke er spesiell for noen ___

4. Stort sett har jeg ikke hatt noen som egentlig lytter til meg, forstår meg eller oppfatter mine innerste behov og følelser ___

5. Jeg har sjelden hatt en sterk person som kunne gitt meg gode råd eller veiledning når jeg ikke er sikker på hva jeg skal gjøre ___

6. Jeg klamrer meg til folk som står meg nær, fordi jeg er redd for at de vil forlate meg ___

7. Jeg trenger andre så sterkt at jeg er redd for å miste dem ___

8. Jeg er bekymret for at de som står meg nær vil forlate eller avvise meg ___

9. Når jeg føler at noen jeg bryr meg om trekkes bort fra meg, blir jeg desperat ___

10. Noen ganger er jeg så bekymret for at andre skal forlate meg at jeg driver dem unna ___

11. Jeg føler at folk vil utnytte meg ___

12. Jeg føler at jeg må forsvare meg mot andre, ellers vil de forsøke å skade meg ___

13. Det er bare et spørsmål om tid før noen forråder meg ___

14. Jeg er nokså mistenksom på andre folks motiver ___

15. Jeg er vanligvis på utkikk etter baktanker med ting som andre har ___

16. Jeg passer ikke inn ___

17. Jeg er fundamentalt forskjellig fra andre mennesker ___

18. Jeg tilhører ingen steder; jeg er noe for meg selv ___

19. Jeg føler meg fremmed overfor andre ___

20. Jeg føler meg alltid utenfor i forhold til alle grupper ___

21. Ingen av de jeg begjærer ville elske meg hvis de så mine feil ___

22. Ingen jeg begjærer ville stå meg nær dersom han/hun kjente hvordan jeg egentlig er ___

23. Jeg fortjener ikke kjærlighet, omtanke og respekt fra andre ___

1 = Beskriver meg ikke, 2 = Beskriver meg stort sett ikke, 3 = Beskriver meg litt, 4 = Beskriver meg ganske godt, 5 = Beskriver meg stort sett slik jeg er, 6 = Beskriver meg helt presis

24. Jeg føler at ingen vil kunne elske meg ___

25. Det er for mye uakseptabelt ved meg til å avsløre meg for andre ___

26. Nesten ingenting jeg gjør på jobben (eller skolen) er så godt som det andre folk gjør ___

27. Jeg er inkompetent når det gjelder ferdigheter ___

28. De fleste andre er mer kapabel enn meg når det gjelder arbeid og ferdigheter ___

29. Jeg er ikke så talentfull som de fleste andre i deres arbeid ___

30. Jeg er ikke så intelligent som de fleste andre når det gjelder arbeid eller skole ___

31. Jeg føler meg ikke i stand til å klare meg på egen hånd i hverdagen ___

32. Jeg tenker på meg selv som en avhengig, når det kommer til hvordan jeg fungerer til daglig ___

33. Jeg mangler sunn fornuft ___

34. Min dømmekraft kan ikke stoles på i hverdagssituasjoner ___

35. Jeg er usikker på min egen evne til å løse de hverdagsproblemer som dukker opp ___

36. Jeg klarer ikke å unngå å føle at noe galt snart vil skje ___

37. Jeg føler at en katastrofe (natur, kriminalitet, økonomi, sykdom) kan oppstå hvert øyeblikk ___

38. Jeg er bekymret for å bli angrepet ___

39. Jeg er bekymret for at jeg skal miste alle pengene mine og bli fattig ___

40. Jeg er bekymret for at jeg kan få en alvorlig sykdom, selv om intet alvorlig har blitt diagnostisert av legen ___

41. Jeg har ikke vært i stand til å selvstendiggjøre meg i forhold til mine foreldre på samme mate som mine jevnaldrende har ___

42. Mine foreldre og jeg synes å være overinvolvert i hverandres liv og problemer ___

43. Det er veldig vanskelig for både mine foreldre og meg å holde intime detaljer skjult for hverandre, uten å føle seg skyldbetynget eller sveket ___

