# The Use of the Psychopathy Content Scale-16 (P-16)

# in an Adolescent Inpatient Setting:

By

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A Doctoral Project Submitted in Partial Fulfillment of
the Requirements of the Degree of Doctor of Psychology
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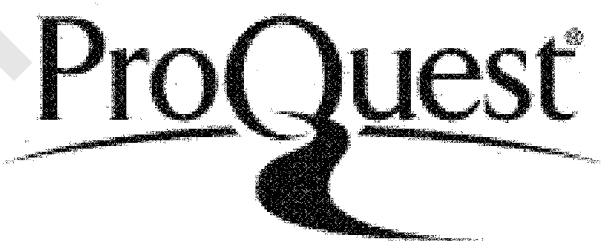

**PSY.D PROJECT FINAL APPROVAL FORM**

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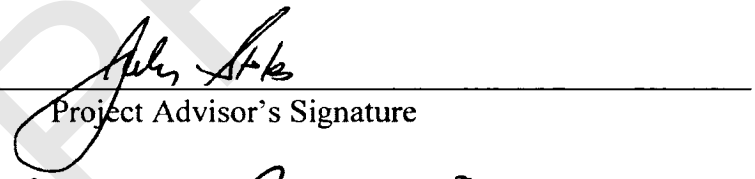
FINAL APPROVAL OF COMPLETED PROJECT:

I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Clinical Child Psychology.



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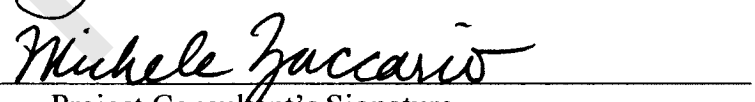

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## ABSTRACT

This study was an effort to explore and expand the research in the field regarding the credibility of self-report measures when measuring psychopathic-like traits in children and adolescents. Some clinical research efforts have been devoted to developing screening indicators to ascertain whether a more comprehensive assessment of psychopathy traits might be advisable. This study examined the relationships between the abbreviated Psychopathy Content Scale (P-16; Salekin, Ziegler, Larrea, Anthony, & Bennett, 2003) taken from the Millon Adolescent Clinical Inventory (MACI; Millon, 1993) with performance and self- report based measures. Findings supported the convergent validity of the P-16 as a potential screener of psychopathic-like traits in youth. The strongest relationships were found when using the P-16 Total Scale score. Furthermore, using the P-16 cut off score of 10 or higher yielded the most predictable results. It was found that those adolescents that scored high in psychopathy were between 6 to 7 percent of the total inpatient adolescent sample. Conclusions showed that it is of upmost importance to obtain a clearer picture of those psychopathic traits that might develop early in childhood in order to delineate a more homogenous subgroup of children with conduct problems that may be at risk for psychopathy. The assessment of psychopathic-like features with vulnerable youth can then help facilitate prevention, early intervention, and treatment.

# CHAPTER I

## INTRODUCTION

Psychopathy is a personality disorder that is made up of a constellation of factors. It includes deficits in affect (i.e. low empathy and lack of remorse), interpersonal relations (i.e. manipulativeness and grandiosity) and behavior (i.e. violation of social norms). While related to Antisocial Personality Disorder (ASPD), a pervasive pattern of disregard for, and violation of, the rights of others (5th ed; DSM-V, APA 2013), this construct originally defined by Cleckley (1976; 5th ed.) focuses mainly on an individual's affective and interpersonal deficits. In short, Cleckley described the psychopath as someone who is superficially charming but dishonest and manipulative. The individual is egocentric, rarely feels empathy, and tends to not form lasting relationships with people. The psychopath shows a lack of remorse and a failure to learn from prior experiences. He or she violates social norms without guilt or regret (Cleckley, 1976). Over the years, psychopathy has been identified in 1% of the population and between 15-25% of the prison population (Andrade, 2008). The literature has not yet identified the base rate for psychopathy in a psychiatric population.

The research in the field demonstrates that the psychopathy construct at the adult level has great value. Credible self-report measures such as the Psychopathy Checklist-Revised (PCL-R; Hare, 1991) have been established and are used extensively to measure adult psychopathy. Researchers and clinicians use the PCL-R to evaluate both adult forensic and psychiatric patients (Lykken, 1995). The PCL–R has adequate psychometric

properties including generally high interrater reliability estimates and demonstrates both concurrent and predictive validity (Hare, 1991). Studies have shown that adult psychopathy as measured on the PCL-R is able to predict both violence and general recidivism. It is also associated with poor response to treatment and criminal recidivism (Salekin, Rogers, & Sewell, 1996).

