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REBELS WITH A CAUSE:

AN EMPIRICAL STUDY INTO THE AFFECTIVE AND INTERPERSONAL DYNAMICS OF PSYCHOPATHIC BEHAVIOR AND THE LIVED EXPERIENCE OF PSYCHIATRIC LABELS IN YOUTH

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Voor mama,

Nooit is er een voor de beschaving bepalende waarde geweest
die niet iets van vrouwelijkheid inhield, van zachtheid,
compassie, geweldloosheid en gerespecteerde zwakheid…
De eerste relatie tussen een kind en de beschaving is zijn relatie
tot zijn moeder.

Romain Gary, *La nuit sera calme*

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1

General Introduction

In this introductory chapter we discuss the history and the current debates concerning the concept of juvenile psychopathy. More specifically, we give a concise overview of theoretical developments and empirical research about the association between psychopathic traits and internalizing psychopathology in juveniles. Furthermore, we debate some ethical concerns in relation to the assessment of psychopathic traits in youth. Taking into account the limitations of previous research, we subsequently present the research questions, design, measures and samples used in this study. We conclude with an overview of the different chapters presented in this dissertation.

INTRODUCTION

The largest part of what we call 'personality' is determined
by how we've opted to defend ourselves against anxiety and sadness.
— Alain de Botton, *Status anxiety* (2005)

According to psychoanalysis, anxiety is the basic affect of mankind. More than that, it is through primordial anxiety that the infant comes into existence, to acquire language, to develop an identity, and finally to become an individual *in relation to* other human beings (Verhaeghe, 2004). Freud (1978 [1926d]) considered man's reaction to external danger and internal threat (one's own drive impulses causing internal disequilibrium, unpleasure and pain) as a prototype of anxiety. Because of the infant's biological helplessness in relation to its own drives is he forced to appeal to significant others to manage this internal imbalance and to survive. Anxiety emerges when the other's response to the appeal is missing or inadequate (Verhaeghe, 2004). As a consequence, from the beginning, anxiety is related to and emerges within the relationship between the individual and significant other(s).

Most interestingly, one of the key topics in psychopathy research concerns anxiety, or rather the "absence of anxiety." Founders of the current concept of psychopathy generated the initial impetus for the rapidly increasing amount of research on the relationship between psychopathy and (a lack of) internalizing psychopathology, such as mood and anxiety disorders. In particular, Cleckley (1976) includes the absence of nervousness (i.e. trait anxiety) or psychoneurotic symptoms as one of the determining diagnostic criteria for psychopathy. He argues that compared to 'normal,' neurotic persons, psychopaths are characterized by a lack of anxiety disorders, but also by an absence of normal affects, such as tension, worry and emotional distress in response to disturbing everyday situations. Moreover, he postulates that there are no valid signs of depression in psychopathic individuals, they don't experience feelings of shame and remorse, and rarely undertake suicide attempts. In addition, Lykken (1957) designated fearlessness as the primary deficit in psychopathy. In contrast with Cleckley, he proposed that psychopathic individuals exhibit significantly lower levels of fear, but do not differ in levels of trait anxiety.

One of the main objectives of this doctoral thesis is to study the status of anxiety in relation to psychopathy, in particular, by investigating the relationship between internalizing psychopathology and juvenile psychopathy. In addition, we will indirectly consider the potential impact a psychiatric label might have on the identity development of young people.

