

Psychological Assessment with the Rorschach and the MMPI-2 in a Forensic Psychiatric Hospital

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Abstract. In this article, the possibilities of forensic psychological assessment by means of several diagnostic methods (i.e., the MMPI-2 and the Rorschach Inkblot Method) are reviewed. A case example illustrates the serious personality pathology that is often present in forensic psychiatric patients. The basic premise of this case example is that the psychologist's armamentarium of assessment techniques can be strengthened by using the MMPI-2 and the Rorschach together in a complimentary fashion, and these can be of value in evaluating progress (i.e., change in psychopathology) during long-term forensic psychiatric treatment. It is concluded that only the objective measurement of such change, using reliable and valid psychological tests, can increase our knowledge of the effectiveness of forensic psychiatric treatment

Keywords: MMPI-2, Rorschach, forensic psychological assessment, forensic psychiatric treatment

Introduction

Forensic psychological assessment is a specific form of psychological assessment requiring specific test instruments, diagnostic expertise, and ways of reporting. Generally, forensic clients do not voluntarily take part in a psychological examination. In addition, the well-being of the client is not the primary focus of attention; assisting the trier-of-fact is (Greenberg & Shuman, 1997). The involuntary aspect of forensic psychological examinations and the possible legal consequences of such an evaluation can lead to socially desirable responding and deception by the client (de Ruiter, 2000[a or b?]; Rogers, 1997). As a consequence, standards for

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forensic assessment are higher compared to standards for diagnostic assessment in a clinical context (American Psychology-Law Society [AP-LS], 1991). For this reason, in several Anglo-Saxon countries specific professional training programs exist as well as a specific professional ethics code for forensic psychologists (see, among others, AP-LS, 1991; British Psychological Society, 2002). Forensic psychologists need to base their judgment on the evaluated individual in detail and thoroughly test several competing hypotheses before answering the diagnostic questions (Art. VI.B. and VI.C., AP-LS, 1991).

In this article, we clarify the possibilities of forensic psychological assessment by means of several diagnostic issues that are the focus of attention in forensic psychological assessment. Also, a case example is presented. The basic premise of this case example is that the psychologist's armamentarium of assessment techniques can be strengthened by using the MMPI-2 and the Rorschach together in a complimentary fashion, and these can be of value in evaluating the effectiveness of forensic psychiatric treatment. First of all, however, we provide a brief overview of the legal context in which the treatment of personality disordered offenders takes place in The Netherlands. (For a more extensive discussion of Dutch criminal law in relation to mentally disordered offenders, see de Ruiter and Hildebrand, 2003). Finally, we review the findings from recent studies on the prevalence of personality disorders and research into treatment effectiveness in different forensic settings in The Netherlands.

Disposal to Be Involuntarily Admitted to a Forensic Psychiatric Hospital on Behalf of the State

According to the Dutch Code of Criminal Procedure (*Wetboek van Strafvordering*, Sv., Article 352, Section 2) and the Dutch Code of Criminal Law (*Wetboek van Strafrecht*, Sr., Article 39), as a general rule, in cases where the criminal act is legally proven but the offender cannot be held responsible for the crime he committed because of mental defect or disorder, the offender will not be considered punishable. Dutch criminal law recognizes two measures that can be applied to mentally disturbed offenders. First, the law offers the possibility for a defendant who is found not responsible for the crime to be admitted to a psychiatric hospital, but only if he is a danger to himself or to others or to the

general safety of persons or property (Article 37, Section 1 Sr.). Second, Article 37a of the Dutch Code of Criminal Law states that a defendant who, at the time of the alleged crime, suffered from a mental defect or disorder may receive what is called a “disposal involuntary admittance to a forensic psychiatric hospital on behalf of the state” (*maatregel van terbeschikkingstelling, TBS*). In the remainder of this article, we will refer to this judicial measure as a “TBS order.”

The law requires that *at least* two experts from different disciplines report on the defendant, before the trial court can decide to impose a TBS order. One of the experts must be a psychiatrist (Article 37a, Section 3 and Article 37, Section 2 Sr.). A TBS order can be imposed by the court if the following conditions apply (Article 37a Sr.):

1. The defendant must suffer from a mental disorder, which means that his responsibility for the alleged crime is (severely) diminished or absent. In the following, we elaborate on the degrees of criminal responsibility in the Dutch legal system.
2. The crime carries a prison sentence of at least 4 years, or the offense belongs to a category of offenses carrying a lesser sentence specifically mentioned in the law.
3. There is a risk for the safety of other people or for the general safety of persons or goods.

In theory, a TBS order is of indefinite duration (Article 38e, Section 2 Sr.). Initially imposed for 2 years (Article 38d, Section 1 Sr.), it may be extended for 1- or 2-year periods as the court re-evaluates the patient to determine whether the risk for the safety of other people or for the general safety of persons or goods is still too high (Article 38d, Section 2 Sr.). TBS involves involuntary admission to a specialized maximum-security forensic psychiatric hospital (Article 37d, Section 1 Sr.) aimed at motivating the patient to participate voluntarily in the treatment programs offered by the hospital. The implication for clinical practice is that it is legally permitted to place a patient in a living group with fellow patients and to structure his daily life in such a way that it is almost impossible for him to avoid contact with members of the hospital staff. However, patients are free to refuse, for example, pharmacotherapy and to avoid participating in specific therapeutic activities such as psychotherapy. Because the TBS order can be extended as long as the TBS patient poses a risk, refusal of treatment generally implies a prolonged stay in the hospital. Although there are (rather large) differences in the treatment models the 13 Dutch forensic psychiatric hospitals adhere to,

the treatment provided within the legal framework of the TBS generally strives to effect behavioral change that leads to a reduction in violence risk.

Prevalence of Psychiatric Disorders in TBS Patients

During the past decade, the number of beds in forensic hospitals in The Netherlands has shown a steady increase from 650 in 1995 to around 1650 in 2006 (Dienst Justitiële Inrichtingen, 2006[not in refs]). Approximately 95% of patients are male, 28% are nonnative (mostly Antillean, Surinamese, Indonesian, Turkish, Moroccan), and 83% have only elementary school or lower vocational training. The offenses for which they are sentenced are violent crimes, such as (attempted) murder or manslaughter, rape, indecent assault, arson, pedosexual offences, robbery, and extortion (van Emmerik, 2001[not in refs]).

Research has shown that 25% of TBS patients suffer from a psychotic disorder (18% schizophrenia, 2% organic psychosis, and 5% other psychotic disorders), and approximately 80% fulfill diagnostic criteria for one or more DSM-III-R or DSM-IV personality disorders (American Psychiatric Association, 1994; van Emmerik, 2001[not in refs]; Greeven, 1997; Hildebrand & de Ruiter, 2004). In sharp contrast to the situation in North America, a large proportion of patients in Dutch forensic psychiatric hospitals have a personality disorder (PD) without a concomitant major mental disorder. In a sample of 94 TBS patients from the Dr. Henri van der Hoeven Kliniek, using the Dutch version of the Structured Interview for DSM-IV Personality Disorders (SIDP; Pfohl, Blum, & Zimmerman, 1995) Hildebrand and De Ruiter (2004) found that 66% fulfilled diagnostic criteria for a Cluster B personality disorder; for Cluster A, 29% fulfilled criteria and for Cluster C, 22%. The most frequently diagnosed Cluster B disorders were: antisocial (48%), narcissistic (28%), and borderline (26%). Paranoid PD also had a relatively high prevalence rate (19%). Lifetime comorbidity between Axis I and Axis II disorders was 72%; 48% met criteria for at least one substance-related disorder (Hildebrand & de Ruiter, 2004). Seventeen percent of the sample met criteria for schizophrenia or another psychotic disorder.

Timmerman and Emmelkamp (2001) studied the prevalence of DSM-III-R Axis I and Axis II disorders with standardized semistructured interviews in a sample of 39 TBS patients from Forensic Psychiatric Center

Veldzicht. They found that 87% received a diagnosis of PD, most often from Cluster B. Only 3 of the 39 patients were diagnosed with a major mental disorder (schizophrenia, bipolar disorder).

Treatment Under the TBS Order

Every forensic psychiatric hospital has a legal obligation to (1) provide security to society, (2) treatment for the offender-patient, and (3) to protect the civil rights of the latter. These three components need to be balanced in the forensic psychiatric setting and each hospital makes its own choices in this regard, in conjunction with its therapeutic model and level of security. Although the treatment models of the hospitals vary, they all involve a composite of education, work training, individual and group psychotherapy, and creative arts and leisure activities. The general treatment aim is a reduction in future violence risk by means of a positive change in those factors that are associated with (sexual) violence for the individual patient. For instance, in cases of schizophrenia, treatment is focused on psycho-education about psychosis and its precursors, on medication adherence, and daily living skills. Patients with personality disorders participate in various group-therapy programs, such as social skills training, and aggression and impulsivity management. There are special programs for substance abusers and sex offenders. Almost all patients receive individual psychotherapy that focuses on their individual risk factors for reoffending by means of the so-called offense script and relapse prevention (van Beek, 1999). Education and job training are an important aspect of treatment, because many patients are lacking the skills they need to be successful on the job market (de Ruiter, 2000[a or b?]).

