Defining youth psychopathy

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DEFINING YOUTH PSYCHOPATHY

by

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Bachelor of Arts
University of Illinois Urbana Champaign
1999

A thesis submitted in partial fulfillment of the requirements for the

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Department of Psychology
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ABSTRACT

Defining Youth Psychopathy

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Psychopathy has been considered one of the most dangerous and pervasive of disorders known to date. The construct has been researched extensively in the adult male criminal population but an ongoing debate remains as to whether personality or behavioral criteria should be considered cardinal to this disorder. A preliminary construct for “adolescent psychopathy” has been based on downward extensions of adult criteria such as the Psychopathy Checklist Revised (PCL-R). This process has been controversial, however, and yielded no conclusive findings. This study adopted a “back to basics” approach to define the construct of adolescent psychopathy using clinicians’ judgments.
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CHAPTER 1

INTRODUCTION

Psychopathy has been historically understood as a severe disturbance in conscience and morality without deficits in intellectual or cognitive capacities. Since its acknowledgment, the label and identifying criteria for psychopathy have been refined several times. Each generation of identifying characteristics has been criticized for being overly inclusive of other mental disorders. The modern construct of psychopathy developed by Cleckley (1964) has remained relatively stable over the years and the personality and behavior characteristics used to identify the disorder are considered specific to psychopathy. Hare's (1991) efforts to operationalize Cleckley's criteria have fueled a fierce debate as to whether antisocial behavior is central to psychopathy. Regardless of this controversy, individuals afflicted with psychopathy have been considered dangerous and beyond rehabilitation. Such considerations have motivated efforts to identify this disorder during early stages of development when intervention may be more effective.

To date, most investigations related to psychopathy have been primarily conducted with adult, white, male offenders. Such practices have constrained our understanding of the development of this disorder. Some researchers (e.g., Forth & Burke, 1998; Frick, Barry, & Bodin, 2000; Lynam, 1996, 1997, 2002) speculate that
psychopathy is continuous from childhood to adulthood. Hence, the construct for youth psychopathy has been directly extended from adulthood to childhood with few alterations to the criteria suggested by Hare (1991). Such practices have been criticized for being developmentally inappropriate (Edens, Skeem, Cruise, & Cauffman, 2001), and have caused much confusion in the classification of youth psychopathy. Thus, there has been a call for a fresh perspective to investigate the developmental processes of psychopathy.

The proposed study applies a combination of “bottom up” and “top down” approaches to develop a prototypical construct for adolescent psychopathy using clinical impressions. First, this paper reviews the development of the modern construct of adult psychopathy by Cleckley (1964) and its operationalization by Hare (1991). Second, the discrepancies between Cleckley’s model of psychopathy and Hare’s scientific measure, and the consequent threat to construct validity, are reviewed. Next, the development of youth psychopathy measures is discussed. The development of a preliminary construct of youth psychopathy via downward extensions is reviewed. Finally, the rationale, procedure and methods used to develop a more developmentally appropriate conception of adolescent psychopathy is provided.

Development of Cleckley’s Seminal Criteria

Based on clinical observation in a psychiatric hospital, Cleckley (1964) began defining the modern construct of psychopathy. While treating individuals with various pathologies, Cleckley noticed that certain patients had peculiar personalities. They charmed their way into social situations by donning a “mask of sanity” that fit others’ expectations but they also had a strong proclivity for wreaking havoc within their
communities. Intrigued, Cleckley (1964) began systematically observing these individuals' interpersonal, affective, and behavioral characteristics and distilled these traits into a list of 16 criteria that he believed defined "psychopathy." These traits include:

1. Superficial charm and good intelligence
2. Absence of delusions and other signs of irrational thinking
3. Absence of nervousness, unreliability
4. Untruthfulness and insincerity
5. Lack of remorse and shame
6. Inadequately motivated antisocial behavior
7. Poor judgment and failure to learn by experience
8. Pathologic egocentricity and incapacity for love
9. General poverty in major affective reactions
10. Specific loss of insight
11. Unresponsiveness in general interpersonal relations
12. Fantastic and uninviting behavior with drink and sometimes without
13. Suicide rarely carried out
14. Impersonal
15. Trivial and poorly integrated sex life
16. Failure to follow any life plan

Individuals who embodied such characteristics were called "psychopaths" (Cleckley, 1964). Although behavioral features related to antisocial traits were
considered, such as criminality, propensity to pick fights, or placing oneself in risky situations, personality characteristics such as callousness and grandiosity remained at the heart of the concept. Cleckley’s formulation of the construct of psychopathy remained unchanged over the years. However, a consensus has yet to be reached, especially in relation to whether personality traits or behavioral characteristics should be considered cardinal to psychopathy.

Post-Cleckleyan Definitions of the Concept

The DSM-II (APA, 1968) was the only DSM version that emphasized Cleckley’s personality traits to identify psychopathy (Rogers et al., 2000). The behavioral revolution that took place soon after transformed the way in which psychopathy was identified. The existing personality-based criteria for psychopathy were criticized for requiring a great deal of clinical inference (Hare, 2005; Robins, 1978). There was now a demand for more observable and reliably rated criteria. Hence, these personality traits were replaced by concrete behavioral characteristics, and psychopathic personality disorder was referred to as Antisocial Personality Disorder or APD (Hare, 2005). From the DSM-III (APA, 1987) to the DSM-IV (APA, 1994), the diagnostic criteria for psychopathy progressively relied more heavily on overt behavioral and criminal characteristics (e.g., antisocial behavior, history of conduct disorder) (Arrigo & Shipley, 2001; Rogers et al., 2000). For instance, the DSM-III did not include personality and internal affective criteria such as “callousness,” “manipulativeness” and “lack of remorse” (Hare, Hart, & Harpur, 1991).

Although not intentional, reliance on a fixed set of behavioral features led to discrepancies between the classic definition of psychopathy and the contemporary
definition of APD. Essentially, a diagnosis of APD relies heavily on behavioral features, whereas the identification of psychopathy is largely based on personality features. A fixed set of behavioral features did not adequately cover the broader scope of psychopathic personality traits (Hare, Hart, & Harpur, 1991). The APD criteria were suitable for consistently identifying individuals who displayed criminal behaviors but were not appropriate to identify psychopaths in particular. For instance, 80% of incarcerated offenders meet criteria of APD but only 15-25% meet criteria for psychopathy (Hare, 1991; Hart & Hare, 1989). Similarly, 4% of the general population meet criteria for APD, as opposed to a scarce 1-2% for psychopathy. Furthermore, psychopathy is a continuous construct. For example, an individual can possess degrees of psychopathic tendencies, whereas APD is presented as a dichotomous construct in that the disorder is considered present or absent based on the number of symptoms present (Skilling et al., 2002). Relatedly, given that the DSM only requires 3 of 7 criteria to warrant a diagnosis of APD, individuals may qualify for an APD diagnoses without manifesting personality traits (e.g., callousness, lack of empathy) that are crucial for the identification of psychopathy. Lastly, a diagnosis of APD requires the presence of conduct disorder (juvenile version of APD) prior to age 15 years. The diagnosis of psychopathy has no such requirements. Hence, scholars have argued that the shift from psychopathy to APD in the diagnostic system improved reliability, but at the expense of construct validity in identifying psychopathy (Lilienfeld, 1994).

To increase the relevance of APD criteria to psychopathy, the APA introduced personality characteristics fundamental to psychopathy such as “superficial charm,” “arrogant self appraisal,” and “lack of concern towards suffering caused to others” to the
DSM-III/III-R APD criteria. However, for several reasons, the DSM-IV criteria created greater confusion regarding the diagnostic clarity of psychopathy (Hare, 1998). First, the DSM-IV interchangeably uses the diagnostic labels of APD, sociopathy, dissociative personality disorder, and psychopathy. Second, the addition of interpersonal traits only partially represents the central, interpersonal and affective deficits of psychopathy. Third, the diagnostic manual does not provide explicit guidelines as to how to incorporate these traits when making a diagnosis (Hare, 2005; Skilling et al., 2002). Essentially, the DSM modifications to psychopathy criteria seem to have greatly hindered the diagnostic clarity for psychopathy.

Hare’s Operationalization of Psychopathy

Hare is one of many scholars who have argued persuasively for a renewed emphasis on the affective and interpersonal characteristics of psychopathy. Hare developed the most widely used measure for operationalizing psychopathy: the Revised Psychopathy Checklist (PCL-R; Hare, 1991, 2003). Initially, Hare applied Cleckley’s criteria to his research. Although Cleckley had studied psychopathy in clinical populations, Hare focused on criminal populations, conducting the bulk of his research with adult, white, Canadian male offenders. The development of this tool in a criminal population may have created a drift from Cleckley’s original criteria and a re-conceptualization of psychopathy (Cooke & Michie, 2001; Skeem & Mulvey, 2001). Because the PCL-R has virtually become equated with psychopathy, its development is worthy of attention.
**PCL/R Development**

Hare (1991) argued that Cleckley's list of characteristics was not designed for assessment purposes, but merely to summarize Cleckley's concept of the prototypic psychopath. To operationalize Cleckley's concept, Hare and Cox (1978) initially developed a single item, 7-point global scale to detect psychopathy in adult offenders. Expert raters with substantial prison-based experience integrated interview and file data, reviewed a description of Cleckley's criteria, and then applied the rating scale to assign a global score that reflected the extent to which an individual matched Cleckley's prototypic psychopath (Hare, 1985). Surprisingly, this single item scale was highly reliable ($r = 0.90$) for trained raters (Dengerink & Bertilson, 1975). However, scoring of the item required a great deal of experience working with prison inmates, as well as interpretation and clinical inference. Furthermore, the single score obscured the basis and or reasoning behind the ratings. To address such criticisms, Hare developed a 22-item Psychopathy Checklist (PCL). The PCL and the older, global rating scale were highly correlated ($r = .83$) (Hare, 1985, 1991), and the reliability coefficients for the checklist ($r = .82-.92$) were similar to that of the global scale (.90). However, the checklist provided two main advantages over the rating scale. First, the 22 items measured psychopathy in a more transparent way. Second, this scale could be used efficiently by less experienced coders trained in applying each of the 22 item descriptions.

Of the 22 PCL items, "Drug or alcohol abuse, not directly caused by antisocial behavior" was often difficult to score, and "Previous diagnosis of psychopathy or similar" was redundant. Consequently, these items were dropped, giving rise to the 20-item Psychopathy Checklist–Revised (PCL-R, Hare, 1991). Particularly since its
commercial publication in 1991, the PCL-R has garnered substantial empirical and
clinical attention chiefly due to its ability to be a relatively good predictor of future
violence and criminal recidivism (Bolt, Hare, Vitale, & Newman, 2004; Hare, 1991,
2003; Salekin et al., 1996). For instance, based on a meta-analysis of 18 studies, Salekin
et al. (1996) found the PCL measures to be relatively good predictors (r=.26) of violence,
non-violent recidivism, institutional violence, and sexual sadism for adult male offenders.
The rates of antisocial behaviors and criminal recidivism for PCL-R psychopaths have
been estimated at three to four times higher than the rate for non-psychopathic offenders
(Harris, Rice, & Cormier, 1991; Williamson, Hare, & Wong, 1987).
CHAPTER 2

CONTROVERSY OVER THE CONSTRUCT OF PSYCHOPATHY

Despite the relative utility of psychopathy in predicting future violence, considerable debate exists about the nature of the construct that underpins the PCL measures. Initially, the PCL measures approached psychopathy from a two-factor model (Hare, 1991, Harpur et al., 1988). Factor 1 represented interpersonal and affective personality characteristics of psychopathy and Factor 2 represented antisocial behaviors sometimes associated with the construct. Although distinct from one another, the two factors are moderately correlated in offender populations ($r=0.50$; Hare, 1991). Harpur and Hare (1988) used exploratory factor analysis to examine six samples ($N=1,119$, $M=187$) of Anglo male prisoners in Canada, United States, and England and found a two-factor structure for the PCL. Hare (1995) replicated these findings using the PCL-R on five prison samples ($N=925$) and three psychiatric samples ($N=356$).

Despite such promising reports by Hare and his colleagues, recent reports in the literature raise concerns about the adequacy of this two-factor structure. For instance, Harpur and colleagues (1988) employed split-half cross-validation and reported high congruency between the factors in a majority of samples. A close scrutiny of the data revealed that a sizable proportion of the congruency coefficients were below the recommended value of .95 (Cooke & Michie, 2001). Values of .95 have been considered
adequate, whereas values less than .90 (Van de Vijer & Poortinga, 1994) or a less stringent .85 (Barrett, 1986) and below have been considered to indicate “non-negligible incongruities” (Cooke & Michie, 2001). Simply put, these results do not adequately support the stability of the two-factor structure.

Other reports in the literature have raised concerns about the PCL/PCL-R’s ability to distinguish psychopathy from criminality. Use of total PCL/PCL-R scores to identify psychopathy gives equal weight to antisocial and personality factors. Hence, individuals with elevated F1 scores but overall low scores may not be considered psychopathic. Those obtaining high overall scores may be considered psychopathic even if predominantly based on high F2 scores. This is in direct opposition to the notions of Cleckley and several other personality theorists who consider personality features to hold diagnostic prominence. They do not consider behavioral items to be distinct identifiers of psychopathy (Blackburn, 1988) as they represent symptomatic manifestations that could reflect psychopathy as well as many other mental disorders (Lilienfeld, 1994).