JUVENILE PSYCHOPATHY: HISTORY OF THE CONCEPT AND CURRENT DEBATES

The 'fledgling' psychopath: a downward extension of its adult counterpart

The concept of child or juvenile psychopathy has a long history. In his seminal text, *The mask of Sanity,* Cleckley (1941) suggested that psychopathy undoubtedly has its roots in childhood. Coeval Karpman (1959), who for many years had been concerned with the study of the lives of adult criminals at the St. Elizabeths Hospital in Washington, organized three symposia[1] for the American Orthopsychiatric Association on the study of psychopathic behavior in infants and youth. In line with Cleckley, Karpman concluded the first round table discussion by stating that there is little doubt that the adult psychopathic individual is the vertical continuation of the psychopathic infant. In an attempt to formulate defining characteristics of the psychopathic child similarities with the adult psychopath were stressed: "The child who presents the behavior described in the adult psychopath, (…), who lacks the ability to develop an affection tie to the therapist and therefore cannot respond to treatment, and who shows no evidence of guilt or anxiety from intrapsychic conflict, may be said to have failed to develop a normal superego and may be called a psychopath" (Karpman, 1959, pp. 41-42). Also McCord and McCord (1956) contended that the child psychopath has the embryonic personality traits (i.e. a lack of anxiety, lack of identifying ability, and a lack of guilt) of adult psychopathy: "His tantrums and delinquencies betray his aggressiveness. His truancies reflect his impulsivity. His cruelties to animals and children reveal his asociality. The child psychopath has little if any – remorse for his diffuse, brutal, usually purposeless activities, and he seems unable to affiliate with other human beings" (p. 99). These early descriptions illustrate how the notion of juvenile psychopathy was mainly a downward extension of the construct of adult psychopathy. In contemporary research on child psychopathy nothing fundamental has really changed on that matter.

Since the 1990s, much research has investigated whether juvenile psychopathy can be defined by the same constellation of traits as its adult counterpart, and whether it is surrounded by a nomological network similar to that of adult psychopathy (Salekin & Lynam, 2010). In our current definition, adult psychopathy represents a distinctive constellation of interpersonal (e.g. superficial charm, manipulative), affective (e.g. callousness, lack of remorse), and behavioral (e.g. impulsivity, irresponsibility) characteristics (Hare, 1991). The ('golden') standard clinical measure for this syndrome in forensic adult settings is Hare's (1991) Psychopathy Checklist-Revised (PCL-R). The PCL-R consists of 20 items that mirror, to a large extent, Cleckley's original set of descriptive criteria for psychopathy (see Table 1). The PCL-R allowed an investigation into the structure of the psychopathy construct through factor analyses (e.g. Edens, Skeem, Cruise, & Cauffman, 2001). Although psychopathy is traditionally treated as a homogeneous and unitary construct, initial factor analysis of the PCL-R generated two separate, but highly correlated factors (see Appendix 1; Hare, 1991). Factor 1 is interpreted as the 'Selfish, callous, and remorseless use of others' and reflects the core affective and interpersonal features of psychopathy (e.g. callousness and lack of empathy, lack of remorse or guilt). Factor 2 represents the 'Chronically unstable and antisocial lifestyle' (e.g. proneness to boredom, irresponsibility).

Cooke and Michie (2001) criticized this two-factor conceptualization of psychopathy through an in-depth review of factor analytic studies of the PCL-R. Based on a reanalysis of several large previously used samples, they proposed a new, three-factor hierarchical model (see Appendix 1). In this three-factor solution the initial Factor 1 (Hare, 1991) was re-conceptualized as two separate factors: i.e. a factor presenting an "Arrogant and Deceitful Interpersonal Style" and a factor termed "Deficient Affective Experience." Factor 3 represents an "Impulsive and Irresponsible Behavioral Style" and is a revision of Hare's (1991) Social Deviant Lifestyle factor.

Table 1

Cleckley's (1976) criteria for psychopathy with corresponding factors from the Four-Factor Model of Hare (2003)

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

Based on supplementary item response theory analyses (Cooke & Michie, 1997) they argued that 7 items from the PCL-R were not strong indicators of the underlying psychopathy construct, but rather epiphenomena of the disorder; i.e., five items that assess antisocial behavior and two items on sexual and relationship history. These items were excluded in the three-factor model of Cooke and Michie (2001). Hare (2003) in turn, refuted the three-factor model and proposed a new model (see Appendix 1), by adding a fourth factor to Cooke and Michie's (2001) model. The fourth factor consists of items concerning antisocial behavior (e.g. criminal versatility, juvenile delinquency).