Observation and Assessment

Prior to admission to the hospital, the prospective patient is visited while he is still in prison. These visits are meant to provide the new patient with some basic information about the hospital and to get to know him. The first months of his actual stay at the hospital are used for extensive observation, assessment, and preparation for treatment. From the first day on, the patient has a program of daily activities, including work,

education, creative arts, and sports. Work supervisors, group leaders, and teachers observe patients during their activities and report on their observations.

During this period, forensic psychologists see the patient for personality and cognitive assessment. The objective of personality assessment is to obtain insight into the factors that are related to the patient's risk of violence. To this end, semistructured interviews (for DSM-IV Axis II disorders and the Psychopathy Checklist-Revised interview), self-report personality inventories such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2, Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), as well as anger, impulsivity, and interpersonal behavior scales and indirect tests (e.g., the Rorschach Inkblot Method; Exner, 1993) are administered. Personality assessment results are used to help formulate treatment goals and a treatment plan, and to provide standardized information for empirical research. The findings from the cognitive assessment result in a plan for work and education.

Evaluation of Treatment

Treatment progress is evaluated on a regular basis, e.g., every 3 months, both orally and in writing. The patient's progress is discussed with fellow patients during a meeting with the living group and during a meeting with the persons (teachers, therapists, etc.) who are involved in the patient's treatment. In most hospitals, after a period of time (e.g., 1 year) the patient is retested with a number of the personality tests that were administered upon admission to the hospital. In this way, objective instruments provide information on the patient's progress. Important phases in the treatment process, such as extended leave, are discussed at evaluations.

Resocialization

In general, hospital staff aims to limit the duration of the inpatient treatment phase for each patient, of course without losing sight of society's safety. When feasible, a patient is placed in a so-called "transmural setting." These patients are supported by a special team of group leaders of the hospital, who supervise them during this resocialization phase.

Supervision is sometimes conducted in collaboration with other mental health institutions, such as half-way houses.

Violence Risk Assessment and Management Under the TBS Order

Risk assessment and management are ongoing tasks of the staff of forensic psychiatric hospitals where TBS patients stay. All proposals for extensions of leave have to be announced to the Ministry of Justice, who carries the ultimate responsibility for the execution of the TBS order. Leave decisions that have to be approved include, for instance, the first time the TBS patient is allowed outside the physical security of the institution, still under staff supervision, travel without staff supervision, and leave on probation.

Every 1 or 2 years, the patient's case has to be reviewed by the court (Article 38d, Section 1 Sr.), which decides whether the TBS needs to be extended or can be terminated in the individual case. The forensic hospital has to submit a report to the court that gives information on the mental disorder of the patient, treatment progress, the assessment of recidivism risk, and advice on the extension or termination of the TBS. Judges do not always follow the hospital's advice; in one in five cases they opt for termination of the TBS against the latter's advice. Several studies have shown that forensic hospital staff is better at predicting recidivism in their patients than judges. In a long-term follow-up (> 5 years) of 40 patients who had been treated at the Van der Hoeven Kliniek, violent recidivism rates of patients who had been released by the judge against the hospital's advice were significantly higher than recidivism rates of patients released on the hospital's advice (25% vs. 55%; Niemantsverdriet, 1993). Similar findings are reported by van Emmerik (1989) and Leuw (1999).

Nowadays, as a general procedure, structured clinical guidelines for the assessment of violence risk (e.g., the HCR-20; Webster, Douglas, Eaves, & Hart, 1997; Dutch translation: Philipse, de Ruiter, Hildebrand, & Bouman, 2000) and sexual violence risk (SVR-20; Boer, Hart, Kropp, & Webster, 1997; Dutch translation: Hildebrand, de Ruiter, & van Beek, 2001) are administered and judgments on the patient's risk are based on these structured methods. These instruments are significantly better predictors of violent recidivism than unstructured clinical judgment (de Vogel, de Ruiter, van Beek, & Mead, 2004; de Vogel, de Ruiter, Hildebrand, Bos, & van de Ven, 2004). Typically, these instruments consist of

20 items (risk factors), all developed from a thorough consideration of the empirical literature and the clinical expertise of a number of experienced forensic mental health professionals. Items relate to risk factors in the past (historical scale), to the present state of the patient (clinical scale), and to the future (risk management scale). The items are coded on a 3-point scale: 0 = *item does not apply according to the available information*, 1 = *item probably or partially applies*, and 2 = *item definitely applies*. Information needed to code the items includes, for example, criminal records/police files, psychological/psychiatric reports, observations, and is preferably from [OK?] different sources and gathered with different methods. The coding of the items should be viewed as the first step in the assessment process. In any given risk assessment, there can be additional, case-specific risk factors that are relevant. *The final risk judgment*, the structured professional judgment that is arrived at through the process of coding the items and integrating all available information, has to be judged as “low,” “moderate,” or “high” and is valid for a specific time period (e.g., during a specific treatment phase) and/or for a given context (e.g., inpatient or outpatient). The final risk judgment is not a simple summation of the item scores of the instrument (e.g., HCR-20 or SVR-20), but also depends on specific combinations or factors or other considerations (i.e., case-specific factors). Using these instruments reduces the risk of missing important or specific risk factors or emphasizing risk factors based on personal biases. By using standardized risk assessment instruments, the appraisal of offense-risk gains in standardization, transparency, and empirical support (Webster et al., 1997).

Treatment Effectiveness Research

The Dutch forensic mental health field is increasingly aware that forensic treatment needs to be evidence-based. Most forensic hospitals offer cognitive-behavioral treatments but, thus far, no controlled studies of outcome have been reported. Timmerman and Emmelkamp (2005) conducted a naturalistic follow-up study with 39 forensic inpatients across a 3-year follow-up period. They reported a significant decrease on self-report measures of distrust and anger, and a significant decrease in oppositional behavior on staff ratings, but no effect on prosocial behaviors. Most significant effects were moderate in terms of Cohen’s effect size *d*.

Greeven and de Ruiter (2004) obtained somewhat more favorable find-

ings with their naturalistic study design in a sample of 59 personality-disordered TBS patients. After 2 years of inpatient forensic treatment, the PDQ-R showed significant improvement on all PD dimensions, except for histrionic PD. Some 39% of the sample improved reliably (by more than 2 *SDs*; Jacobson & Truax, 1991) and 27% also fulfilled criteria for clinically significant change on self-reported PD symptoms. However, as previously mentioned, the PDQ-R is a self-report inventory and it should be noted that the use of self-report measures to diagnose PDs, in particular in forensic populations, has serious drawbacks because of underreporting.

Hildebrand, de Ruiter, and van Zaane (submitted) studied 87 mentally disordered offenders during a 2-year time interval, from admission to 2 years into treatment in one forensic hospital. They used a standardized test battery including semistructured interviews, self-report inventories, staff observation scales, and performance-based personality tests to examine change in dynamic risk factors for violence such as egocentricity, hostility, impulsivity, and distrust. In this study, the same risk factor (e.g., hostility) was always assessed using more than one diagnostic method (e.g., staff observation *and* self-report) The results indicated that the patients, on average, showed very little change in the dynamic risk factors when multimethod assessment was used. Of course, the generalizability of these findings to other forensic hospitals is limited. However, this study shows that it is not easy to effect psychological and behavioral change in patients who are staying in a forensic hospital, even though the assessment instruments that were used had been sensitive to change in earlier research, with other patient populations.

Forensic Psychological Assessment: Some Hazards and Guidelines

The objective of forensic clinical personality assessment is to obtain insight into the factors that are related to the patient's risk for violence. Whether a mental disorder is present, and if so, which one, is usually more complicated to determine in forensic psychological than in a general psychological evaluation. First, when examining a suspect of a severe crime, for example, there is often a substantial time period between the time of the alleged crime and the psychological evaluation. The question that a judge wants answered is whether the suspect was suffering from a mental disorder at the time of the alleged crime, and to evaluate a situation in the past (post diction). In general, psychologists

are trained in determining the present status of an individual and the psychological tests they use do not quite fit post diction purposes.