Additionally, critics argued that the new focus on behavioral indices of criminality and delinquency missed the “essence of psychopathy” (Epstine, 1979; Millon, 1980). Cleckley’s conceptualization considered criminality to be a possible but rare and relatively unimportant component of psychopathy. Furthermore, new criteria have been criticized for being overinclusive in that they identified individuals who were antisocial but not psychopathic (Lilienfeld, 1994). Lastly, a less popular criticism is that the new criteria may not identify “successful” psychopaths who express psychopathic tendencies in a prosocial manner (e.g., Marines during a military operation) or psychopaths that manage to escape formal contacts with the legal system (Hare, 1985; Lilienfeld, 1994).
Relatedly, although the PCL supposedly represents Cleckley's personality components, Rogers (1995) found that 68.2% of PCL items show a disparity from Cleckley's model of psychopathy. Specifically, nine of Cleckley's 16 characteristics, such as egocentricity, have been entirely excluded. Of the remaining seven, only four (untruthfulness, remorse, affect, planning) represent exactly what Cleckley intended. The remaining three (superficial charm, sexual promiscuity, egocentricity) share key characteristics. A combination of such studies suggest that the PCL-R is a good heuristic device to guide research on psychopathy but does not provide an adequate structural model for psychopathy.

To further refine the construct of psychopathy, Cooke and Michie (2001) reanalyzed large data sets (N = 2,067) using methods such as item response theory and confirmatory factor analysis. Their analysis revealed a 3-factor hierarchical model, which is analogous to Cleckley's original concept of interpersonal, affective, and behavioral traits. The three factors for their model are “arrogant and deceitful interpersonal style,” “deficient affective experience,” and “impulsive and irresponsible behavioral style.” This 3-factor model is considered more appropriate than the original 2-factor model of psychopathy for several reasons. First, the three factors purportedly capture personality traits that internally motivate psychopathic tendencies, rather than antisocial behaviors that could have originated from a combination of various sources (Blackburn, 1988). Second, the 3-factor model sharpens the distinction between personality and behavior by removing several behavioral items and shifting emphasis toward the personality domain (Cooke & Michie, 2001). For instance, Factor 1 and some Factor 2 items (impulsivity and need for stimulation) are particularly discriminating of psychopathy. Others, such as
“revocation of conditional release” and “criminal versatility,” were eliminated (Cooke & Michie, 1997). Third, the 3-factor model presents criminality as a potential consequence of psychopathy rather than as its identifier.

Finally, the 3-factor model may be more generalizable to other groups than the two-factor model. For example, on examining Caucasian (n=230) and African American (N=123) male prisoners via the PCL, Kosson et al. (1990) found congruency factors of .67 and .93 for factors 1 and 2, respectively, suggesting a “low cross sample” generalizability. On the other hand, based on a sample of North America and Scottish (N = 2,542) offenders, Cooke and Michie (2001) found the 3-factor model of psychopathy to be valid across ethnicities. Hence, a comparison between the cross-sample validities of the 2-and 3-factor models suggests that the latter may better discriminate psychopaths from non-psychopaths.

Despite its shortcomings, popularity of the PCL-R has encouraged the measure’s use to (a) inform legal decisions in capital cases, and (b) extend conception of PCL-R-defined psychopathy to populations other than adult male offenders, such as females, civil psychiatric patients, and, most importantly for the purposes of this study, adolescents. The following section focuses on the shortcomings related to use of the PCL-R within such contexts.

Perceptions of Psychopathic Dangerousness in Capital Cases

Psychopaths are considered to be perpetually dangerous offenders. In fact, the dangerousness prototypes of lay persons, judges, lawyers, and clinicians include psychopathic personality characteristics (Edens, Colwell, Desforges, & Fernandez, in
Since the PCL-R's commercial publication and purported success in identifying dangerous and violent criminals, the measure has been used as an assessment tool to inform legal decisions in adult capital cases (Costanzo & Peterson, 1994; Otto & Heilburn, 2002). When found guilty in a capital case, a defendant's character plays an important role in whether he receives the death penalty or life in prison (Bowers, Sandys, & Steiner, 1998). In murder trials, jurors are more likely to vote for the death penalty when jurors perceive the defendant to possess psychopathic personality traits such as callousness and lack of remorse (Bowers et al., 1998). Such decisions were often based on a juror's notion that such individuals were extremely dangerous and capable of repeatedly committing heinous crimes. Relatedly, prosecutors have been known to describe defendants as being "cold blooded," "remorseless," and "lacking in empathy" to sway jurors during capital sentencing (Costanzo & Peterson, 1994). The PCL has also been used to bolster expert witness claims that defendants will continue to be a dangerous threat to society (Cunningham & Reidy, 1998).

Contrary to such notions, the base rates of violence exhibited by death row inmates and inmates serving life sentences are less than 10% (Edens, Petrilla, & Buffington-Vollum, 2001). Relatedly, the relationship between scores on the PCL-R and prediction of future violence in capital cases have been found to be nonsignificant or modest at best (Edens, Poythress, & Lilienfeld, 1999; Kosson, Steuerwald, Forth, & Kirkhart, 1997; Walter, Duncan, & Geyer, 2003). Studies where PCL-R scores were moderately correlated with violence, the term "violence" had not been operationalized (Cunningham & Reidy, 1998). Hence, the violence reported in these studies could include infractions, from verbal outbursts and property violations to bodily harm.
Furthermore, although psychopathic offenders are considered to be violent and
dangerous throughout their lives, extant data suggests that, after 40 years of age,
psychopathic offenders are equally prone to burn out as non-psychopathic offenders
(Edens, Desforges, Fernandez, & Palac, 2004). Such findings question the association
between PCL-R scores and the type of violence specific to capital cases (Edens et al.,
2001; Edens et al., in press). Hence, although the PCL-R purportedly meets legal
admissibility standards, examiners are advised to hold themselves to higher standards
when selecting tools to make determinations of dangerousness in such cases (Edens,

Extension of the Psychopathy “Revolution” to Juveniles

The primary interest in juvenile psychopathy is based on the PCL’s ability to
predict violence in adult male criminals. Since 1980, there has been a rising concern
about the increased severity of youth crime and violence. The extensive and eye-catching
news coverage of juvenile violence during the summer of 1993 brought the purported rise
in juvenile violent crime into sharp focus (Dilulio, 1996). These delinquent youth were
described as a new breed of juvenile delinquents called “super predators” that were
younger and more dangerous compared to delinquent youth from earlier generations
(Dilulio, 1996). Since then, in the interest of preserving public safety and deterring
juvenile crime, the juvenile justice system has given harsher sentences to juvenile
delinquents in the form of swift transfers of juveniles to the adult criminal system
(Bishop, Frazier, Lanza-Kaduce, & Winner, 1996). Research with clinicians and forensic
diplomates found that youth considered appropriate candidates for certification possessed
psychopathic personality traits such as "lack of remorse," "glibness," "grandiosity," and "need for stimulation" (Salekin et al., 2001). Furthermore, researchers have found violence rates in a sub-sample of adjudicated juveniles to resemble that of adult psychopathic samples (Forth et al., 1994; Forth & Burke, 1998; Forth & Mailloux, 2000).

Such reports, in combination with the volume and versatility of criminal acts committed by adult psychopaths (as defined by the PCL-R), sent a rising call for identification of psychopathic traits during earlier and, theoretically more malleable, periods of development. Despite the general reluctance associated with assigning the malignant personality disordered diagnosis of psychopathy to minors, some researchers believe that psychopathic personality disorder can be identified early in life (Forth et al., 1999; Forth & Burke, 1998; Forth & Mailloux, 2000; Frick and Hare, 1994; Lynam, 1996). Nevertheless, the field has not accepted this disorder for adolescence given the paucity of research on the reliability and validity of psychopathy during this developmental period.

The limited research on adolescents has been based on the assumption that psychopathy is continuous from childhood to adulthood. But there is a lack of empirical evidence to support this assumption. However, most conceptions and measures of juvenile psychopathy are downward extensions of the adult concept tapped by the PCL-R. The three most commonly used measures of juvenile psychopathy are the Psychopathy Checklist – Youth Version (PCL-YV; Forth, Kosson, & Hare, 1994), Antisocial Process Screening Device (Frick & Hare, 2001), and Child Psychopathy Checklist (Lynam, 1996). Controversy over the construct of psychopathy revealed by the
parent measure (PCL-R) necessitates a close scrutiny of the conceptual basis and
correct validity of each of these measures.

_Psychopathy Checklist – Youth Version (PCL-YV)_

The PCL-YV (Forth, Kosson, & Hare, 1994) is a direct translation of the PCL-R for adolescents aged 13-18 years. This measure consists of essentially the same 20 items as the PCL-R, with modified item descriptions to focus on youth-relevant experiences in peer, family, and school environments (Forth & Burke, 1998; Forth & Mailloux, 2000). The development of the PCL-YV was inspired by a preliminary study conducted by Forth, Hart, and Hare (1990). These authors assessed the psychometric properties of the PCL-R with 75 (White and Native American) incarcerated adolescent male offenders (M = 16.5 years). To accommodate the limited life experiences of adolescents, two PCL-R items, “parasitic lifestyle” and “many short term relationships,” were excluded. In addition, the scoring criteria for two other items (juvenile delinquency; criminal versatility) were altered, resulting in an 18-item modified version of the PCL-R. The results of this study revealed that the measure significantly correlated with DSM-III criteria for conduct disorder (r = 0.64), past violent offenses and institutional aggression (r = .27-.46), and number of violent offense convictions (r = .26). The interrater reliability was respectable (ICC = .88).

Based in part upon suggestions that the PCL-R might be applicable to adolescent offenders, Forth, Kosson, and Hare (1994) developed the Youth Version of the Psychopathy Checklist, or PCL-YV, for offenders aged 13-18 years. The two items deleted in Forth et al. (1990) were reintroduced. Since then, many studies have examined the reliability and validity of the PCL-YV and found the measure’s reliability and

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predictive power for violence to be comparable to the PCL-R. Results from several studies using community and incarcerated samples report high interrater reliabilities (Cronbach’s alpha = .90 - .93) and internal consistencies (0.83 - 0.85) (Brandt et al., 1997; Edens et. al., 2001; Forth, 1995, Forth & Burke, 1998; Forth & Mailloux, 2000). Regarding the scale’s correlations with externalizing criteria, the PCL-YV has shown high correlations with conduct disorder, externalizing scales of the Minnesota Multiphasic Personality Inventory (MMPI) (Brandt et al., 1997; Edens et al., 2001; Forth, 1995; Forth & Burke, 1998; Forth & Mailloux, 2000), and externalizing factor and aggressive subscales of the Child Behavior Checklist (CBCL) (Brandt et al., 1997). Although most studies found no correlation between PCL-YV scores and demographic variables, Forth and Burke (1998) found that abuse, neglect, marital discord, parental criminality, and substance abuse predicted high scores on the PCL-YV in community samples.

Regarding general recidivism and violence prediction, high scorers on the PCL-YV, as opposed to low scorers, recidivated sooner in terms of violent and non-violent offenses (Brandt et al., 1997), showed poorer institutional adjustment, and increased their violent acts with age (Forth & Burke, 1998). They also had lower age of onset related to violent offenses (Forth, 1995). Furthermore, PCL-YV factor 2 and, to a lesser extent factor 1, added incremental validity for violence prediction over and above other predictors such as demographic variables, criminal history, and the conduct disorder criteria from the MMPI and CBCL (Brandt et al., 1997, Salekin, Neumann, Leistico, DiCicco, & Duros, 2004).

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The abovementioned correlations were primarily accounted for by factor 2 (behavioral items), and/or total scores, rather than factor 1 scores, which purportedly represent personality features most central to psychopathy. Additionally, the 2-factor structure of psychopathy did not generalize to community-based adolescent samples (Kosson, Trina, Steuerwald, Newman, Walker-Mathews, 2002). A 3-factor solution by Cooke and Michie (2001) provided a slightly better fit, though it was far from adequate. Finally, the construct validity of the PCL-YV is questionable given that Kosson and colleagues (2002) found the PCL-YV to be positively related to anxiety, whereas Brandt et al. (1997) found a lack of such a relationship. Contrary to such theoretically inappropriate relations, a new measure called the Youth Psychopathic Inventory (YPI; Andershed, Kerr, Stattin, & Lavender, 2002), which places a heavier focus on the core interpersonal deficits related to psychopathy, found a theoretically consistent, inverse relationship with anxiety (Skeem & Cauffman, 2003).

The Child Psychopathy Scale (CPS)

Given his view of adult psychopaths as habitual, violent offenders who fail to benefit from rehabilitative efforts, Lynam (1996) is an ardent proponent of identifying psychopathy and providing timely intervention aimed at regulating interpersonal abnormalities. To accommodate this aim, Lynam (1996) examined several studies and conducted a separate study (Lynam, 1998) that compared groups of children with hyperactivity and inattention (HIA), conduct problems (CP), and a combination of all three (HIA-CP) on measures such as mother-reported psychopathic traits, teacher reported attention problems, self-reported delinquency, and neuropsychological tasks used to distinguish adult psychopaths from non-psychopaths.
Results indicated that the HIA-CP group displayed more severe violence and delinquency patterns (Lynam, 1998; Stewart & Behar, 1983; Stewart, Cummings, Singer, & DeBlois, 1981), showed reward dominant response styles while ignoring punishing cues (Freeman, 1978; Lynam, 1998), and had lower physiological arousal to aversive stimuli, similar to that found in adult psychopaths (Pelham et al., 1991). Hence, via extensive literature review, Lynam (1996) provided a well-developed argument that children with co-occurring HIA (hyperactivity, impulsivity and inattention) and CP (conduct problems) were very likely, as adults, to lead antisocial lifestyles and suffer from serious personality disorders such as psychopathy or APD.