The development of the PCL-R (Hare, 1991) re-vitalized the research into child and juvenile psychopathy. In particular Lynam (1996, 1997 & 1998), and Frick and colleagues (e.g. Frick, O'Brien, Wootton, & McBurnet, 1994), made great efforts to extend the construct of psychopathy to youth and to 'capture the fledgling psychopath in a nomological net.' Frick et al. (1994) took on the task of validating the construct of child psychopathy by focusing on the presence of callous and unemotional traits (e.g. lack of remorse and

empathy). Factor analysis of their newly developed Psychopathy Screening Device (PSD; Frick et al., 1994)[2] in a sample of 95 clinically-referred children generated two factors; a Callous-Unemotional (CU) factor and an Impulsive-Conduct Problems (ICP) factor. According to Frick et al. (1994) the CU and ICP factors corresponded with the two factors found on the PCL-R (Hare, 1991). Subsequent studies (e.g., Bary, Frick, DeShazo, McCoy, Ellis, & Loney (2000); Frick & Marsee, (2006)) indicated that CU traits are decisive for the identification of high risk groups of antisocial youth, and suggest that conduct disordered youth with CU traits exhibit a range of features consistent with adult psychopathy. Lynam (1997, 1998) elaborated on Frick and colleagues' (1994) work of validating the construct of child psychopathy and concluded, based on his empirical work (Lynam, 1998), that children who combined symptoms of hyperactivity-impulsivity-attention problems (HIA) and conduct problems (CP) most closely resemble psychopathic adults. Based on a systematic construct validation study with his Child Psychopathy Scale[3] (CPS), Lynam (1997) contended that childhood psychopathy fits into the nomological network surrounding adult psychopathy and that children with psychopathic traits, like adult psychopaths, were serious and stable offenders; impulsive; and more prone to externalizing than to internalizing psychopathology. In the same time period, Forth, Hart and Hare (1990) examined the construct of psychopathy in a group of adolescent offenders using a modified version of the PCL-R, eventually resulting in the Psychopathy Checklist: Youth Version (PCL :YV ; Forth, Kosson, & Hare, 2003). The two-scale composition of the PCL :YV (Forth et al., 2003), which is considered as the state of the art method of assessing juvenile psychopathy, is also a direct downward extension of the two-factor PCL-R adult model of psychopathy (Skeem & Cauffman, 2003). In addition, adequate fit results have been attained for both three- and four-factor solutions (see Appendix 1). In sum, these and subsequent studies suggest that 'fledgling psychopaths' are characterized by a similar constellation of interrelated affective (e.g. grandiosity, manipulation), interpersonal (e.g. callousness, lack of remorse), and behavioral characteristics (e.g. impulsivity, irresponsibility) to that of adult psychopaths (e.g. Vasey, Kotov, Frick, & Loney, 2005). Moreover, an important aspect of the adult psychopathy construct is its relation to externalizing psychopathology in general and antisocial behavior in particular. Several studies with community and referred samples have indicated that in this respect, 'juvenile psychopaths' also share many features with adult psychopaths, such as more persistent, serious and violent antisocial behavior, and an increased risk of recidivism

and institutional infractions (e.g. Brandt , Kennedy, Patrick, & Curtin, 1997 ; Corrado, Vincent, Hart, & Cohen, 2004 ; Frick, Stickle, Dandreaux, Farell, & Kimonis, 2005 ; Salekin, Leistico, Trobst, Schrum, & Lochman, 2005; Stafford & Cornell, 2003; Toupin, Mercier, Dery, Cote, & Hodgins, 1996). On the other hand, to date, the link between internalizing psychopathology and psychopathy is less documented and remains more obscure, in particular among juvenile psychopaths.