44. Jeg føler ofte at foreldrene mine lever gjennom meg – Jeg har ikke mitt eget liv ___

45. Jeg føler ofte at jeg ikke har min egen identitet eller er forskjellig fra mine foreldre eller partnere ___

46. Jeg tror at hvis jeg gjør som jeg ønsker, ber jeg om bråk ___

47. Jeg føler at jeg ikke har annet valg enn å gi etter for andres ønsker, for ellers vil de slå tilbake eller avvise meg ___

48. I forhold til andre lar jeg dem ha styringen ___

1 = Beskriver meg ikke, 2 = Beskriver meg stort sett ikke, 3 = Beskriver meg litt, 4 = Beskriver meg ganske godt, 5 = Beskriver meg stort sett slik jeg er, 6 = Beskriver meg helt presis

49. Jeg lar alltid andre gjøre valg for meg, så jeg vet egentlig ikke hva jeg vil ___

50. Jeg har store vansker med å kreve at mine rettigheter blir respektert og at man tar hensyn til mine følelser ___

51. Jeg er den som vanligvis ender opp med å ta vare på personer som står meg nær ___

52. Jeg er et godt menneske fordi jeg tenker mer på andre enn meg selv ___

53. Jeg er så opptatt med å ordne for de jeg er glad i, så jeg får liten tid til meg selv ___

54. Jeg har alltid vært den som lytter til andres problemer ___

55. Folk ser meg som en person som gjør alt for mye for andre og ikke nok for meg selv ___

56. Jeg er for sjenert til å vise positive følelser for andre ___

57. Jeg synes det er flaut å gi uttrykk for mine følelser for andre ___

58. Jeg synes det er vanskelig å være varm og spontan ___

59. Jeg kontrollerer meg selv så mye at folk tror at jeg ikke har følelser ___

60. Folk ser på meg som følelsesmessig forknytt ___

61. Jeg må være best i det aller meste av det jeg gjør; jeg aksepterer ikke å være nest best ___

62. Jeg prøver å gjøre mitt beste, jeg slår meg ikke til ro meg "godt nok" ___

63. Jeg må oppfylle alle mine forpliktelser ___

64. Jeg føler at det er et konstant press på meg for å oppnå resultater og få ting gjort ___

65. Jeg lar meg ikke slippe unna lett eller lager unnskyldninger for mine feil ___

66. Jeg har store vansker meg å akseptere nei for et svar når jeg ønsker noe fra andre mennesker ___

67. Jeg er spesiell og skulle ikke akseptere mange av de begrensninger som pådyttes folk ___

68. Jeg hater å bli hemmet ellet tvunget fra å gjøre det jeg vil ___

69. Jeg føler at jeg ikke trenger å følge de normale reglene og normene som andre folk følger ___

70. Jeg føler at mine bidrag er mer verdifulle enn de bidrag andre kommer med ___

71. Jeg klarer ikke å disiplinere meg til å fullføre rutinemessige eller kjedelige oppgaver ___

72. Hvis jeg ikke kan nå et mål blir jeg lett frustrert og gir opp ___

73. Jeg har vanskelig for å utsette umiddelbar tilfredsstillelse for å oppnå langsiktige mål ___

74. Jeg kan ikke tvinge meg selv til å gjøre ting jeg ikke liker, selv om jeg vet at det er til mitt eget beste ___

75. Jeg har sjeldent klart å holde meg til det jeg har besluttet ___

The DSM-IV & ICD-10 personality questionnaire (DIP-Q)

De neste utsagnene handler om *hvordan du er som menneske*, dvs. hva du føler, tenker og gjør. Tenkt deg et personlig gjennomsnitt for *de siste 6 månedene*. Enkelte påstander kan virke litt merkelige. Til sammen utgjør imidlertid svarene dine et viktig mønster. Vi er interessert i hva nettopp du opplever, ikke hva andre synes, eller hva du tror andre synes man bør mene. Det finnes ingen "riktige" eller "gale" svar. Kryss av for om du mener påstanden om deg "stemmer" eller "ikke stemmer". Ta stilling til alle spørsmålene og forsøk å svare så oppriktig som mulig.