To develop a definitive link between childhood HIA-CP and adult psychopathy, Lynam (1996) proposed a “subtype” theory whereby only a subtype of children with HIA and CP who were lacking in “Psychopathic constraint” or “P-constraint” (Tellegen, 1985) were at risk for developing psychopathy. Essentially, individuals without “P-constraint” were impulsive, adventurous, and rejecting of social norms. Lynam described such children as “fledgling psychopaths” and designed an instrument called the Child Psychopathy Scale (CPS; Lynam, 1996) to identify such individuals among highly delinquent children (Lynam, 1997).

CPS items were chosen from pre-existing instruments. Specifically, 41 items from the Child Behavior Checklist (CBCL; Achenbach, 1991) and California Child Q-set (CCQ; Block & Block, 1980) were chosen as proxy measures of traits captured by the PCL-R. PCL-R traits that were considered irrelevant to childhood (e.g., early behavior problems, promiscuity, short-term marital relationships, revocation of conditional release) or that had no representation in the CBCL and CCQ scales (e.g., need for
stimulation, proneness to boredom and grandiosity) were not used, meaning that only 13 of the 20 traits captured by the PCL-R were ostensibly captured by the CPS. The resulting CPS consisted of 20 scales (with 1-3 items per scale). Although Lynam sought to replicate the two-factor structure of the PCL-R, the two CPS scales were essentially redundant with one another (r=0.95; Lynam, 1997). To date, there are no reports regarding the test-retest reliability of this measure (Edens et al., 2001, Vincent & Hart, 2000).

In accordance with Lynam’s assumption that stable antisocial behaviors and impulsivity are hallmarks of psychopathy, the CPS correlated positively with externalizing behaviors and negatively with internalizing behaviors (Lynam, 1997). Furthermore, CPS total scores were related to measures of delinquency, cognitive and behavioral impulsivity, and chronic antisocial behavior. Boys who were called “stable delinquents” (i.e., displayed criminal patterns with early onset leading to chronic offending with minimal crime-free periods, and progressive criminal versatility) obtained CPS scores that were .75 of a standard deviation above non-delinquents. CPS scores also provided incremental utility in predicting delinquency over other well-known predictors such as SES and IQ. The scale’s relation to the construct of psychopathy, however, remains weak.

Antisocial Process Screening Device (APSD)

The APSD (Frick & Hare, 1994) was developed to identify a particularly virulent strain of conduct-disordered children who also possessed interpersonal and affective deficits found in adult psychopaths. This measure was designed to facilitate research on developmental pathways toward serious antisocial and aggressive behavior patterns, and
is the most studied youth psychopathy measure to date. The contents of the scale are mostly items on the PCL-R that were modified or eliminated to fit the developmental states of children. Although no specific age range has been specified, the measure was based on 92 clinic referred children aged 6-13 years. However, the measure has also been recommended for use with older adolescents (Edens et al., 2001). The APSD has a parent teacher version as well as a self-report version, and has 2-and 3-factor solutions similar to the PCL-R and PCL-YV.

The APSD was originally found to have two related factors (r = .50), “Callous and Unemotional” (CU) and “Impulsive and Conduct Problems” (I/CP). The CU represents the interpersonal and affective features considered cardinal to psychopathy, and the I/CP captures behavioral traits such as impulsivity and delinquency. Psychometric results indicate that the two correlated factors have respectable internal consistency coefficients; 0.73 for the CU scale and 0.83 for the I/CP scale (McBurnett et al., 1994). This 20-item rating scale was originally designed for use with children’s parents and teachers as the primary informants (Frick et al., 1994). The interrater reliability between parents and teachers revealed inconsistencies (r = .26 -.43) (Frick, Bodin, & Barry, 2000; Frick, Lilienfeld, Ellis, Loney, & Silverthorn, 1999). However, use of multiple informants provided an opportunity to gather information about the extent to which youth behaviors were consistent across settings, as psychopathic traits are expected to be (Frick et al., 1994). Relatedly, given that pre-adolescents provide unreliable self-reports (Lykken, 1995), parent and teacher reports were preferred. Additionally, the parent-teacher version is best suited for pre-adolescents for whom such informants are available. In instances where children and adolescents are wards of the state and their parents are unavailable,
researchers have used staff members as the primary informants (Murrie & Cornell, 2002) or used a comparable self-report version for adolescents.

Results of several studies support the usefulness of the APSD self-report version in distinguishing subgroups of juvenile offenders who display patterns of violence typical to PCL-R measured psychopaths (e.g., Caputo, Frick, & Brodsky 1999; Loney, Frick, Clements, Ellis, & Kerlin, 2003; Salekin et al., 2004). Other studies, however, question the measure’s utility. For instance, Lee, Hart, and Corrondo (2002) found that the APSD self-report scale identified a smaller percentage (12%) of youth as psychopathic compared to the PCL-YV (25%). Murrie and Cornell (2002) found poor correlations between the PCL-YV and the APSD self-report, and Salekin and colleagues(2004) found that the self-report scale did not provide incremental utility for predicting violence over and above disruptive behavior disorders such as conduct disorder. The latter two findings were true for the parent-teacher rating version as well. Furthermore, the self-report and parent-teacher versions were found to be uncorrelated with each other (Murrie & Cornell, 2002).

The lack of congruency between the scales is problematic given that the PCL-YV and the APSD are direct downward extensions of the same measure (i.e., the PCL-R) and the self-report and parent-teacher rating scales are meant to be parallel versions of the APSD scale. The authors provide an explanation by suggesting that many items on the APSD (e.g., “you think you are better or more important than most people,” “your emotions are shallow and fake”) are worded in such a way that their intention to gather evidence for negative behaviors seems obvious. Such “unpalatable” items may elicit response sets that are tainted with impression management (Edens et al., 2001; Murrie &
Cornell, 2002). Furthermore, given that psychopaths are by nature skilled at lying and conning, they may present differently in different surroundings to trick their audience (Murrie & Cornell, 2002). Nevertheless, such findings question the utility of the self-report scale and call for further research.

There is also cause for concern regarding the stability of the measure’s factor structure. To test the dimensionality of the two-factor APSD on a non-referred, community sample of male and female adolescents, Frick, Bodin, and Barry (2000) discovered the emergence of a 3-factor structure. The third dimension transpired when the I/CP factor split into two distinct dimensions, narcissism and impulsivity. The three scales (callous/unemotional, narcissism, impulsivity) were highly correlated with each other and showed a high degree of internal consistency when used with community and clinic-referred samples.

A comparison of the 2- and 3-factor solutions, as applied to clinic-referred and community youths, indicated that the 3-factor solution provided few advantages over the 2-factor solution (Frick et al., 2000). For instance, the 3-factor solution provided a slightly better fit for data gathered from community and clinic-referred samples. The 3-factor solution also revealed gender-specific differences that were not apparent with the two-factor structure. For example, 60% of girls scoring high on the overall measure scored highest on the narcissistic scale and lowest on the I/CP and CU scales, suggesting that, in girls, narcissistic features may be better indicators of future antisocial tendencies.

According to the 3-factor solution in adolescent populations, the narcissistic dimension was more closely related to behavioral indices. This may indicate important distinctions between child/adolescent and adult manifestations of psychopathy given that,
in adults, narcissistic traits are related more to personality criteria. Relatedly, the 3-factor solution revealed sharper distinctions between external correlates of the APSD scales. For instance, together all three scales showed high correlations ($r = .50-.70$) with the three disruptive behaviors (CD, ODD, and ADHD) commonly linked with “fledgling psychopathy,” and identified the most behavior disordered youth. Individual examination of each scale indicated that the narcissism scale was most highly correlated with oppositional defiant disorder, followed by conduct disorder. The impulsivity scale was most highly correlated with the inattention and disorganization criteria of the ADHD diagnosis, and the CU scale showed negligent correlations with the DSM criteria. Additionally, 32-38% of youths who showed high degrees of comorbid conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder did not score high on the CU scale. Such results highlight the salience of CU traits by revealing that high comorbidity between ADHD, CD, and ODD alone, in the absence of callous and unemotional traits, may not be indicative of psychopathic tendencies.

**Evaluation of Youth Psychopathy Measures**

Thus far, research on youth psychopathy measures has revealed differing reports regarding factor structure solutions, predictive utility of violence potential, and association with externalizing and internalizing disorders. However, the factor related to psychopathic personality characteristics (i.e., the APSD CU scale) has remained stable irrespective of differing factor solutions. In addition the CU factor has consistently been found to have low correlations with DSM criteria and, most importantly, is highly correlated with theoretically consistent indices of psychopathy such as anxiety and
deficits in information and emotional processing related to fearlessness and callousness (Blair, 1999). Such evidence is a strong indicator of the CU factor’s construct validity in relation to the concept of psychopathy. The related findings and implications are discussed in the following section.

**Promising Directions: Callous/Unemotional Traits**

Fearlessness, callousness, and an inability to form meaningful relationships are considered to be some of the cardinal features of psychopathy. Several researchers report a link between early temperament and future development of “moral emotions” such as guilt, remorse, empathy, and prosocial behaviors (Caspi & Silva, 1995; Eisenberg, 2000; Kochanska, 1991, 1997; Rothbart & Ahadi, 1994; Zahn-Waxler & Robinson, 1995). Children who show a lack of such emotions at a very early age have been found to be more callous in their attitudes, especially related to violence (Widiger & Lynam, 1998). Callous tendencies have also been related to children with peculiar temperaments related to “fearlessness,” as evinced by an underactive behavioral activation system that inhibits negative behaviors by producing anxiety (Frick et al., 1999; Walker et al., 1991).

Toddlers showing avoidant attachments with their caregivers developed superficial relationships later in childhood, lacked empathy when responding to others’ distress, and displayed daily aggression generally related to callousness such as intimidating or bullying others (Sroufe et al., 1997).

A series of studies with incarcerated, clinically-referred, and non-referred samples suggest that the CU scale of the Antisocial Processing Device best captures such tendencies among children and adolescents. For instance, researchers have found a group of non-anxious conduct-disordered children scoring high on the CU factor to have a
reward-dominant response style similar to that found in adult psychopaths (O'Brien & Frick, 1994; O'Brien, Frick, & Lynam, 1994). They were unable to resist responding to the task despite a growing number of punishing cues. This response pattern was found related to "fearlessness" and was not a consequence of impulsivity. This indicated information processing deficits that have typically been related to psychopathy in adults. Although these findings highlighted the importance of callous and unemotional factors, the findings also suggest that anxiety is unrelated to psychopathy. Theoretically, anxiety is believed to have a negative relationship with psychopathy. The authors attributed such discrepancies to the use of participants who possessed high levels of CU traits but who were also highly conduct-disordered. The use of such a population made it difficult to tease apart the role of callous and antisocial traits in relation to psychopathic tendencies.

To date, no studies have been conducted using participants who are exclusively callous and unemotional without being conduct-disordered. Recently, however, studies have statistically controlled for each trait to reveal a cleaner picture regarding the divergent relationships between various external correlates and the two APSD scales. More importantly, the relationships between various traits and each factor were found to correlate in theoretically appropriate directions with psychopathy. The factors most relevant to psychopathy were often exclusively related to the CU factor. For instance, prior to controlling for each factor, Frick, Lilienfeld, Ellis, and Loney (1999) found that the CU and I/CP scales were unrelated to fearlessness and only the I/CP scale positively correlated with trait anxiety. After controlling for each scale, however, the CU scale correlated negatively with anxiety and positively with fearlessness, whereas the I/CP
scale remained uncorrelated with fearlessness and positively correlated with general anxiety.

A fearless temperament has been considered a risk factor for the lack of conscience development (Blair, 1999). Furthermore, Loney, Frick, Clements, Ellis, and Kerlin (2003) and Blair (1999) studied emotional responses to visual cues in delinquent males and found that only those participants who scored high on CU traits showed a diminished response style to negative/threatening stimuli similar to adult psychopaths. Participants who scored high on I/CP with antisocial, impulsive, and hyperactivity symptoms and low on CU traits displayed appropriate emotional responses to the respective stimuli. The emotional disturbance in Blair’s (1999) sample, however, was less severe than typically found in adult psychopaths.

In a group of adjudicated adolescents, Pardini, Lochman, and Frick (2003) found that participants with high CU scores showed a pattern of violence motivated by a focus on the positive aspects of aggression such as dominance and control over the victim, rather than to avoid future conflicts inflicted on them by others. These adolescents were less likely to inhibit aggressive behaviors based on the anticipation of punishment to themselves or victim distress. Such tendencies have been related to a distinct pattern of information and emotional processing deficits related to callousness and lack of empathy (Blair, 1999). The aggression displayed by high I/CP scores after controlling for the effects of CU was mostly related to emotional dysregulation, which typically causes individuals to become more sensitive and emotionally reactive to distress (Barry et al. 2000).
Overall, these studies suggest that callous and unemotional traits evinced early in life may be related to the development of psychopathy in adulthood. However, a recent longitudinal study by Frick, Kimmons, Dandreaux, and Farell (2003) found that CU traits were moderately stable at best over the course of four years. The authors followed 98 children who were either high CU-low I/CP, low CU-high I/CP, high on both, or low on both. Over four years (grades 3-7), a majority of children who initially scored high on CU either showed a pattern of desistance or substantial fluctuations in level of CU traits. Only 12 participants consistently scored high on CU traits. With respect to external predictors, unlike the findings of most studies, parenting and SES were the only variables that successfully distinguished CU from the other groups. Furthermore, a reward-dominant response style did not serve as a strong predictor for psychopathic tendencies. Frick et al. (2003) highlighted the importance of parents as a powerful influence on a child’s development, which is consistent with the suggestions by several developmental theorists (Saltaris, 2002) and has been found to be an important component for improving treatment gains with psychopathic youth (Salekin, 2002).