Also, a psychological assessment in a forensic context can interfere with making an accurate diagnosis. The individual under examination (e.g., suspect, forensic inpatient) is often forced by law to stay in a secure setting and/or unwilling to take part in forensic examination. The evaluated individual may, therefore, be more inclined to give defensive or socially desirable answers and possibly even have a deceptive or manipulative attitude. In choosing psychological tests it is important to bear in mind that tests that correct for such misrepresentations are preferable, as well as tests in which the instrument's purpose is not transparent to the evaluated subject. The Rorschach Inkblot Method (RIM; Exner, 2001; Weiner, 1998[**not in refs**]) is such a method. Furthermore, answering questions on the nature of a mental disorder can be complicated by the presence of personality pathology, which is often the case in forensic subjects. Stated previously, several personality disorders from the DSM-IV, the paranoid, antisocial, narcissistic, and borderline personality disorders, are overrepresented in forensic settings (Greeven, 1997; Hildebrand & de Ruiter, 2004). These disorders are characterized by an unrealistic self-image and the inclination to externalize the cause of personal problems. If a combination of narcissistic and antisocial problems (a diagnosis of psychopathy: Psychopathy Checklist-Revised [PCL-R]) is present, pathological lying and conscious manipulation may easily occur. Therefore, in order to get insight in the psychological functioning of an individual, forensic psychologists need to examine collateral information such as file-information and interviews with or behavioral reports from key informants (e.g., family, friends, treating clinicians, prison officers) and not exclusively base their judgment on self-reports by the subject. Research results indicate that instruments requiring collateral information, such as the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl et al., 1995) should be used in forensic settings instead of measures based solely on self-report such as the Personality Disorder Questionnaire-Revised (PDQ-R; Hyler & Rieder, 1987). PDs common in forensic settings, such as the antisocial and the narcissistic personality disorder are under diagnosed when using the PDQ-R in comparison to the SIDP-R (de Ruiter & Greeven, 2000).

Based on the above-mentioned specific hazards that can occur during forensic psychological evaluation, guidelines can be outlined for the choice and the use of psychological tests in a forensic setting. First, multimethod assessment should be employed, because distinct assess-

ment methods provide unique sources of data. On the basis of a large array of evidence, Meyer et al. (2000; see also Meyer, 1997) argued that “optimal knowledge in clinical practice (as in research) is obtained from the sophisticated integration of information derived from a multimethod assessment battery” (p. 155). Multimethod assessment is particularly important in forensic subjects, who tend to be more prone to defensive responding, faking good, or faking bad than subjects who are not assessed under mandatory conditions. By using different types of tests to assess the same personality trait (e.g., impulsivity, egocentricity) the findings with one method can be cross-validated against the findings obtained with another measure. Secondly, the use of file-information and hetero-anamnesis data is indispensable, among other things to test the truthfulness of the individual’s statements. Third, objective instruments are used to assess the extent to which a patient has changed during the treatment, or to examine the effectiveness of recommendations and interventions. Finally, forensic psychological assessment requires the use of specific forensic test instruments such as the PCL-R (Hare, 1991, 2003), since psychopathy is a strong predictor of (sexual) violent reoffending (Hildebrand, de Ruiter, & de Vogel, 2004; Salekin, Rogers, & Sewell, 1996).

Table 1. Forensic psychological test battery

Domain	Instruments
Risk of future violence	HCR-20/SVR-20
Impulsivity	BIS; MMPI-2; PCL-R; RIM CS
Interpersonal behavior	ICL-R
Personality structure/disorders	MMPI-2; Rim CS; SIDP-IV
Psychopathy	PCL-R
Substance use problems	ASI, MMPI-2
Anger/anger control	MMPI-2; NAS; RIM CS
Egocentrism	RIM CS

Note. ASI = Addiction Severity Index (McLellan, Luborsky, Woody, & O’Brien, 1980); BIS = Barratt Impulsiveness Scale (Barratt, 1959, 1994); HCR-20 = Historical, Clinical, Risk Management-20 (Webster et al., 1997); ICL-R = Interpersonal Checklist-Revised (LaForge & Suczek, 1955); MMPI-2 = Minnesota Multiphasic Personality Inventory (Butcher et al., 1989); NAS = Novaco Anger Scale (Novaco, 1994); PCL-R = Psychopathy Checklist-Revised (Hare, 1991, 2003); RIM CS = Rorschach Inkblot Method, according to the Comprehensive System (Exner, 1993, 2001); SIDP-IV = Structured Interview for DSM-IV Personality Disorders (Pfohl et al., 1995); SVR-20 = Sexual Violence Risk-20 (Boer et al., 1997).

In Table 1 we present what we call a standard forensic psychological test battery, including semistructured interviews (for DSM-IV Axis II disorders and the PCL-R interview), self-report personality inventories (e.g., the MMPI-2; Butcher et al., 1989) and anger, impulsivity, and interpersonal behavior scales), and indirect tests (e.g., the RIM; Exner, 1993). The use of the battery will be illustrated in the following case example.

Case Example

Walter is a 39-year-old man convicted for extortion. He has been sentenced to 6 years imprisonment and mandatory treatment under the TBS order. In the past, Walter has been convicted for robbery and aggravated assault. He is admitted to a forensic psychiatric hospital and takes part in a psychological evaluation to determine treatment targets. Treatment will focus on reducing the risk of reoffending.

Background Information

Walter was raised as the oldest child in a family of four children. He has two sisters and a brother. The family functioned as a relatively closed system, where there was hardly any contact with family members, neither from the father's side, nor from the mother's side, nor with people outside of the family. The parents said they were happy together. Mother is described as a loving, caring woman, but she was not able to provide structure and rules to the children. Father was active doing chores around the house, organized activities with the children, and provided the necessary order. Father was strict and sometimes harsh, but Walter appreciated him.

The first years of Walter's life proceeded without many problems. He liked elementary school and had a lot of friends. He did have a tendency to go his own way.

When Walter was 12 years old his father died of cancer. The death of his father clearly influenced Walter's development. He felt guilty because he had wished him dead at times during their quarrels. He could not talk with his mother about the loss. She did not want her children to see a grieving mother; so she kept her feelings strictly to herself. Walter lost interest in family activities and was unable to have fun after his

father's death. While he was doing reasonably well in elementary school, Walter did much worse in secondary vocational school. At 15, he dropped out of school. He found work as a bricklayer, but enlisted with the Royal Marine two years later. The adventure and thrill appealed to him. After his initial training he was stationed on a marine ship, which turned out to be a great disappointment. He found the work boring and after a few incidents for which he received disciplinary sanctions, he was laid off. He literally ended up on the streets. Because of the frequent quarrels, he could not return home. Together with a group of peers, he started on a criminal career, beginning with burglary, followed by robberies.

Walter started to lead a double-life. On the one hand there was his criminal behavior; on the other hand, he had a relationship with his girlfriend – whom he later married; she was unaware of his criminal activities, just like his other family members. He kept everything secret, conjured up excuses, and was able to convince the people around him of his good intentions. After a while, his wife discovered what Walter was up to, and filed for divorce. Walter was 30 years old at the time. According to Walter, something snapped inside him at that time. Within a period of 2 years he had committed a set of offenses, he claims because of lack of money. He was ultimately arrested after he had threatened an employee of a jeweler store with a firearm, after which she gave him a suitcase with money.

Psychological Assessment upon Admission

Psychological assessment upon admission (T1) focuses on treatment targets. The following test methods were used to obtain insight into the nature and seriousness of Walter's problems; all instruments were administered according to standard administration procedures explained in the respective test manuals.

- *Semistructured interviews:* Walter was interviewed to obtain data on PCL-R psychopathy and on DSM-IV personality disorders. Psychopathy was assessed using the Dutch language version (Vertommen, Verheul, de Ruiters, & Hildebrand, 2002[not in refs]) of the PCL-R (Hare, 1991, 2003). The PCL-R was completed on the basis of the semistructured interview and file information. DSM-IV Axis II diagnoses were obtained by administration of the Dutch translation of the SIDP-IV.
- *Self-report inventories:* Dutch translations of the Barratt Impulsivity

Scale (BIS), Interpersonal Checklist-Revised (ICL-R), Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and Novaco Anger Scale (NAS). For the interpretation of the self-test report test findings in this case example, only the MMPI-2 was used.

- *Performance based personality test*: RIM (Comprehensive System; Exner, 2000).

Test Results and Interpretation

- *SIDP-IV*. Walter meets criteria for (DSM-IV) antisocial personality disorder.
- *MMPI-2*. The T-scores on the MMPI-2 validity and clinical Scales are presented in Figure 1. The validity scales (L = 41, F = 50, K = 61) are within expected limits (Friedman, Lewak, Nichols, & Webb, 2003[**not in refs, or 2001?**]). There were no indications of an attempt either to defensively minimize or to exaggerate symptoms or psychological problems.

