



Examining relationships between facial emotion recognition, self-control, and psychopathic traits in a non-clinical sample



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ABSTRACT

Although psychopathy is a low prevalence disorder, individuals with sub-clinical psychopathic traits have been shown to reside within the community. One account of psychopathy proposes that deficits in self-control play a causal role. Other theorists propose that psychopathy-related antisocial behaviour can be attributed to a constitutional deficit of empathy, resulting from an inability to interpret and respond to the affective cues of others. These theoretical perspectives may both be relevant if psychopathy is understood as a dimensional construct, with primary psychopathy the consequence of a neurological vulnerability to emotional deficits, and secondary psychopathy reflecting an environmental adaptation and subsequent failure of self-control. Using a non-clinical sample ($n = 479$), this study examined the relationship between sub-clinical psychopathic traits, self-control and the identification of facial emotion. Both primary and secondary psychopathic traits were associated with reduced accuracy in identifying facial affect, with more pronounced impairments seen for primary psychopathy. While both primary and secondary psychopathic traits were found to be related to deficits in dispositional self-control, the effect was significantly greater for secondary psychopathy.

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1. Introduction

Few clinical conditions are considered to be as malignant as psychopathy, and as a result it has been extensively studied (Skeem, Johansson, Andershed, Kerr, & Loudon, 2007). Despite this work, disagreement persists regarding the causes and underlying features of the disorder (Fowles, 2011). Some investigators have suggested the phenomenology of the disorder is heterogeneous, with different developmental routes contributing to the expression of subtypes of psychopathy (Skeem et al., 2007; Vaughn, Edens, Howard, & Smith, 2009). While the majority of research in this area has been undertaken using clinical populations, usually drawn from forensic settings (Neumann, Hare, & Pardini, 2014), it is now well established that some individuals with high levels of psychopathic traits live successfully within the community (Cleckley, 1982). Several researchers (e.g., Lilienfeld, 1994; Lilienfeld, 1998; Lynam, 2002) have argued that rather than existing as an all-or-none category, personality traits associated with psychopathic behaviours may actually exist on a continuum, with less extreme variations of the condition observed across the wider population (Lilienfeld, 1994; Lynam, 2002).

1.1. A continuum of psychopathic traits

Psychopathy is primarily characterised by a lack of empathy, diminished capacity for remorse and poor behavioural control (Cleckley, 1982). However, the range of behaviours that make up the psychopathic personality are wide ranging, and several theorists (e.g., Hare & Neumann, 2008; Marcus, John, & Edens, 2004; Skeem, Poythress, Edens, Lilienfeld, & Cale, 2003) have argued that psychopathy is a dimensional construct. Non-clinical samples can therefore be employed for study in terms of degree of psychopathic traits, rather than limiting studies to extreme groups alone (Book & Quinsey, 2004; Paulhus & Williams, 2002; Sellbom & Verona, 2007). Karpman (1948) was likely the first investigator to describe the distinction between primary and secondary psychopathy, however this differentiation has since been elaborated upon by a number of subsequent influential theorists (Blackburn, 1975; Hare, 1968; Porter, 1996). Both primary and secondary psychopathy are similar in that each subtype is associated with high levels of antisocial and criminal behaviour, however primary and secondary psychopathy are thought to differ in terms of their underlying causes (Hicks, Vaidyanathan, & Patrick, 2010). Primary psychopaths are thought to be incapable of empathy, regardless of environmental influences. They are theorised to have a constitutional deficit that leads to callous and manipulative behaviour, superficial relations, and impoverished negative affect including

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guilt, fear and anxiety (Dean et al., 2013). Conversely, secondary psychopaths are theorised to initially have a relatively normal capacity for emotional experience. As a result of environmental influences such as parental abuse or trauma, secondary psychopaths develop a proneness to poorly regulated negative affect characterised by high levels of anxiety, emotional distress, hostility, aggression, and impulsive behaviour (Dean et al., 2013). Although support for the distinction between primary and secondary psychopathy in clinical populations is well established (e.g., Morrison & Gilbert, 2001; Skeem et al., 2007; Vaughn et al., 2009), Lee and Salekin (2010) suggest that further investigation of the correlates of these subtypes in non-clinical samples is warranted.

1.2. Empathy dysfunction

A key aspect of many theories of psychopathy is the suggestion that psychopaths process emotions differently than do non-psychopaths (Williamson, Harpur, & Hare, 1991). In typically developing individuals, Huebner, Dwyer, and Hauser (2009) contend that feelings of guilt and shame about actions that harm others typically compel us to refrain from socially unacceptable behaviours. Cleckley (1982) argues that psychopaths have difficulty understanding and expressing affective cues. These emotional deficits may then interfere with moral socialisation, and subsequently increase susceptibility to engaging in antisocial behaviour (Blair, 1995). Blair has described the violence inhibition mechanism (VIM), which proposes that psychopaths fail to experience the fear and sadness of others as aversive. The VIM contends that there is a neurological system that preferentially responds to negative affect, particularly sad and fearful emotional displays (Blair, 1995).

