



# Research in Review

**Bureau of Planning, Research, Statistics and Grants**

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## **Special Focus on *Psychopathy***

The first issue of Volume 12 of *Research in Review* features a briefing paper on psychopathy. Psychopathy is a complicated and controversial condition that is thought to contribute to a variety of extreme and persistent anti-social and violent behavior. Given the many complexities and nuances surrounding the definition, assessment and treatment of this diagnosis, the primer presented below attempts to lay out the basics of what the research tells us about psychopathy.

The next issue of RIR will feature a review of the National Institute on Drug Abuse's Criminal Justice Drug and Alcohol Treatment Study (CJDATS), as the PADOc is now a part of this research network, in partnership with Temple University. Other upcoming issues will feature summaries of recently completed partnership evaluations, such as the long term outcome evaluation of our Therapeutic Communities with Dr. Wayne Welsh of Temple University and the recently completed outcome evaluation of our Community Orientation Reintegration (COR) program with Dr. Linda Smith. A report on the third phase of the PADOc Parole Violator Study, which includes an analysis of surveys and focus groups conducted with parole officers and community corrections providers to gain their perspective on the factors relating to success or failure on parole, is also forthcoming.

As always, as we enter our twelfth year of publication, we at RIR hope that you find these topics to be informative, practical, and relevant to your work in corrections.

## **PSYCHOPATHY: ETIOLOGY, DIAGNOSIS AND TREATMENT**

by

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The following provides a brief review of research on psychopathy, focusing on its core features, assessment approaches and treatment prospects.

### Psychopathy – Definition and Core Features

Psychopathy can be thought of as an extreme manifestation of the antisocial, but not necessarily criminal, personality. While the term “psychopath” is widely tossed around in the popular culture - embodied in the fictional Hannibal Lecter - it is also widely misunderstood and misapplied. The concept of psychopathy has its roots in 19<sup>th</sup> century discussions of “moral insanity” and “underdeveloped superego”, but the contemporary description of the psychopath was developed by Cleckley (1941). The key clinical features of the psychopath are:

- Manipulative.
- Superficial charm.
- Above-average intelligence.
- Absence of psychotic symptoms (e.g. delusions, hallucinations, etc.).
- Absence of anxiety.
- Lack of remorse.
- Failure to learn from experience.
- Egocentric.
- Lacks emotional depth (e.g. flat affect).

Other characteristics can include impulsivity, erratic and parasitic lifestyle, pathological lying and of course anti-social behavior.

Working from this basic definition, there are several key points to consider in understanding psychopathy. First, psychopaths are not necessarily mentally ill. Strictly speaking, psychopathy is not recognized by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV; more on this below). Thus, they may appear to be perfectly normal individuals during day-to-day interactions. Indeed, psychopaths may actually have a high level of social skill and may function seemingly normally in the community for many years. For example, Ted Bundy used his strong social skills to lure victims. The BTK killer (Dennis Rader) and the Green River killer (Gary Ridgway) maintained jobs, families and a community presence for decades while committing their crimes (Rader even had a degree in Administration of Justice and worked as a codes enforcement officer).

Second, psychopaths are highly resistant to punishment or other forms of social control. They often have a suppressed fear response, which allows them to engage in high risk crimes with little anxiety. Their exaggerated egos also often make them indifferent to, or even contemptuous of, conventional incentives for pro-social behavior. This gets at the issue of possibilities for the treatment of psychopathy, discussed below.

Third, criminal behavior is not necessarily associated with psychopathy. Thus, most criminals are not psychopaths, and not all psychopaths actually engage in criminal behavior. Recent discussions of the latter type of non-criminal psychopath has coined the term “snakes in suits”, referring to individuals in business, politics and other professions who exhibit many of the personality traits of psychopaths in their quest for power and advancement (Babiak and Hare, 2006). There have even been attempts to develop instruments to assess such individuals, although this remains a controversial endeavor. In practical terms, we should understand that a theory of psychopathy does not necessarily suffice as a theory of crime, and vice versa.

