

Psychopathy – A Narrative Historical Review

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Abstract

Psychopathy is a rare, but significant construct in the field of forensic psychology. Drawing much attention in popular media, most of those accused of bizarre or criminal acts are assumed by the general public to be psychopathic. However, very few people actually meet criteria for psychopathy. A strong predictor of violence, psychopathy is assumed to be untreatable, with some arguing that treatment is iatrogenic. This argument, along with the clear negative implications of being diagnosed with psychopathy (e.g., longer detainment, stigma), brings attention to the significant ethical concerns surrounding psychopathy assessment. Additionally, there are cultural considerations that factor into the assessment process, including the trend of over-diagnosing Black and Brown men with psychopathy and associated personality disorders. Associated with increased violence, both during incarceration and in the community, psychopathy's reputation for being untreatable also makes assessing for the diagnosis a daunting task. Once there is a diagnosis, the implication is that there must be a treatment. These concerns may be addressed with further research into the etiology of psychopathy and the development of appropriate treatment interventions. Although there is general agreement about its manifestations (e.g., manipulateness, lack of empathy, criminality), there remains disagreement about psychopathy's factor structure. There is also much to be learned about the neurobiology of psychopathy. A better understanding of psychopathy could give rise to more ethical and efficacious responses to those who have this diagnosis.

Key words: psychopathy; assessment; ethics; violence

Introduction

Psychopathy is a widely misunderstood construct. While people tend to attribute any violent, aberrant, or unusual behavior to that of a "psychopath," only 1% of the general population and 15-25% of the prison population meets full criteria for psychopathy (23). For this reason, psychopathy has been described as the great white shark of constructs – many people believe that they have encountered someone with psychopathy, when this is, in fact, quite a rare occurrence. However, the rarity of psychopathy does not do justice to the havoc it can create. A robust predictor of violence within the criminal and psychiatric population, psychopathy has been found among those committing more crimes, earlier in their lifetimes, with more violence, and with a more diffuse offending profile (10). Factored together with sexual deviance, psychopathy also predicts sexual offense recidivism (14). Once in custody, those with psychopathy are responsible for more behavioral disruption and tend not to respond to treatment (8).

Psychopathy is the "single most important clinical construct in the criminal justice system, with particularly strong implications for the assessment of risk for recidivism and violence and for the selection of appropriate treatment and management programmes" (sic; 10) Hemphill et al. (1998) found that offenders with psychopathy were four times as likely to commit another violent crime than their non-psychopathic peers (15). Moreover, Hare et al. (1988) noted that they reoffended at a rate of 65.2%, while their peers with lower rates of psychopathy recidivated at a rate of 23.5%, replicating those findings two years later. Male psychiatric patients with psychopathy were

also more likely to commit acts of violence (Monahan et al., 2001), engaging in post-release violence at a rate of 40% (22), with similar findings among female psychiatric patients. (Notably, the prevalence of psychopathy among psychiatric patients is close to that of the general population).

People with psychopathy live life on their own terms, often expressing themselves in an aggressive, delinquent, and manipulative manner (10). Thus, despite their small numbers, people with psychopathy negatively impact those around them, whether in the community or in custody. Psychopathy also impacts the person with those traits, particularly when they experience sanctions for their behavior. Those assessed to possess psychopathic traits are subject to longer civil commitment sentences and are thought to be untreatable (6; 12). Due to these strong negative impacts, it is important to understand predisposing elements to psychopathy so that interventions and controls can be employed, both early and often. This paper will explore the history of this disorder, with attention to the social impact and diagnostic considerations for evaluators, including cultural and ethical concerns.

History

As early as the 1700s, psychopathy was known as *manie sans délire* and congenital delinquency. In fact, psychopathy is one of the earliest personality disorders identified in the literature (Ogloff, 2006). In 1835, building upon the *manie sans délire* concept, J.C. Prichard introduced moral insanity, which described "mental derangement" with "depravity" but without

intellectual impairment [7]. Benjamin Rush, in his exploration of the “perversion of moral faculties,” postulated that corporeal disease or congenital factors may have been at play [7]. Regardless of the etiology of the psychopathology, researchers were beginning to wrestle with how a person could display depraved behavior without apparent intellectual impairment.

