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Psychopathy: Its Relevance, Nature, Assessment, and Treatment

Bradley A. White, *Virginia Tech*

Mark E. Olver, *University of Saskatchewan*

Scott O. Lilienfeld, *Emory University*

Why Care About Psychopathy?

Fascination with individuals who chronically violate the rules and demonstrate reckless disregard for others dates back to antiquity. In the Book of Deuteronomy, Moses (c. 600 B.C.) described “a wayward and defiant son, who does not heed father or mother and does not obey them even after they disciplined him.” In his portrayal of personality types, the Greek philosopher and student of Aristotle, Theophrastus (c. 300 B.C.), described *The Unscrupulous Man* as “a cheat, rascal, a borrower who never repays, thief, incorrigible.” French physician Philippe Pinel (1745-1826) later used the terms *la folie raisonnante* (moral insanity) and *manie sans délire* (insanity without delirium) to describe patients who behaved in irresponsible and immoral ways despite intact rationality and intellect. Other historical conceptualizations include American psychiatrist Benjamin Rush’s (1746-1845) notion of *innate preternatural moral depravity*, British psychiatrist Henry Maudsley’s (1835-1918) description of “some few who are congenitally deprived of moral sense,” German psychiatrist Emil Kraepelin’s (1893-1915) proposition that congenital defects lead to *moral degeneration*, and German-American psychiatrist Karl Birnbaum’s (1878-1950) introduction of the label “*sociopathic*” to emphasize societal influences on the development of antisocial traits (although the term “sociopath” has since been confused with “psychopath”).

Contemporary conceptualizations of *psychopathic personality*, often known simply as *psychopathy*, derive largely from the vivid case studies provided by American psychiatrist Hervey Cleckley in his classic 1941 monograph, *The Mask of Sanity*. Psychopathy is now seen as a constellation of affective (e.g., callousness, guiltlessness), interpersonal (dishonesty, grandiosity), and behavioral traits (impulsivity, irresponsibility) that exist not only in forensic and clinical settings, but that also

vary dimensionally in youth and adults in the general population (e.g., Guay, Ruscio, Knight, & Hare, 2007; Murrie et al., 2007). Some authors have argued that psychopathic traits are one of the strongest dispositional risk factors for antisocial behavior, including physical and sexual aggression, behavioral problems during incarceration, and criminal recidivism across age ranges and contexts (e.g., Forsman, Lichtenstein, Andershed, & Larsson, 2010; Guy, Edens, Anthony, & Douglas, 2005; Lynam, 1997; Reidy et al., 2015; Yang, Wong, & Coid, 2010); although as we describe later, the nature of this association is somewhat controversial. Psychopathy has also been found to be associated with poorer response to treatment in some studies, but not in others (e.g., Skeem, Monahan, & Mulvey, 2002).

As a result of its potential impact on individual functioning and criminological risk, as well as questions about its malleability, psychopathy has received considerable attention in both clinical and forensic contexts. Beyond mental health and legal settings, there has been growing interest in, and controversy concerning, *successful psychopathy* in the general population (Widom, 1977), including whether certain levels or features of psychopathy facilitate success in certain vocations or avocations, such as politics, business, and high-risk sports (Lilienfeld, Watts, & Smith, 2015). Even in community contexts, psychopathic traits may be associated with elevated but more subtle forms of antisocial behavior (Czar, Dahlen, Bullock, & Nicholson, 2011) such as proactive relational aggression, in which others’ relationships or social status are intentionally harmed by means such as gossip or humiliation without provocation, for sake of instrumental gain (White, Gordon, & Guerra, 2015). Psychopathic traits in such contexts are also associated with more prosocial acts when an audience is present, but lower levels of anonymous and altruistically motivated prosocial acts (White, 2014). Yet important questions remain regarding how to define “successful

psychopathy” (Gao & Raine, 2010). In addition, it is unclear whether successful psychopathy reflects a more mild version of unsuccessful psychopathy, a distinct configuration of psychopathic traits, or an attenuated expression of core psychopathic traits tempered by protective factors (Ishikawa, Raine, Lencz, Bihrlé, & Lacasse, 2001; Lilienfeld et al., 2015).