The etiology of psychopathy is unclear. Some argue that it stems from abusive and traumatic upbringing, and is thus in some sense a survival mechanism for such individuals. Others find evidence of a biological origin (Elliot, 1999; Vien, et al, 2006). Some studies have found that psychopaths have a low blink-startle response, low heart rate, suppressed fear reactions, and a high tolerance (and even desire) for risk/danger. It is likely, though, that both environment and biology play a role in the development of psychopathy (Ridenour, 2000).

Assessment research (see below) has resulted in a classification of psychopathy that breaks it into two factors (Hare, et al. 1990). Factor 1, called Interpersonal/Affective, addresses the personality traits of the psychopath, such as glibness, manipulative, callousness, lack of remorse, lack of emotion, etc. Factor 1 can manifest diversely in practice, ranging from the relatively affable and manipulative example found with Ted Bundy and the relatively normal (if somewhat “peculiar”) family men found with Dennis Rader and Gary Ridgway to the socially isolated, “coldblooded” example found in Richard Ramirez (California’s “Nightstalker”). The common feature though is some combination of the affective deficits described above. Factor 2, called Lifestyle/Behavioral, addresses the behavioral characteristics of the psychopath, such as irresponsibility, impulsivity, parasitic lifestyle, criminal deviance, etc. More recent research has broken this further into four factors (Hare, 2003), but the original two factor model suffices for a basic understanding of the concept.

These factors are commonly referenced in research on psychopathy, leading to discussions more recently of *primary* and *secondary* psychopaths (Poythress and Skeem, 2006). A primary psychopath is one who exhibits the full range of psychopathic characteristics (Factors 1 & 2), but most especially the Factor 1 traits. Secondary psychopaths are less likely to manifest the Factor 1 traits, and have higher levels of anxiety and often more substance abuse than primary psychopaths. Psychopaths commonly portrayed in the media, such as the serial killers referenced earlier, are generally primary psychopaths.

The examples of psychopaths above were all serial killers, as these cases attract much popular attention<sup>1</sup>. We should note that most psychopaths do not demonstrate such extreme examples of criminal deviance. They can also be serial thieves, con artists, etc. who demonstrate little or no violent behavior, but who still exhibit the traits (especially Factor 2) of a psychopath. Thus, we should not necessarily equate psychopathy with extreme violence, or vice versa.

Due to the challenges of assessing for psychopathy (discussed below), there is no good estimate of the prevalence of psychopathy in the general or offender populations. In a study of violent offenders declared by the Canadian courts to be “dangerous offenders” (a legal category in Canada, typically resulting in long term incarceration), nearly 40% were found to be psychopaths (Bonta, et al, 1996). The sample used for this study, though, was hardly representative of violent offenders in general, as it consisted of the “worst of the worst” in the Canadian penal system.

As noted earlier, the DSM-IV (American Psychiatric Association, 2000) does not specifically recognize psychopathy. Instead, it identifies the condition of Antisocial Personality Disorder (APD; ICD code 301.7). While there is a fair degree of overlap between the two concepts, APD differs from psychopathy in that APD focuses more on the behavioral aspects (i.e. Factor 2) than on the affective aspects (i.e. Factor 1). The diagnostic criteria for APD are outlined below. APD seems to have a relatively high prevalence. In a study of nearly 23,000 prisoners in 12 countries, 47% of male prisoners and 21% of females were found to have APD (Fazel and Danesh, 2002). Other studies have found prevalence rates of APD among prisoners as high as 80% (Moran, 1999). It should be noted that conditions with such a high prevalence rate are relatively less useful in discriminating between offenders (i.e. if they all have it, you cannot use it to predict who will do what). Both psychopathy and APD are diagnosed more commonly in males than females.

Having established a basic working definition of psychopathy and the related construct of APD, we turn to the assessment and measurement of these conditions.

