



# Behaving badly: A perspective on mechanisms of dysfunction in psychopathy



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**ABSTRACT**

Psychopathy is a personality construct defined by lack of empathy, impulsivity, grandiosity, callous and manipulative interpersonal interactions, and the tendency to engage in socially deviant behavior. Psychopathy has been associated with aggression, recidivism, and other behaviors harmful to others. Individuals high in psychopathy have been thought to be notoriously difficult to treat. Many scholars have suggested that considering mechanisms of dysfunction in psychological difficulties will lead to the development of more effective and efficacious treatments. Fearlessness, lack of empathy, and response modulation difficulties have commonly been discussed as mechanisms of dysfunction in psychopathy. The current review provides a brief overview of examinations of these mechanisms of dysfunction in psychopathy, comments on research methodology, and provides suggestions for remedying potential pitfalls.

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**1. Introduction**

Psychopathy has been defined as a constellation of traits, including lack of guilt and empathy, grandiosity, callous and manipulative relationships, shallow emotions, impulsivity, and tendency towards persistent engagement in socially deviant behavior (Hare, Hart, & Harpur, 1991). Cleckley (1941, 1976) described psychopathic patients as having behavioral difficulties while appearing to lack distress and

other signs of mental illness. Psychopathy (defined as scores above a diagnostic cut off) has been demonstrated to be present in about 1% of the general population (Forth, Brown, Hart, & Hare, 1996) and 20% to 30% of offenders (Edens, 2006; Hare, 1993). Psychopathy has predicted recidivism (Hemphill, Hare, & Wong, 1998; Pedersen, Kunz, Rasmussen, & Elass, 2010), physical aggression, and institutional misconduct (Guy, Edens, Anthony, & Douglas, 2005). Offenders high in psychopathy have been more likely to reoffend and receive probation suspensions and much more likely to reoffend violently (Hart, Kropp, & Hare, 1988; Pedersen et al., 2010).

Psychopaths appear qualitatively different from other clients (Hare, 1993; Karpman, 1941, 1948) and have come to be viewed as “untreatable” by many (Salekin, 2002). Treatment (through a peer

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therapeutic community program) seemed iatrogenic, with treated psychopathic offenders being more likely to reoffend than untreated (Harris, Rice, & Cormier, 1994). Psychopathic mentally ill offenders who went through a therapeutic treatment community program were found to be more likely to reoffend violently (although lower violent recidivism among treated offenders low in psychopathy was obtained; Rice, Harris, & Cormier, 1992). Psychopathic sex offenders, who therapists believed to be doing well in treatment, were more likely to reoffend violently and sexually than those seen as doing poorly (Seto & Barbaree, 1999). Kernberg (1998) asserted that psychopaths were particularly difficult to treat because their “major gratification in life is the destruction of those who are attempting to help them” (Kernberg, 1998 p. 391). Rollins (1975) added that psychopaths are not only unlikely to benefit from traditional inpatient treatment, but also likely to harm other patients.

While psychopathic clients undoubtedly present a unique challenge, Skeem, Monahan, and Mulvey (2002) point out that appropriateness of interventions must be considered. For example, Rice et al. (1992) reported therapeutic community data that used an intervention including mandatory nude encounter groups, hallucinogens, and compulsory treatment receipt (Skeem et al., 2002). Given this form of treatment, negative effects of treatment reported by Rice et al. (1992) are not entirely surprising. Scared straight programs and military style boot camps have similarly demonstrated harmful effects among a portion of youth with behavioral difficulties (Lilienfeld, 2007), although a number of other treatments have been found effective (Eyberg, Nelson, & Boggs, 2008). Psychopathic clients present unique challenges because of the characteristics defining the construct. Lack of empathy has been thought to attenuate the non-specific therapeutic relationship benefits psychopathic clients may derive; shallow emotions and lack of distress decrease motivation for treatment, and difficulties modifying behavior (sometimes termed an inability to learn) among psychopathic individuals pose additional barriers (Hare & Neumann, 2009; Salekin, 2002; Wallace & Newman, 2004).

Despite these difficulties, researchers have suggested that some avenues may be useful to pursue with psychopathic clients. Salekin (2002) reviewed a number of treatment studies and noted that some interventions have shown promise; specifically, 62% psychopathic participants evidenced some improvement in cognitive behavioral treatments, 59% in psychodynamic treatments, and 86% in treatments combining cognitive behavioral and insight techniques. Wallace and Newman (2004) suggested that a combination of motivational interviewing strategies, self regulation (pausing before responding), and cognitive restructuring of antisocial beliefs, may provide useful avenues for future treatment development research. Hare and Neumann (2009) similarly cautiously consider the possibility that harm reduction and cognitive behavioral programs may be useful in the treatment of psychopathic clients.

