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Why psychopathy matters: Implications for public health and violence prevention☆

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ABSTRACT

Psychopathy is an early-appearing risk factor for severe and chronic violence. The violence largely attributable to psychopathy constitutes a substantial portion of the societal burden to the public health and criminal justice systems, and thus necessitates significant attention from prevention experts. Yet, despite a vast base of research in psychology and criminology, the public health approach to violence has generally neglected to consider this key variable. Fundamentally, the public health approach to violence prevention is focused on achieving change at the population level to provide the most benefit to the maximum number of people. Increasing attention to the individual-level factor of psychopathy in public health could improve our ability to reduce violence at the community and societal levels. We conclude that the research literature on psychopathy points to a pressing need for a broad-based public health approach with a focus on primary prevention. Further, we consider how measuring psychopathy in public health research may benefit violence prevention, and ultimately society, in general.

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Contents

☆ The findings and conclusions in this report are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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1. Introduction

"By any measure, violence is a major contributor to premature death, disability, and injury" (Mercy, Rosenberg, Powell, Broome, & Roper, 1993, p. 8) and therefore poses a serious threat to public health. Violence was identified as a public health concern in the Surgeon General's 1979 report on health promotion (U.S. Department of Health, Education, and Welfare, 1979) and has since been recognized as a major international public health problem by the World Health Organization (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). In 2012, there were nearly 17,000 deaths stemming from violence in the U.S. alone (Centers for Disease Control & Prevention); a number that seems miniscule compared to global homicide rates of approximately 500,000 (Krug et al., 2002). Of course, fatal violence represents only a small fraction of the victimization that occurs each year. Violence, including physical assault, sexual violence, and child maltreatment, can result in severe injuries and serious long-term effects on the physical and mental health of victims. Violence also results in significant economic costs to individuals and nations. The World Health Organization's World Report on Violence and Health concluded that violence-related health care, law enforcement and judicial services, lost work days, and reduced productivity cost the global economy billions of U.S. dollars per year (Krug et al., 2002). In fact, the most current estimated single year cost for medical expenses and lost productivity due to homicide and nonfatal assaults reaches approximately $61 billion in the U.S. alone (CDC).[1]

Due to the impact of violence on the safety and well-being of our communities, significant resources have been devoted to responding to violence, with most efforts directed toward health care innovations to improve outcomes for victims, or criminal justice interventions to deter offenders and reduce recidivism (Mercy et al., 1993; Moore, 1995). Although critical to the violence response, these reactive approaches alone have failed to sufficiently reduce population levels of violence (Mercy & Hammond, 1999; Mercy, Krug, Dahlberg, & Zwi, 2003). For this reason, the public health system applies a proactive approach to violence focused on preventing violence before it occurs, that is, primary prevention. Primary prevention is distinctive in its focus on attempting to forestall the *initiation* of violent behavior. In this respect, primary prevention differs from secondary and tertiary prevention, which aim to reduce recidivism and ameliorate the short- and long-term effects of violence perpetration and victimization. The public health system works in tandem with the criminal justice system, which emphasizes the secondary and tertiary levels of prevention (Moore, 1995).

Whereas the primary/secondary/tertiary prevention distinction describes the timing of intervention, the distinction among universal, selected, and indicated interventions describes the intended population that the intervention will target. Universal programs are intended to reach everyone within a defined population regardless of their level of risk; selected programs are directed to a population that is at-risk for violence but has yet to engage in violent behavior; and indicated programs are those that target those showing minimal early warning signs of potential for violence (Matjasko et al., 2012). Fundamentally, the public health approach to violence prevention focuses on achieving change at the population level to provide the most benefit to the maximum number of people (Dahlberg, 2007; Hemenway & Miller, 2013). However, individual-level factors remain an important component of this approach, suggesting that prevention efforts must attend to risk factors across multiple levels of the social ecology (Matjasko et al., 2012). Moreover, psychological characteristics of individuals contribute strongly to their risk for violence, in particular when considering the fact that as few as 5% of the population perpetrates a large or majority proportion of violent crime (Beaver, 2013; Moffitt, 1993; Vaughn, Salas-Wright, Delisi, & Maynard, 2013; Vaughn et al., 2011; Wolfgang, Figlio, & Sellin, 1972). In their seminal study in Philadelphia, Wolfgang et al. (1972) found that approximately 6% of boys from a group of 10,000 were the main perpetrators of crime and violence and were responsible for approximately 70% of all murders, rapes, and aggravated assaults. In a second cohort of 13,000 from the same city, the authors found that 7% of habitual offenders were responsible for 60% of murders, 75% of rapes, and 65% of aggravated assaults (Tracy, Wolfgang, & Figlio, 1990). These findings have been replicated in contemporary nationally representative samples, which showed approximately 5% of adolescents were responsible for approximately 30% of the most "severe" violent crimes (Vaughn et al., 2013). Beaver (2013) further reported that 5% of all families were responsible for 50% of crime, 10% of families accounted for 80% of crime, and 25% of families accounted for 100% of crime in a nationally representative longitudinal sample. Thus, strategies that involve identifying the small minority of the population at the highest risk for perpetrating the most chronic serious forms of violence, and tailoring prevention approaches for those individuals may prove fruitful in reducing violence at all levels of the social ecology. That is, targeting the few may yield maximum benefit for the greatest number of people which, ultimately, is the goal of the public health model (Dahlberg, 2007).

The public health model starts "upstream" by focusing on identifying risk and protective factors for violent behavior and developing interventions that address these factors to prevent the cascade of circumstances and behaviors that can result in violent injury and death. A number of evidence-based strategies have demonstrated impact on reducing individuals' risk for violence. Many of these strategies have also been shown to reduce the long-term costs associated with violence, such as injury, mental health, and criminal justice involvement (Drake, Aos, & Miller, 2009; Fagan & Catalano, 2013; Matjasko et al., 2012). Numerous risk and some protective factors for violence perpetration have been identified by researchers, including individual beliefs, experiences, and personality traits and characteristics of one's family, peers, and neighborhood. Many of these factors have been considered as possible points for intervention, and prevention programs that target these factors have been developed and evaluated, with varying levels of success (Drake et al., 2009; Fagan & Catalano, 2013; Matjasko et al., 2012). One strikingly significant risk factor for violence, that has rarely been addressed or considered in the primary prevention literature, however, involves the constellation of personality traits that comprise psychopathy.

In this article, we discuss why psychopathy is of considerable pragmatic importance to society. To do so, we examine the relevance of psychopathy to the public health approach to violence prevention by delineating the societal burden of psychopathy and its role as a significant risk factor for violence. We present the risk and protective factors associated with psychopathy, developmental processes predisposing to psychopathy associated violence, and the efficacy of existing treatments aimed at reducing violence perpetrated by offenders with psychopathic traits. We attempt to integrate the current state of knowledge concerning psychopathy as a risk factor for violent behavior from a public health perspective and consider whether and how increased attention to this personality disorder can inform or improve our violence prevention efforts. We argue that psychopathy has an early genesis and may therefore necessitate intervention at early stages of life. Ultimately, this article is a call to motivate researchers in numerous fields, especially public health, psychology, and psychiatry, to consider psychopathy in their violence prevention efforts.

2. Psychopathy

Psychopathy is typically conceptualized as a loosely correlated set of interpersonal, affective, and behavioral features that includes superficial charm, social poise, dishonesty, grandiosity, guiltlessness, callousness, promiscuous sexual behavior, and poor impulse control

[1] Updated from U.S. dollars in 2010 to U.S. dollars 2014 using consumer price index.