To account for fluctuating CU trait levels, the authors addressed the use of various informants as a potential source of measurement error and the moderate internal stability of the CU scale as potential barriers to capturing the stability of these traits. Furthermore, factors that initially predict CU traits may differ from the factors that predict such traits over time (Frick et al., 2003). Such discrepancies reveal an urgent need to further refine the construct validity of the CU scale. However, overall, CU traits appear to share a meaningful link with facets of future psychopathy and thus require further attention.
Construct Validation Concerns

Unfortunately, the leading measures of psychopathy are disproportionately saturated with behavior criteria. Although youth psychopathy measures provide respectable utility in predicting violent and antisocial behaviors among adjudicated youth and yield youth psychopathy prevalence rates similar to those found in adult criminal populations, this does not provide sufficient evidence for the measure’s construct validity with respect to psychopathy. Behavioral disturbances are important to Hare’s (1991) conceptualization of psychopathy, partly due to his research with incarcerated populations, but were not central to Cleckley’s (1964) conceptualizations.

Overemphasis on behavior features seems to have hindered diagnostic clarity, especially in children and adolescents. A stringent test to assess the construct validity of the psychopathy measures would be to test their ability to distinguish psychopathy from types of comorbid psychopathology that may present with “psychopathy-like” symptoms. Relatively strong evidence supports the existence of psychopathy as a unique disorder in adults (Hart & Hare, 1989). For instance, psychopathic adults have been found to present with severe symptoms that cannot be attributed to substance abuse or other Axis I and II diagnoses (Harris, Skilling, & Rice, 2003). For children and adolescents, however, evidence is less clear. For example, psychopathy measures (PLC-YV and APSD) are positively correlated with the disruptive behavior criteria of ADD, ODD, CD, (convergent validity coefficients 0.35- 0.49) and psychosocial problems such as substance abuse, anger, aggression, and interpersonal problems (mean convergent validity coefficient = 0.29; Salekin et al., 2004). However, the measures were also correlated with internalizing disorders such as depression and anxiety. The individual
scales of the psychopathy measures were more highly correlated with CD and ODD than they were with each other, which is indicative of "less than adequate" discriminant validity. Simply put, the psychopathy scales were more efficient for identifying CD and ODD than they were for identifying psychopathy.

CD and ODD have often been found to occur with each other as well as with other pathologies such as depression, anxiety, substance abuse, and attention disorders (Achenbach, Howell, McConaughy, & Stanger, 1995; Caron & Rutter, 1991; Hinshaw & Zupan, 1997). Salekin et al. (2004) found CD and ODD to be as efficient as APSD in distinguishing a subgroup of participants who were highly violent and aggressive. Such results beg the question of whether youth psychopathy measures make behavior-disordered youth appear psychopathic due to the comorbid pathologies, or that CD and ODD are in fact precursors of psychopathy (Burns, 2000). Researchers (Lynam, 1997) have attempted to control for comorbidity by statistical manipulations, but essentially comorbidity exists and clinicians will have to recognize the presence of psychopathy through the complex web of co-occurring disorders (Seagrave & Grisso, 2002).

**Developmental Concerns**

Another issue that often arises is the questionable applicability of using downward extensions of an adult measure to assess children and adolescents. According to retrospective accounts, most criminal psychopaths were antisocial youngsters, but only a fraction of individuals who were antisocial during youth went on to meet criteria for psychopathy during adulthood (Lahey et al., 1995).

Modifying the coding criteria of certain adult items such as "criminality," "impulsivity," and "parasitic lifestyle" does not provide a suitable alternative for children
and adolescents because, in essence, these criteria are almost normative during this developmental state (Edens et al., 2001; Hart, Watt, & Vincent, 2002; Seagrave & Grisso, 2002; Vincent & Hart, 2000). Failure to consider normative developmental trends may make a disproportionate number of youth seem psychopathic (Cleckley, 1964). For instance, adults are better able to control their actions because they are psychosocially more mature and hence are able to exert more control over their actions (Cauffman & Steinberg, 2000). Teenagers, however, tend to weigh the costs and benefits of activities differently than adults (Cauffman & Steinberg, 1995). In large part due to their lack of temperance, they are less likely to resist from engaging in risky behaviors.

In addition, several characteristics during youth are transient in nature, such as delinquency and behavior disorders. Several studies indicate that more than 50% of children exhibiting conduct problems desist by the time they reach adulthood (Forth & Burke, 1998; Forth & Mailloux, 2001; Lynam, 1996). McCrae and colleagues (2002) conducted a series of three studies over the course of four years using a cross-sectional sample of adolescents aged 12–18 years to test the stability of the five-factor model of personality (i.e., openness, consciousness, extroversion, agreeableness, neuroticism). The findings of this study suggest that, though adolescents possessed traits similar to adults, 40% of the sample showed a change at the group level as well as intrapersonally on the five factors over the course of the study. This means that trait changes in one cohort could be reliably different from trait changes in another cohort. These results reveal the fluctuating nature of personality during adolescence.

Relatedly, pathologies have been found to have varying manifestations over the course of one's development. For instance, the same pathology can have several different
pathways (equifinality), various manifestations at different stages of development (heterotypic continuity; Kagan, 1969), or similar manifestations can eventually lead to different outcomes (multifinality; Cicchetti & Donald, 1995). Most of the literature suggesting continuity between adulthood and childhood psychopathic traits has been based on retrospective or cross-sectional accounts. However, a paucity of systematic longitudinal studies that follow youths from adolescence to adulthood questions the claim that juvenile psychopathy will develop into adult psychopathy.

*Criteria for Depression as a Case in Point*

The problems arising from the use of modified adult criteria to identify disorders in childhood and adolescence is not restricted to psychopathy, but is also apparent in cases of long-established disorders such as depression. Although adult depression is a well-established construct within clinical and research communities, the application of this concept to children has been marked by considerable debate and controversy (e.g., Digdon & Gotlib, 1985; Murray, 1970). Three schools of thought posit that childhood depression (1) is similar to adult depression and should be diagnosed by extending the adult criteria directly downward, (2) is different from adult depression and thus should have separate diagnostic criteria, or (3) requires provisional, consensus criteria to permit its study, validation, and refinement as a clinical entity (Cytryn, McKnew, & Bunney, 1980).

The recognition of depression in children began with case studies of children with various complaints seemingly unrelated to depression (Glasser, 1967). Therapists combined clinical art with developmental considerations to recognize that the manifestations of depression varied at different ages. Glasser (1967) reported case
observations at infancy, childhood, and adolescence, and Spitz and Wolf (1946) described “anaclitic depression” across developmental stages. During infancy, depressive symptoms are expressed in the form of emotional outbursts aimed at seeking maternal attention, followed by a loss of interest in people, an apathetic disposition, and decreased activity level. In older children, symptoms are expressed through overt behavior problems such as delinquency, temper tantrums, rebelliousness, running away from home (Toolan, 1962), and poor school performance (Silverman et al., 1959; Wertz, 1963), and psychophysiological reactions such as body aches (Keeler, 1954). According to Weiss and Garber (2000) very young children may express dysphoric mood by excessive crying, whereas adolescents may display irritability. Relatedly, though suicide is commonly linked to depression in adulthood, it is not a typical consequence of childhood and adulthood depression (Quay, Routh, & Shapiro, 1987).

Despite such theories supporting symptomatic variation between age groups, relegation of adult criteria to diagnose childhood depression prevails as a common and highly criticized practice. As acknowledged by several researchers, aligning childhood disorder criteria with that of adult classifications may promote diagnostic uniformity (Cytryn, McKnew, & Bunney, 1980). Nevertheless, such alignment seems imprudent if it results in a misdiagnosis of children in applied settings. For children and adolescents, diagnostic accuracy requires developmental consideration, which is neglected when using adult downward extensions of a disorder (Hammen, Rudolph, Weisz, Rao, & Burge, 1999). Children are not only being diagnosed using ill-fitting adult criteria, but are also being treated with drugs found to effectively treat adults with depression. Adolescents and children often experience adverse reactions to these drugs, sometimes including
violent and or suicidal behavior, which may be attributed to phenotypic and biological dissimilarities between the two groups (Ambrosini, 2000). Hence, differences between children and adults render downward extensions for some disorders inappropriate.

Construct Clarification Using a Top-Down Approach

Alternative to the downward extensions, Salekin et al. (2001) and Cruise, Colwell, Lyons, and Baker (2003) conducted studies to obtain frontline professionals’ prototypes of adolescent psychopathy. Salekin et al. (2001) asked 511 expert clinical child psychologists to identify the central features of the disorder. The sample included 243 males and 268 females with varying degrees of clinical experience. The clinicians received a 61-item checklist consisting of items borrowed from various scales used to identify psychopathy, such as (1) ODD and CD symptoms from DSM-III, DSM III-R, and DSM-IV, (2) PCL-YV, ICD-10, APSD, CPS, and APD criteria, (3) Cleckley’s criteria, (4) Minnesota Multiphasic Personality Inventory-Adolescent version (MMPI-A), and (5) the California Personality Inventory (CPI). Using a 7-point rating scale, participants rated the prototypicality of each item on the checklist with respect to adolescent psychopathy in males or females.

Analysis of the data suggested a 2-factor structure (behavior and personality) for both male and female adolescents. Behavioral and personality features were considered equally important in identifying psychopathy among adolescents. The two factors for males were called “violent antisocial behavior” and “irresponsible, grandiose, and manipulative,” and for females they were called “non-violent antisocial behavior” and “manipulative, lack of genuine emotions.” The items were distributed differently between...
males and females. For instance, the overt antisocial items were more important to psychopathy in male adolescents, whereas items related to deceitfulness and lack of remorse were more important to female psychopathy.

Interestingly, certain items presented on all three youth psychopathy measures have been considered normative to adolescents by developmental theorists. "Parasitic lifestyle," "lack of long term planning," "impulsivity," "failure to accept responsibility," and "criminal versatility" were considered non-prototypical to youth psychopathy by a majority of the clinicians in this study. This suggests that adolescent psychopathy may be symptomatically different from adult psychopathy, and clinicians are aware of this disparity.

Cruise et al. (2003) conducted a similar study with 218 juvenile justice personnel (probation and detention officers) but obtained different findings. For instance, a confirmatory factor analysis (CFA) in this study revealed a 5-factor solution for both males and females. Four factors consisted of various behavioral items and one consisted of personality features. Juvenile justice personnel placed a larger emphasis on items such as "parasitic lifestyle" and "impulsivity" to be prototypical of adolescent psychopathy. Clinicians in Salekin et al. (2001) considered such characteristics normative during adolescent development and not prototypical of psychopathy. Furthermore, similar items were used to identify psychopathy in males and females. Despite considerable emphasis on behavioral items, the lone interpersonal factor labeled "Lacks Empathy/Conning and Manipulative Use of Others" had one of the highest factor means among the five factors. In other words, the interpersonal items were consistently and highly correlated with the higher order factor of psychopathy.
Discrepancies were also evident within the views of the two groups of juvenile justice professionals. For instance, probation officers estimated that 11.5% of the delinquent population consisted of psychopathic youth. The detention officers estimated prevalence rates to be around 20.4% and reported that psychopathic youth display more severe symptoms of manipulativeness and verbal and physical aggression. Such discrepancies in conceptions of psychopathy may indicate a selection bias. Participants may be selecting items that are typically or commonly seen in their respective populations rather than items that may be consistent with the construct of psychopathy. Furthermore, the list of potential features of psychopathy provided to the participants primarily consisted of behavioral items. This may have artificially increased the chances of such items to be rated as prototypical compared to items related to personality traits. Additionally, use of a pre-made list provided by experimenters does not represent a truly bottom-up prototype approach to exploring the construct of psychopathy. Such an approach, for example, may represent the experimenter’s or field’s prototype rather than the professional’s own prototype.

Implications of Using Downward Extensions of Psychopathy

There is little doubt that psychopathy is a pervasive and dangerous condition. The ominous nature of psychopathic personality disorder provides urgent cause to identify features that may accurately recognize this disorder during early stages of development. There is some evidence to suggest that select core features of psychopathy remain consistent over the course of development. However, current adolescent measures use downwardly extended adult criteria without developmental considerations and include
various behavioral identifiers that are non-specific to psychopathy. Furthermore, lack of consensus exists in the way youth psychopathy measures collect information. For example, the PCL-YV is a semi-structured interview, whereas the APSD has a parent-teacher and a self-report scale. The assessment tools also target varying age groups. Additionally, counter to traditional methods of construct development where the construct typically informs measures, the extant construct of youth psychopathy has been informed using data from measures. Such practices seem to have created a tangled thicket of criteria that serve as catch basins for various pathologies unrelated to psychopathy. This suggests a crucial need for a highly refined system of identification that can distinguish with greater accuracy youth who will develop into adult psychopaths.

There is a risk in applying the grim label of psychopathy to an age group whose normative developmental characteristics sometimes resemble traits of adult psychopathy. For example, earlier studies suggested that psychopathy was predictive of treatment noncompliance (Harris, Rice, & Cormier, 1994; Whiteley, 1970). Although recent reports suggest that youth psychopaths are responsive to long-term (Salekin et al., 2001) and non-traditional forms of treatment (Caldwell, Skeem, Salekin, & Van Royborck, 2003), there is a general misconception that psychopathic youth are unamenable to treatment (Salekin et al., 2001).