	Stemmer	Stemmer ikke
1. Jeg foretrekker å arbeide sammen med andre og er ikke redd for kritikk eller avvisning	□	□
2. Jeg omgås helst ikke andre mennesker hvis jeg ikke er sikker på at jeg blir likt	□	□
3. Jeg er forsiktig i nære relasjoner fordi jeg er redd for å dumme meg ut eller for å bli avvist	□	□
4. Jeg har ofte en følelse av at jeg ikke duger, eller at mitt nærvær er uønsket	□	□
5. Jeg føler meg trygg og sikker og har ingenting i mot å stifte nye bekjentskaper	□	□
6. Jeg tror at jeg er sosialt udugelig, lite attraktiv eller mindre verd enn andre	□	□
7. For å unngå å havne i pinlige situasjoner gir jeg meg ugjerne i kast med nye ting	□	□
8. Jeg føler meg for det meste anspent og engstelig	□	□
9. Jeg driver ikke med noe som kan innebære risiko for fysiske skader	□	□
10. Jeg har lett for å ta hverdagslige beslutninger og er ikke avhengig av råd eller støtte fra andre	□	□
11. Jeg overlater helst ansvaret for hvordan jeg skal leve livet mitt, til andre	□	□
12. Jeg sier meg ikke enig med noen som jeg mener tar feil	□	□
13. Jeg har vanskelig for å gå i gang med ting fordi jeg er redd for å gjøre feil	□	□
14. Jeg kan gå med på å gjøre ting som jeg egentlig ikke vil, bare for å få støtte og bli likt	□	□
15. Jeg klarer meg bra selv og har ikke problemer med å være alene	□	□
16. Hvis partneren min hadde forlatt meg, ville jeg straks ha funnet meg en ny partner bare for å slippe å være alene	□	□
17. Jeg føler meg trygg fordi jeg vet at jeg kan ta vare på meg selv	□	□

	Stemmer	Stemmer ikke
18. Jeg har vanskelig for å stille krav til mennesker som jeg er avhengig av	☐	☐
19. Jeg har vanskelig for å hevde mine behov overfor arbeidskolleger og slektninger	☐	☐
20. Jeg fortaper meg lett i detaljer på bekostning av helheten	☐	☐
21. Jeg har vanskelig for å avslutte oppgaver fordi jeg kun aksepterer et perfekt resultat	☐	☐
22. Jeg prioriterer jobben fremfor familie, venner, og fornøyelse	☐	☐
23. Jeg har sterkere sans for moral enn de fleste	☐	☐
24. Jeg har ingen problemer med å kaste utslitte eller verdiløse gjenstander	☐	☐
25. Jeg vil at andre skal gjøre ting på min måte	☐	☐
26. Når det gjelder penger er jeg en sjenerøs person, og jeg legger ikke noe til side til eventuelle fremtidige nødssituasjoner	☐	☐
27. Jeg er sta og vil alltid gjøre ting slik jeg er vant til å gjøre dem	☐	☐
28. Jeg gjør helst ting selv, ellers kan jeg ikke stole på at det blir gjort ordentlig	☐	☐
29. Jeg er forsiktig og prøver alltid å gardere meg mot feil gjennom kontroll og ettertanke	☐	☐
30. Jeg er tvilrådig og har vanskelig for å ta viktige beslutninger	☐	☐
31. Jeg holder fast på tradisjoner og sosiale normer	☐	☐
32. Jeg er på vakt for ikke å bli utnyttet eller bedratt	☐	☐
33. Jeg tviler bestandig på at de menneskene jeg kjenner virkelig er til å stole på	☐	☐
34. Jeg må beskytte meg mot andres ondsinnethet og misliker derfor å betro meg til andre	☐	☐
35. Jeg er på vakt og lurer alltid på hva folk virkelig mener med det de sier eller gjør	☐	☐
36. Jeg stoler på andre mennesker og tar det for gitt at de er lojale	☐	☐
37. Jeg føler meg ofte tvunget til å forsvare både mitt ry og min person mot angrep fra andre	☐	☐
38. Jeg mistenker ofte partneren min for å være utro	☐	☐
39. Jeg tror at vennlighet og tjenestevillighet er en måte å skjule onde hensikter på	☐	☐