By the later 19th century, researchers of psychopathy were looking more closely at its manifestations, specifically, at repetitive criminality. It was thought that psychopathy was associated with feeble-mindedness or epilepsy as well as an innate criminality. Gouster ascribed to psychopaths’ characteristics of “malice, disobedience, dishonesty” beginning in infancy, “poor judgment, hypochondriasis” as adults, and with physical abnormalities of the face and cranium (7). Koch, a contemporary of Gouster, suggested that psychopathy represented the middle of a continuum of heterogeneous conditions from psychosis to neurosis. Schneider (1923) expanded upon Koch, arguing that psychopathy represented a difference in degree, but not kind of personality (7). Hervey Cleckley (1941) described psychopathic people as “having a lack of remorse, empathy, and insight, poor affective reactions, and superficial charm” [5] with behaviors such as lying, interpersonal unresponsiveness, impersonal sex, and “failure to follow any life plan” (Cleckley, 1941). In the 1940’s, Cleckley cited 21 diagnostic features of psychopathy; he reduced this list to 16 in 1976 (13).

In 1952, the first edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) used the term, “sociopathic personality disturbance” [13] to describe individuals who found themselves in conflict with society due to their “disloyal, selfish, and basically unsocialized” behavior [24]. By unsocialized, the manual was attempting to capture the belief that these individuals benefited neither from experience nor punishment, with no loyalties to anyone but their own desires. DSM-II (1968) expanded the definition of antisocial personality closer to that of psychopathy, adding several interpersonal and affective criteria [4]. The advent of DSM-III (1980), along with improvements in the science of clinical interviewing, was hoped to yield a significant improvement in inter-rater reliability of diagnoses. The work of Robins (1966) and Feighner (1972) contributed to further refinement of what was being called sociopathy, as opposed to Cleckley’s psychopathy [4]. While Robins’ definition of psychopathy differed somewhat from Cleckley, her criteria included measurable qualifiers of theretofore vague terms (e.g., impulsivity, poor marital history). Thus, antisocial was the first of the personality disorders to be this specific.

The development of the DSM-III coincided with the development of the PCL (1980), which was based closely upon Cleckley’s model, and which signaled a growing divide between antisocial personality disorder and psychopathy. For example, diagnosis of antisocial personality disorder did (and still does) require evidence of pre-existing conduct disorder; the PCL-R did not. The DSM-III-R’s revision furthered this divide, inciting criticism that while the DSM-III-R assessed behaviors (specifically, criminality), the PCL assessed personality traits. Hare (1980) argued that given the PCL’s empirical support, it was the superior model for assessing psychopathy (4). The DSM and PCL were revised within three years of each other (1994 and 1991, respectively). By this time, the PCL had settled on its two-factor model, and antisocial personality disorder, as defined by DSM-IV, mapped onto the second factor (social deviance). This meant that while the DSM-IV defined the antisocial personality disorder criteria, psychopathy sat squarely with the PCL-R. A major difference is that the DSM is designed for use in clinical settings, and the PCL-R is used in forensic settings.

By 2000, the DSM-IV-TR highlighted antisocial personality disorder, whose criteria included evidence of conduct disorder prior to age 15, failure to comply with social and legal norms, lying, conning, impulsivity, irritability, recklessness, irresponsibility, and lack of remorse [1]. These behavioral criteria distinguished antisocial personality disorder from Cleckley’s model

of psychopathy, which focused on affective and interpersonal traits. These are found more closely replicated by the International Classification of Diseases, 10th edition (ICD-10) in their dissocial personality disorder, which encompassed both behavioral and personality features: callousness, irresponsibility, incapacity for sustained relationships, low frustration tolerance, lack of guilt, externalization of blame, and irritability [24]. However, Hare’s Psychopathy Checklist-Revised (PCL-R) is the most comprehensive of psychopathy’s affective, interpersonal, and behavioral features.

By the time DSM-V emerged, psychopathy had seen a research surge, as compared to antisocial personality disorder. There seemed to be a desire to move the antisocial personality disorder criteria closer to that of psychopathy, and there was even consideration of a name change to “antisocial/psychopathic” [31]. But these apparent intentions were short-lived. DSM-V authors instead turned to the concurrently developed Triarchic Psychopathy Measure (TriPM; Patrick et al., 2009). This model focuses on three constructs: boldness, meanness, and disinhibition, constructs that align with other contemporary assessments such as the Psychopathic Personality Inventory-Revised (PPI-R; Lilienfeld & Widows, 2005) and the Elemental Psychopathy Assessment (Lynam et al., 2011).