Recently, efforts have been dedicated to extend the adult psychopathy construct downward to children and adolescents. There are already additional comprehensive instruments in the field with adequate reliability and validity that are designed to evaluate psychopathy in youth (Lynam, 1996; Frick & Hare, 2001). Time constraints in clinical assessment in most psychiatric settings, however make routine inclusion of these techniques difficult. Accordingly, some clinical research efforts have been devoted to developing screening indicators to ascertain whether a more comprehensive assessment of psychopathy traits might be advisable. This study will be examining the relationships between the abbreviated Psychopathy Content Scale (P-16; Salekin, Ziegler, Larrea, Anthony, & Bennett, 2003) taken from the Millon Adolescent Clinical Inventory (MACI; Millon, 1993) with performance and self- report based measures.

It is less clear of the applicability of the psychopathy construct to children and adolescents and its ability to predict violent and general recidivism. The overall aim of this study is to build upon the research in this area and to identify the risk factors in youth. Specifically, it aims to explore and expand the research in the field regarding the credibility of self-report measures when measuring psychopathic-like traits in children and adolescents.

# CHAPTER II

# LITERATURE REVIEW

## The Beginning of Psychopathy

The construct of psychopathy was examined and developed by many clinicians and theorists all over the world. The French psychiatrist, Philippe Pinel was one of the first clinician to write about this disorder. In 1801, he wrote about his encounters with patients who were free of psychotic illness but were impulsive, violent and lacked remorse for their behaviors. He described this disorder as "manie sans delire", which was translated to mean "insanity without delirium". Pinel focused on the shallowness and lack of affect inherent among this group of patients. He was of the mindset that while these individuals displayed a high level of social impairment, which resulted in criminal behavior, they showed intact intellectual functioning and werefully aware of the irrationality and destructive nature of their behaviors (Henderson, 1947).

Around the same time period, American and British psychiatrists began to report similar findings in their clinical work. In 1812, Benjamin Rush, an American physician, described a similar condition, which he named "moral derangement" or "anomia". He described a group of people who engaged in socially disruptive behaviors without showing remorse, guilt or preoccupation with the negative consequences of their actions. He believed that psychopathic individuals were best treated in medical facilities as opposed to prisons since it was his belief that psychopaths were not responsible for their behavior. He hypothesized a physiological basis for the disease and said that psychopathy

resulted from a congenital defect of moral derangement (Rush, 1812). Prichard (1835), an England physician built on this idea and termed the psychiatrist state as "moral insanity". Like both Pinel and Rush, he believed that the psychopath's intellectual functioning is intact and the disorder is manifested principally or alone in the state of feelings, and habits. He believed that while psychopaths knew the difference between right and wrong, they behaved because of an underlying physiological defect. Prichard was instrumental in introducing Pinel's work and the concept to the English-speaking world. Both Prichard and Rush wrote that these people have strong criminal records, were not able to change and should be socially condemned.

A parallel situation was happening in Germany during the latter part of the 19th century. In 1891, Koch coined the term "psychopathic inferiority" to describe a group of individuals who did not display typical psychiatric symptoms of a mental disorder such as psychosis and mania, but still displayed abnormal behavior. He was the first to introduce the term psychopathy in the psychiatrist literature. The problem with this term was the fact that "psychopathic inferiority" categorized all individuals with a pervasive personality disorder. It included all mental defections whether the defects were congenital or acquired through the environment. The unique traits that were associated with psychopathy were eliminated and the term encompassed what we see today as personality disorders. Regardless, Koch set the stage for later psychiatrists to investigate psychopathy as a personality disorder rather than a clinical syndrome (Herve, 2007).

In the early 1900s, Emil Kraelplin postulated a theory on psychopathy, which was influenced from Prichard's moral insanity and Koch's view of personality disorders. He proposed several types of psychopathies (personality disorders) that were

not specific to any one clinical disease (Hare, 1996). The first type he described as "obsessive, impulsive, and exhibiting sexual deviations" and the second type as "those who display odd or peculiar personality attributes". He listed seven subtypes, which include the excitable, unstable/impulsive, eccentric, liars, swindlers, antisocial and quarrelsome. The characteristics of the criminals, liars and swindlers show features of the current conceptualization of psychopathy (Herve, 2007).

**The Refinement of the Construct**

During the middle to late 19th century, psychologists focused on restricting the term psychopathy to mean one rather than many disorders. Partidge, an American psychologist advocated for the term sociopathy to describe this group of individuals. Partidge focused on the etiology of the disorder and believed that sociopathy could easily be the product of an environment in addition to biological factors (Partridge, 1930). In 1947, another clinician named Henderson defined psychopathy as a personality disorder, encompassing individuals that were unable to live as social beings, as they had no thoughts or feelings that were similar to those who were living around them. Similar to the earlier beliefs, he saw psychopathy as a separation of the affective system from the intellect. Regarding its etiology, unlike Partridge, he believed psychopathy to have a strong biological basis with a limited environmental influence (Henderson, 1947). Karpman (1946) was a psychoanalyst who shared many similar beliefs on psychopaths as Henderson. He focused on the internal world of the psychopath and wrote about the emotional experiences of these individuals. Karpman stated that psychopaths do not experience deep rooted, complex social emotions (i.e. love, empathy, guilt, remorse) and cannot effectively cope with an emotional build up for an extended period of time. They

feel superficial emotions (i.e. tension, worry, discomfort, fear and rage) that dissipate upon action. This creates an individual who is impulsive, irresponsible and socially destructive.