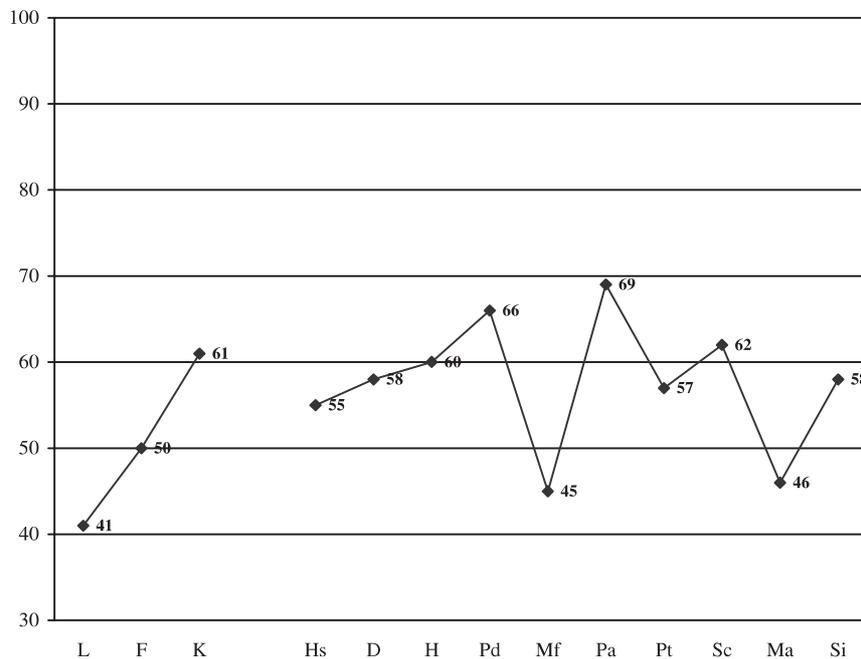


Figure 1. Walter's MMPI-2 validity and clinical scales (T-scores) at admission (T1).

Forensic Rorschach Assessment

Table 2. T1: RIAP™ structural summary

Client Name: Walter	Gender: Male	Test Date:
Client ID:	Date of Birth: 01-01-1964	Description: T1

Location Features	Determinants	Contents	S-Constellation																																										
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AG	= 0	PHR = 4																																											
COP	= 1	MOR = 1																																											
CP	= 0	PER = 0																																											
		PSV = 0																																											
Form Quality <table border="1"> <thead> <tr> <th>FQx</th> <th>MQual</th> <th>W+D</th> </tr> </thead> <tbody> <tr> <td>+ = 0</td> <td>0</td> <td>0</td> </tr> <tr> <td>o = 16</td> <td>3</td> <td>15</td> </tr> <tr> <td>u = 14</td> <td>0</td> <td>10</td> </tr> <tr> <td>- = 5</td> <td>1</td> <td>4</td> </tr> <tr> <td>none = 0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	FQx	MQual	W+D	+ = 0	0	0	o = 16	3	15	u = 14	0	10	- = 5	1	4	none = 0	0	0																											
FQx	MQual	W+D																																											
+ = 0	0	0																																											
o = 16	3	15																																											
u = 14	0	10																																											
- = 5	1	4																																											
none = 0	0	0																																											

RATIOS, PERCENTAGES, AND DERIVATIONS

R = 35	L = 1.19	AFFECT	INTERPERSONAL
EB = 4 : 4.5	EA = 8.5	EBPer = N/A	COP = 1
eb = 7 : 7	es = 14	D = -2	AG = 0
	Adj es = 14	Adj D = -2	GHR:PHR = 4 : 4
			a:p = 9 : 2
			Food = 0
FM = 6	SumC' = 4	SumT = 0	SumT = 0
m = 1	SumV = 1	SumY = 2	Human Content = 9
			Pure H = 2
			PER = 0
			Isolation Index = 0.22
		FC:CF+C = 1 : 4	
		Pure C = 0	
		SumC' : WSumC = 4 : 4.5	
		Afr = 0.67	
		S = 7	
		Blends:R = 7 : 35	
		CP = 0	

IDEATION	MEDIATION	PROCESSING	SELF-PERCEPTION
a:p = 9 : 2	XA% = 0.86	Zf = 22	3r+(2)/R = 0.19
Ma:Mp = 4 : 0	WDA% = 0.86	W:D:Dd = 13:16:6	Fr+rF = 0
2AB+(Art+Ay) = 3	X-% = 0.14	W : M = 13 : 4	SumV = 1
MOR = 1	S- = 1	Zd = -5.0	FD = 0
	P = 8	PSV = 0	An+Xy = 1
	X+% = 0.46	DQ+ = 11	MOR = 1
	Xu% = 0.40	DQv = 1	H:(H)+Hd+(Hd) = 2 : 7

PTI = 0	<input checked="" type="checkbox"/> DEPI = 5	<input type="checkbox"/> CDI = 2	<input type="checkbox"/> S-CON = 7	<input checked="" type="checkbox"/> HVI = Yes	<input type="checkbox"/> OBS = No
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With regard to the clinical scales, the 46/64 codetype suggests that Walter frequently feels angry, resentful, and irritable. He typically tries to suppress, ignore, and conceal anger as he views being angry as shameful and does not want others to think he is a hostile, resentful person. As a result of his tendency to deny anger, he may not be aware of the intensity of his hurt and angry feelings. He typically expresses anger in a passive way that others may find difficult to deal with. He focuses instead on how he has been hurt, neglected, mistreated, or ignored by others. Walter experiences a conflict concerning dependency needs.

- *Rorschach*. The Rorschach Structural Summary on which the interpretation is based is included in Table 2. The coding procedure of Rorschach results is described in more detail in Exner (2000); we briefly discuss the interpretation of the results here.

Several key variables are positive, including the *DEPI*, elevated *Lambda*, and Hypervigilance index (*HVI*). Interpretation of Walter's Rorschach protocol starts with the significant elevation of *DEPI* that signals the presence of sadness and pessimistic thinking associated with depression (*DEPI* = 5). In general, Walter does not have a consistent style of coping with stressful situations. Because he has not developed an effective way of responding to stressful situations, he is quite vulnerable to being disorganized by stress (*D* score = -2; *Adj D* = -2). A considerable potential for impulsive, unpredictable behavior exists given his chronic lack of control over emotions and limited ability to respond effectively to stress (*Adj D* = -2).

The positive *HVI* indicates that Walter is quite guarded and mistrustful of others. He makes a considerable effort to be alert to as many of the cues in his environment as possible. This is reflected in a heightened concern for minor, unusual details that others would ignore or view as unimportant (*Dd* = 6). His efforts to be alert to his environment are (in part) related to a concern that others will act in a hostile, attacking manner (*S* = 6; *COP* = 1). However, Walter takes in too little information and consequently tends to examine his experience less thoroughly than would be advisable. Instead of weighing decisions carefully, he comes to conclusions too hastily, after only cursory attention to relevant considerations (*Zd* = -5.0). Besides, he is not able to think flexibly (*a:p* = 9:2), which may cause a problem in accepting different viewpoints, as is often necessary in psychotherapy.

The Rorschach further suggests that Walter compares himself unfa-

vorably to other people, whom he regards as being more worthwhile than himself ($3r + (2)/R = .19$) and that he experiences feelings of guilt or shame ($V = 1$).

Treatment Targets

It is expected that Walter will behave in a supportive and helping way on his living-group ward. Chances are that he will become sort of “invisible.” To avoid this, group leaders should pay attention to Walter’s experiences. He should be encouraged to ask for help, in order to gain trust in others. It is suggested that creative activities such as drama may be of help in teaching Walter to pay attention to and express his feelings. Aggression regulation training is advised, so Walter can learn to recognize rising tension levels and seek adequate ways of expressing them. Furthermore, Walter could benefit from intensive, twice a week, insight-oriented psychotherapy.

Treatment Progress

According to the treatment staff, Walter appeared increasingly motivated to participate in the treatment program during the first 18 months of his stay at the hospital. He made progress in starting personal contact, his insight into his problems increased, and his distrust and emotional avoidance decreased. He also seems to accept support more easily. Slowly he is realizing that treatment should mainly focus on the development of behavioral control, i.e., recognizing and expressing feelings in acceptable ways. When tensions rise, he tends to retreat into himself, reacts distrustful and hurt, and closes off to others. To retain his psychological balance and to remain focused on his treatment, Walter continues to need the support and encouragement of the treatment staff.

Psychological Assessment After 1.5 Years of Treatment (T2)

In order to provide objective information on treatment progress, Walter was retested with the same assessment battery (interviews excluded) 18 months after admission (T2). The “What Works” literature (e.g., An-

draws, 1995[not in refs]; Andrews & Bonta, 2003[not in refs]) highlights the importance of having evaluation procedures built into offender treatment programs to check if they are meeting the stated objectives. In addition, behavior change (the ultimate goal) is not expected to occur in a vacuum: Concomitant changes in personality, beliefs, and attitudes are expected.

A remarkable observation during the second testing session was that Walter described all contacts within his current situation in terms of “injustice.” Walter considers himself as someone who puts a lot of effort in and works hard, but does not receive anything in return, while others seem to have a much easier time. Feelings of helplessness, anger, and jealousy intermittently arose during these moments and the assessment psychologist felt pushed by the patient to help him find a solution.

