

Above the Law: Escapes from a Maximum Security Forensic Hospital and Psychopathy

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This brief report is the second in a series of studies¹ examining characteristics of problematic forensic patient groups. In comparing hospitalized insanity acquittees and hospitalized insanity acquittees who successfully malingered, we found malingerers were more likely to be psychopathic, to have murdered or raped, and to carry a diagnosis of antisocial personality disorder (ASPD) or sexual sadism.² They were also more likely to be verbally or physically assaultive, require specialized treatment plans to control their aggression, have sexual relations with female staff, deal drugs, and be considered an escape risk within the hospital setting.^{2, 3} The impact on the hospital milieu was disproportionate to their numbers ($N = 18$), raising questions as to whether psychopathic forensic patients should ever be committed to a hospital setting.

In this preliminary investigation,* characteristics of another problematic group, forensic patients with an escape history, are examined. As with malingering, a positive relationship between escape behavior and psychopathy was predicted.

Subject Selection and Procedures

All patients who had escaped from a maximum security forensic hospital over a 10-year period were identified and placed in an escapee group. Commitment status, age, ethnicity, diagnosis, and Psychopathy Checklist-Revised (PCL-R)⁵ scores were recorded. Comparison subjects were randomly selected from the same hospital population⁴ and matched to "escapee" subjects by commitment status, ethnicity, and age.

When escapees could not be directly interviewed, PCL-R scores were obtained by scoring available records, a reliable and valid method for assessing psychopathy.⁶ Independent scoring by two raters ensured adequate reliability (Spearman's $Rho = .98$).^{1, 7}

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* Speth and Roske are attempting to determine whether demographic and assessment data can predict escape among forensic patients.⁴

Table 1
Forensic Psychiatric Patients Axis I Diagnosis^a

	Matched Comparisons (N = 18)		Escapees (N = 18)	
	%	(n)	%	(n)
Malingering	5	(1)	66	(12) ^b
Substance abuse	77	(14)	44	(8)
Alcohol abuse	27	(5)	22	(4)
Sexual sadism	0	(0)	16	(3)
Psychotic Dx ^c				
Schizophrenia	16	(3)	5	(1)
Schizoaffective	27	(5)	0	
Bipolar	5	(1)	5	(1)
Organic	11	(2)	0	
Delusional	5	(1)	0	
Major depression/Psychotic	16	(3)	0	
Medication				
Neuroleptic	83	(15)	33	(6) ^d
Antidepressant	5	(1)	5	(1)
No medications	11	(2)	61	(11)

^a Only malingering, psychotic diagnosis, and neuroleptic medications were statistically compared.

^b $\chi^2 = 14.5$, $df = 1$, $p < .001$.

^c $\chi^2 = 18.84$, $df = 1$, $p < .001$.

^d $\chi^2 = 9.26$, $df = 1$, $p < .01$.

Results

Escapees were significantly more likely to receive a diagnosis of malingering ($p < .001$), and less likely to carry a psychotic diagnosis ($p < .001$; see Table 1). They were also less likely to be recipients of neuroleptics ($p < .01$).

With the exception of ASPD, Axis II diagnoses were underrepresented in both groups. The presence or absence of ASPD was carefully reviewed; however, several cases were not given the ASPD diagnosis because the presence of conduct disorder (before age 15) could not be verified. More subjects likely met ASPD criteria than were found (61% comparisons; 55% escapees). The underrepresent-

tation of Axis II personality disorder diagnoses in general may reflect a deemphasis on diagnosing Axis II disorders in forensic psychiatric hospitals when available medical treatment targets Axis I conditions.

Escapees received a disproportionate number of charges/convictions for crimes involving violence toward a victim ($N = 23$; comparison subjects, $N = 9$; see Table 2).

As predicted, PCL-R total and factor 1 (aggressive narcissism)⁸ scores significantly discriminated between groups ($p < .001$; see Table 3). The escapees were more glib and grandiose (items 1 and 2, $p < .001$), more likely to lie and manipulate (items 4 and 5, $p < .005$), and

Table 2
Committing Offenses for Forensic Subjects (*N* = 36)^a

	Matched Comparisons		Escapees	
	%	(<i>n</i>)	%	(<i>n</i>)
Violent				
Murder/attempted murder	11	(2)	11	(2)
Assault with deadly weapon	22	(4)	27	(5)
Battery	5	(1)	5	(2)
Kidnap	0		16	(3)
Robbery	5	(1)	33	(6)
Rape/attempted rape	0		27	(5)
Terrorist threats	5	(1)	0	
Total	100	9	100	23
Nonviolent				
Indecent exposure	0		5	(1)
Child molestation	11	(2)	11	(2)
Burglary	11	(2)	16	(3)
Receiving stolen property	5	(1)	5	(1)
Arson	16	(3)	0	
Auto theft	0		5	(1)
Drug offenses	5	(1)	5	(1)
Extortion	5	(1)	5	(1)
Perjury	5	(1)	0	
Evading police	5	(1)	0	

^a Committed offenses exceed subject numbers, since in several cases multiple criminal offenses led to a subject's commitment.

evidenced greater deficits in affect, empathy, and remorse (items 6, 7, and 8, $p < .05$) than the comparison subjects.