Etiology and Diagnosis

The earliest studies of psychopathy, beginning in the 1700s, implicated genetics in the development of psychopathy. Brain imaging studies suggest that the hippocampus has a primary role in psychopathy, as well as impairment in the frontal lobes and prefrontal cortex. There may also be amygdala dysfunction related to orbitofrontal and ventrolateral cortex deficits in response selection and control [19]. However, there is much to be learned about the etiology of psychopathy. One theory holds that psychopathy is divided into two parts, primary and secondary psychopathy. Primary psychopathy describes an innate inability to process emotions like fear and empathy, while secondary psychopathy has been described using the stress-diathesis model, in that inherent psychopathic traits are expressed as problematic behaviors occurring in response to environmental triggers such as trauma (e.g., childhood abuse) or learned behavior (24; 27). This has also been expressed as the dichotomy of psychopathy and sociopathy, wherein psychopathy represents a congenital emotional hyporesponsivity and sociopathy comes from the interaction of genes and environmental influences, resulting in emotional dysregulation. In both cases, serotonergic functionality is implicated (enhanced versus decreased, respectively) and testosterone has been found to exacerbate emotional dysfunction, increasing the risk of aggression [35]. Emotional hyporesponsivity manifests in fearlessness and decreased empathy, which contributes to the development of an antisocial life view that is expressed in criminality.

Recognized as a constellation of traits across affective, interpersonal, and behavioral domains, psychopathy encompasses fearlessness, shallow affect, and callousness/lack of empathy. Those with psychopathy are interpersonally detached, manipulative of others, and tend to lie pathologically. Their lives are led in an irresponsible manner, with weak behavioral controls [34]. The expression of these traits varies across individuals, some engage in criminal violence, while others’ psychopathic behavior is expressed in corporate misdeeds.

Assessment

Today’s gold standard for the assessment of psychopathy is Robert Hare’s PCL-R. This assessment tool identifies elements across two factors. Factor 1 includes glibness/superficial charm, grandiosity, pathological lying, manipulation, lack of remorse/guilt, shallow affect, lack of empathy, and failure to accept responsibility for actions; Factor 2 includes the externalization of these traits, including a need for stimulation, parasitic lifestyle, poor behavioral controls, early behavioral problems, lack of

realistic long-term goals, impulsivity, irresponsibility, juvenile delinquency, and revocation of conditional release [10]. Hare later splits the two factors into four: interpersonal, affective, lifestyle, and antisocial [27].

Following the Hare's four-factor model, the youth version of the PCL-R, the PCL: YV, is used to measure psychopathy in youth ages 12 to 18. There is mixed support for the primary/secondary model of psychopathy in youth populations, with primary psychopathy having been found responsible for higher PCL scores and secondary psychopathy responsible for more anxiety and psychological distress, but lower PCL scores. Adolescents with primary psychopathy were typically more dangerous, antisocial, and psychologically mature, with less impulsivity than their peers with secondary psychopathy. Certainly, given that adolescents live in a state of emerging physiological (cognitive) and emotional development, determination of psychopathy in this population should be made with extreme caution.

While Hare's remains the most popular model of psychopathy, there are three other tools deserving of attention here: the Psychopathic Personality Inventory-Revised (Lilienfeld & Widiger, 2005), The Triarchic Psychopathy Measure (TriPM; Patrick, 2010), and the Elemental Psychopathy Assessment (EPA; Lynam, 2011). The Psychopathy Personality Inventory was introduced in 1996 (PPI-I) and revised in 2005 (PPI-II). Comprised of two orthogonal scales, fearless dominance and self-centered impulsivity, the PPI-II is a 154-item self-report measure that examines a range of traits representing two constructs: trait fearlessness and externalizing vulnerability across eight subscales testing fearless dominance, impulsive antisociality, and coldheartedness [8,9]. The PPI-II mirrors Cleckley's view of psychopathy in that it predisposes the person to take advantage of others and follow one's impulses at one's convenience [8]. Studies by Eden and McDermott (2010), Uzieblo and colleagues (2009), and others found that despite the good convergent, discriminant, and external validity of the tool, the two-factor structure may not have been sufficient to explain the construct of psychopathy [8,9,33]. Another concern is that the face validity of the self-report design, absent full collateral information, may obscure a full psychopathic presentation. However, the authors of the instrument argue that a self-report measure is economical, eliminates inter-rater reliability concerns, and allows for analysis of "systematic response styles" [18].

A 58-item Likert self-report, the TriPM was built to measure psychopathy pursuant to the triarchic model of psychopathy, which holds that the structure of psychopathy is made of three separate pillars: meanness, boldness, and disinhibition. Patrick and colleagues (2012) note that while the PCL-R measures meanness [26], it leaves out boldness, an important piece of Cleckley's (1946) work [9]. As described in the TriPM manual, meanness is defined as "reflecting tendencies toward callousness, cruelty, predatory aggression, and excitement seeking," and disinhibition is defined as "reflecting tendencies toward impulsiveness, irresponsibility, oppositionality, and anger/hostility" [25]. Boldness is defined as the "nexus of high dominance, low anxiousness, and venturesomeness" [25] and is based upon the PPI's fearless dominance scale. The TriPM was developed into three facets, each divided into three subfacets: *interpersonal behavior* (persuasiveness, social assurance and dominance), *emotional experience* (resiliency, self-assurance, and optimism) and *venturesomeness* (courage, intrepidity and tolerance for uncertainty; 9). As with the PPI-II, the TriPM's self-report face validity is a concern.