The mutually exclusiveness of psychopathy and internalizing psychopathology

As indicated above, several seminal theorists and clinicians (e.g. Cleckley, 1941; Karpman, 1959; McCord & McCord, 1956) believed that both adult and juvenile psychopathy is characterized by a profound absence of anxiety and connected to a lack of intra-psychic conflict. Lykken (1957) supplemented these theories by proposing a low-fear hypothesis, suggesting that psychopathic individuals have lower levels of fear but do not differ in their levels of trait anxiety. These original theories are resumed and nuanced in more recent models on the relationship between psychopathy and internalizing psychopathology. For example, based on experimental studies, Patrick and colleagues (e.g. Patrick, 1994; Patrick, Bradley, & Lang, 1993) argue that startle or fear could be critical to understanding the etiology of psychopathy in adults. In addition, some contemporary researchers claim that psychopaths may experience 'context specific' anxiety (Frick, Lilienfeld, Ellis, Loney, & Silverthorn, 1999; Lilienfeld & Penna, 2001), because they are more exposed to stressful events due to their risk-taking and anti-social behavior and as a consequence experience more negative and distressing outcomes (e.g. criticism of others, incarceration). According to this line of thought, experiences of anxiety in psychopaths would be related to behavioral features (i.e. the Lifestyle and Antisocial Factor) of psychopathy, and not to their personality or temperament as such (e.g. Fowles, 1987; Walker, et al., 1991). More recently, these ideas have been recuperated in the dual deficit model of psychopathy (Corr, 2010; Fowles & Dindo, 2006) which integrates the two-factor model of psychopathy (Hare, 1991) with Gray's Reinforcement Sensitivity Theory of personality (RST; Gray, 1976, 1978, 1979). In sum,[4] the dual deficit theory posits that the Interpersonal/Affective Factor of psychopathy (Hare, 1991) is linked to a weak Behavioral Inhibition System (BIS) and a weak Fight-Flight-Freeze-System (FFFS), and thus associated with low anxiety and low fear. On the other hand, it is argued

that the Lifestyle/Antisocial Factor of psychopathy (Hare, 1991) is related to an overactive BAS (Behavioral Activation System) or an inability to regulate approach behavior, and as a consequence positively associated with anxiety and fear. As mentioned above this could be explained by the observation that impulsive and externalizing individuals are more exposed to and 'suffer' from the negative consequences of their risky but rewarding acts. In addition, Corr (2010) stated that psychopathy in general is related to a dysfunctional BIS. However, to-date, there is not a great deal of research in the juvenile psychopathy literature that supports this model. Moreover, in general, research into the association between juvenile psychopathy and internalizing psychopathology has produced inconsistent results.

For example, Frick and colleagues (1994) found a significant inverse relationship between the CU scale of the Psychopathy Screening Device (PSD; Frick et al., 1994) and teacher reported anxiety in a sample of 95 clinically-referred children (age 6-13 years). Similarly, in a sample of 430 non-referred boys, Lynam (1997) found that total scores on the Child Psychopathy Scale (CPS; Lynam, 1997) were negatively correlated with residualized internalizing problems and anxiety, and positively correlated with residualized externalizing problems for both teacher and self-reports. In addition, in a sample of 143 clinically referred children Frick et al. (1999) found that measures of trait anxiety (both self-report and DSM-III-R diagnoses) exhibited consistent positive correlations with the PSD Impulsive-Conduct Problems (I/CP) factor and were uncorrelated or negatively correlated with the PSD CU factor. Self-reported fearlessness was significantly correlated with CU traits after controlling for the presence of conduct problems. In a previous study (cited in Frick, 1998), Frick and colleagues drew similar conclusions, suggesting that when the number of conduct problems increased, children exhibited more emotional distress or anxiety. However, children with similar levels of conduct problems showed less distress when they exhibited more CU traits. Dolan and Rennie (2007) reported that in a sample of 110 male adolescent offenders self-reported Trait anxiety was significantly negatively related to the Affective factor of the PCL:YV, whereas self-reported fear was significantly negatively related with the Antisocial factor of the PCL:YV and the PCL:YV total score. Whereas these studies largely confirm the expected associations between psychopathic traits and internalizing psychopathy, several other studies yield more inconsistent results.

For example, in a sample of 91 male and 123 female detainees, self-reported symptoms of internalizing psychopathology (measured by the Youth Self Report (YSR)) were not significantly related to the *Interpersonal factor* of the PCL:YV. In boys, anxious-depressive symptoms were negatively correlated with the *Affective factor* of the PCL :YV, but internalizing symptoms were unrelated to the *Lifestyle and Antisocial factor*. In girls, self-reported suicidal behavior was significantly and positively related to the *Lifestyle and the Antisocial factor* of the PCL :YV (Sevecke, Lehmkuhl, & Krischer, 2009). Bauer, Whitman, and Kosson (2011), in their turn, reported significant inverse relationships between the *Interpersonal and Affective factor* of the PCL:YV with an interview-based rating of Major depression, but not with Dysthymic disorder and PTSD, and also a positive relationship between the *Lifestyle factor* of the PCL :YV and an interview-based rating of Major depression.