What Psychopathy Is Not

Beyond the obvious confusion stemming from the unfortunate prefix “psycho” (psychopathy is just one form of personality psychopathology, and most psychopaths are not *psychotic* or otherwise irrational or disoriented), many erroneous beliefs exist about psychopathy (Berg et al., 2013; Skeem, Polaschek, Patrick, & Lilienfeld, 2011). We will cover a few of the most common misconceptions.

Psychopathy Is Not Synonymous With Violence

It is true that psychopathic individuals commit some of the most heinous crimes, and that certain notorious serial killers, like Ted Bundy and John Wayne Gacy, manifested marked psychopathic traits. But others, like Charles Manson, displayed more symptoms of psychosis than psychopathy. And of course, violence is influenced by a host of factors (e.g., historical, economic, and ideological). Although the most widely used measure of psychopathy (Psychopathy Checklist-Revised; Hare, 2003) emphasizes antisocial features (e.g., juvenile delinquency, recidivism, criminal versatility), not all psychopathic individuals exhibit violent or other antisocial tendencies, or end up in prison (Lilienfeld, 1994), even though they may show other socially undesirable characteristics, such as being superficial, smug, and unempathic.

Psychopathy Is Not Equivalent to Antisocial Personality Disorder

Psychopathy is not synonymous with antisocial personality disorder (ASPD; APA, 2013), a heterogeneous DSM diagnosis characterized by a chronic history of antisocial, criminal, and in some cases violent behavior (Cox et al., 2013). Despite earlier editions of the DSM suggesting psychopathy and ASPD are synonymous, ASPD measures and diagnostic criteria focus on antisocial behaviors seen in approximately half of incarcerated samples, whereas psychopathy occurs less often, and measures of psychopathy emphasize distinct personality traits

(described later) that are not observed in most individuals with ASPD (Skeem et al., 2011).

Psychopathy is not unalterable. The conventional belief that psychopathy is innate and unalterable is increasingly challenged by evidence of the interplay of constitutional and environmental influences in this condition (e.g., Waldman & Rhee, 2006). Genes appear to play a significant role in the development of psychopathy, probably by influencing children's information, or affective-processing styles (e.g., difficulty learning from punishment, low emotional reactivity), but there are unlikely to be any specific genes for psychopathy (Viding & McCrory, 2012). Furthermore, twin studies (e.g., Larsson, Andershed, & Lichtenstein, 2006) suggest that only about half of the variability in psychopathic traits reflects heritable factors, and the other half reflects *nonshared environmental influences*—nongenetic factors that make siblings dissimilar from one another, such as birth order, differential parenting, stressors (e.g., injuries, illness, trauma), having different peers, and microbiomes (the community of microorganisms that inhabit our bodies; Peterson et al., 2009). Environmental variables also appear to influence the expression of genetic risk for psychopathy. Particular evidence for the impact of the environment comes from the apparent response of psychopathic traits and associated behaviors to parenting styles (Viding & McCrory) and to treatment, as discussed later.

What Is Psychopathy?

Cleckley's (1941) modern characterization of psychopathy emphasized the confident, well-adjusted, personable presentation (hence, the reference to the word "mask" in his title) of a subset of psychiatric inpatients he was seeing. As with other forms of personality pathology, these individuals revealed their severe underlying deficits over time, which included shallow affect, egocentricity, and irresponsibility, rather than emotionally dysregulated, explosive, violent, or cruel tendencies. Others working with incarcerated individuals have similarly conceptualized psychopathy as marked by superficial emotions, but they placed greater emphasis on callousness, lovelessness, impulsivity, as well as hostile alienation from and exploitation of others (McCord & McCord, 1964).