### Psychopathy – Assessment and Classification

The most commonly used tool to assess for psychopathy is the Psychopathy Checklist-Revised (PCL-R) (Hare, 2003). The PCL-R has 20 items that assess core traits of the psychopath. The PCL-R can require up to three hours to administer, depending upon the quality of the agency’s files and the amenability of the offender. The PCL-R produces a score of 0 to 40, with a score of 30 being the commonly accepted cut-off to diagnose someone as a psychopath.

This cut-off is itself a matter of debate surrounding whether psychopathy is a *taxon* or a *dimensional* construct. Early conceptualizations of psychopathy tended to view it as a taxon, meaning an all or nothing category (i.e. someone either was or was not a psychopath) (Hare, 1993; Harris, et al.,

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<sup>1</sup> It is not known if all of these individuals have been formally assessed as psychopaths, but given what is known of them, such a diagnosis seems plausible.

1994). More recent research tends to support the view of psychopathy as a dimensional construct, where there are varying degrees of psychopathy, which would also imply that some psychopaths are worse than others (Hare and Neuman, 2006).

One issue that should be noted with the PCL-R is that there are fairly specific training requirements and qualifications to administer the tool. Typically, one must have advanced training in psychology, psychiatry or a related field, with a graduate degree preferred. These training requirements may discourage some jurisdictions from the use of the PCL-R, as they lack qualified staff. Given the high level inferences required to assess an offender on the PCL-R, these training requirements seem reasonable.

Research has identified a link between psychopathy and career criminality, indicating that criminals who are assessed as psychopaths are more likely to be persistent offenders than criminals not so assessed (Vaughn and DeLisi, 2008). A number of studies have found that the score on the PCL-R is predictive of recidivism, both general and violent; in other words, the higher the score on the tool, the greater the likelihood of committing additional crimes (Gendreau, et al, 1996; Hemphill, et al, 1998; Salekin, et al, 1996). As with any assessment tool, the PCL-R is not a perfect predictor of reoffending, and there is a certain rate of false positives and false negatives. The correlations between PCL-R score and future violent offending are reasonably strong. Some of the research indicates that the Factor 2 (antisocial lifestyle) items may be more predictive of general criminality than the Factor 1 (affective/personality) items, but that there is no difference between the two factors in predicting violent offending. This suggests that the personality features of psychopathy may be less important than the behavioral items in predicting future crime.

Some have asserted that the PCL-R validation data support a claim that the PCL-R is the “unparalleled” measure of violent recidivism, better than other general purpose risk assessment tools such as the Level of Service Inventory-Revised (LSI-R) (Salekin, et al, 1996). Other research, though, has found that tools such as the LSI-R can predict violent recidivism as well as specialized tools such as the PCL-R (Gendreau, et al, 2002). Indeed, validations of the LSI-R in Pennsylvania have found that it is equally predictive for violent and non-violent offenders.

The PCL-R has contributed to the development of other, more specialized assessment tools, including the Violence Risk Appraisal Guide (VRAG). The VRAG uses a completed PCL-R as a component of the overall assessment. Interestingly, the developers of the VRAG have experimented with using another tool – called the Child and Adolescent Taxon Scale (CATS) – as a replacement for the PCL-R in the VRAG. The CATS is a much simpler tool than the PCL-R, and can be completed by staff without advanced psychological training (Quinsey, et al, 2006). This research is preliminary, but may provide an avenue for the assessment of violence that does not require the assessment of the complex construct of psychopathy.

As noted above, the DSM-IV provides another approach to assessing serious criminal behavior, with the concept of Antisocial Personality Disorder (APD, ICD Code 301.7). The diagnostic criteria for APD are:

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.
- (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
- (3) impulsivity or failure to plan ahead.
- (4) irritability or aggressiveness, as indicated by repeated physical fights or assaults.
- (5) reckless disregard for safety of self or others.
- (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
- (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least 18 years old.