Furthermore, research suggests that delinquent youth identified as psychopathic may face harsh legal sanctions. In mock jury studies regarding juvenile murder cases, jurors were more likely to vote towards the death penalty (Edens et al., in press) or recommend that the youth be tried as an adult (Edens, Guy, & Fernandez, 2003) when the juvenile defendant was described as having psychopathic tendencies. The rates of such
harsh sanctions were significantly lower when the same defendant was described without psychopathic tendencies. In addition to lay perspectives of dangerousness, judges’ and mental health professionals’ perspectives of dangerousness youth also include psychopathic traits (Salekin, Rogers, & Ustad, 2001; Salekin, Yff, Neumann, Leistico, & Zalot, 2002). Furthermore, as mentioned earlier, youth considered most appropriate for transfer to adult court are believed to possess psychopathic personality traits and considered unamenable to treatment (Salekin et al., 2001). Relatedly, the adult psychopathy measures are already being used to assist in legal decision-making. Given the success of the adult measure, juvenile psychopathy measures may soon become available for use in clinical and forensic contexts to identify youth who are considered perpetually dangerous (Seagrave & Grisso, 2002).

**Purpose of the Present Study**

This study aimed to provide a cleaner depiction of youth psychopathy by utilizing clinical judgments rather than research findings based on institutional populations. To address this aim, the current study applied a “back to basics approach” using prototype theory.

*Using the Prototype Approach*

This approach starts from the “ground up” by setting aside adult conceptions of psychopathy and identifying features that may represent psychopathic youth. The theory most conducive to this research design is the “prototype theory” of categorization (Rosch, 1977), which aids in defining constructs when no clear definition for the concept exists (Hampton, 1995). According to prototype theory, categories are defined by a prototype,
or features that are most distinct from rival categories. Determining category membership for an object is based on a similarity matching process to the prototype. The more features an object shares with the category’s prototype, the more likely the object will be classified as a member of that category.

This theory was originally developed to address naturally occurring categories such as birds and colors. Objects occurring in nature are often laced with a variety of physical features (shapes, sizes, colors) and dispositional features. Hence, it is more common to find natural objects that are similar to each other rather than those that are identical to each other, which makes specifying criteria or features that are common to all category members difficult (Clark & Clark, 1977; Rosch, 1978; Rosch & Mervis, 1975). For instance, apples can be small or large in size, and red, green, or yellow in color; not all birds can fly, and not all mammals have lungs. Relatedly, members from two different categories often share common sets of features. For instance, a tomato possesses features common to fruits and vegetables. Hence, the boundaries between categories can be unclear (Rosch, 1978). Prototype theory is well suited to accommodate the range of differences inherent to the natural categorization processes in many scientific and nonscientific domains (Cantor, Smith, French, & Mezzich, 1980). Furthermore, given that boundaries are not rigid or possessive, category membership does not require any “necessary” or “sufficient” criteria. The indistinct boundaries of a prototype allow for feature sharing between category members.

The membership status for a category is graded in that members that share a great number of distinctive features with the prototype are near the category’s center and are referred to as focal features (Rosch, 1977). Members sharing fewer distinctive features
with the prototype fall near the category's indistinct boundaries and are "atypical" members of the category. In short, not all members have equal degrees of membership within the category. Focal features, as well as members that possess more focal features, are recognized and recalled with greater ease and accuracy than borderline or atypical ones (Rosch, 1977).

Similar to naturally occurring categories such as birds or colors, criteria for clinical diagnosis are also imprecise and heterogeneous in nature because features in a diagnosis can differ from person to person. Even relatively typical cases can consist of a different subset of characteristics of the total set of features contained in a category. For instance, a diagnosis of depression does not require all 9 DSM features to be present, but can be based on a combination of any 5 of 9 features. Furthermore, clinical diagnoses often show overlap or comorbidity with other diagnoses, such as depression and anxiety disorders. Substantial comorbidity or overlap makes the diagnosis more difficult to identify. Additionally, a diagnosis can be based on the degree of fit between a patient's cluster of symptoms and the prototypes of various different categories (Cantor, Mischel, & Schwartz, 1982). Prototype theory can account for such lack of clarity and find a diagnostic fit because the theory allows for a "continuum of categorization" (Genero & Cantor, 1987). Essentially, prototype theory helps identify cases that are clearly typical, or atypical, of a category as well as those that clearly belong to another category. For the purposes of this study, a prototypic youth psychopath was conceptualized as a "member," symptoms/traits as "features," a combination of features that mean the same thing as "characteristics," and the diagnosis of psychopathy as the "category."
Using Clinicians’ as Informants of the Prototype

The construct of psychopathy represented by the PCL measures is derived from incarcerated populations, unlike Cleckley’s clinically-based construct. Given that clinicians have a better understanding of mental illness and personality disorders, and are primarily responsible for the treatment and identification of psychopathology, data for this study consisted of clinical judgments related to adolescent psychopathy. Several practical implications exist for using practitioners as a source for construct development. For instance, based on their experiences with the target populations, the practitioners may be aware of core features beyond those commonly known, and may utilize more accurate criteria for identification and treatment.

Furthermore, aside from extensive familiarity with the features, clinicians may also possess a better understanding of the correlations between these attributes (Rosch, 1977). Other possible advantages may be that practitioners are more aware of base rates and normative developmental features, and may be less vulnerable to availability bias than non-clinical professionals. Additionally, greater familiarity may allow clinicians to address the variability of expression and manifestation of traits during adolescence. Thus, they may be able to make astute distinctions between psychopathy and antisocial tendencies and differentiate pervasive traits from the transient traits limited to adolescence.

Study Aims

The primary aim of this study was to identify a consensus prototype for youth psychopathy based on clinicians’ judgments. Given that prototypes were solicited from
individuals who had worked with psychopathic youth (experts) and those who had not (non-experts), differences in expert and non-expert responses were evaluated from an exploratory standpoint. As secondary aims, the study (1) explored whether clinicians would generate additional features on the Feature Elicitation Instrument that were not addressed on Rating and Ranking Scales and (2) evaluated whether personality or behavior features were more important to clinicians' prototypes of youth psychopathy.
CHAPTER 3

METHODOLOGY

Participants

Participants were 40 clinicians recruited from the Clinical Child and Adolescent Psychology specialty division of the American Board of Professional Psychologists (ABPP); Association for the Advancement of Behavior Therapy (AABT); American Psychology and Law Society (APLS); state psychological associations of Colorado, Delaware, Florida, Kansas, Kentucky, Louisiana, Maine, Nebraska, Nevada, New York, Ontario, Oregon, and Texas; University of Nevada, Las Vegas (UNLV); student counseling and psychological services (CAPS) at UNLV; Las Vegas neighborhood care centers; and Summit View youth correctional agency. Over 1800 (n = 1801) psychologists received the surveys, with an estimated response rate of 2%.

Respondents from APLS, CAPS, UNLV, Las Vegas neighborhood care centers, and Summit View were approached and recruited in person. Participants belonging to state psychological associations and AABT were contacted via respective listserves. Due to agency restrictions for the state psychological associations and AABT, the recruitment e-mail for this study was distributed to members only three times over 12 weeks. Contact information for psychologists belonging to ABPP was obtained from an electronic public directory. Each ABPP member was contacted via telephone and e-mail. These clinicians
received a recruitment e-mail or telephone call once a week for four weeks. If a clinician did not respond within four weeks, it was assumed that he or she did not wish to participate and was no longer contacted. Volunteering clinicians were asked to complete a two-part survey. All 40 participants completed Phase I and 36 respondents completed Phase II.

**Experts**

Experts were clinicians who claimed to have worked with youth psychopaths. Respondents were 13 males and 7 females (N=20) aged 36-73 years (M=52.91, SD = 9.98). Clinicians in this group consisted of European American (n =17), African American (n =1), Asian (n=1), Native American (n=1), and other (n=1) ethnicities. Fifteen participants had a Ph.D, 4 had a Psy.D, and 1 had an M.A. in clinical psychology. All participants reportedly worked with adolescents in some capacity and 12 reportedly worked primarily with adolescents.

Experts were asked to provide information about the number of youth psychopaths with whom they may have worked. Experts reportedly worked with at least one psychopath, although most reportedly worked with more than one youth psychopath. An exact account of the number of youth psychopaths with whom experts reportedly worked was difficult to determine given that only 50% (n=10) of experts provided this information. Of these 10 experts, four provided the exact number of psychopathic youth they had worked with and six provided percentages. Experts were also asked to provide reasons for believing that youth they identified as psychopathic had matured into adult psychopaths. Clinicians were allowed to provide more than one reason, which included remaining in contact with youth until adulthood (n = 5), tracking youth’s progress (n= 3),
hearing about youth through a reliable source (n = 7), and other (n = 2). Two clinicians who marked the “other” category did not provide an explanation. Clinicians were asked if they believed youth psychopaths could be successfully treated. Seventeen reported “yes,” 2 reported “no,” and one provided no response. Lastly, experts were asked to provide ratings on a 7-point scale (1 = least confident and 7 = most confident) regarding the degree to which they were confident the features they provided on the Feature Elicitation Instrument were descriptive of a youth who matured into an adult psychopath (M = 5.10, SD = 1.41).

Non-Experts

Non-experts were clinicians who had not worked with youth psychopaths. They provided conceptions of youth psychopathy based on their general clinical knowledge. Respondents were 10 males and 10 females (N = 20) aged 28-61 years (M = 44.21, SD = 10.76). Clinicians in this group were European American (n = 17), Asian (n = 1), Native American (n = 1), and Biracial (n = 1) ethnicities. Twelve participants had a Ph.D, 3 had a Psy.D, 1 had an Ed.D, and 4 had an M.A. in clinical psychology. All participants reportedly worked with adolescents in some capacity and 4 reportedly worked primarily with adolescents. Respondents were asked if they believed youth psychopaths could be successfully treated. Fourteen reported “yes” and 6 reported “no.” Non-experts were asked to provide a rating on a 7-point scale (1 = least confident and 7 = most confident) regarding the degree to which they were confident the features they provided on the FEI were descriptive of a youth that matured into an adult psychopath (M = 4.60, SD = 1.61). Expert and non-expert groups did not differ with respect to ethnicity, level of education, and confidence ratings. Experts and non-experts did differ in terms of age (t(38) = 2.65,
where experts were older. However, age was not controlled for in subsequent analyses given the qualitative nature of this study.

Measures

This study included four instruments: Demographic Questionnaire (DQ), Feature Elicitation Instrument (FEI), Rating Scale, and Ranking Scale.

Demographic Questionnaire (DQ) (Appendix A)

The DQ was used to solicit information such as age, gender, and educational background. Participants were also asked detailed questions to determine their level of experience working with youth psychopaths.

Feature Elicitation Instrument (FEI) (Appendix B)

The FEI is an open-ended questionnaire designed to elicit features that clinicians may consider cardinal to psychopathy. The FEI was based on traditional prototype methodology called "abstract feature set" elicitation (Cantor et al., 1982; Rosch, 1978) and was adapted for the purposes of this study. This particular method of feature elicitation was chosen for several reasons. First, this method was based on the premise that one forms conceptions of a category based on observations of how attributes of that category interrelate with one another or naturally co-occur. Second, for the sake of cognitive economy, individuals often mentally store attributes that are cardinal or most distinctive of a category (e.g., birds have feathers) (Rosch, 1977) as opposed to attributes that are peripheral or common to several other categories (e.g., birds have two legs).

Hence, when asked to describe their prototype of a youth psychopath, respondents for
In addition, Rosch (1977) suggested that asking individuals to form a mental image of the object they wish to represent was a sufficient prompt to elicit their prototype and that features listed via such means reflected features most central to an individual’s conception. For instance, prior research indicates that jurors were able to describe a prototypical insane person when asked to form a mental image of such an individual (Hampton, 1993). Such findings indicate that abstract feature set prototype methodology was the least “stimulus bound” means of investigating individuals’ conception of a construct (Hampton, 1993). Hence, participants in this study were asked to form a mental image of a youth psychopath.

The Rating Scale (Appendix C)

The Rating Scale consisted of 21 features that described 10 characteristics. The scale’s characteristics included classic psychopathic personality characteristics of “grandiosity,” “callousness,” “conning,” and “shallow affect.” The characteristics also included traits related to emotional deficits such as “lack of anxiety,” “fearlessness,” and “lack of guilt.” Lastly, the measure consisted of behavioral domains considered relevant to psychopathy such as “violence” (reactive and instrumental type) and “criminality.” Each characteristic was described using two features, with the exception of grandiosity that was described using three features. For example, the characteristic of “callousness” was described by a) he can be ruthless and uncompromising towards others while teasing or bullying them and b) he is generally unconcerned about how his actions affect others.
The development of these characteristics was influenced by item descriptions of Cleckley (1964), Salekin et al. (2001), Frick et al. (1999, 2003), and Cooke et al. (in press). Features such as “lies easily and skillfully” and “manipulates others for personal gain” were derived from two youth psychopathy measures, the Psychopathy Checklist-Youth Version and Antisocial Process Screening Device. These features were chosen because they were considered highly prototypical to youth psychopathy by clinicians in Salekin et al. (2001). Items related to impulsivity, irresponsibility, and parasitic life style, though present in all youth psychopathy measures, were precluded here because the items have shown stronger correlations with juvenile delinquency and have been found non-specific to psychopathy (Hart & Vincent, 2000; Loeber, 1990; Loeber, Brinthaupt, & Green, 1990; Moffitt, 1993; Salekin et al., 2001). The presentation format for this measure was based on Salekin et al. (2001) and adapted for this study. Clinicians were required to read each item on the Rating Scale and rate each item with respect to its importance to their concept of youth psychopathy. Ratings were provided on a 5-point prototypicality scale (1 = extremely important, 2 = mostly important, 3 = somewhat important, 4 = somewhat unimportant, 5 = mostly unimportant). However, unlike the measure in Salekin et.al., this measure did not include a form for female psychopathy, had fewer items, and contained a higher percentage of personality characteristics.