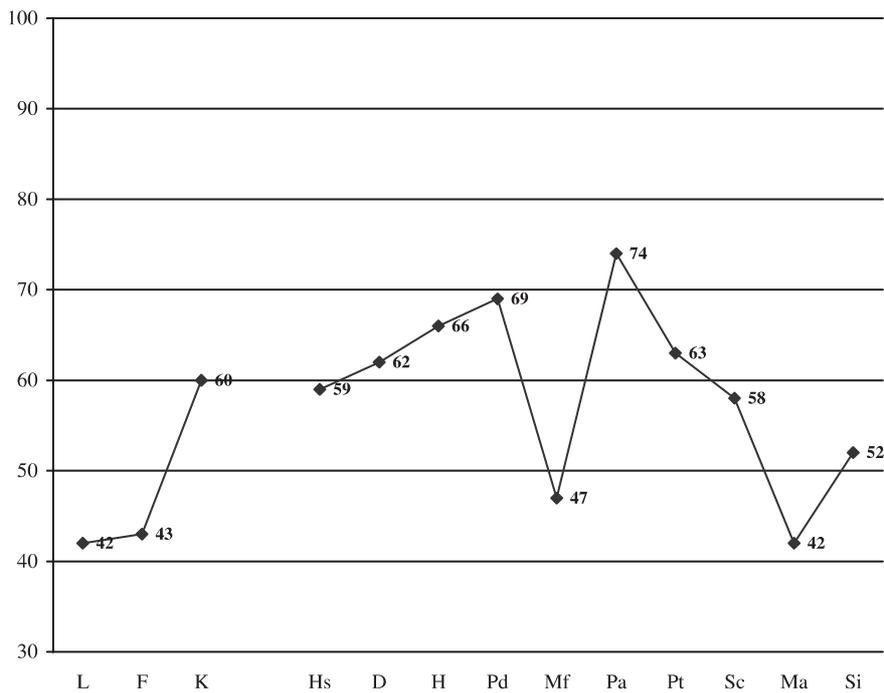


Figure 2. MMPI-2 Validity and Clinical Scales (T-scores) of Walter after 1.5 years of treatment (T2).

Test Results and Interpretation

MMPI-2 Data

Similar to baseline assessment data, the validity scales ($L = 42$, $F = 43$, $K = 60$) are within expected limits. No indications of an attempt either to defensively minimize or to exaggerate symptoms of psychological problems were found.

The scores on the MMPI-2 Clinical Scales (see Figure 2) suggest the presence of more psychological difficulties than at baseline assessment. Scale 4 ($T = 69$) and Scale 6 ($T = 74$) are more elevated than at T1, and Scale 3 is now clinically elevated as well ($T = 66$). According to Friedman et al. (2001), the addition of Scale 3 to the 46/64 code pattern suggests more overcontrol, more neediness, and more superficial “niceness” and role playing, with hostility and resentment remaining below surface (p. 302). Walter (still) is mistrustful, skeptical of others, and suspicious of their motivations. Despite his discomfort with people in general, and his anger at authority, he has strong needs for affection and dependency. Much of his discomfort stems from fear of becoming vulnerable, overly dependent, and, therefore, controlled by others.

Rorschach Data

The key variables *DEPI* and *HVI* are still positive (Table 3). Walter presently experiences the ill effects of more situational stress than he can manage adequately ($D < AdjD$). His responses now suggest that he has some capacity for self-insight ($FD = 2$ instead of $FD = 0$ at T1). Unfortunately, this development goes hand-in-hand with overwhelming feelings of fear and helplessness ($Y = 13$; $m = 3$). Walter still feels inferior and inadequate compared to others ($(3r + (2)/R = .18)$). A positive sign is that Walter seems to have more control over his emotions ($FC:CF + C = 6:2$) compared to baseline assessment ($FC:CF + C = 1:4$).

Theoretical Considerations

In the literature, the personality traits that Walter shows are described as covert symptoms of a hypervigilant, narcissistic personality disorder (Akhtar, 1989, 1999). In the test results at T1 and T2, his weak capacity

Table 3. T2: RIAP™ structural summary

Client Name: Walter	Gender: Male	Test Date:
Client ID:	Date of Birth: 01-01-1964	Description: T2

Location Features	Determinants	Contents	S-Constellation	
Zf = 14 ZSum = 52.0 ZEst = 45.5 W = 9 (Wv = 1) D = 16 W+D = 25 Dd = 12 S = 7	Blends M.FC FD.FY FM.FY YE.FC' YF.m FM.FC.FY FY.m FC.m	Single M = 2 FM = 4 m = 0 FC = 3 CF = 2 C = 0 Cn = 0 FC' = 1 C'F = 0 C' = 0 FT = 0 TF = 0 T = 0 FV = 0 VF = 0 V = 0 FY = 6 YF = 1 Y = 0 Fr = 0 rF = 0 FD = 1 F = 9 (2) = 6	H = 2 (H) = 3 Hd = 2 (Hd) = 1 Hx = 0 A = 15 (A) = 0 Ad = 5 (Ad) = 0 An = 0 Art = 2 Ay = 2 Bl = 0 Bt = 6 Cg = 2 Cl = 0 Ex = 0 Fd = 0 Fi = 2 Ge = 0 Hh = 3 Ls = 1 Na = 0 Sc = 2 Sx = 0 Xy = 0 Idio = 0	<input type="checkbox"/> FV+VF+V+FD > 2 <input checked="" type="checkbox"/> Col-Shd Blends > 0 <input checked="" type="checkbox"/> Ego < .31 or > .44 <input type="checkbox"/> MOR > 3 <input checked="" type="checkbox"/> Zd > ±3.5 <input checked="" type="checkbox"/> es > EA <input type="checkbox"/> CF + C > FC <input checked="" type="checkbox"/> X+% < .70 <input checked="" type="checkbox"/> S > 3 <input type="checkbox"/> P < 3 or > 8 <input type="checkbox"/> Pure H < 2 <input type="checkbox"/> R < 17 6 Total
DQ (FQ-) + = 7 (0) o = 28 (6) v/+ = 0 (0) v = 2 (1)			Special Scores Lvl-1 Lvl-2 DV = 1 x1 0 x2 INC = 0 x2 0 x4 DR = 0 x3 0 x6 FAB = 0 x4 0 x7 ALOG = 0 x5 CON = 0 x7 Raw Sum6 = 1 Wgtd Sum6 = 1 AB = 0 GHR = 4 AG = 0 PHR = 4 COP = 2 MOR = 1 CP = 0 PER = 1 PSV = 0	
Form Quality FQx MQual W+D + = 0 0 0 o = 18 3 18 u = 12 0 5 - = 7 0 2 none = 0 0 0				

RATIOS, PERCENTAGES, AND DERIVATIONS

R = 37 L = 0.32	AFFECT FC:CF+C = 6 : 2 Pure C = 0 SumC' : WSumC = 2 : 5.0 Afr = 0.42 S = 7 Blends:R = 8 : 37 CP = 0	INTERPERSONAL COP = 2 AG = 0 GHR:PHR = 4 : 4 a:p = 10 : 2 Food = 0 SumT = 0 Human Content = 8 Pure H = 2 PER = 1 Isolation Index = 0.19
EB = 3 : 5.0 EA = 8.0 EBPer = 1.7 eb = 9 : 15 es = 24 D = -6 Adj es = 10 Adj D = 0		
FM = 6 SumC' = 2 SumT = 0 m = 3 SumV = 0 SumY = 13		

IDEATION a:p = 10 : 2 Sum6 = 1 Ma:Mp = 3 : 0 Lvl-2 = 0 2AB+(Art+Ay) = 4 WSum6 = 1 MOR = 1 M- = 0 M none = 0	MEDIATION XA% = 0.81 WDA% = 0.92 X-% = 0.19 S- = 2 P = 7 X+% = 0.49 Xu% = 0.32	PROCESSING Zf = 14 W:D:Dd = 9:16:12 W : M = 9 : 3 Zd = +6.5 PSV = 0 DQ+ = 7 DQv = 2	SELF-PERCEPTION 3r+(2)/R = 0.18 Fr+rF = 0 SumV = 0 FD = 2 An+Xy = 0 MOR = 1 H:(H)+Hd+(Hd) = 2 : 6
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PTI = 0	<input checked="" type="checkbox"/> DEPI = 5	<input type="checkbox"/> CDI = 1	<input type="checkbox"/> S-CON = 6	<input checked="" type="checkbox"/> HVI = Yes	<input type="checkbox"/> OBS = No
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for self-control and his depression are central features. Within this theoretical interpretation, loyalty conflicts and feelings of injustice form the top layer that hides the underlying narcissistic problems. The hidden aggression remains one of the few possibilities for him to protect his fragile sense of self. This narrow focus manifests itself in Walter's perception and thinking: He holds on rigidly to a single aspect of his environment, losing sight of other, possibly corrective information

The test results reveal that Walter's narcissistic shield is showing some cracks at T2, compared to T1. His personality structure cannot withstand the threatening anxious, depressive, and aggressive feelings. He experiences the distress in the form of bodily complaints and dissatisfaction with his current situation. At this moment in the treatment, a supportive approach is advised and serves to strengthen a realistic self-image. It is hypothesized that Walter will benefit from an empathic attitude, so he feels his feelings and experiences are taken seriously. It is important not to interpret these feelings in term of his (failed) past. The risk of this type of confrontation is that it would undermine his feeble self-image and, thus, strengthen his narcissistic defence. It is important to realize how sensitive Walter is to external stressors. Reducing external stress will help Walter in creating more possibilities to develop a realistic self-image.