C. There is evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

The diagnostic criteria for APD are in essence “free” (i.e. there is no instrument to purchase, other than a copy of the DSM-IV), but the understanding is that any legally valid diagnosis of the condition must be made by a properly trained and licensed clinician, such as a psychologist or psychiatrist (MD). One advantage of the APD assessment is that APD is codified in the DSM-IV, which is universally recognized as the standard for the diagnosis of mental, personality and behavioral disorders (including substance abuse).

### Psychopathy - Treatment

The potential for rehabilitating psychopaths is a subject of much debate. The conventional wisdom has been that the typical psychopath is beyond help, and that treatment programs will be wasted on them, or may even make them worse (Reid and Gacono, 2000). The latter is predicated on the notion that psychopaths can use the intimate setting of a treatment group to hone their skills of lying, deception and manipulation on other offenders and even on staff (Rice, et al, 1992). Indeed, the other concern is of psychopaths “hijacking” the treatment group and actually making the other participants worse through their charismatic displays of antisocial attitudes and behavior. There are certainly many clinical anecdotes of this sort of thing occurring, but it is unclear if such a pattern has been established empirically.

More recently, there is some evidence that psychopaths, particularly juveniles and young adults, can benefit from treatment (Abracen, et al, 2008; Caldwell, 2006, 2007). The larger question may be not whether psychopaths can be treated, but whether programs currently in existence can work with this population. Many of the programs used to treat psychopaths (and thus the focus of existing evaluations) were poorly conceived for the challenges of this population. Thus, it may not be surprising that the literature shows little promise for the treatment of psychopaths (Hare, et al, 2000).

At the moment, then, we cannot say whether treatment makes a difference for psychopaths, due to poorly designed programs and relatively few studies. Drawing from the Principles of Effective Offender Intervention, we can say that if we do offer treatment programs to psychopaths, the programs should have the following characteristics: (a) target criminogenic needs, (b) use cognitive-behavioral methods, (c) offer intensive services, (d) utilize staff who are specially trained to deal with this population, and most importantly, (e) **do not mix non-psychopaths into the treatment setting**. Efforts have been made recently to develop treatment programs specifically for psychopaths, but little to no evaluation data is available yet on them (Wong and Hare, 2005).

### Psychopathy - Limitations and Summary

Psychopathy is a complex psychological construct that is widely misunderstood and even controversial. Some researchers argue that it is a poorly defined construct that is too difficult to assess and that is susceptible to bias and subjectivity in measurement (especially for the Factor 1 items). Some argue that it is better to rely upon APD and other diagnoses that are recognized by the DSM-IV. Others are concerned about the labeling effect associated with the assessment, as well as with the conclusion that those so assessed are “beyond help” (Edens, et al, 2006). This concern applies especially to the assessment of psychopathy in children, adolescents and even young adults, where traits that are associated with normal adolescent development may be misinterpreted as indicators of psychopathy (Edens, et al, 2001).

In spite of the concerns noted above, psychopathy, as well as APD, appear to be reasonably well established constructs that can have some value in our efforts to assess and treat offenders. It is important, though, that we acknowledge the limitations of psychopathy assessment and that we understand what it is telling us. Being assessed as a psychopath is neither a necessary nor a sufficient condition for violent offending. On a related point, the use of the PCL-R and/or the DSM-IV standards for APD should also be accompanied by a broader package of risk and needs assessment, and be reviewed by a properly trained and experienced clinician. While objective assessment tools are an absolutely essential part of the overall treatment process, no assessment tool is intended to stand alone or to be used as a substitute for professional decision making (American Psychiatric Association, 2000). Next, we should not unconditionally accept the conclusion that all individuals diagnosed with psychopathy or APD are beyond the reach of treatment programs. The challenge is to identify and properly implement programs that are designed for the demands of this population. Finally, applying the label of “psychopath” to an individual carries enormous implications for the disposition of that individual within the criminal justice system. Accordingly, the system has the responsibility to exercise care in this assessment and in the interpretation of the results.

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