Measuring Psychopathy

In forensic settings, the most frequently used measure for the assessment and diagnosis of psychopathy is the Hare Psychopathy Checklist–Revised (PCL-R; Hare, 2003), which relies on a semistructured clinical interview and corroborative information (e.g., criminal records) to assign values on a 20-item symptom-based rating scale. Scores range from 0–40 with a research-based diagnostic cutoff for psychopathy of ≥ 30 (or 25 when rated via file only; Wong, 1988). Two broad dimensions have been derived via factor analysis that account for much of the covariation among the items on the PCL-R and its variants (Harpur, Hare, & Hakstian, 1989). Factor I encompasses core affective (callousness, lack of remorse) and interpersonal (grandiosity, superficiality) features; whereas Factor II encompasses unstable lifestyle (irresponsible, impulsive) and antisocial behavior (early behavior problems, criminal versatility). Subsequent three-factor (Cooke & Michie, 2001) and four-factor (Hare, 2003) models further parse Factor I into separable but correlated affective and interpersonal features. The PCL-R has been extended downward to adolescents as the Psychopathy Checklist: Youth Version (PCL: YV; Forth, Kosson, & Hare, 2003).

The time and expertise required to conduct the PCL-R interview has led to the development of briefer self-report questionnaires, particularly in research settings (Lilienfeld & Fowler, 2006). Such measures include the Levenson Self-Report Psychopathy Scale (LSRP; Levenson, Kiehl, & Fitzpatrick, 1995), Self-Report Psychopathy Scale (SRP-III; Paulhus, Hemphill, & Hare, 2012), the Psychopathic Personality Inventory–Revised (PPI-R; Lilienfeld & Widows, 2005), and the Triarchic Psychopathy Measure (TriPM; Patrick, 2010).

Influenced by the classic writings of Karpman (1941), Levenson and colleagues (1995) developed the LSRP, a now well-validated self-report measure to differentiate psychopathy subtypes. They conceptualized *primary psychopathy* as encompassing interpersonal characteristics such as selfishness, uncaring, and manipulateness, combined with general intelligence, emotional stability, and seemingly adequate outward adjustment. In contrast, *secondary psychopathy* encompasses impulsivity, emotional dysregulation, anxiety, self-defeating tendencies, and general psychopathology.

The SRP-III (Paulhus et al., 2012) is the second revision of a scale developed by Hare and colleagues as a self-report counterpart to the PCL-R for use in community samples. The current version was revised to fit the four-facet structure of the PCL-R. It contains 64 items and produces a global psychopathy score, as well as four subscales, with Callous Affect and Interpersonal Manipulation subscales reflecting PCL-R Factor 1, and Erratic Lifestyle and Antisocial Behavior subscales reflecting Factor II.

The PPI-R (Lilienfeld & Widows, 2005) is an adult 154-item self-report measure usable for community, clinical, and forensic settings that offers a total score as well as eight factor-analytically derived content scales, most of which often, although not always (Neumann, Malterer, & Newman, 2008), load onto two higher-order factors. The first of these higher-order dimensions, Fearless Dominance, comprises the Social Influence, Fearlessness, and Stress Immunity scales and is associated with assertiveness, poise, stress resilience, and thrill-seeking; although it is largely unassociated with PCL-R total scores, it is modestly associated with its interpersonal facet. The second, Self-Centered Impulsivity, comprises Machiavellian Egocentricity, Rebellious Nonconformity, Blame Externalization, and Carefree Nonplanfulness scales and is associated with impulsivity, ruthless narcissism, manipulateness, and hostile attribution bias; it correlates highly with PCL-R Factor II. The Coldheartedness scale does not load highly on either PPI-R higher-order factor, and is associated with lack of deep social emotions including empathy and guilt; it correlates moderately with PCL-R Factor I (Marcus, Fulton, & Edens, 2013). The PPI-R is standardized for community samples in the United States, offers norms for male offenders, and can detect positive and negative impression management and careless responding.

More recently, Patrick, Fowles, and Krueger (2009) introduced an increasingly popular triarchic model of psychopathy, which attempts to reconcile competing historical models by conceptualizing psychopathy as encompassing three interrelated phenotypic dispositions of boldness, meanness, and disinhibition. Each domain is captured in a 58-item self-report questionnaire (TriPM; Patrick, 2010). *Boldness* comprises emotional resiliency, confidence, social assertiveness, and venturesomeness. It is based largely on the Fearless Dominance factor of the PPI-R and intended to capture the "mask" features of