Treatment Progress

The period between T2 and T3 (3 years after baseline) was a stressful period for Walter because of his move to a transmural setting. He now works outside the hospital setting and is getting oriented toward leisure activities. His awareness of his limited stress tolerance is increasing during this period. Treatment staff notices that he shares his feelings and experiences more, and asks for help when needed. Still, the danger of self-aggrandizement, distrust, and social withdrawal is quite high.

Psychological Assessment After 3 Years of Treatment

It was no problem to get Walter to cooperate with the third assessment. The desire for someone whom he trusts and who can be trusted, was an important theme during this evaluation. The change to a new treatment facility with new staff has been difficult for him. He has the feeling he

keeps having to prove that he can be trusted and that he is able to manage his own life. He is very sensitive to doubts concerning his personal integrity. These painful experiences are accompanied by (fear of) loss of self-control.

Test Results and Interpretation

MMPI-2 data

In general, the scores on the validity scales (L = 38, F = 43, K = 65) are similar to those on T2, although K (T = 65) is more elevated now. However, there are no signs that Walter attempted either to defensively minimize or to exaggerate symptoms of psychological difficulties.

Also, the scores on the MMPI-2 Clinical Scales (Figure 3) suggest similar psychological difficulties as at the second assessment, although Scale 4 is significantly higher at T3 (T = 80), suggesting a stronger ten-

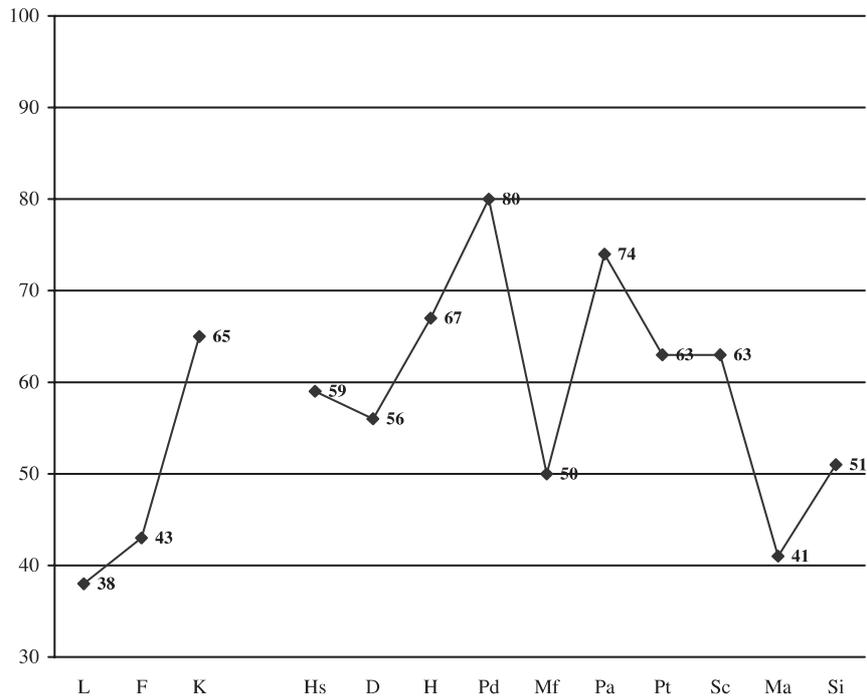


Figure 3. T3: Scores on MMPI-2 validity and clinical scales after 3 years of treatment.

Forensic Rorschach Assessment

Table 4. T3: RIAP™ structural summary

Client Name: Walter	Gender: Male	Test Date:
Client ID:	Date of Birth: 01-01-1964	Description: T3

Location Features	Determinants	Contents	S-Constellation																																										
Zf = 20 ZSum = 64.0 ZEst = 66.5 W = 13 (Wv = 0) D = 18 W+D = 31 Dd = 2 S = 4	Blends M.CF FY.FC.m M.FC' FC.FY M.V FM.FY FM.FY FC.m CF.Y YF.m	Single M = 0 FM = 7 m = 0 FC = 2 CF = 1 C = 0 Cn = 0 FC' = 0 C'F = 0 C' = 0 FT = 1 TF = 1 T = 0 FV = 0 VF = 0 V = 0 FY = 2 YF = 0 Y = 0 Fr = 0 rF = 0 FD = 3 F = 6 (2) = 6	H = 2 (H) = 2 Hd = 3 (Hd) = 1 Hx = 0 A = 13 (A) = 0 Ad = 3 (Ad) = 0 An = 0 Art = 3 Ay = 1 Bl = 0 Bt = 5 Cg = 4 Cl = 0 Ex = 0 Fd = 0 Fi = 2 Ge = 0 Hh = 3 Ls = 0 Na = 0 Sc = 1 Sx = 0 Xy = 0 Idio = 1	<input checked="" type="checkbox"/> FV+VF+V+FD > 2 <input checked="" type="checkbox"/> Col-Shd Blends > 0 <input checked="" type="checkbox"/> Ego < .31 or > .44 <input type="checkbox"/> MOR > 3 <input type="checkbox"/> Zd > ±3.5 <input checked="" type="checkbox"/> es > EA <input type="checkbox"/> CF + C > FC <input checked="" type="checkbox"/> X+% < .70 <input checked="" type="checkbox"/> S > 3 <input type="checkbox"/> P < 3 or > 8 <input type="checkbox"/> Pure H < 2 <input type="checkbox"/> R < 17 6 Total																																									
DQ (FQ-) + = 10 (3) o = 23 (0) v/+ = 0 (0) v = 0 (0)			Special Scores <table border="1"> <thead> <tr> <th></th> <th>Lvl-1</th> <th>Lvl-2</th> </tr> </thead> <tbody> <tr> <td>DV</td> <td>= 2 x1</td> <td>0 x2</td> </tr> <tr> <td>INC</td> <td>= 0 x2</td> <td>0 x4</td> </tr> <tr> <td>DR</td> <td>= 2 x3</td> <td>0 x6</td> </tr> <tr> <td>FAB</td> <td>= 0 x4</td> <td>0 x7</td> </tr> <tr> <td>ALOG</td> <td>= 0 x5</td> <td></td> </tr> <tr> <td>CON</td> <td>= 0 x7</td> <td></td> </tr> <tr> <td>Raw Sum6</td> <td>= 4</td> <td></td> </tr> <tr> <td>Wgtd Sum6</td> <td>= 8</td> <td></td> </tr> <tr> <td>AB</td> <td>= 0</td> <td>GHR = 5</td> </tr> <tr> <td>AG</td> <td>= 0</td> <td>PHR = 3</td> </tr> <tr> <td>COP</td> <td>= 3</td> <td>MOR = 0</td> </tr> <tr> <td>CP</td> <td>= 0</td> <td>PER = 1</td> </tr> <tr> <td></td> <td></td> <td>PSV = 0</td> </tr> </tbody> </table>		Lvl-1	Lvl-2	DV	= 2 x1	0 x2	INC	= 0 x2	0 x4	DR	= 2 x3	0 x6	FAB	= 0 x4	0 x7	ALOG	= 0 x5		CON	= 0 x7		Raw Sum6	= 4		Wgtd Sum6	= 8		AB	= 0	GHR = 5	AG	= 0	PHR = 3	COP	= 3	MOR = 0	CP	= 0	PER = 1			PSV = 0
	Lvl-1	Lvl-2																																											
DV	= 2 x1	0 x2																																											
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CON	= 0 x7																																												
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CP	= 0	PER = 1																																											
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Form Quality <table border="1"> <thead> <tr> <th>FQx</th> <th>MQual</th> <th>W+D</th> </tr> </thead> <tbody> <tr> <td>+ = 0</td> <td>0</td> <td>0</td> </tr> <tr> <td>o = 21</td> <td>3</td> <td>21</td> </tr> <tr> <td>u = 9</td> <td>0</td> <td>8</td> </tr> <tr> <td>- = 3</td> <td>0</td> <td>2</td> </tr> <tr> <td>none = 0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	FQx	MQual	W+D	+ = 0	0	0	o = 21	3	21	u = 9	0	8	- = 3	0	2	none = 0	0	0																											
FQx	MQual	W+D																																											
+ = 0	0	0																																											
o = 21	3	21																																											
u = 9	0	8																																											
- = 3	0	2																																											
none = 0	0	0																																											