	Stemmer	Stemmer ikke
40. Jeg blir veldig sint når noe går meg imot	☐	☐
41. Jeg ser på mine oppfatninger som de eneste rette	☐	☐
42. Jeg liker å omgås venner	☐	☐
43. I min familie står vi hverandre følelsesmessig nær	☐	☐
44. Stort sett trives jeg best når jeg får være sammen med andre mennesker	☐	☐
45. Jeg er så å si ikke interessert i seksuell kontakt	☐	☐
46. Jeg bekymrer meg ofte over de vanskelighetene jeg har i relasjon til andre mennesker	☐	☐
47. Det er ikke mye jeg gjerne bruker tid på	☐	☐
48. Det finnes mennesker utenom familien min som står meg nær	☐	☐
49. Jeg tar meg ikke nær av verken ros eller kritikk	☐	☐
50. Andre oppfatter meg som kald, ufølsom eller utilgjengelig	☐	☐
51. Jeg har vanskelig for å uttrykk sterke følelser overfor andre	☐	☐
52. Jeg er en ”filosofisk” person i den forstand at jeg lett henfaller i grublerier og dype tanker	☐	☐
53. Jeg forstår ikke hvordan jeg skal være for ikke å bryte samfunnets skrevne og uskrevne regler	☐	☐
54. Jeg synes ofte at folk prater om meg	☐	☐
55. Jeg oppfatter spesielle budskap i det som skjer omkring meg	☐	☐
56. Jeg kan kommunisere med andre gjennom telepati	☐	☐
57. Jeg har en spesiell evne til å vite når visse ting skal skje, før de virkelig skjer	☐	☐
58. Skygger eller gjenstander i et rom kan ofte ta menneskelig form for meg	☐	☐
59. Jeg har ofte kroppsopplevelser som andre synes er merkelige og har problemer med å forstå	☐	☐
60. Folk synes ofte at jeg uttrykker meg på en merkelig måte	☐	☐
61. Jeg er svært bekymret for hvordan jeg er som menneske	☐	☐
62. Andre reagerer på min måte å vise følelser på	☐	☐

	Stemmer	Stemmer ikke
63. Folk mener nok at jeg er litt rar, merkelig eller spesiell	□	□
64. Jeg føler meg trygg sammen med mennesker jeg kjenner	□	□
65. Jeg synes i blant at jeg hører lyder som andre ikke hører, eller ser ting som andre ikke ser	□	□
66. Det finnes folk som mener at jeg er reservert og avvisende	□	□
67. Jeg fortaper meg lett i grublerier om detaljer ved utseendet mitt	□	□
68. Jeg fortaper meg lett i grublerier om sex eller vold	□	□
69. Jeg har vanskelig for å tilpasse meg samfunnets normer og har flere ganger begått ulovlige handlinger	□	□
70. Jeg lyver hvis det tjener mine formål	□	□
71. Jeg er impulsiv og følger øyeblikkets innskytelse	□	□
72. Jeg har ”kort lunte”, noe som gjør at jeg har havnet i flere slagsmål	□	□
73. Jeg liker å leve farlig og tenker sjelden på min egen eller andres sikkerhet	□	□
74. Jeg er omhyggelig med å utføre arbeidet mitt på best mulig måte	□	□
75. Jeg er nøye med å betale regningene mine i god tid	□	□
76. Jeg bryr meg ikke om at andre har det vondt, så lenge jeg får det som jeg vil	□	□
77. Hvis ting ikke går som jeg vil, blir jeg rasende eller voldelig	□	□
78. Samfunnets regler gjelder for andre, men ikke for meg	□	□
79. Når jeg mislykkes med noe, er det som oftest en annens feil	□	□
80. Den som står i veien for meg, får takke seg selv hvis han eller hun kommer ille ut	□	□
81. Jeg har vanskelig for å beholde venner, men til gjengjeld lett for å skaffe meg nye	□	□
82. Jeg plages aldri av skyldfølelse	□	□
83. Jeg tar ikke lærdom av straff i den forstand at jeg endrer atferd	□	□
84. Hvis jeg innser at et forhold er uholdbart, kan jeg avslutte det på en rolig og ordnet måte	□	□
85. Jeg har ofte sterke følelser for andre, og følelsene kan skifte raskt mellom det ekstremt positive og det ekstremt negative	□	□