**Ranking Scale (Appendix D)**

The Ranking Scale consisted of the same 21 items as the Rating Scale and utilized the “full ranking” procedure (Howell, 2002). According to this procedure, the number of ranks is equal to the number of items on the scale and rank ordering is based on careful comparisons of individual items. Individuals responsible for ranking the items are forced
to decide which items are more important to the higher order construct in comparison to the rest.

*Rationale for using the FEI and Ranking and Rating Scales.* The current study used a combination of bottom up (FEI) and top down measures (Rating and Ranking Scales) to collect the most comprehensive set of prototypical features. This process created an integrative method with several advantages over previous studies (e.g., Cruise et al., 2003; Salekin et al., 2001). This method capitalized on the strengths of top down and bottom up measures while compensating for the shortcomings of each. For instance, personality constructs are "open constructs" that are best explained by examples rather than a restricted set of criteria (Lilienfeld, 1999). The FEI had the potential to solicit unrestrained accounts of a clinician's prototype based on clinical experience (Cantor et al., 1982) and hence was conducive for exploring a personality construct. However, clinicians may provide information in a manner that is difficult for the coder to understand, inadvertently omit certain features due to memory failure, or have difficulty developing a prototype. To accommodate, the Rating and Ranking Scales had a fixed number of features that provided participants with a uniform guideline to construct their prototype. Hence, a combination of top down (Rating and Ranking Scales) and bottom up (FEI) measures provided a well-suited strategy for constructing a consensus prototype.

**Procedure**

Clinicians who agreed to participate were asked to complete a two-part survey. Part I included the Demographic Questionnaire and Feature Elicitation Instrument and Part II included the Rating Scale and the Ranking Scale. Respondents received an
electronic copy of Part I. An electronic copy of Part II was sent following completion of the Demographic Questionnaire and Feature Elicitation Instrument. Each part took approximately 15 minutes to complete. All 40 participants completed Part I (expert n=20; non-expert n=20) and 36 participants completed Part II (expert n=18; non-expert n=18).

Participants were given 10 days to complete each part. If completed materials for Part I were not received within 10 days, the participant received weekly (for 8 weeks) reminders via e-mail to return completed materials. If a clinician did not respond by the end of 8 weeks, it was assumed that he or she no longer wished to participate. Non-respondents received an e-mail informing them of their exclusion from the study. If participants completed Part I, they received a reminder e-mail every week for 12 weeks. If a completed protocol was not received by the end of 12 weeks, it was assumed that the participant no longer wished to participate. Upon request, participants were provided extra time to complete the survey.

*The Feature Elicitation Instrument*

The FEI required clinicians to form a mental image of a youth psychopath aged 13-17 years who would mature into an adult psychopath. Clinicians were asked to elicit characteristics that were pervasive, stable, and that would distinguish behavior disordered youth (who temporarily appeared psychopathic) from youth who were fledgling psychopaths. Following the formation of a mental image, participants were asked to provide a list of features describing such a youth. Clinicians were encouraged to consult with available file or case history information to supplement their descriptions.
Training coders to code features on the FEI. Once a completed Feature Elicitation Instrument was received, its narratives regarding clinician’s prototypes were coded into manageable pieces of data, or features. Prior to coding features on the FEI, two graduate student coders were trained. Coders were provided with information regarding the definition of a feature. A feature was described as any sentence or phrase that conveyed a coherent idea related to the participant’s prototype. For example, a sentence such as “my conception of a youth psychopath includes someone who only cares about himself and does not have any regard for the thoughts and feelings of others” yielded the following features: “only cares about himself,” “does not have any regard for the thoughts of others,” and “does not have any regard for the feelings of others.”

Once the narratives were coded into features, each coder was trained to assign the feature to a characteristic. This part of training included educating coders on the various characteristics present on the Rating Scale by providing examples. On the Rating Scale, for example, a callous individual was described as someone who was “ruthless and uncompassionate towards others and was generally unconcerned about how his actions affected others.” Hence, the feature “someone who does not care about the feelings of others” was coded under the characteristic of “callousness.” Features that did not match an existing characteristic were coded under a characteristic entitled “unique.” A detailed account of feature coding is provided in the data analysis section for the FEI.

Once this part of training was complete, each coder independently coded the FEI of a randomly chosen participant. Interrater reliability was assessed using Kappa. A Kappa of .70 or above was considered satisfactory. Kappa was chosen because it is a conservative statistic that corrects for chance agreements. Until the desired Kappa (.70 or
greater) was received, coders jointly examined the FEI to discuss agreements and
disagreements. Discrepancies were resolved by the primary researcher. Once the desired
Kappa was received, the training concluded and coders were randomly assigned FEIs to
code. Reliability was checked periodically to ensure coding consistency. Reliability for
this phase was checked for 3 of 40 cases (Kappa .88, .89, and .91).

Following this phase, coders sorted unique features into new characteristics. This
procedure is described in the data analysis section of the FEI. Once coders were trained in
this method of unique feature coding, each coder independently coded the FEI of a
randomly chosen participant. Until the desired Kappa (.70) was received, coders jointly
examined the FEI to discuss agreements and disagreements. Discrepancies were resolved
by the primary researcher. This time, all features on the FEI were assigned to a
characteristic, so no characteristics were labeled “unique.” Once the desired Kappa was
received, training concluded and the coders were randomly assigned FEIs to code.
Reliability was checked periodically to ensure coding consistency. Reliability for this
phase was checked for 10 of the 40 cases (Kappa .80-.94).

The Rating Scale

Clinicians were required to read each item on the Rating Scale and rate each item
with respect to its importance to their concept of youth psychopathy. Ratings were
provided on a 5-point prototypicality scale (1 = extremely important, 2 = mostly
important, 3 = somewhat important, 4 = somewhat unimportant, 5 =mostly unimportant).
The Ranking Scale

Clinicians were required to read each of the 21 items on the Ranking Scale and rank each item in order of highest to lowest importance to their conception of youth psychopathy (1 = highest importance, 21 = lowest importance).

Data Analysis

To determine a consensus prototype, expert and non-expert responses were analyzed separately. If group differences emerged, a separate prototype was to be generated for experts and non-experts. If no group differences emerged, expert and non-expert responses were to be combined into one group to generate one prototype. A similar approach was taken to address the secondary aims.

Analyzing the FEI

The FEI narratives can potentially generate an infinite amount of information that must be reduced to manageable pieces of information (i.e., features). To determine the nature of features associated with clinicians' prototypes, a qualitative data analysis of clinicians' open-ended responses to the FEI was performed. The N5 software package for qualitative analysis was used to conduct this analysis (Richards, 2000). N5 addresses non-numerical and unstructured data and provided an efficient means to code FEI features. The 10 characteristics initially addressed on the Rating Scale were used to explore FEI data. To prepare the data for N5, features were transferred into text documents. FEI features that matched any of the 10 characteristics were coded as such. Unique features that did not match any of the 10 characteristics were coded under a
characteristic entitled “unique” (see Eno-Louden, 2003). This procedure was conducted by two trained coders and interrater reliability was assessed using Kappa.

Two trained coders examined unique features to condense and label them into new characteristics. The procedure for this process was similar to that used by Skeem and Golding (2001). First, to reduce the number of features to a manageable set, two coders combined any feature that “meant the same thing” into one characteristic. Labels were then assigned to these characteristics using N5. This software allowed for the development of new categories. The development of labels was based on participants’ natural language and judgment about the meaning of each feature. Interrater reliability was checked using Kappa. The primary researcher resolved any disagreements.

Once data were coded, N5 provided tallies for the number of times a feature corresponding to a characteristic was reported, whether a participant endorsed a characteristic (yes/no), and how many features were elicited by less than 5% of participants. The latter were considered idiosyncratic and discarded. Lastly, N5 exported these coding patterns for further statistical analysis such as chi-square, which was used to evaluate differences between experts and non-experts with respect to the number of participants who endorsed a feature.

Identifying Top Rated Features on the Rating Scale

Mean ratings were derived for each feature on the Ratings Scale for the expert group and non-expert group. A multivariate analysis of variance was conducted to evaluate differences between expert and non-expert group ratings.
Identifying Top Ranked Features on the Ranking Scale

Mean rankings were derived for each feature on the Ranking Scale for the expert group and the non-expert group. Mann-Whitney U test for ranked data was used to evaluate differences between expert and non-expert group rankings.

Identifying the Consensus Prototype

Lastly, a “consensus” list of characteristics relevant to clinician prototypes was generated. FEI characteristics endorsed by 60% or more of participants were chosen. These characteristics were included on the consensus prototype. To maintain a balance across measures, an equal number of characteristics assigned highest importance on the Ranking and Rating scales were chosen. A combination of these characteristics generated the consensus prototype.
CHAPTER 4

RESULTS

Feature Elicitation Instrument

In the expert group, N5 detected 308 features and 38 characteristics once the features were condensed and labeled. The number of experts endorsing each characteristic is presented in Table 1. In the non-expert group, N5 generated 296 features and 26 characteristics once the features were condensed and labeled. The number of non-experts endorsing each characteristic is presented in Table 2.

To determine group differences, separate chi-square tests were conducted on each characteristic. No statistically significant differences between expert and non-expert groups were evident for any of the characteristics. As a result, expert and non-expert groups were combined to generate one overall prototype. With the combined data, N5 detected 543 features and 26 characteristics once the features were combined and labeled. The number of clinicians (experts and non-experts) endorsing each characteristic is presented in Table 3.

Rating Scale

Means and standard deviations of ratings for each feature on the Rating Scale for the expert group, non-expert group, and combined group are presented in Table 4. Multivariate tests of analyses of variance (MANOVA) revealed no differences in expert

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and non-expert ratings. No statistically significant differences were found between groups for ratings of psychopathy features. Univariate analysis of variance (generated by the MANOVA) for each feature also yielded no significant findings.

**Ranking Scale**

Means and standard deviations of the rankings for each feature on the Ranking Scale for the expert group, non-expert group, and combined group are presented in Table 5. Mann-Whitney U was used to evaluate differences in expert and non-expert rankings for each feature. Three features, “does not get nervous,” “engages in instrumental violence,” and “engages in a variety of criminal behaviors,” were ranked significantly higher by non-experts than experts. However, these differences were not considered significant once a Bonferroni correction was applied to correct for Type I error.

**Consensus Prototype**

Lastly, a “consensus” list of characteristics relevant to clinician prototypes was generated. Three FEI characteristics were endorsed by 60% or more participants. Specifically, clinicians endorsed callousness (75%), conning (70%), and egocentricity (60%). These features were chosen for the consensus prototype. Three features with highest means on the Rating and Ranking Scales were thus chosen. The characteristics corresponding to these features on the Rating Scale included callousness, lack of guilt, and conning. Mean ratings for these were 1.50, 1.55, and 1.77, respectively. The characteristics corresponding to the highest ranked features on the Ranking Scale included lack of guilt, callousness, and conning. Mean rankings for these were 5.40, 5.50, and 6.00, respectively. The resulting consensus prototype thus included conning, callousness, egocentricity, and lack of guilt.
Unique Characteristic Elicitation

Of the 26 FEI characteristics detected by N5 from the combined expert and non-expert group, 15 were unique characteristics (see Table 6). These characteristics were not addressed by the 10 characteristics on the Rating and Ranking Scales. In addition to the 26 characteristics, N5 detected 14 idiosyncratic features endorsed by less than 5% of the participants. These features were discarded.

Personality Versus Behavior Characteristics

Of the 26 characteristics detected by N5 from the combined expert and non-expert groups, only seven addressed behavior disturbances (violence, instrumental, reactive, criminal behaviors, behavior problems, impulsivity, and sexual misconduct). The remainder (19) pertained to disturbances in personality.
CHAPTER 5

DISCUSSION

This study was designed to identify a consensus prototype using clinicians' conceptions of youth psychopathy. The study assessed whether clinicians' prototypes differed from extant conceptions and whether clinicians emphasized personality or behavioral characteristics as central to youth psychopathy. A combination of bottom up and top down measures provided a consensus prototype that consisted of four characteristics: conning, callousness, egocentricity, and lack of guilt. In addition, unique characteristics not addressed on the Rating and Ranking Scales were generated. Lastly, results indicated that psychopathy was generally considered more a deficit in personality than a disturbance in behavior.

Primary Aim

To identify a consensus prototype, expert and non-expert responses were initially compared. Given the lack of group differences, expert and non-expert responses were combined to generate one consensus prototype. The lack of group differences may suggest that the construct of psychopathy has been integrated into clinical knowledge at a level that dilutes any such differences. The fact that experts and non-experts have similar conceptions could indicate that a reliable and valid definition was reached by this study.
However, similarity in conceptualizations could also indicate that a common definition for adults has become generally accepted and simply applied to adolescents. Psychopathy is a relatively rare disorder that purportedly exists in 1-2% of the general population (Hare, 1991; Hart & Hare, 1989). Hence, there may not be a large number of clinicians who have specifically worked with youth displaying psychopathic tendencies.