Cleckley's (1941) conceptualization of psychopathy, as well as a lack of behavioral inhibition. *Meanness* comprises lack of empathy and affiliative capacity, contempt toward others, predatory exploitativeness, and empowerment through cruelty or destructiveness, thus overlapping with Callous Unemotional traits in youth (see discussion below, "Psychopathy in Children?"), as well as the Coldheartedness scale of the PPI-R. *Disinhibition* entails impulsiveness, weak restraint, hostility and mistrust, and difficulties in regulating emotion, and relates strongly to the Self-Centered Impulsivity factor of the PPI-R. An important distinction between the PPI-R and TriPM, on the one hand, and many other psychopathy measures, on the other, is their inclusion of the Fearless Dominance/Boldness dimension, which is less well represented within such measures as the LSRP and SRP-III, as well as the youth-based APSD described later (Patrick & Drislane, 2015).

Definitional Controversies

There is still ongoing debate on the role and relevance of certain psychopathy features in defining the personality syndrome. For example, although Cleckley (1941) noted a lack of extreme meanness in prototypical psychopaths, the triarchic model accords a central role to meanness. Hence, the place of meanness within the psychopathy construct requires clarification.

Similarly, although some scholars have argued that adaptive features, such as boldness (as assessed largely by the PPI-R Fearless Dominance dimension), are largely or entirely irrelevant to psychopathy (e.g., Miller & Lynam, 2012), others have argued that they play a key role, accounting in large measure for Cleckley's (1941) "mask" of superficially healthy functioning (Lilienfeld et al., 2012; Venables, Hall, & Patrick, 2014). Adding to the confusion, boldness measures tend to be moderately to highly correlated with total scores on some psychopathy measures, but not with total scores on measures derived from the PCL-R, probably reflecting the PCL-R's emphasis on maladaptive (e.g., antisocial and criminal) behavior (Lilienfeld et al., in press).

Others have argued that disinhibition is merely a secondary correlate or consequence of psychopathy rather than a core component (Cooke, Michie, Hart, & Clarke, 2004). Because the PCL-R includes items assessing prior antisocial behavior, there is also ongoing debate regarding how much psychopathy per se adds to the pre-

diction of future violence beyond preexisting history of violence (e.g., Hare & Neumann, 2010; Skeem & Cooke, 2010a, b).

Notably, the construct of psychopathy has also been deconstructed in terms of Big Five (or Big Three) normal-range personality traits, with the aforementioned psychopathy measures typically reflecting low Agreeableness (i.e., high antagonism, including suspiciousness and deceptiveness) and low Conscientiousness (i.e., low constraint, including impulsivity and non-traditional values). Some measures also reflect the more psychologically adaptive traits of low Neuroticism, high agentic Extraversion, and high Openness, depending upon how psychopathy is conceptualized and operationalized (Lilienfeld, Watts, Smith, Berg, & Latzman, 2015).

Psychopathy in Children?

Certain psychopathic features appear to emerge early in development and have been measured in children as young as 2 to 3 years of age (Kimonis, Frick, Boris, et al., 2006). The most widely used measures of psychopathic features in youth have been the PCL:YV (Forth et al., 2003) and the Antisocial Process Screening Device (APSD; Frick, O'Brien, Wooton, & McBurnett, 1994). Both are 20-item adaptations of the adult PCL-R, although the PCL:YV follows the PCL-R format of requiring a semi-structured interview and review of records, whereas the APSD is based upon parent or teacher report or adolescent self-report. Factor structures of these measures largely mirror those of the PCL-R (Kotler & McMahon, 2010), although these factors tend to be more positively correlated with negative emotionality (e.g., depression, anxiety) in youth than in adults (Sevecke & Kosson, 2010).

Other instruments have been developed, such as the 50-item Youth Psychopathic Traits Inventory (YPI; Andershed, Kerr, Stattin, & Levander, 2002), a self-report measure that contains items designed to tap each of 10 core psychopathic traits identified in nonincarcerated adolescent samples in a manner similar to the PCL, without requiring the administration training and time of the PCL:YV. A modified version of the YPI, the Child Problematic Traits Inventory (CPTI; Colins et al., 2014), developed for children ages 3 to 12, excludes the YPI and PCL behavioral dimension (e.g., rule-breaking, antisociality, impulsivity) to avoid confounding measurement of traits with behavioral symptoms of conduct disorder.

