



Psychopathy and internalizing psychopathology

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ABSTRACT

There is general consensus in clinical and research literature that the core feature of psychopathy consists of an affective deficit. However, previous studies tend to find weak and inconsistent associations between psychopathy and measures of internalizing psychopathology. In this study we test whether the predominant practice of using questionnaires to assess internalizing psychopathology has influenced the results of previous research. We argue that questionnaires measure general distress rather than specific symptoms of internalizing psychopathology, and that the validity of questionnaires might be impaired by psychopathic traits, such as impression management and lack of affective experience. Combining a questionnaire (Depression Anxiety Stress Scales-21; DASS-21) and a semi-structured interview (Structured Clinical Interview for DSM-IV-R Axis 1 Disorders; SCID-I) for internalizing psychopathology, we test the differential association of both measures with the Psychopathy Checklist–Revised (PCL-R) in a sample of 89 male detainees. In accordance with our prediction, we found moderate negative associations between the Interpersonal and Affective facets of the PCL-R and SCID-I, but no significant associations with the DASS-21. We found no evidence that psychopathic traits decrease the validity of the responses on a questionnaire. We conclude that the interpersonal and affective features of psychopathy are negatively related to specific symptoms of internalizing psychopathology, but not with general distress.

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1. Introduction

Psychopathy is a severe personality disorder that consists of interpersonal, affective, and behavioral features. On the interpersonal level, psychopaths are grandiose, arrogant, callous, dominant, and manipulative. Affectively, they are short-tempered, unable to form strong emotional bonds with others, and lacking in guilt or empathy. These interpersonal and affective features are associated with a socially deviant lifestyle characterized by irresponsible, impulsive, rule-breaking behavior, and a tendency to ignore or violate social conventions and mores (Cleckley, 1976; Hare, 2003; Hare & Neumann, 2005, 2008). From a clinical point of view, a lack of internalizing psychopathology has long been considered an essential feature of psychopathy. The authors who laid the foundation of the current concept of psychopathy defined it as anti-neurosis, i.e., lacking the inner conflict, guilt, nervousness, and anxiety that are typical in neurotic individuals (e.g. Cleckley, 1976; Karpman, 1941; McCord & McCord, 1964). Moreover, several recent theories on psychopathy present this affective deficit as the core feature of psychopathy (Blair, Mitchell, & Blair, 2005; Fowles & Dindo, 2006; Patrick, 2007). Nevertheless, the Psychopathy Checklist–Revised (PCL-R; Hare,

2003), now considered the golden standard for the assessment of psychopathy, does not contain items that explicitly probe for a lack of internalizing psychopathology. During the early development phase of the PCL-R, lack of anxiety did not emerge as a discriminating feature of psychopathy in a forensic population (Hare, 2003). Moreover, the empirical evidence for absence of internalizing psychopathology in psychopaths is inconsistent. This contrast between clinical descriptions and theories on the one hand, and empirical evidence on the other hand, can mean two things: either the theories on the affective deficit in psychopathy are inadequate, or the PCL-R does not fully succeed in measuring the concept of psychopathy. Therefore, the relation between psychopathy and internalizing psychopathology remains one of the main topics in current psychopathy research (Lilienfeld, 1994; Patrick, 2006; Skeem & Cooke, 2010). In this study, we aim to contribute to this topic by highlighting a factor that might blur the association between internalizing psychopathology and psychopathy, namely the dominant practice of using questionnaires to measure depression, anxiety and fear. As we will elaborate below, we have reasons to believe that the use of a questionnaire versus an interview method for assessing internalizing symptoms will result in different associations. Our aim is to compare the association between the PCL-R and scores for internalizing psychopathology gathered with questionnaire and semi-structured interview methods. We will start by expounding the current theoretical model of psychopathy and internalizing psychopathology, in addition to its empirical evidence.

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The relation between psychopathy and internalizing psychopathology has been conceptualized in the dual deficit or dual process theory (Fowles & Dindo, 2006; Patrick, 2007). This theory is a combination of (1) the two-factor model of psychopathy, and (2) the reinforcement sensitivity theory by Gray (Gray & McNaughton, 2000). The two-factor model of psychopathy is a factor-analytically derived model according to which the PCL-R consists of a personality factor (the interpersonal and affective traits) and a behavioral factor (impulsive, irresponsible and antisocial behavior) (Hare, 2003). The personality factor consists of interpersonal grandiosity, dominance, manipulation, and affective superficiality and callousness. The behavioral factor taps into an impulsive and irresponsible lifestyle, and antisocial behavior (both criminal and non-criminal). Each factor can be traced to a specific neuropsychological deficit or dysfunction. Gray postulated three interacting neuropsychological systems underlying emotion, motivation, and learning: the Fight/Flight/Freeze System (FFFS), the Behavioral Inhibition System (BIS), and the Behavioral Activation System (BAS). In the revised reinforcement sensitivity theory (Gray & McNaughton, 2000), the FFFS is thought to mediate responses to all aversive stimuli (conditioned and unconditioned) and leads to avoidance behavior (fight/flight/freeze). Subjectively, activity of the FFFS is experienced as fear. The BAS functions as a reward system that mediates responses to appetitive stimuli (conditioned and unconditioned) and leads to approach behavior. The BIS is considered a system that detects and resolves conflicts between the FFFS and BAS. This means that when a stimulus simultaneously activates avoidance and approach behavior (i.e., a dangerous but rewarding situation such as stealing money), then the BIS will block these conflicting behaviors and, through recursive loops, increase the negative valence of the stimulus until resolution occurs either in favor of approach or avoidance. During this recursive process, the individual scans his/her memory and the environment for cues that might help to resolve the conflict. Subjectively, the activity of the BIS is experienced as worry, apprehension, and the feeling that action might lead to a bad outcome.