The EPA is a 299-item, Likert self-report measure based upon the five-factor model of personality, addressing the maladaptive elements of the 18 identified traits: distrust, manipulation, self-centeredness, opposition, arrogance, callousness, conscientiousness disobliterated, impersistence, rashness, coldness, dominance, thrill-seeking, unconcern, anger, self-contentment, self-assurance, urgency, and invulnerability; validity scales include infrequency and too good to be true [18]. The authors maintain that the elemental approach to assessing psychopathy draws cross-comparisons

across psychopathy's different conceptualizations and explains their findings and clarifies factoring disagreements [18].

Cultural Considerations

There is an obvious sociocultural component to the expression of psychopathy, wherein people with access and privilege tend to express their psychopathy in corporate greed and white-collar crime, while others from underserved communities are more likely to engage in street crimes and violence. As in all psychological assessment, there are concerns about the potential for racial bias. While mixed-race sample studies have not attributed psychopathy to any one ethnic group over another, inherent bias toward giving Black and Brown men with socially pejorative diagnoses has been established in the research [21].

While studies have found the PCL-R to have good inter-rater reliability, there is indication that this may not apply cross-culturally. Cooke and colleagues (2004, 2004, 1999, 2001) suggested that in different cultures and environments, some behaviors are encouraged while others are discouraged, thereby differentially impacting the way the psychopathy is expressed [27]. Second, the characteristics of manipulateness or selfishness are culturally bound. Last, different local legal constructs may influence what behaviors are included when assessing lawlessness [27]. Therefore, the racial background of both the examiner and the examinee have potential to impact a determination of psychopathy. There are developmental factors implicated in psychopathy that are also culturally determined. Exposure to inconsistent and abusive parental styles, both of which are culturally bound, was found to be associated with psychopathy.

Gender is another identity that may impact a determination of psychopathy. Most studies of psychopathy have centered on male gender, but there has been some comparative research between male and female genders. (There remains a dearth of information available across the gender spectrum). Male gender is more frequently associated with psychopathy than female gender [27,29]. Additionally, those of male gender have been found to score higher levels of psychopathy than those of female gender. With differing base rates across these two genders, questions arise about the predictive ability of existing models [27]. Gender analyses in juveniles have yielded mixed results. While some studies have shown differences along a gender binary [29], others have failed to show difference [28]. It is possible, given that models were created based upon the study of male gender, that the existing two-factor model simply does not apply to the female gender; the four-factor model was found to fit slightly better [27]. Further, there may be differences in how PCL items function in female gender, with some items being more predictive than others [29]. Perhaps this is related to research on gender role socialization, which hypothesizes that genders are socialized differently, resulting in more externalizing behaviors in males and internalizing behaviors in females [30]. This points to potential differences in the criminal expression of psychopathy (as well as aggression) in males versus females.

Treatment

A diagnosis of psychopathy is typically a signal that, due to their grave affective impairments, the person is immune to treatment. Internationally, psychopathy is seen as untreatable and chronic [12,32]. As a result, the diagnosis has been more useful as an assessment and supervision tool than a treatment guide. However, Larsen (2019) argued that this position is "medically erroneous" due to a lack of empirical support (243), noting that psychopathy should not even be called a "diagnosis" because it does not exist within the DSM, but rather as a subset of antisocial personality disorder characteristics [16]. If not a diagnosis, then, psychopathy is simply a construct whose model has not been scientifically agreed upon. In fact, psychopathy may be so heterogeneous that subtypes should be elucidated to reflect the various etiologies and expressions of the "disorder" [16].

The "clinical pessimism" around psychopathy and its treatability began with Cleckley, who believed that the ego-syntonic nature of the disorder meant,

“there is not really much that can be done” [16]. Hare saw their prognosis the same way: “many writers on the subject have commented that the shortest chapter in any book on psychopathy should be the one on treatment” [10]. Hare might argue that treatment of those with psychopathy may even be iatrogenic, increasing their antisociality and resulting in increased institutional and post-release violence and recidivism; Larsen counters that there is simply a dearth of research on treatment efficacy [16]. After all, the Risk-Need-Responsivity model, a well-researched and forensically supported model of forensic treatment, calls for the application of the most intensive treatment to the most high-risk people (Andrews et al., 1990); those called psychopaths surely fall within this category.