An alternative approach by Frick and colleagues emphasizes callous/unemotional (CU) traits, such as shallow emotions, lack of guilt or remorse, disregard for others' feelings, and lack of concern regarding one's own performance in important activities. CU traits tend to be associated with relatively high levels of antisocial behavior (Christian, Frick, Hill, & Tyler, 1997), including early onset and persistence of serious conduct problems (Moffitt, 2006; Patterson, 1996), repetitive deceitfulness, rule violations, physical cruelty, and property destruction (Frick, Ray, Thornton, & Kahn, 2014), as well as fearlessness (e.g., Pardini, Lochman, & Powell, 2007). Youth with elevated conduct problems and CU traits are less responsive to others' distress (Kimonis, Frick, Fazekas, & Loney, 2006), show deficits in fear recognition (Dadds et al., 2006), and are more prone to proactive aggression (Marsee & Frick, 2007), compared with other youth. Such findings have led to expansion of the six items originally forming the CU subscale on the APSD to form a separate 24-item Inventory of Callous-Unemotional Traits (Frick, 2004; Kimonis et al., 2008). Others researchers (Willoughby, Waschbusch, Moore, & Propper, 2011) have constructed CU scales by combining selected items from commonly used symptom inventories, such as the Child Behavior Checklist (Achenbach & Rescorla, 2000).

To acknowledge that youth with elevated CU traits comprise a unique subgroup among those with serious conduct problems, while attempting to minimize potential harm in labeling such youth, the latest edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) added the specifier "With Limited Prosocial Emotions" to the diagnosis of conduct disorder to designate those with CU traits. A clinician-rated *Clinical Assessment of Prosocial Emotions* (Frick, 2013) is currently under development to facilitate determination of the corresponding DSM-5 CD specifier.

Ethical Implications

Important ethical concerns remain regarding the potential negative impact, including stigma and negative juror impressions, of labeling children and adolescents with a term that implies the presence of pre-psychopathic features (Edens, Mowle, Clark, & Magyar, 2016). Moreover, the downward extension of psychopathic traits to children has been controversial on

scientific grounds. Although rank-order estimates suggest moderate stability of CU traits across later childhood into adulthood, there is significant individual variability in trajectories over time (Pardini & Loeber, 2008), and some children with CU traits appear to “grow out” of this pattern (Edens, Skeem, Cruise, & Cauffman, 2001). Those examining CU tendencies in early childhood sometimes use the term “behavior” rather than “traits” to emphasize their temporal instability during this developmental period (Waller et al., 2015).

Etiology

A review of the etiology of psychopathic traits is beyond the scope of this article. Nevertheless, research suggests that callous behaviors can develop early (e.g., Waller et al., 2015), with some evidence for moderate to high heritability (Viding & McCrory, 2012). There appear to be at least two alternative pathways that reflect either largely innate (“primary psychopathy”) or environmental (“secondary psychopathy”) influences (Karpman, 1941; Kimonis, Frick, Cauffman, Goldweber, & Skeem, 2012). Some prominent etiological models of psychopathy are primarily “bottom up,” emphasizing the role of emotional disturbances in shaping psychopathic deficits. For example, some posit that deficits in the capacity to process fear and closely related emotions give rise to the core features of the condition, such as guiltlessness, callousness, and superficial charm (e.g., Blair, 2008; Kiehl, 2006; Lykken, 1957). In contrast, other major etiological models are primarily “top down,” emphasizing the role of higher cortical processes, such as insufficient attentional allocation to extraneous cues, in shaping the core features of the condition (Moul, Killcross, & Dadds, 2012; Patterson & Newman, 1993). Still other recent models posit a mix of bottom-up and top-down etiological influences (e.g., impaired integration model; Hamilton, Racer, & Newman, 2015).

Do Psychopathic Traits Worsen Treatment Outcomes for Youth?