Kazdin (2008) and Kazdin and Nock (2003) suggested that considering mechanisms of dysfunction and therapeutic change could prove fruitful in increasing intervention effectiveness. Fearlessness, lack of empathy, and response modulation difficulties have commonly been proposed to be mechanisms of dysfunction in psychopathic pathology (Patrick, 2010). Consideration of the existing research on mechanisms of dysfunction may provide an improved conceptualization of psychopathy. The purpose of this paper is to provide a brief overview of relevant research and consider the methodology used.

## 2. Fearlessness

Hare (1965, 1968) argued that lack of negative emotion in response to punishment led to the development of maladaptive psychopathic behavior. Without aversive emotions, psychopathic individuals were thought to lack sufficient motivation to avoid taking risks and breaking social norms. Researchers have used autonomic arousal as a proxy for negative emotional response. Hare (1968) evaluated autonomic

response among 51 maximum security male inmates, classified as primary psychopaths (classic definition), secondary psychopaths (meeting criteria for psychopathy with neurotic features), and non-psychopaths using prison staff ratings. Primary psychopathic participants demonstrated lower resting skin conductance than the non-psychopathic. After baseline, autonomic activity was measured while participants were: asked to inflate a balloon until it burst, exposed to a series of novel tones, and asked to solve math problems. Skin conductance response of both psychopathic groups decreased to below resting levels throughout the tone portion of the study, whereas non-psychopathic participants did not display significant changes. Autonomic response increased for all participants while solving arithmetic, although primary psychopathic participants had a greater increase in the number of responses than the non-psychopathic. Primary psychopathic participants demonstrated less heart rate habituation than the non-psychopathic group during the tone portion. When autonomic activity measures were corrected for an individual's range (using their greatest and smallest responses), group response at rest or during tone and arithmetic periods did not differ. Hare (1968) asserted that findings supported decreased autonomic response hypothesis and elucidated that smaller responses among psychopathic participants may indicate a similar relative magnitude as greater ones among the non-psychopathic. Hare (1968) suggested that psychopathic individuals may be less responsive to their surroundings, or at least to those aspects they do not perceive to be important.

Fung et al. (2005) analyzed skin conductance response and parent rated psychopathy among 335 adolescents from the Pittsburg Youth Study (selected on the basis of high or low risk for antisocial behavior). Risk was determined using antisocial behavior data collected when participants were in the first grade. Participants were separated into high and low psychopathy groups on the basis of obtaining scores in the top and bottom 20%, respectively. Measures of IQ, a diagnostic ADHD interview, SES estimated based on family member occupation, and self, parent, and teacher reports of antisocial behavior were collected. Skin conductance was assessed at rest and in response to predictable (by a visual countdown) and unpredictable aversive noises. Participants did not differ in rates of non-responding or average size of skin conductance response when awaiting noise without a countdown. When a countdown predicted noise, a greater proportion of participants high compared to low in psychopathy failed to respond (63.1% vs. 41.5%, respectively), although magnitude of skin conductance response did not differ. A greater proportion of high psychopathy participants failed to respond after noise was presented both unpredictably (47.7% high psychopathy vs. 23.1% low psychopathy) and after a countdown (30.8% high psychopathy vs. 15.4% low psychopathy). Participants of low SES (68%) were less likely to respond when awaiting noise with a countdown than those of high SES (47%). Participants with higher scores on parent, teacher, and self report delinquency were more likely to be non-responders than those with lower delinquency scores. Delinquent participants high and low in psychopathy did not differ in skin conductance responsiveness. Fung et al. (2005) concluded that deficits in autonomic response were associated with both psychopathy and antisocial behavior in youth.

Glenn, Raine, Venables, and Mednick (2007) measured psychopathy in 335 Mauritian adults whose autonomic responding and temperament were assessed at age three as part of another study. Participants in the current study tended to be of a lower SES at age three than those in the larger cohort ( $d = -.147$ ), but did not differ on temperamental or physiological measures. Participants completed a self report measure of psychopathy at age 28. Childhood behavioral observation data related to temperament, social responsiveness, and fear were collected. Participants obtaining scores one standard deviation above and below the mean on psychopathy were categorized as high and low scorers, respectively. Those scoring high in psychopathy as adults displayed more disinhibition ( $d = 0.46$ ), verbalizations ( $d = 0.28$ ), friendliness towards the researcher ( $d = 0.39$ ), and social play with

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