RATIOS, PERCENTAGES, AND DERIVATIONS

R = 33 L = 0.22	AFFECT	INTERPERSONAL
EB = 3 : 5.5 EA = 8.5 EBPer = 1.8 eb = 12 : 12 es = 24 D = -6 Adj es = 15 Adj D = -2	FC:CF+C = 5 : 3 Pure C = 0 SumC' : WSumC = 1 : 5.5 Afr = 0.72 S = 4 Blends:R = 10 : 33 CP = 0	COP = 3 AG = 0 GHR:PHR = 5 : 3 a:p = 11 : 4 Food = 0 SumT = 2 Human Content = 8 Pure H = 2 PER = 1 Isolation Index = 0.15
FM = 9 SumC' = 1 SumT = 2 m = 3 SumV = 1 SumY = 8	IDEATION	SELF-PERCEPTION
a:p = 11 : 4 Sum6 = 4 Ma:Mp = 3 : 0 Lvl-2 = 0 2AB+(Art+Ay) = 4 WSum6 = 8 MOR = 0 M- = 0 M none = 0	MEDIATION XA% = 0.91 WDA% = 0.94 X-% = 0.09 S- = 1 P = 8 X+% = 0.64 Xu% = 0.27	PROCESSING Zf = 20 W:D:Dd = 13:18:2 W : M = 13 : 3 Zd = -2.5 PSV = 0 DQ+ = 10 DQv = 0
PTI = 0 <input type="checkbox"/> DEPI = 4 <input type="checkbox"/> CDI = 2 <input type="checkbox"/> S-CON = 6 <input type="checkbox"/> HV1 = No <input type="checkbox"/> OBS = No		

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dency to externalize difficulties. The codetype 463 is the same as at T2, suggesting overcontrol, neediness, superficial “niceness,” and role playing with the hostility and resentment showing underneath.

Rorschach Data

The Rorschach protocol at T3 (Table 4) suggests some changes in Walter’s psychological make-up. Remarkably, *DEPI* and *HVI* are no longer positive. However, he still experiences the ill effects of more situational stress than he can manage adequately ($D < AdjD$). His responses do suggest a growing capacity for self-insight ($FD = 3$, whereas at T2 $FD = 2$, and at T1 $FD = 0$). This positive development (unfortunately) still goes hand-in-hand with overwhelming feelings of fear, helplessness (“too upset to think straight”), and a collapse of coping effectiveness subsequent to the onset of stress ($Y = 8$; $D = -6$; $AdjD = -2$). At the same time, however, Walter’s *Afr* .72 (*Afr* was .42 at T2) indicates that he is less likely to avoid emotional interaction with his environment. Walter has chronic inferiority feelings ($3r + (2)/R = .19$). At present, he is more outgoing and seeking out harmonious relationships with others ($COP = 3$, whereas at T2 $COP = 2$, and at T1 $COP = 1$). His strong need for emotional closeness, however, is ungratified and he experiences distress as a result ($T = 2$). Given the difficulties he has interacting with people in general, it is understandable that he would become deeply dependent on a person who gratifies his needs for affection and warmth. It is also expected that he would react with profound hurt and anger if this relationship were threatened.

Treatment Recommendations

In light of the test results, it is expected that it will take a substantial amount of time before Walter and the new treatment staff will have established a working alliance. For the patient, a supportive and structured approach remains advised, to assist Walter in arranging his life in such a way that his stress levels are more in line with his limited resources. (*D*-score and *Adj. D*-score are both minus). Positive contact with his employer and colleagues, relaxing leisure activities, and realistic plans for the future are important foci for this treatment phase.

**Risk Assessment After 3 Years of Treatment:
Administration of the HCR-20**

The hospital aims to limit the duration of the inpatient treatment phase for each patient, of course without losing sight of society's safety. Preceding the next transmural phase in the treatment, the HCR-20 for the assessment of violence risk is completed independently by a psychologist as well as by Walter's treatment supervisor. In a consensus meeting they arrive at the coding of the HCR-20 shown in Table 5.

Table 5. HCR-20 of Walter, preceding his transmural phase

Name: Walter		
	<i>Historical items</i>	Code (0, 1, 2)
H 1	Previous violence	2
H 2	Young age at first violent incident	2
H 3	Relationship instability	2
H 4	Employment problems	1
H 5	Substance use problems	2
H 6	Major mental illness	0
H 7	Psychopathy	1
H 8	Early maladjustment	2
H 9	Personality disorder	2
H10	Prior supervision failure	2
<i>Total historical items:</i>		16/20
	<i>Clinical items</i>	Code (0, 1, 2)
C1	Lack of insight	1
C2	Negative attitudes	1
C3	Active symptoms of major mental illness	0
C4	Impulsivity	1
C5	Unresponsive to treatment	1
<i>Total clinical items:</i>		3/10
	<i>Risk management items</i> <input type="checkbox"/> In <input checked="" type="checkbox"/> Out (transmural phase)	Code (0,1, 2)
R1	Plans lack feasibility	1
R2	Exposure to destabilizers	1
R3	Lack of personal support	1
R4	Noncompliance with remediation attempts	0
R5	Stress	1
<i>Total risk management items:</i>		3/10
<i>HCR-20 total score:</i>		21/40
<i>Final risk judgment</i> <input checked="" type="checkbox"/> low <input type="checkbox"/> moderate <input type="checkbox"/> high		

According to the psychologist and Walter's treatment supervisor, he fulfilled the criteria for most of the historical risk. They also agree on the fact that four of the five clinical risk factors are partially present, just like a few of the risk management items: plans lack feasibility, exposure to destabilizers, lack of personal support, and stress. Their final risk judgment is "low risk"; all the risk factors that are present are historical in nature, none of the clinical and risk management items are "definitely present." They also conclude that his job (he has work at his own level) is an important protective factor for Walter, because it enhances his self-esteem and keeps the depression at a distance.

Final Remarks

In this article, we described a broad outline of the specific possibilities of psychological assessment in a forensic context. Forensic psychology, and forensic psychological assessment, is a relatively young discipline, certainly in The Netherlands. The research base is small, as a result of which the ideal of *evidence-based practice* tends to be *practice-based evidence*. There are practically no normative data available on forensic populations. For many cases, the relationship between a mental disorder and an offense cannot be proven based on empirical evidence.

The nature of psychological assessment in a forensic context and its fragile scientific basis impose a heavy responsibility on psychologists in choosing a suitable test battery and in reporting the results as transparently as possible. The ethical standards for cautious formulations apply even more in forensic psychological assessment than in general psychological assessment.

The case example illustrates the serious and structural personality pathology that is often present in forensic psychiatric patients. This psychopathology is difficult to change, as indicated by the stability of the MMPI-2 profiles and the variables of the RIM CS. However, there were some positive changes in the test results. Only the objective measurement of such changes, using reliable and valid psychological tests, can increase our knowledge on the effectiveness of forensic psychiatric treatment.

References

- Akhtar, S. (1989). Narcissistic personality disorder: Descriptive features and differential diagnosis. *Psychiatric Clinics of North America*, 12, 505–529.
- Akhtar, S. (1999). *Inner torment: Living between conflict and fragmentation*. Northvale, NJ: Aronson.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: Fourth edition (DSM-IV)*. Washington, DC: Author.
- American Psychology-Law Society. (1991). Forensic psychology specialty guidelines. *Law and Human Behavior*, 15, 655–665.
- Barratt, E.S. (1959). Anxiety and impulsiveness related to psychomotor efficiency. *Perceptual and Motor Skills*, 9, 191–198.
- Barratt, E.S. (1994). Impulsiveness and aggression. In J. Monahan & H. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 61–79). Chicago: University of Chicago Press.
- Beek, D.J. van (1999). *De delictscenarioprocedure bij seksueel agressieve delinquenten* [The offence script procedure with sexually aggressive offenders]. Deventer, The Netherlands: Gouda Quint.
- Boer, D.P., Hart, S.D., Kropp, P.R., & Webster, C.D. (1997). *Manual for the Sexual Violence Risk-20: Professional guidelines for assessing risk of sexual violence*. Vancouver, BC: British Columbia Institute Against Family Violence.
- British Psychological Society. (2002). *Ethical guidelines on forensic psychology*. Leicester, UK: British Psychological Society.
- Butcher, J.N., Dahlstrom, W.G., Graham, J.R., Tellegen, A., & Kaemmer, B. (1989). *Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring*. Minneapolis: University of Minnesota Press.
- Emmerik, J.L. van (1989). *TBS en recidive: Een beschrijving van ter beschikking gestelden van wie de maatregel is beëindigd in de periode 1979–1983*. [Recidivism after forensic psychiatric treatment: A description of forensic patients who were released between 1973–1983]. Arnhem, the Netherlands: Gouda Quint.
- [not cited in text]**Emmerik, J.L. van (1997). *Prevalence findings TBS 1990–1996*. Utrecht, The Netherlands: Dr. F.S. Meijers Instituut, Department of Monitoring and Research.
- Exner, J.E., Jr. (1993). *The Rorschach: A comprehensive system* (Vol. 1, 3rd ed.). New York: Wiley.
- Exner, J.E. (2000). *A primer for Rorschach interpretation*. Asheville, NC: Rorschach Workshops.
- Exner, J.E., Jr. (2001). *A Rorschach workbook for the comprehensive system*. Asheville, NC: Rorschach Workshops.
- [may have been cited incorrectly]**Friedman, A.F., Lewak, R., Nichols, D.S., & Webb, J.T. (2001). *Psychological assessment with the MMPI-2*. Mahwah, NJ: Erlbaum.
- Gacono, C.B., & **[not cited in text]**Meloy, J.R. (1994). *The Rorschach assessment of aggressive and psychopathic personalities*. Hillsdale, NJ: Erlbaum.