An alternative explanation for the lack of group differences in this study may be small sample size. Research with larger samples could have revealed differences between the expert and non-expert groups. Additionally, lack of differences could be attributable to an expert group that did not have much experience with psychopathy. Perhaps their level of experience was not sufficient to distinguish them from non-experts for defining psychopathy.

The consensus prototype preliminarily identified several characteristics important to clinicians' conceptions of youth psychopathy. In particular, conning, callousness, egocentricity, and lack of guilt were identified as central to each participant’s prototype. These characteristics represent affective and interpersonal deficits that have been considered essential to psychopathy by several generations of researchers and theorists. For example, conning, callousness, egocentricity, and lack of guilt are similar to Cleckley's (1964) descriptions of untruthfulness and insincerity, specific lack of insight, pathological egocentricity and incapacity for love, and lack of remorse or shame, respectively.

Conning, callousness, and lack of guilt are also represented on the factor relevant to personality characteristics on major psychopathy measures (e.g., PCL, PCL-R, PCL-YV, APSD). Other researchers have also cited the role of emotional deficits to identify
youth who display psychopathic tendencies. Individuals displaying callous and unemotional tendencies have been recognized as pathologically egocentric (Cleckley, 1941; Widiger & Lynam, 1998) and devoid of moral reasoning (Norma, Jonas, & Kohlberg, 1976). Additionally, these individuals tend to lack appreciation for the perspective of others (Blair, Jones, Clark, & Smith, 1995), use others for personal gain without considering their feelings or welfare (Widiger & Lynam, 1998), and are generally undeterred by their victim’s pain and distress (Saltaris, 2002). Previous findings suggest that the four characteristics identified in the current study may indeed represent core features related to youth psychopathy.

Secondary Aims

*Unique Characteristic Elicitation*

Findings from clinicians’ FEI responses suggested that participants provided several characteristics that did not overlap heavily with characteristics addressed on the Rating and Ranking Scales. These findings indicate that clinicians’ conceptions of youth psychopathy differ from extant conceptions based on downward extensions of adult criteria. For example, characteristics such as egocentricity, defensiveness, and lack of conscience were unique characteristics generated by clinicians that were not addressed on Rating and Ranking Scale items. Egocentricity was an essential trait in Cleckley’s (1964) description of psychopathy, but was one of many traits excluded in Hare’s (1991) operationalization of the construct based on institutional populations (Rogers, 1995). The identification of unique characteristics in the current study may suggest that clinicians use diagnostic criteria that parallel original conceptualizations of psychopathy based on
clinical observations. In addition, clinicians may be using characteristics not recognized in the empirical literature.

Such findings are consistent with Genero and Cantor (1987), who suggested that clinicians could be aware of additional features not realized in extant research. Unique features in the current study may indicate a need to revise the classification system based on current literature. This revision could better reflect the description of youth psychopathy as conceptualized and potentially utilized by clinicians in this study.

In related fashion, four characteristics were found most salient to the construct of youth psychopathy as described by clinicians in the current study, but the presence of other characteristics could indicate potential heterogeneity in the presentation and manifestation of youth psychopathy. For example, evidence of fearlessness and an inability to form meaningful relationships during adolescence are considered risk factors for future psychopathy (Blair, 1999; Frick, 1999; Loney et al., 2003). Similarly, youth who display instrumental violence have been found to display emotional deficits cardinal to psychopathy such as callousness and lack of empathy (Barry et al., 2000; Pardini, Lochman, & Frick, 2003). However, clinicians in this study assigned a low degree of importance to these characteristics across the three measures. Such discrepancies could indicate within group differences in the adolescent population. Hence, if results of this study were to be generalized, clinicians and researchers should be made aware of not only the four consensus characteristics but of potential heterogeneity in youth who display psychopathic tendencies.
Personality Versus Behavior Characteristics

In this study, participants were more likely to endorse characteristics relevant to personality disturbances than behavior disturbances. Additionally, few participants reported that character disturbances associated with psychopathy were different from and considerably more severe than behavior disturbances described in the DSM-IV (e.g., conduct disorder, impulsivity, and attention problems). While behavior disturbances may be important, these characteristics seem less essential to clinicians' conceptualizations of male youth psychopathy. Such results are consistent with seminal works by Cleckley (1964) and several other theorists (Blackburn, 1988; Epstein, 1979; Lilienfeld, 1994; Millon, 1981) who considered psychopathy to be a personality disorder. These researchers and theorists did not consider behavior characteristics such as violence and criminality to be essential to psychopathy. Rather, these theorists considered behavior features to be either consequences of interpersonal and affective deficits inherent to psychopathy or symptomatic manifestations that could reflect psychopathy as well as other disorders.

Behavior features such as impulsivity and criminal versatility were important to Hare's (1991) conception of adult psychopathy. Since their introduction to the construct, however, behavior features have been criticized for hindering diagnostic clarity for psychopathy (Lilienfeld, 1994), especially in relation to youth psychopathy. For example, youth psychopathy measures have been criticized for using criteria such as impulsivity and parasitic lifestyle because such features have been considered normative during youth (Salekin et al., 2001). Furthermore, characteristics consistent with conduct disorder and delinquency are considered unsuitable identifiers for youth psychopathy because
these features are transient during adolescence. More than 50% of youth displaying delinquent and criminal behaviors desist from these activities by the time they reach adulthood (Forth & Burke, 1998; Forth & Mailloux, 2001; Lahey et al., 1993; Lynam, 1996).

Furthermore, most research conducted to validate measures of youth psychopathy has been conducted on behavior disordered and incarcerated youth (e.g., Brandt et al., 1997; Forth, 1995; Lynam, 1997; Salekin et al., 2004). Overreliance on behavior features has raised construct validity concerns about whether these measures falsely identify behavior disordered youth as psychopathic or if psychopathic youth possess virulent behavior and conduct disordered traits (Burns, 2000). Hence, behavior features do not appear to be reliable predictors of psychopathy. Findings from the current study seem to redirect the emphasis to personality traits over behavioral characteristics in relation to youth psychopathy and indicate that personality characteristics may be more accurate identifiers of youth psychopathy.

Developmental Considerations

Results from this study may also address issues related to using downwardly extended adult criteria to identify youth with psychopathic tendencies. The four characteristics represented on the youth psychopathy consensus prototype are considered important to adult psychopathy as well. Other traits considered central to adult psychopathy (e.g., grandiosity, shallow affect, and superficial charm) (Hare, 1991) and good discriminators of adult psychopathy (e.g., impulsivity and sensation seeking) (Cooke & Michie, 1997) were endorsed by fewer participants as important to youth psychopathy on the FEI. Such findings suggest that adult criteria are of some relevance to
youth psychopathy and indicate that continuity may exist between fledgling and adult psychopathy. However, due to maturational differences, the importance of each trait may differ between the two age groups. In other words, characteristics that predict psychopathy may differ over time. Certain traits (e.g., grandiosity, superficial charm) may manifest during youth but not be considered central to psychopathy until adulthood.

A related explanation for these symptomatic differences could be that traits considered essential to adult psychopathy may be normal during adolescence. Such results seem inconsistent with the notion that adult models can simply be extended downward to youth. Hence, caution should be used when applying downward extensions of adult criteria to identify youth with psychopathic tendencies. Failure to consider such normative trends may identify a disproportionate number of youth as psychopathic (Cleckley, 1964). Given that clinicians in the current study allotted greater prominence to some characteristics over others may suggest that clinicians were aware of normative developmental trends. Clinicians may have assigned a lower degree of importance to developmentally inappropriate characteristics and a higher degree of importance to traits more likely to be stable and pervasive.

Future Implications

The consensus prototype identified in this study is consistent with prior research that cites the importance of affective and interpersonal deficits as central to psychopathic personality disorder. This study was the first to systematically investigate clinicians' views on the construct of youth psychopathy and generate a construct based on theory-driven conceptions. Further research should substantiate these results with a larger and
more diverse sample of clinicians. Given that the consensus prototype identified in this study was for male psychopathy in particular, future studies should also investigate whether similar traits emerge for females. Racial and ethnic differences among youth with psychopathic tendencies warrant continued attention as well. Furthermore, different ways to generate clinician prototypes should be explored.

To further evaluate the utility of traits found in this study, cross-sectional research should be conducted with forensic and community-based populations. Also, characteristics obtained in this study could be presented to a focus group of clinicians to solicit their opinions and judgments regarding the importance of these characteristics to youth psychopathy. Given that most studies of youth psychopathy are based on retrospective accounts (Lynam, 1997), longitudinal studies should be conducted to assess the association of the four consensus characteristics (conning, callousness, egocentricity, lack of guilt) with maturational effects to evaluate if these traits remain stable. In addition, the results of this study indicate potential differences between adult and youth psychopathy. Given the negative implications of mistakenly identifying a youth as psychopathic, further efforts are needed to generate developmentally appropriate, accurate criteria to identify youth with psychopathic tendencies.

Such criteria can provide the impetus for generating measurement tools appropriate for identifying psychopathic youth. Use of accurate criteria can help clinicians study the correlation of psychopathy with various psychiatric diagnoses. Furthermore, such criteria can help distinguish psychopathy from comorbid disorders that have been confused with psychopathic tendencies (e.g., conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder). The ability to differentially
diagnose psychopathy from other disorders may reduce the number of institutionalized youth who have been incorrectly diagnosed as psychopathic. Importantly, developing efficient and accurate identification tools may hold important implications for treating youth with psychopathic tendencies. Clear identification criteria can help detect psychopathy at a developmentally malleable period during which treatment can be more effective. In addition, such criteria can guide the development of efficient treatment models suitable for managing a dangerous and pervasive disorder.

Limitations

This study had some notable limitations. First, the sample size was small. Despite efforts to recruit a large and geographically diverse sample, time and budget restrictions limited the study’s response rate. In addition, most participants were recruited via listserves or electronic public directories. Such recruitment procedures may have precluded people who do not subscribe to, or regularly utilize, the particular listserves solicited. Furthermore, whether sample demographics were representative of clinicians nationwide was unclear.

Although the use of electronic questionnaires was the most practical way to conduct this study with practicing clinicians, conditions under which the materials were completed could not be controlled. Clinicians could have consulted sources such as colleagues, the DSM-IV-TR, or a published article rather than their own clinical experience to describe a prototypical youth psychopath. Clinicians’ conceptions may also have been influenced by clients they recently encountered. This could have biased their
conceptualizations of youth psychopathy. Any of these factors could reduce the
generalizability of the study’s findings.

A small sample size also precluded use of statistics such as Model Based Cluster (MC) analyses (Banfield & Rafferty, 1993) that may be more appropriate for identifying a consensus prototype. MC analysis is a procedure that purportedly reveals the presence of a predominant group if one should exist and identifies subgroups (differences in experts and non-experts) and patterns that significantly differ from others (Hicks, Markon, Patrick, & Krueger, in press). Results generated by MC analyses would likely indicate the extent to which a consensus exists among clinicians in relation to categories most relevant to adolescent psychopathy.

In addition, the Ranking Scale required participants to assign ranks to 21 features considered in the literature to be important to youth psychopathy. Clinicians may have found it cumbersome to rank order 21 items and even more difficult to make fine distinctions when assigning importance to one feature over another. Some of these rankings may have been arbitrary. Instead of a ranking scale, more appropriate Q methodology (or Q sorting) may have been more useful. This methodology requires that certain items be rank-ordered as highly important, moderately important, neutral, or least important to psychopathy (see McKewon & Thomas, 1988). Unfortunately, these statistical methods (MC analysis and Q sorting) could not be applied. Lastly, the Ranking and Rating Scales were designed by the researcher, so their psychometric properties were unknown. Despite the primary researcher’s best attempts to include items considered relevant to youth psychopathy, the included features were limited to the researcher’s knowledge and expertise.
Conclusion

The construct of youth psychopathy has been widely debated and even questioned. The existing conceptualization of youth psychopathy rests on notions that psychopathy is a personality disorder and, though identified in adulthood, consists of stable traits that originate early in life. These notions encouraged the development of youth psychopathy measures based on downwardly extended adult criteria and generated a volume of research supporting the use of such criteria to identify psychopathic tendencies in young male offenders. Such practices seem to have created substantial confusion regarding the nature of youth psychopathy. In contrast, the current study aimed to develop a construct based on theory-driven conceptions described by practicing clinicians.

This study was the first to systematically investigate the construct of youth psychopathy using clinicians’ opinions. The procedures used in this study were reasonably effective for generating a consensus prototype. The consensus prototype was consistent with personality traits suggested by Cleckley. This study indicates that prototype theory holds promise in furthering our understanding of the manifestations and course of youth psychopathy. Despite the significant limitations of this study, the results appear to hold theoretical and practical implications for future research with respect to the evolving construct of youth psychopathy. Future comparative and longitudinal studies can help determine if traits identified in this study are transient, given the nature of adolescence, or stable and predictive of a later dangerous and pervasive disorder.
APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE:
BACKGROUND SURVEY

I. Demographic Questionnaire: Background Survey

Please provide the following information. All information collected will be kept confidential.

1. Age _______

2. Gender (Place an ‘X’ in the appropriate blank.):
   _______ Male  _______ Female

3. Ethnicity / Race (Place an ‘X’ next to the one which best describes you.)
   ____ African-American  ____ Asian-American  ____ Caucasian
   ____ Hispanic-American  ____ Native American  ____ Other:

4. What is the highest degree you have completed?
   _______Ph.D
   _______Psy/D
   _______JD/PsyD
   _______JD/PhD
   _______Ed.D
   _______Other

5. How long have you been a practicing psychology?
   _______ Years _______ Months

6. Your professional orientation is primarily in
7. Your main employment setting could best be described as: (Choose only one.)