The theory of empathy dysfunction in clinical samples is supported by a number of studies that have shown psychopaths to be significantly less accurate at recognising facial emotion than are non-psychopaths (e.g. Blair et al., 2004; Hastings, Tangney, & Stuewig, 2008; Marsh & Blair, 2008). Hastings et al. (2008) studied 145 male jail inmates and found that psychopathy was associated with impoverished affect recognition, particularly for sad and fearful emotional expressions. Blair et al. (2004) found similar results when 200 psychopathic individuals showed selective impairment for the recognition of fearful expressions. Marsh and Blair (2008) have suggested that such findings could be attributed to dysfunction among antisocial individuals in specific neural structures, most notably the amygdala, which is crucially involved in processing fearful facial affect.

Although studies using clinical samples have often demonstrated a link between deficits in processing facial affect and psychopathic traits, the results from non-clinical samples have been equivocal. In a study that investigated 175 undergraduate students (119 females and 56 males), Del Gaizo and Falkenbach (2008) found participants who scored highly on primary psychopathic traits were more accurate at interpreting facial emotions overall, including the fear emotions, with no relationship found between secondary psychopathic traits and affect recognition. Conversely, a study by Montagne et al. (2005) investigated 32 participants from the general population, 16 of whom were selected after scoring highly on psychopathic personality characteristics, and 16 scoring low to act as controls. Montagne and colleagues found that while the two groups did not differ in their overall ability to recognise facial affect, participants scoring highly on psychopathic personality characteristics were significantly less accurate at recognising the fear expression as compared to controls.

1.3. Self-control deficits

Several authors (e.g., Morgan & Lilienfeld, 2000; O'Gorman & Baxter, 2002) have suggested that deficits of self-control are an

important characteristic of psychopathy, and a significant body of research supports the notion that poor self-control is associated with increased aggression and antisocial behaviour (e.g., Burton, Cullen, Evans, Alarid, & Dunaway, 1998; Roussy & Toupin, 2000). It has also been suggested that self-control failure is expressed differently in primary versus secondary psychopathy (Levenson, Kiehl, & Fitzpatrick, 1995). Consequently, developing an understanding of the extent to which deficits in self-control might predict the emergence of psychopathic traits may be important when considering the aetiology of and interventions for psychopathic behaviours.

1.4. The current study

Findings from clinical populations generally support the proposition that some form of affect recognition deficit exists for psychopathic individuals. However, the evidence from non-clinical samples is less robust and the current study seeks to clarify if similar deficits are also evident in these populations. Based on the empathy dysfunction model and given the support in the literature demonstrating that clinical populations of psychopathic individuals are impaired when required to identify facial affect, it was hypothesised that individuals who scored highly on a measure of psychopathic traits (primary and secondary) in a non-clinical sample would show a correlated deficit in accurately recognising facial emotion. Specifically, it was hypothesised that the affect recognition deficit for these individuals would be greater for the fear and sad expressions in particular. Furthermore, it was hypothesised that individuals who scored highly on a measure of primary psychopathy would demonstrate a greater affect recognition deficit as compared to those who scored highly on a measure of secondary psychopathic traits. In contrast, those scoring highly on measures of secondary psychopathy would demonstrate greater deficits of self-control as compared to individuals who scored highly on measures of primary psychopathy.

2. Method

2.1. Procedure and participants

Participants were recruited via email, social media and printed advertising. The sample consisted of 479 participants, 26.93% ($n = 129$) of whom were male. The mean age of the participants was 27.29 years ($SD = 11.18$, range 18–69 years). The sample included participants from various racial and ethnic backgrounds with 72.7% ($n = 348$) Caucasian, 11.7% ($n = 56$) Asian, 3.8% ($n = 18$) Hispanic, 2.9% ($n = 14$) African and 9% ($n = 43$) from other racial backgrounds. 62.2% ($n = 298$) of participants were full time and 14% ($n = 67$) were part time university students.

2.2. Measures

2.2.1. Levenson self-report psychopathy scale (LSRPS; Levenson et al., 1995)

The LSRPS is a 26-item two-factor self-report instrument developed for use in non-institutionalised populations. In a factor analysis of the subscales of the LSRPS, Levenson et al. (1995) found two underlying factors that are representative of primary psychopathy (LSRPS I) and secondary psychopathy (LSRPS II). The two factor structure of the LSRPS has been replicated (Lynam, Whiteside, & Jones, 1999), and has been found to correlate with the Hare Psychopathy Checklist-Revised (Brinkley, Schmitt, Smith, & Newman, 2001). Studies have shown the LSRPS to have good convergent and discriminant validity (Sellbom, 2011) and reliability (Lynam et al., 1999). Internal consistencies of the subscales ranged from

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