Factor 2 scores (antisocial lifestyle),⁵ although elevated in both groups (comparisons = 12.1; escapees = 13.9), were significantly higher among escapees ($p < .05$). The lack of significant difference between factor 2 item clusters speaks to the high prevalence of ASPD among all of the forensic subjects regardless of group inclusion.[†] Most patients with maximum security status frequently exhibit patterns of stimulus seeking (item 3, proneness to bore-

dom), impulsivity (item 14), irresponsibility (item 15), and have problems with anger (item 10). Total and factor 1 scores for comparison subjects were similar to our previous findings¹ and to Hare's⁵ pooled sample of forensic patients.

Discussion

Patients who escape from maximum security forensic hospitals are likely to be primary or severe psychopaths with a violent committing offense, to have been diagnosed as malingering, and to have evidenced no treatable psychosis prior to their escape. They distinguish themselves from other antisocial forensic patients by their

[†] ASPD² correlates more highly with factor 2 of the PCL-R than with factor 1.⁵

Table 3
PCL-R Scores for Forensic Psychiatric Patients

	Matched Comparisons		Escapees	
	Mean	SD	Mean	SD
Total score	22.8	(6.5)	31.0	(5.0) ^a
Factor 1 score	8.28	(3.2)	12.7	(2.9) ^a
Item clusters				
1/2	1.05	(1.2)	2.67	(1.2) ^a
4/5	1.83	(1.1)	3.11	(1.2) ^b
6/7/8	4.05	(1.5)	5.05	(1.1) ^c
Factor 2 score	12.1	(3.4)	13.9	(2.3) ^d
Item 10 ^e	1.20	(.55)	1.50	(.63)
Item cluster				
3/14/15	4.39	(1.5)	4.94	(1.0)

^a $p < .001$, Mann-Whitney U and t test, one-tailed.

^b $p < .005$, Mann-Whitney U and t test, one-tailed.

^c $p < .05$, Mann-Whitney U and t tests, one-tailed.

^d $p < .05$, t test.

^e 28% of comparisons and 50% of escapees scored < 2 .

“selfish, callous, and remorseless use of others,” a phrase that captures the meaning of factor 1 of the PCL-R (p. 38).⁵ We emphasize the significantly greater aggressive narcissism of these escapees when compared with other patients who do not attempt to escape from forensic hospitals. Their sense of entitlement, a facet of their grandiose sense of self-worth, and their manipulateness may contribute to both their inclination and ability to escape.

Although we did not try to statistically predict escape in this preliminary study, findings suggest that forensic patients who score higher than 30 on the PCL-R should be considered possible escape risks in forensic hospitals. Freedom is near and dear to the heart of the psychopath; as Miller⁹ wrote, “he seems to be walking through snow without leaving footprints” (p. 535). The psychopathic patient who does successfully escape poses a tangible risk to both forensic clinicians and the community at large.

References

1. Gacono CB, Meloy JR, Sheppard K, Speth EB, Roske A: A clinical investigation of malingering and psychopathy in hospitalized insanity acquittees. *Bull Am Acad Psychiatry Law*, 23:1-11, 1995
2. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* (ed 4). Washington, DC: APA, 1994
3. Gacono CB, Meloy JR: *The Rorschach Assessment of Aggressive and Psychopathic Personalities*. Hillsdale, NJ: Lawrence Erlbaum Associates, 1994
4. Speth E, Roske A, Gacono C, Hare R, Hart S: The utility of the Psychopath Checklist-Revised in predicting violent behavior in an inpatient forensic setting: a prospective study. Atascadero, CA: Atascadero State Hospital, 1996 (unpublished)
5. Hare R: *Manual for the Hare Psychopathy Checklist-Revised*. Toronto: Multihealth Systems, 1991
6. Wong S: Is Hare's Psychopathy Checklist reliable without the interview? *Psych Rep* 62:931-4, 1988
7. Gacono CB, Hutton HE: Suggestions for the clinical and forensic use of the Hare Psychopathy Checklist-Revised (PCL-R). *Int J Law Psychiatry* 17:303-17, 1994
8. Meloy R: *Violent Attachments*. Northvale, NJ: Aronson, 1992
9. Miller MH: Time and the character disorder. *J Nerv Ment Dis* 138:535-40, 1964