	Stemmer	Stemmer ikke
86. Mennesker som jeg har sett opp til har ofte skuffet meg	□	□
87. Min måte å være på som person medfører ofte problemer på jobben, i skolen eller hjemme	□	□
88. Jeg føler en sterk indre forvirring - jeg vet egentlig ikke hvem jeg er	□	□

Jeg handler ofte uoverveid eller impulsivt, noe som fører til at jeg:

	Stemmer	Stemmer ikke
89. – sløser bort for mye penger	□	□
90. – har sex med folk jeg knapt kjenner	□	□
91. – drikker for mye	□	□
92. – bruker stoff	□	□
93. – har ukontrollerte spiseanfall	□	□
94. – kjører bil hensynsløst	□	□
95. Andre mennesker virker å ha problemer med ting jeg gjør eller sier	□	□
96. Jeg har aldri truet med å begå selvmord	□	□
97. Jeg bruker ikke å forsøke å skade meg gjennom f. eks. å skjære meg eller ta for mange tabletter	□	□
98. Humøret mitt kan skifte raskt: I det ene øyeblikket har jeg det bra, og i det neste føler jeg meg trist, irritert eller engstelig	□	□
99. Jeg plages av en følelse av indre tomhet	□	□
100. Jeg blir ofte så sint at jeg mister kontrollen	□	□
101. Når jeg har det virkelig dårlig kan jeg få plagsomme uvirkelighetsfølelser	□	□
102. Når jeg føler meg presset, kan jeg få for meg at mennesker vil meg ondt	□	□
103. Jeg har lett for å havne i bråk eller diskusjoner, spesielt når jeg føler meg hindret eller styrt	□	□
104. Skal jeg engasjere meg i noe, så vil jeg se raske resultater eller få rask avkastning, ellers får det bare være	□	□
105. Jeg er usikker på hva jeg vil gjøre med livet mitt	□	□
106. Jeg føler meg ille til mote hvis jeg ikke er i sentrum for oppmerksomheten	□	□
107. Mange synes at jeg er seksuelt utfordrende	□	□

	Stemmer	Stemmer ikke
108. Mange oppfatter meg som overfladisk og følelsesmessig labil	☐	☐
109. Jeg bruker utseendet mitt for å få oppmerksomhet	☐	☐
110. Personligheten min har vært et hinder for å nå de målene jeg har satt meg	☐	☐
111. Andre klager over at jeg prater mye uten å få sagt noe viktig	☐	☐
112. Jeg er en person som gjerne spiller ut hele mitt følelsesregister	☐	☐
113. Jeg påvirkes veldig lett av andre personer eller av ting som skjer	☐	☐
114. Jeg er så åpen at utkjente raskt føles om nære venner	☐	☐
115. Jeg har et sterkt behov for spenning og oppmerksomhet	☐	☐
116. Andre innser ikke alltid hvilken viktig og talentfull person jeg er	☐	☐
117. Jeg tenker ofte på for en overlegen person jeg er eller kommer til å bli	☐	☐
118. Bare noen få utvalgte mennesker kan forstå meg eller bli mine venner	☐	☐
119. For meg er det viktigst å bli beundret	☐	☐
120. Jeg forventer at andre skal gjøre meg tjenester	☐	☐
121. Enkelte mener at jeg bruker andre for vinnings skyld	☐	☐
122. Folk klager over at jeg ikke viser sympati eller medfølelse	☐	☐
123. Jeg er sjelden misunnelig på andres prestasjoner eller suksess	☐	☐
124. Jeg tror ikke at andre er misunnelige på meg	☐	☐
125. Jeg har blitt beskyldt for å være altfor selvsikker og overlegen	☐	☐

Da jeg var barn (under 15 år), gjorde jeg følgende:

	Stemmer	Stemmer ikke
126. Jeg mobbet, skremte eller truet ofte andre	☐	☐
127. Jeg startet ofte slagsmål	☐	☐
128. Jeg truet med pistol eller andre farlige gjenstander, f. eks. kniv, balltre eller knust flaske	☐	☐
129. Jeg var grusom mot andre mennesker	☐	☐
130. Jeg var grusom mot dyr	☐	☐