- Private Practice
- Forensic Hospital
- Prison / Correctional Setting
- Court Clinic
- Research organization
- Academic
- Community Mental Health Center
- Medical Hospital
- Rehabilitation Hospitals
- Other (please specify)

8. Which of the following groups do you primarily work with

- Children
- Adolescents
- Families

9. Please check the types of adolescents (ages 13-17) you have worked with

- Conduct Disorder
- Attention Deficit Disorder
- Oppositional defiant disorder
- Psychopathic personality disorder

Thank you for completing this questionnaire. Please proceed to the next section.
APPENDIX B

FEATURE ELICITATION QUESTIONNAIRE

II. Feature Elicitation Questionnaire (FEI)

We are interested in your conception of a prototypic male adolescent (who will mature into, an adult psychopath. By “prototypic” we mean the adolescent who best represents future psychopaths as a group. Based on your experiences as a clinician please list the features that are most distinguishing of male adolescent psychopaths who are 13-17 years of age.

We encourage you to not restrict yourself to literary conceptions of this disorder. You may use your file and or interview notes.

First, take a few minutes to form a mental image of the prototypic male psychopath as an adolescent. You may have encountered such an individual during the course of your profession (e.g., during treatment or assessment). By mental image we do not mean a strict visual image, rather we would like you to bring to mind as complete, detailed and vivid of a mental representation of this person as you can.

Next, describe your conceptions in the space provided below. Please be as elaborate and candid in your description as possible. Your description may include the youth’s usual patterns of thought, feeling, and behavior, including their interpersonal style. Your descriptions can be framed in terms of tendencies that are present (e.g., this individual is...) or absent (e.g., this individual is not...). Please note that these are rough guidelines; emphasize whatever features are important to your conception.
1. How many of the adolescents that displayed psychopathic tendencies during youth matured into adult psychopaths? ______________________________

2. How many of them were:
   _____ Males  _____ Females

3. What reasons do you have to believe that these individuals matured into adult psychopaths? (Please check all that apply)

   _____ You were in contact with them until adulthood (e.g. they remained your patient
   _____ You tracked their progress
   _____ You heard about them through a reliable source
   _____ This is your personal belief
   _____ Other (Please specify)

4. Do you think such adolescents could be successfully treated?
   YES  NO

   On a scale of 1 to 7, please provide the degree to which you are confident that your features are descriptive of someone who will mature into an adult psychopath.

   1  2  3  4  5  6  7

   1 = very unsure, 4 = somewhat sure, and 7 = very sure

You have reached the end of phase I of the study. We would like to thank you for your patience and cooperation in this study. Please return all the study materials to the researcher. Please be advised that once materials from part 1 are received by the experimenter, you will receive materials for the final part of this study.
APPENDIX C

RATING SCALE

III. Rating Scale

Please read each statement below carefully and mark the appropriate number in terms of how much the statement describes a male adolescent psychopath. Please use the following scale to select your responses:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely</td>
<td>Mostly</td>
<td>Somewhat</td>
<td>Somewhat</td>
<td>Mostly</td>
</tr>
<tr>
<td>Important</td>
<td>Important</td>
<td>Important</td>
<td>Un-important</td>
<td>Un-important</td>
</tr>
</tbody>
</table>

1. He has a condescending and conceited attitude towards others
   1  2  3  4  5

2. He has a sense of being special, extraordinary or exceptional
   1  2  3  4  5

3. He is guarded and untrusting of people
   1  2  3  4  5

4. He can be ruthless and uncompassionate towards others when teasing or bullying them
   1  2  3  4  5

5. He is generally unconcerned about how his actions affect others
   1  2  3  4  5

6. He seems disingenuous and insincere in his interactions with others e.g., when he apologizes or shows interest in someone.
   1  2  3  4  5

7. He is able to provide elaborate justifications in order to minimize the seriousness of his actions
   1  2  3  4  5
8. He manipulates or exploits others for personal gain
   1 2 3 4 5

9. He can lie and deceive easily and skillfully
   1 2 3 4 5

<table>
<thead>
<tr>
<th>Extremely</th>
<th>Mostly</th>
<th>Somewhat</th>
<th>Somewhat</th>
<th>Mostly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important</td>
<td>Important</td>
<td>Important</td>
<td>Un-important</td>
<td>Un-important</td>
</tr>
</tbody>
</table>

10. He is undeterred by punishment or reprimand.
    1 2 3 4 5

11. He does not experience nervousness when faced with stressful or aversive situations (e.g., getting caught in a lie or having to experience physical pain).
    1 2 3 4 5

12. He is insensitive to classic fear evoking situations (e.g., heights and loud noises).
    1 2 3 4 5

13. He participates in risky situations (criminal or otherwise) as a form of entertainment. During these activities he is either alone or is the ring leader.
    1 2 3 4 5

14. He is a loner and has not desire to form meaningful attachments with peers or family members.
    1 2 3 4 5

15. He does not experience emotions such as deep sadness or being in love
    1 2 3 4 5

16. He is hypervigilant to aggressive cues, feels threatened easily and reacts aggressively.
    1 2 3 4 5

17. His violence or aggression is motivated by a specific need (e.g., revenge or to
establish control)

18. He rarely feels guilty even after causing others serious harm.

19. He has a "people get what they deserve" attitude about having hurt people either emotionally or physically

20. Early onset of delinquency.

21. Versatile in his criminal endeavors e.g. could be involved in various crimes such as robbery, arson, possession of weapons, theft, use and sales of illicit substances.

Thank you. This concludes this phase of the study. Please move on the next section and complete the questionnaire listed.
APPENDIX D

RANKING SCALE

IV. Ranking Scale:

This scale consists of 22 features that have been considered relevant to the concept of adolescent psychopathy at one time or another. Because of your clinical experience in working with child and adolescent populations we are interested in your views about what features would be cardinal to identifying an adolescent who displays psychopathic tendencies during adolescences (ages 13-17), and is sure to mature into an adult psychopath. Please take 10-15 minutes to rank the items provided in the order of most to least importance in relation to your conceptions of male adolescent psychopathy.

First we would like you to take a few minutes and form a mental image of the prototypical adolescent psychopath. You may have encountered such an individual during the course of your profession (e.g., during treatment or assessment). By mental image we do not mean a strict visual image, rather we would like you to bring to mind as complete, detailed and vivid of a mental representation of this person as you can. Your conception may include the youth’s personality traits, interpersonal interaction style (e.g., how they relate to peers, parents), emotional capacity, and behavior problems.

Please do not restrict your conceptions of literary accounts. Remember we are interested in your conceptions. You are encouraged to use file information if available.

Second when you have a mental representation of such an individual please follow the steps to provide us with your rankings:

Please read each and every item on the list. Then rank these items in the order of importance to male youth psychopathy.

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>Rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early onset of delinquency</td>
<td></td>
</tr>
<tr>
<td>Participates in risky situations (criminal or otherwise) as a form of entertainment. During these activities he is either alone or is the ring leader</td>
<td></td>
</tr>
</tbody>
</table>

77
<table>
<thead>
<tr>
<th>He rarely feels guilty even after causing others serious harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>He is hypervigilant to aggressive cues, feels threatened easily and reacts aggressively</td>
</tr>
<tr>
<td>He does not experience emotions such as deep sadness or being in love.</td>
</tr>
<tr>
<td>He manipulates or exploits others for personal gain</td>
</tr>
<tr>
<td>He does not experiences nervousness when faced with stressful or aversive situations (e.g., getting caught in a lie, having to experience physical pain)</td>
</tr>
<tr>
<td>His violence or aggression is motivated by a specific need (e.g., revenge, to establish control)</td>
</tr>
<tr>
<td>He has a “people get what they deserve” attitude about having hurt people either emotionally or physically.</td>
</tr>
<tr>
<td>He seems disingenuous and insincere in his interactions with others (e.g., when he apologizes, or shows interest in someone)</td>
</tr>
<tr>
<td>He can be ruthless and uncompassionate towards others when teasing or bullying them</td>
</tr>
<tr>
<td>He is guarded and untrusting of people</td>
</tr>
<tr>
<td>He has a condescending and conceited attitude towards others</td>
</tr>
<tr>
<td>He is generally unconcerned about how his actions affect others</td>
</tr>
<tr>
<td>He is able to provide elaborate</td>
</tr>
</tbody>
</table>
justifications in order to minimize the seriousness of his actions

He is a loner and has no desire to form meaningful attachments with peers or family members

He can lie and deceive easily and skillfully

He is versatile in his criminal endeavors (e.g., could be involved in various crimes such as robbery, arson, possession of weapons, theft, use and sales of illicit substances)

He is undeterred by punishment or reprimand

He is insensitive to classic fear evoking situations (e.g., heights and loud noises)

He has a sense of being special, extraordinary or exceptional

This concludes the study. We would like to thank you for your patience and cooperation with this project. Please return the study materials to the researcher.
### Table 1

**FEI responses generated by experts**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of features reported</th>
<th>Percentage of experts endorsing a characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Callousness</td>
<td>27</td>
<td>70</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>22</td>
<td>65</td>
</tr>
<tr>
<td>Conning</td>
<td>20</td>
<td>55</td>
</tr>
<tr>
<td>Grandiosity</td>
<td>13</td>
<td>50</td>
</tr>
<tr>
<td>Shallow Affect</td>
<td>24</td>
<td>50</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>27</td>
<td>50</td>
</tr>
<tr>
<td>Lack of Guilt</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td>Superficial Charm</td>
<td>18</td>
<td>40</td>
</tr>
<tr>
<td>Defensiveness</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Criminal Behavior</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Family and Peer</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Influences</td>
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<td></td>
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80

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<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Different from DSM-IV Disorders</td>
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<td></td>
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<tr>
<td>Early Childhood Pathology</td>
<td>4</td>
<td>20</td>
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<tr>
<td>Sexual Misconduct</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Instrumental</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Conscience</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Sensation - Seeking</td>
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<td>15</td>
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<tr>
<td>Lack of Anxiety</td>
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<td>10</td>
</tr>
<tr>
<td>Fearlessness</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Cynical</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Violence</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Inconsistent Behaviors</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Responsiveness to Treatment</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

81
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disordered</td>
<td>1</td>
</tr>
<tr>
<td>Attachment</td>
<td>5</td>
</tr>
<tr>
<td>Above Average Intelligence</td>
<td>1</td>
</tr>
<tr>
<td>Worried Behaviors Will Not Change</td>
<td>5</td>
</tr>
<tr>
<td>Caricatures of Adult Views</td>
<td>1</td>
</tr>
<tr>
<td>Average Cognitive Abilities</td>
<td>5</td>
</tr>
<tr>
<td>History of Learning Disorders</td>
<td>1</td>
</tr>
<tr>
<td>Takes Psychotropic Medications</td>
<td>5</td>
</tr>
<tr>
<td>Suicidal Tendencies</td>
<td>1</td>
</tr>
<tr>
<td>More Attractive than Most</td>
<td>5</td>
</tr>
<tr>
<td>Is Sexually Active</td>
<td>1</td>
</tr>
<tr>
<td>Like Other Serial Killers</td>
<td>5</td>
</tr>
<tr>
<td>Often Resourceful</td>
<td>2</td>
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</table>

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Attempt at Normal Behavior
Table 2

**FEI responses generated by non-experts**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of features reported</th>
<th>Percentage of non-experts endorsing a characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conning</td>
<td>38</td>
<td>85</td>
</tr>
<tr>
<td>Callousness</td>
<td>55</td>
<td>80</td>
</tr>
<tr>
<td>Grandiosity</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Lack of Guilt</td>
<td>19</td>
<td>50</td>
</tr>
<tr>
<td>Shallow Affect</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Lack of Conscience</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Criminal Behavior</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Superficial Charm</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Defensiveness</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Lack of Anxiety</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Fearlessness</td>
<td>4</td>
<td>15</td>
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<table>
<thead>
<tr>
<th>Category</th>
<th>Value 1</th>
<th>Value 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Peer Influences</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Disordered Attachment</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Above Average Intelligence</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Violence</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Reactive</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Instrumental</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Responsiveness to Treatment</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Early Childhood Pathology</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Sexual Misconduct</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Often Resourceful</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Cynical</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Number of features reported</td>
<td>Percentage of respondents endorsing a characteristic</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Callousness</td>
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<td>75</td>
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<tr>
<td>Conning</td>
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<td>70</td>
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<tr>
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<tr>
<td>Lack of Guilt</td>
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<tr>
<td>Superficial Charm</td>
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<tr>
<td>Behavior Problems</td>
<td>32</td>
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<tr>
<td>Negative Affect</td>
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<td>28</td>
</tr>
<tr>
<td>Lack of Conscience</td>
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<td>28</td>
</tr>
<tr>
<td>Criminal Behaviors</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Family and Peer Influences</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Lack of Anxiety</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>Fearlessness</td>
<td>4</td>
<td>20</td>
</tr>
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### Table 4

**Means and standard deviations for Rating Scale**

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<td>2.56 (1.30)</td>
<td>2.72 (1.41)</td>
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<tr>
<td>Is guarded</td>
<td>3.06 (1.41)</td>
<td>2.44 (1.32)</td>
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<td><strong>Calmousness</strong></td>
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Table 6

Unique Characteristics

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Publications:


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Committee Member, Dr. Marta Meana, Ph.D.
Graduate Faculty Representative, Dr. Joel Lieberman, Ph.D.