Behavioral interventions for conduct problems in children, particularly parent management training, are well-established (Michelson, Davenport, Dretzke, Barlow, & Day, 2013), yet about 40% to 50% of youth do not show substantial benefit (Ollendick et al., 2015). There is reason to be concerned about treatment outcomes for youth with elevated CU traits in particular, as such youth appear to be at greatest risk for chronic and severe disruptive

behavior problems. However, there is ongoing debate concerning whether CU traits attenuate treatment effectiveness (Hawes, Price, & Dadds, 2014), or merely reflect the fact that such youth start with higher levels of conduct problems but improve at the same rate in treatment as those without CU traits (Waller, Gardner, & Hyde, 2013). A recent comprehensive review (Hawes et al., 2014) of parenting interventions for youth with CU traits suggests that parent training is effective in reducing behavioral problems in these youth, particularly when emphasis is placed on positive reinforcement and promotion of parental warmth. Other research suggests that a warm and responsive parent-child relationship may enhance conscience development (Somech & Elizur, 2012). Furthermore, there is preliminary evidence that emotion recognition training may serve as a useful adjunct to parent training for youth with CU traits (Dadds, Cauchi, Wimalaweera, Hawes, & Brennan, 2012).

Are Adult Psychopaths Untreatable?

Turning to adults, there is surprisingly little evidence to support the common skepticism regarding the treatability of psychopathy or the presumption that psychopathy adversely moderates the effectiveness of treatments for adult antisocial behavior (Skeem et al., 2002). The roots of doubt appear to stem largely from an earlier intervention study that reported increased criminal recidivism among psychopathic individuals who had participated in a radical “therapeutic community” (Rice, Harris, & Cormier, 1992). In this program, devised by Canadian psychiatrist Elliot Barker and authorized by the Canadian government (Barker & Buck, 1977), patients in a maximum security hospital were mandated to participate without voluntary consent. They were stripped of their clothing, locked in “total encounter capsule” rooms for days on end, administered psychedelic drugs, fed through tubes in the wall, offered minimal contact with professional staff, and received no attempts to alter criminal attitudes or teach social or problem solving skills—certainly a far cry from modern-day ethical evidence-based approaches.

Countering the pessimism regarding treatability, growing evidence suggests that individuals with elevated psychopathy are best seen as high-risk cases that are in need of intensive treatment (Skeem et al., 2011). Although early optimistic reviews (Salekin,

2002) have been limited by methodological concerns, including a lack of well-designed studies (D’Silva, Duggan, & McCarthy, 2004; Harris & Rice, 2006), more recent reviews (Caldwell, McCormick, Umstead, & Van Rybroek, 2007; Polaschek, 2014; Salekin, Worley, & Grimes, 2010) at least partially support the treatability of psychopathy.

Recent Treatment Advances

Some new experimental intervention approaches feature the application of computerized cognitive/affective remediation paradigms in attempts to target hypothesized psychopathy-specific deficits (e.g., Baskin-Sommers, Curtin, & Newman, 2015; Schönberg et al., 2014). These approaches are intended to alter specific cognitive-affective dysfunctions, such as perceptual insensitivity to others’ emotions (Schönberg et al.), failure to utilize contextual information (for psychopathic, high-Factor I individuals), or the inability to regulate affective reactions (for externalizing, or high Factor II/low Factor I individuals; Baskin-Sommers et al., 2015). Preliminary support has been obtained, for instance, for deficit-matched cognitive training based on offender subtype. Specifically, Baskin-Sommers and colleagues found improved attention to context among psychopathic men, and improved affect regulation among externalizing men. The results underscore the importance of cognitive factors and the potential incremental value of novel computerized interventions in developing specific cognitive and affective information processing skills that might, in turn, curb antisocial behavior. Nevertheless, it is too early to tell whether these computerized interventions will translate into long-term gains in real-world settings.

A larger body of research from high-intensity violence-reduction programs, broadly adhering to risk-need-responsivity (RNR) principles (discussed further by Mitchell, Wormith, & Tafrate, 2016, this issue), offers some clarity regarding what potentially works with psychopathic offenders. Emerging evidence suggests that effective programs must provide high-intensity services for high-risk offenders (risk principle), prioritize criminogenic needs to be targeted for risk-reduction services (need principle), deliver services in a flexible and clinically engaging manner (general responsiveness), and be attentive to the unique needs of each client (specific responsiveness). When these core compo-

nents can be harnessed, positive risk-relevant changes have been linked to reductions in sexual (Olver & Wong, 2009) and violent (Olver, Lewis, & Wong, 2013; Wong, Gordon, Gu, Lewis, & Olver, 2012) recidivism after controlling for baseline risk and individual differences in psychopathy.