	Stemmer	Stemmer ikke
131. Jeg stjal eller ranet fra andre	☐	☐
132. Jeg tvang andre til sex	☐	☐
133. Jeg tente på brann med vilje	☐	☐
134. Jeg knuste vindusruter eller ødela andre gjenstander	☐	☐
135. Jeg gjorde innbrudd i noens hus eller bil	☐	☐
136. Jeg løy mye	☐	☐
137. Jeg stjal og nasket ofte	☐	☐
138. Jeg ble borte over natten uten lov allerede før jeg fylte 13 år	☐	☐
139. Jeg rømte hjemmefra og ble borte hele natten mer enn én gang	☐	☐
140. Jeg skulket ofte skolen	☐	☐

Angi med ett tall *hvordan du har fungert de siste 6 månedene* (gå ut i fra de tre beste månedene), og hvordan du har fungert *de siste ukene.*

Tenk deg at du angir 100 hvis du har vært helt frisk, *ikke hatt noen psykiske symptomer og har fungert utmerket i forhold til familie og arbeid*. Tenk deg at du angir 1 hvis du har vært svært alvorlig psykisk syk og helt ute av stand til å ta hånd om deg selv. Du kan velge et hvilket som helst tall mellom 1 og 100, f. eks. 45, 68 eller 72. *Se bort fra funksjonsnedsetting på grunn av kroppslige plager.*

Les alle eksemplene nedenfor og angi i rutene det tallet som svarer best til funksjonsnivået ditt.

De siste seks månedene: ____ **De siste ukene: ____**

100 Du har ikke hatt noen som helst symptomer. Du har deltatt i mange ulike aktiviteter og fungert utmerket hjemme, blant venner og på arbeid.

90 Du har fungert bra og bare hatt veldig lette symptomer som nervøsitet foran en prøve eller en opptreden. En gang i blant kan du ha hatt små hverdagslige problemer eller bekymringer (f. eks. kranglet med noen i familien).

80 Du har hatt LETTE, forbigående symptomer og problemer som var enkle å forstå ut ifra hva som har skjedd.

70 Du har hatt MILDE symptomer, du har f. eks. vært litt nedstemt eller hatt lette søvnvansker. Du har stort sett fungert bra og har hatt flere gode venner, men du kan ha hatt visse problemer på arbeid eller skole.

60 Du har hatt MODERATE symptomer, f. eks. enkelte angstanfall, eller følt deg deprimert av og til, *eller* du har få venner og har hatt en del konflikter privat eller på arbeid.

50 Du har hatt ALVORLIGE symptomer. Du har f. eks. vært dypt nedstemt og tenkt på å ta livet av deg, *eller* du har ikke hatt venner i det hele tatt, du har hatt det så dårlig at du ikke klarte å arbeide eller studere.

40 Du har hatt SVÆRT ALVORLIG symptomer som merkelige tanker og hallusinasjoner, eller vært så dypt nedstemt at du ikke brydde deg om familie eller venner, *og* du har hatt store problemer hjemme og ikke kunnet være på arbeid eller skolen.

30 Du har hatt SVÆRT ALVORLIG symptomer, f. eks. stadige selvmordsplaner eller befalende hørselshallusinasjoner, *eller* du har ikke fungert verken hjemme eller på arbeid og for det meste ligget til sengs.

20 Du har hatt EKSTREMT ALVORLIGE symptomer (som overfor), *og* du har gjort selvmordsforsøk eller forsøkt å skade en annen person, *eller* du har hatt så store problemer at du i perioder ikke kunne ta hånd om deg selv.

10 Du har hatt EKSTREMT ALVORLIGE symptomer med gjentatte selvmordsforsøk. Du har måttet hatt tilsyn for ikke å skade deg selv eller andre, *eller* du har fungert så dårlig at du ikke har kunnet spise eller ivareta hygienen din, og behøv hjelp med alt.