The construct of psychopathy was examined and developed by many clinicians and theorists all over the world. The foundation for modern conceptualizations and measures of psychopathy, however remains to be Hervey Cleckley and his book called "The Mask of Sanity", originally published in 1941 (5th edition, 1976). This book was based on Cleckley's accounts with inpatients at a large psychiatric hospital. Central to Cleckley's definition of a psychopathy was the idea that these individuals appeared to be confident, personable and psychologically well adjusted, however the pathology revealed itself after continued interaction.

In his book, Cleckley provided a specific and well-defined list of symptoms to define the construct. He described 16 personality traits of the psychopath, which can be grouped into three conceptual categories. The first category included indicators of positive psychological developmental such as superficial charm and good intelligence, absence of delusions and other signs of irrational thinking, absence of "nervousness" or psychoneurotic manifestations, and low incidence of suicide. On the surface the psychopath shows equal or better adjustment than the typical human being and demonstrates no indication of the disorder within. This mimicry allows the psychopath to function quite adaptively in a normal society. Further, the construct is devoid of behavioral characteristics and focuses primarily on personality characteristics (Cleckley, 1976).

The second category reflected severe behavior pathology reflected in impulsive antisocial acts, unreliability ("irresponsibility"), promiscuity, poor judgment and failure to learn from experience, and an absence of a set life plan. The third category consisted of items of emotional unresponsiveness and impaired social relatedness such as lack of remorse or shame, pathologic egocentricity and incapacity for love, general poverty in major affective reactions, untruthfulness and insincerity, specific loss of insight, unresponsiveness in general interpersonal relations, and lastly, impersonal, trivial and poorly integrated sex life (Cleckley, 1976).

Cleckley's definition deviated from historical descriptions of the psychopath since it did not include violent and antisocial behavioral characteristics. He wrote that most psychopaths are not violent or react in an angry, explosive and temper driven manner. They display a deep-rooted impairment in emotional processing that define the presence of the disorder rather than make the individual behave in an overt explosive manner. He sees the harm they do to others as a consequence of their shallow, non-empathetic nature. Cleckley describes:

> He is not likely to commit major crimes that result in long prison terms. He is also distinguished by his ability to escape ordinary legal punishments and restraints. Though he regularly makes trouble for society, as well as for himself, and frequently is handled by the police, his characteristic behavior does not usually include committing felonies, which would bring about permanent or adequate restrictions of his activities. He is often arrested, perhaps one hundred times or more. But he nearly always regains his freedom and returns to his old patterns of maladjustment. (Cleckley, p. 19)

Cleckley's contemporaries during this time definition of psychopathy contrasted from this definition of psychopathy. McCord and McCord (1964) described the psychopath as "cold, vicious and exploitative". They believed that all psychopaths

behave in an aggressive and violent manner. Similarly, Craft (1966) described psychopaths as aggressive individuals who exhibit high levels of antisocial behaviors. These two conceptualizations were found to be different based on the populations on which these constructs were based. Cleckley formulated his theory based on his experiences with psychiatric inpatients that came for treatment because their antisocial acts were of a nonviolent nature. Furthermore, these patients were from high or middle socioeconomic status. Consequently, Cleckley's theory has value in identifying psychopaths outside of correctional settings. In contrast, Cleckley's contemporaries studied incarcerated criminal offenders and youthful delinquents who were from impoverished, and abusive backgrounds.

**The DSM and Psychopathy**

*The Diagnostic and Statistical Manual of Mental Disorders* (DSM) reflects the confusion in the field regarding the psychopathy construct. The first edition of the DSM (1st ed.; DSM-I; American Psychiatric Association [APA], 1952) labeled the disorder as Sociopathic Personality Disturbance. The DSM-I used Cleckley's description of psychopathy and included personality traits in its description such as a lack of anxiety, lack of guilt, impulsivity, callousness and a lack of accepting responsibility for actions. As Cleckley believed, the *DSM-I* did not include antisocial behaviors or a list of behavioral criteria necessary for the diagnosis of the disease (Andrade, 2008).

The *DSM-II* (APA, 1968) kept the previous description as described in the *DSM*. It kept the previous clinical descriptions of the psychopath but did not include any guidelines for diagnosis. This resulted in poor reliability between diagnosticians when diagnosing the disorder. It merely described the psychopath as individuals who were