M. Hildebrand & C. de Ruiter

- Greenberg, S.A., & Shuman, D.W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice*, 28, 50–57.
- Greeven, P.G.J. (1997). *De intramurale behandeling van forensisch psychiatrische patiënten met een persoonlijkheidsstoornis: een empirisch studie* [Treatment outcome in personality disordered forensic patients: An empirical study]. Deventer, The Netherlands: Gouda Quint.
- Greeven, P.G.J., & Ruiter, C., de (2004). Personality disorders in a Dutch forensic psychiatric sample: Changes with treatment. *Criminal Behavior and Mental Health*, 14, 280–290.
- [not cited in text]Hagen, M.A. (1997). *Whores of the court: The fraud of psychiatric testimony and the rape of American justice*. New York: HarperCollins.
- Hare, R.D. (1991). *Manual for the Hare Psychopathy Checklist-Revised*. Toronto, Canada: Multi-Health Systems.
- Hare, R.D. (2003). *Hare Psychopathy Checklist-Revised* (2nd ed.). Toronto, Canada: Multi-Health Systems.
- Hildebrand, M. (2004). *Psychopathy in the treatment of forensic psychiatric patients: Assessment, prevalence, predictive validity, and clinical implications*. Amsterdam: Dutch University Press.
- [not cited in text]Hildebrand, M., & Ruiter, C. de (1999). Classificatie en diagnostiek [TRANSLATION PLEASE]. In C. de Ruiter & M. Hildebrand (Eds.), *Behandlungsstrategieën bij forensisch psychiatrische patiënten* [TRANSLATION PLEASE] (pp. 1–8). Houten: Bohn Stafleu Van Loghum.
- Hildebrand, M., & Ruiter, C. de (2004). PCL-R psychopathy and its relation to DSM-IV Axis I and Axis II disorders in a sample of male forensic psychiatric patients in The Netherlands. *International Journal of Law and Psychiatry*, 27, 233–248.
- Hildebrand, M., Ruiter, C. de, & Beek, D.J. van (2001). *SVR-20: Richtlijnen voor het beoordelen van het risico van seksueel gewelddadig gedrag* [SVR-20. Guidelines for the assessment of risk of sexual violence]. Utrecht, The Netherlands: Dr. Henri van der Hoeven Stichting, Forum Educatief.
- [not cited in text]Hildebrand, M., Ruiter, C. de, & Nijman, H. (2004). PCL-R psychopathy predicts disruptive behavior among male offenders in a Dutch forensic psychiatric hospital. *Journal of Interpersonal Violence*, 19, 13–29.
- Hildebrand, M., Ruiter, C. de, & Vogel, V. de (2004). Psychopathy and sexual deviance in treated rapists: Association with sexual and nonsexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, 16, 1–24.
- Hildebrand, M., Ruiter, C. de & Zaane, B. van. (submitted). PCL-R psychopathy and change in dynamic risk factors during inpatient psychiatric treatment.
- Hyler, S.E., & Rieder, R.O. (1987). *Personality Disorder Questionnaire-Revised*. New York: New York State Psychiatric Institute.
- Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12–19.
- LaForge, R., & Suczek, R.F. (1955). The interpersonal dimension of personality: III. An interpersonal checklist. *Journal of Personality*, 24, 94–94–112.

- Leuw, E. (1999). *Recidive na de TBS: patronen, trends en de inschatting van gevaar* [Recidivism after forensic psychiatric treatment: Patterns, trends, processes, and risk assessment]. Deventer: Gouda Quint.
- [not cited in text]Malsch, M., & Hielkema, J. (1999). Forensic assessment in Dutch criminal insanity cases: Participants' perspectives. In M. Malsch & J.F. Nijboer (Eds.), *Complex cases: Perspectives on The Netherlands criminal justice system* (pp. 213–228). Amsterdam: Thela Thesis.
- McLellan, A.T., Luborsky, L., Woody, G.E., & O'Brien, C.P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The addiction severity index. *Journal of Nervous and Mental Disease*, 168, 26–33.
- Meyer, G.J. (1997). On the integration of personality assessment method: The Rorschach and MMPI. *Journal of personality Assessment*, 68, 297–330.
- Meyer, G.J., Finn, S.E., Eyde, L.D., Kay, G.G., Moreland, K.L., Dies, R.R., Eisman, E.J. et al. (2000). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist*, 56, 128–165.
- Niemantsverdriet, J.R. (1993). *Achteraf bezien: over het evalueren van ter beschikking stellingen* [In retrospect: Evaluating committals to a forensic mental hospital]. Utrecht, The Netherlands: Elinkwijk.
- Novaco, R.W. (1994). Anger as a risk factor for violence among the mentally disordered. In J. Monahan & H. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 21–59). Chicago: University of Chicago Press.
- Pfohl, B., Blum, N., & Zimmerman, M. (1995). *Structured Interview for DSM-IV Personality (SIDP-IV)*. Iowa City: University of Iowa, Department of Psychiatry.
- Philipse, M., Ruiter, C. de, Hildebrand, M., & Bouman, Y. (2000). *HCR-20. Beoordelen van het risico van gewelddadig gedrag. Versie 2* [HCR-20. Assessing the risk of violence. Version 2]. Nijmegen/Utrecht: Prof.mr. W.P.J. Pompestichting/Dr. Henri van der Hoeven Stichting.
- Rogers, R. (Ed.) (1997). *Clinical assessment of malingering and deception* (2nd ed.). New York: Guilford.
- [may have been cited incorrectly]Ruiter, C. de (2000a). Forensische psychodiagnostiek en risicotaxatie: ontwerp van een forensisch psychologisch testinstrumentarium [Forensic psychological assessment and risk assessment: Design of a forensic psychological test battery]. In T.I. Oei & M.S. Groenhuijsen (Red.), *Forensische psychiatrie anno 2000: Actuele ontwikkelingen in breed perspectief* [TRANSLATION PLEASE] (pp. 301–315). Deventer: Gouda Quint.
- [may have been cited incorrectly]Ruiter, C. de (2000b). Persoonlijkheidsstoornissen en delinquent gedrag, milieutherapie in een forensisch psychiatrisch ziekenhuis. [Personality disorders and delinquent behavior: Milieu therapy in a forensic psychiatric hospital]. In C. Janzing, A. van den Berg, & F. Kruisdijk (Eds.), *Handboek voor milieutherapie: Theorie en praktijk van de klinische psychotherapie* [Handbook for milieutherapie: The theory and practice of clinical psychotherapy] (pp. 56–71). Assen, The Netherlands: Van Gorcum.
- Ruiter, C., de & Greeven, P.G.J. (2000). Personality disorders in a Dutch forensic

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psychiatric sample: Convergence of interview and self-report measures. *Journal of Personality Disorders*, 14, 162–170.

- Ruiter, C., de, & Hildebrand, M. (2003). The dual nature of forensic psychiatric practice: Risk assessment and management under the Dutch TBS order. In P.J. van Koppen & S.D. Penrod (Eds.), *Adversarial vs. inquisitorial justice: Psychological perspectives on criminal justice systems* (pp. 91–106). New York: Plenum.
- 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 and Practice*, 3, 203–215.
- Timmerman, I.G.H., & Emmelkamp, P.M.G. (2001). The prevalence and comorbidity of Axis I and Axis II disorders in a group of forensic patients. *International Journal of Offender Therapy and Comparative Criminology*, 45, 136–149.
- Timmerman, I.G.H., & Emmelkamp, P.M.G. (2005). The effects of cognitive-behavioral treatment for forensic inpatients. *International Journal of Offender Therapy and Comparative Criminology*, 49, 590–606.
- Vogel, V. de, Ruiter, C. de, Beek, D. van, & Mead, G. (2004). Predictive validity of the SVR-20- and Static-99 in a Dutch sample of treated sex offenders. *Law and Human Behavior*, 28, 235–251.
- Vogel, V. de, Ruiter, C. de, Hildebrand, M., Bos, B., & Ven, P. van de (2004). Type of discharge and risk of recidivism measured by the HCR-20: A retrospective study in a Dutch sample of treated forensic psychiatric patients. *International Journal of Forensic Mental Health*, 3, 149–165.
- Webster, C.D., Douglas, K.S., Eaves, D., & Hart, S.D. (1997). *HCR-20: Assessing risk for violence, version 2*. Burnaby, BC, Canada: Simon Fraser University.

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