Studies by Wong and colleagues (2012) suggest that the factor weights of the individual may serve as a guide to certain cognitive behavioral treatment approaches. Specifically, factor 2-heavy people (those with typical criminogenic features) may, in fact, benefit from the type of treatments usually applied to other violent offenders [16]. Similarly, in their samples, Sewall and Olver (2019) and Polaschek and Ross (2010) found similar treatment benefit for psychopaths and non-psychopaths alike [16]. Here, individualizing treatment that targets specific subtype deficits has been the key to finding treatment that is efficacious.

Ethical Considerations

Ethical issues stem from various parts of the process of defining, assessing, monitoring, and treating those with psychopathy. Granted, there are many risk assessment tools that have been normed on one population and utilized with others; there remains a dearth of research into the use of many popular actuarial tools with Black and Brown people. Perhaps the greatest ethical dilemma concerns the perception that those found to possess psychopathic traits are untreatable. Larsen (2019) describes ethical discussions in forensic psychiatry as “meager,” but ascribes this to the fact that it is still a relatively young field [16]. Perhaps there is hope that ethics will draw more of a focus in psychopathy research going forward.

Some of the ethical considerations come from our lack of understanding of its etiology. First, there lacks a solid neurological explanation for the construct. Without a neurobiological understanding of its roots, how can we devise a targeted treatment [19]. A second concern is that psychopathy is a fundamentally value-laden construct, making it susceptible to diagnostic drift and inaccurate clinical judgment [19]. However, it might be argued that all mental disorders are value-laden, as there must first exist a value judgment on normality in order to define abnormality.

Larsen and colleagues (2022) argue that psychopathy assessments are inherently unethical because they violate the principles of beneficence and nonmaleficence: “indeed, psychopathy assessment provide no clear benefit to the patient, and there are *de facto* and potential harms causally associated with their intended use, which are evidentially not outweighed by any significant social benefits” [17]. Citing studies that show the reliability and utility of psychopathy assessments have been overstated, they go on to argue that such assessments should be banned and that those who complete them be given ethical sanctions.

Psychologists are bound to a practice stance that focuses on the best interest of the individual and does no harm. This is no different for psychologists practicing in the forensic realm. Psychopathy assessments are generally used for two different, but related, purposes: diagnostic and statistically inferential (i.e., predictive of future behaviors). These purposes are based upon separate sciences but are typically used together in the forensic field [17], in fact, much of the research talks about how to diagnose psychopathy and then what that diagnosis means about potential behavior. That psychopathy assessments are an important part of a forensic mental health evaluation cannot be overstated, but, according to Larsen and colleagues (2022), what is not clear is how the individual test informs forensic decision-making. Given the dire predictions that come from a psychopathy diagnosis, the

individual evaluator cannot control how that piece of information may be used by forensic non-mental health practitioners in the future. This information is used in parole eligibility, sexually violent predator status, sentencing/placement, capital sentencing, and treatment and rehabilitation amenability decisions, and it is generally agreed-upon that the result of a psychopathy diagnosis is constrictive [6,12]. Patient-focused uses for psychopathy assessment, such as for treatment recommendations, are uncommon given the widespread belief that people with psychopathy are untreatable [16]. Like their exclusion by the American Psychological Association from military interrogation and torture, Larsen and colleagues (2022) argue that psychologists should advise their clients against a psychopathy assessment and recuse themselves from any assessment in which one is legally ordered [19].

It seems that the ethical issue at stake is not necessarily the assessment practice but the use of the information that is gleaned. There is an argument against diagnosing anyone with a mental health disorder, due to the stigma that people with such disorders face. There is also an argument against assessing for something without offering treatment. Perhaps the greatest ethical obstacle to the use of psychopathy assessments is the stigma that practitioners hold against those with psychopathy; that stigma is likely the greatest barrier to developing treatment modalities, which have simply not yet been discovered.

Conclusion

Despite more than 2000 years of exploration, psychopathy remains misunderstood, and its etiology is still being studied. While psychopathic traits are widely recognized, there is disagreement on how to even measure the construct. These unknowns have generated ethical and cultural competence issues for forensic mental health professionals seeking to assess these individuals. Unfortunately, what we do know suggests that due to the ego-syntonic nature of the disorder, treatment may not ameliorate its behavioral manifestations. Given the great costs, both to the safety of the general public and to the civil liberties of people with this diagnosis, it is incumbent upon researchers and mental health professionals to better understand this phenomenon.

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