Wong proposed a two-component model for the treatment of psychopathy that prioritizes services, in part based on the structure of psychopathic traits (see Wong et al., 2012; Wong & Hare, 2005). Component 1 is essentially a responsibility prong, in which service providers manage the interpersonal and affective features of psychopathy (i.e., Factor I traits). For instance, psychopathic offenders tend to engage in disruptive behavior within groups, pit staff against one another and push boundaries, intimidate co-patients, fail to accept responsibility, and show a lack of empathy or emotional connectedness toward others. Since Factor I features appear to be linked to decreased therapeutic progress (Olver et al., 2013), increased dropout (Olver & Wong, 2011), and weaker working alliances, particularly the therapeutic bond (DeSorcy, Olver, & Wormith, 2016), Wong and colleagues recommended managing Factor I through containing treatment-interfering behaviors rather than trying to treat and change Factor I per se. For example, service providers can maintain open lines of communication, present a united front, maintain clear boundaries, avoid power and control battles with challenging clients, and engage in routine consultation and support. Such strategies are essential in maintaining psychopathic client engagement in treatment and avoiding program dropout.

Component 2 (criminogenic component) essentially corresponds to the risk and need principles, and entails delivering high-intensity risk-reduction services targeting criminogenic needs (i.e., dynamic risk factors) associated with PCL-R Factor II. The criminal lifestyle features of psychopathy correlate highly with measures of criminogenic needs (Olver & Wong, 2009; Simourd & Hoge, 2000; Wong & Gordon, 2006), and Factor II bears particularly strong links to recidivism. Many of the features of Factor II are dynamic in principle (e.g., impulsivity, irresponsibility, lack of goals, poor behavior controls, parasitic lifestyle), and conceptually share much in common with treatment foci of correctional programs. The criminogenic needs of psychopathic offenders are not different than those of nonpsychopathic individuals;

they tend to be more severe and probably larger in number (Wong & Gordon). Comprehensive and integrated cognitive-behavioral programs targeting general and specific criminogenic need domains are likely to yield larger net gains and potential for recidivism reduction (Wong & Hare, 2005; Wong et al., 2012). For possible gains to be realized, of course, psychopathic clientele need to be retained and engaged in treatment. In summary, service providers are advised to manage, rather than to try to alter, the characteristics associated with Factor I, and to actively target the criminogenic features associated with Factor II (see also Harkness & Lilienfeld, 1997).

Conclusions

Behavioral and cognitive-behavioral therapists have long focused on internalizing problems, particularly anxiety-related disorders. We believe that the time has come to examine further the opposite end of the spectrum, which may be just as maladaptive, albeit in ways that differently impact individuals and those around them. Countering the prevailing pessimism about this client group, a growing literature suggests that, although psychopathic traits may increase risk for chronic and severe conduct problems, the affective, interpersonal, and behavioral patterns that comprise psychopathy may prove to be amenable to cognitive-behavioral approaches. An analogy to borderline personality disorder may be helpful in this context. Borderline was once viewed widely as an untreatable condition, but such views have receded in the wake of major therapeutic advances (Linehan, 1993). Similarly, the treatability of psychopathy, once assumed to be a quixotic or even pointless venture, is increasingly coming to be regarded as a promising new frontier. At the same time, important conceptual and practical questions await further investigation with regard to the nature and development of interventions for psychopathy, creating exciting opportunities for future research.

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Correspondence to Bradley A. White, Ph.D., Department of Psychology, 109 Williams Hall (0436), Virginia Tech, Blacksburg, VA 24061; whiteba@vt.edu



Election Results



Sabine Wilhelm, Ph.D.
President-Elect, 2016-2017



Simon Rego, Ph.D.
Representative-at-Large, 2016-2019

The membership also passed two bylaws proposals:

1. Article III: Membership
2. Article V: Voting