According to the dual deficit theory, the personality factor of psychopathy is linked to underactivity in the BIS system, and possibly to underactivity in the FFFS system as well (Corr, 2010). This would result in less conflict between approach and avoidance behavior, less worry about possible negative outcomes, and less fear when confronted with aversive situations or stimuli. As a consequence, the personality factor of psychopathy is expected to be negatively associated with measures of fear and anxiety. A number of studies using a variety of questionnaires to measure fear and anxiety have indeed found a negative association between the personality factor of the PCL-R and fear/anxiety in offender samples (Blonigen et al., 2010; Harpur, Hare, & Hakstian, 1989; Hicks & Patrick, 2006). However, a large number of studies using the same questionnaires in offender samples found weak negative (or even weak positive) associations between the PCL-R and fear/anxiety (Hale, Goldstein, Abramowitz, Calamari, & Kosson, 2004; Hare, 2003; Schmitt & Newman, 1999).

On the other hand, the behavioral factor of the PCL-R would be associated with a deficient BAS system, which is reflected in behavior that is hyper-reactive to opportunities for reward. Evidence for this claim is found in research on the correlates of the behavioral factor: this factor is correlated with measures for impulsivity (Benning, Patrick, Hicks, Blonigen, & Krueger, 2003), drug abuse, and externalizing personality disorders (Coid et al., 2009; Pham & Saloppé, 2010). Within the dual deficit theory, it is postulated that the behavioral features of psychopathy are positively associated with both fear and anxiety. This positive association would be the result of the increased exposure to adverse outcomes because of the inability to regulate approach behavior: impulsive and externalizing individuals suffer more often from the negative consequences of risky but rewarding behavior (e.g., criminal actions leading to legal proceedings, irresponsible behavior leading to criticisms and quarrels at home or at work,...).

Evidence for the positive association between the behavioral factor and fear/anxiety was found in some studies (Blonigen et al., 2010; Hale et al., 2004; Hicks & Patrick, 2006), but not in others (Hare, 2003; Harpur et al., 1989; Schmitt & Newman, 1999). Hare (2003, p. 104) summarized the results of zero-order correlational analyses in different samples and with different questionnaires for anxiety; his conclusion is that '[o]n balance, the available evidence suggests that psychopathy is, at best, weakly and inconsistently related to self-report anxiety and fear scales'.

The predominant practice of using questionnaires might obfuscate the relation between internalizing psychopathology and psychopathy. We have three arguments for why the use of the questionnaire method will result in different associations with psychopathy, in comparison to the interview method.

First, psychopaths are notorious for their dishonesty (Cleckley, 1976; Hare, 2003). They lie easily in situations in which they can obtain a tangible benefit, but they also lie just for fun. They have an inclination to impression management, i.e., looking good in situations where good impressions would be beneficial, or creating a negative impression if they think this is desirable. A number of studies have confirmed that psychopathic individuals have a higher propensity to malingering (Edens, Buffington, & Tomacic, 2000; Kucharski, Duncan, Egan, & Falkenbach, 2006; Porter & Woodworth, 2007). On the other hand, there is evidence that psychopaths are not particularly successful in deceiving (Edens, Buffington, & Tomacic, 2000; Klaver, Lee, Spidel, & Hart, 2009). Interview assessment allows one to check whether their interpersonal style corresponds to the reported symptoms of internalizing psychopathology (e.g., major depression and social phobia), which is not possible with questionnaires. Therefore, we expect that malingering more strongly influences scores on a questionnaire than scores on an interview.

The second argument stems from the emotional deficit of psychopathy. Lilienfeld and Fowler (2006) recently pointed out that it might be problematic to ask individuals who never experience internalizing symptoms to report on their absence. When one has never experienced anxiety or depression, one is unable to grasp the emotional complexity and depth that is implied in items on internalizing psychopathology. Because of their shallow affect, psychopaths might equate sadness with frustration and boredom, and anxiety with displeasure and impatience. Thus, psychopaths may very well interpret the items in an idiosyncratic way, thereby undermining their validity. This problem can be considered as a consequence of what Cleckley (1976, p. 379) coined as the core deficit in psychopaths: semantic aphasia. 'In semantic aphasia [...] inner speech or verbal thought is seriously crippled, and the patient usually cannot formulate anything very pertinent or meaningful within his own awareness. He cannot by gesture or verbal approximations hint at his message because he lacks the inner experience on which a message might be formulated'. We therefore have reasons to assume that the psychopath's response on items referring to internalizing symptoms on a questionnaire might not be valid. While they may be reporting something similar, it is most likely not what is intended in the item. During an interview, the interviewer can evaluate the clinical validity of symptoms reported by the interviewee, and check whether the emotional presentation corresponds to the reported symptoms. Therefore, we expect that the emotional deficit influences symptom reporting more strongly on a questionnaire than during an interview.

However, a third argument has to be considered. The procedural differences between questionnaire and semi-structured interview assessment methods have implications for the construct being measured (Coyne, 1994; Harris & Brown, 2010). In semi-structured interviews primary symptoms (e.g., mood disturbance in the case of major depression or re-experiencing in the case of PTSD) are given more importance than secondary symptoms (e.g., sleep disturbances in major depression), while in questionnaires all symptoms are valued equally. Semi-structured interviews stipulate a minimum

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