1

Livshendelser

Ulike påkjenninger kan påvirke hvordan man har det fysisk og psykisk. Har du i løpet av de siste 6 månedene hatt problemer av det slaget som beskrives nedenfor? Les gjennom spørsmålene og sett ring rundt det svaret som stemmer for deg.

Har du hatt problemer innenfor familien, f. eks. skilsmisse, konflikter eller bekymringer for et annet familiemedlems helse?	**JA**	**NEI**
Har du vært ensom og isolert?	**JA**	**NEI**
Har du mistet en viktig person, f. eks en nær slektning?	**JA**	**NEI**
Har du vært fysisk syk?	**JA**	**NEI**
Hvis du ikke er pensjonist: Har du hatt jobbrelaterte problemer (har du f. eks. vært eller er du arbeidsledig), eller er du misfornøyd med arbeidssituasjonen din?	**JA**	**NEI**
Hvis du studerer: Har du hatt problemer med studiene, eller er du misfornøyd med studievalget ditt eller studiemiljøet ditt?	**JA**	**NEI**
Har du hatt boligrelaterte problemer, f. eks. vært uten bolig eller vært utilfreds med boligen din eller bostedet ditt?	**JA**	**NEI**
Har du hatt økonomiske problemer, f. eks. hatt gjeld eller hatt problemer med å få pengene til å strekke til?	**JA**	**NEI**
Har du hatt problemer med å få hjelp fra helsevesenet, f. eks. på grunn av økonomi, transportproblemer, utilgjengelighet eller annet?	**JA**	**NEI**
Har du hatt med rettsvesenet å gjøre, enten fordi du selv har vært utsatt for en forbrytelse, eller fordi du har blitt anklaget eller dømt for en forbrytelse?	**JA**	**NEI**
Har du opplev katastrofer, f. eks. krig, naturkatastrofe eller en alvorlig ulykke?	**JA**	**NEI**

Hvis du har svart ja på ett eller flere spørsmål overfor – hvilken grad av belastning mener du at det alt i alt har vært for deg? Forsøk å vurdere den totale alvorlighetsgraden ved hjelp av skalaen nedenfor og sett ring rundt det tallet som passer best for deg:

1: Ingen **2: Lett** **3: Moderat** **4: Stor** **5: Ekstrem** **6: Katastrofal**

12 Articles I - III

In this section, papers are presented in accordance with, and in the order of the overreaching aims, research questions, and chosen methods of the study.

International Journal of Offender Therapy and Comparative Criminology

http://ijo.sagepub.com/

Looking for the Hannibal Behind the Cannibal: Current Status of Case Research

Aina Sundt Gullhaugen and Jim Aage Nøttestad

Int J Offender Ther Comp Criminol 2011 55: 350 originally published online 22 April 2010

DOI: 10.1177/0306624X10362659

The online version of this article can be found at:
http://ijo.sagepub.com/content/55/3/350

Published by:

http://www.sagepublications.com

Additional services and information for *International Journal of Offender Therapy and Comparative Criminology* can be found at:

Email Alerts: http://ijo.sagepub.com/cgi/alerts

Subscriptions: http://ijo.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations: http://ijo.sagepub.com/content/55/3/350.refs.html

Downloaded from ijo.sagepub.com at NTNU - Trondheim on April 28, 2011

Is not included due to copyright

International Journal of Offender Therapy and Comparative Criminology
http://ijo.sagepub.com/

Under the Surface: The Dynamic Interpersonal and Affective World of Psychopathic High-Security and Detention Prisoners

Aina Sundt Gullhaugen and Jim Aage Nøttestad
Int J Offender Ther Comp Criminol published online 26 July 2011
DOI: 10.1177/0306624X11415633

The online version of this article can be found at:
http://ijo.sagepub.com/content/early/2011/07/14/0306624X11415633

Published by:

http://www.sagepublications.com

Additional services and information for *International Journal of Offender Therapy and Comparative Criminology* can be found at:

Email Alerts: http://ijo.sagepub.com/cgi/alerts

Subscriptions: http://ijo.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Downloaded from ijo.sagepub.com at NTNU - Trondheim on September 19, 2011

Is not included due to copyright

Treatment of psychopathy? Testing theoretical models for the purpose of future forensic practice.

Is not included due to copyright