In addition, positive correlations between total PCL:YV scores and self-report measures of negative affect have been found in a sample of 115 adolescent males on probation (Kosson, Cyterski, Steuerwald, Neumann, & Walker-Matthews, 2002) using the Welsh Anxiety Inventory (WAI), in a community-based sample of 130 adjudicated adolescents (Schmidt, McKinnon, Chatta, & Brownlee, 2006) using the YSR, and in a sample of 130 juvenile offenders (Kubak & Salekin, 2009) using the Adolescent Psychopathology Scale (i.e., the APS-Anxiety Scales) and the Personality Assessment Inventory (i.e., the PAI-Fearlesness scale). Positive correlations have also been observed between self-reported total psychopathy scores and self-reported symptoms of internalizing disorders in a sample of 130 adolescent offenders (Salekin, Neumann, Leistico, Dicicco, & Duros, 2004; using the APS). Similarly, Hipwell et al. (2007) reported a positive correlation between parent and teacher ratings of CU traits with parent and teacher ratings of depressive symptoms and negative emotionality, but no significant correlations were observed with parent and teacher ratings of anxiety measures.

In addition, several other studies found no significant correlations at all between total PCL:YV scores and self-reported depression and internalizing problems in a sample of 130 adolescent offenders (Salekin et al., 2004; using the APS), or in a sample of 226 male and female incarcerated adolescent offenders (Campbell, Porter, & Santor, 2004; using the internalizing subscales of the YSR, the Beck Depression Inventory-II (BDI-II) and the Depressive Experiences Questionnaire for Adolescents (DEQ-A)). Furthermore, Bauer et al.

(2011) found that total PCL:YV scores were unrelated to clinical diagnoses of major depressive disorder, dysthimic disorder and posttraumatic disorder, and to self-reported depression (BDI) and anxiety (Anxiety Sensitivity Index (ASI)).

At least two conclusions can be drawn from this concise overview of studies examining the relationship between juvenile psychopathy and internalizing psychopathology. First, few studies have addressed which and how separate dimensions/factors of juvenile psychopathy (i.e. according the three- or four-factor conceptualization of psychopathy) are associated with internalizing psychopathology. Instead, several studies use total psychopathy scores. Second, almost all studies use self-report measures for at least one or both constructs (i.e. psychopathy and internalizing psychopathology). Both aspects might influence the observed relationship between internalizing psychopathology and psychopathy. Therefore, several scholars have argued that the inconsistent findings concerning the relationship between juvenile psychopathy and internalizing psychopathology require additional research using multiple measures for each construct (i.e. psychopathy and internalizing psychopathology) to determine whether the inconsistencies reflect differences among measures versus heterogeneity among youth with psychopathic traits (e.g. Sevecke & Kosson, 2010).

Pursuing the juvenile psychopath: some ethical concerns

Concerning the social reception and implementation of psychopathy research a double tendency can be observed. On the one hand, several scholars call for more research on juvenile psychopathy and for the development of reliable assessment instruments for the purpose of early identification and rehabilitation of high-risk groups of juvenile offenders (e.g. Andershed, Kerr, Stattin, & Levander, 2001; Frick, 2002). On the other hand, several scholars expressed concerns about this trend and express reservations with respect to the use of the diagnosis of psychopathy, in particular in youth. Gunn (2003) and Blackburn (2011) outline how, almost from its inception, the construct of psychopathy became associated with moral judgments such as ‘evil’ and ‘badness’ and with the conviction of 'untreatability'[5]. In addition, Edens, Skeem, Cruise, and Cauffman (2001) argue that, based on their in-depth review of the literature, a diagnoses of juvenile psychopathy has only moderate value in predicting long-term violence and that there is no sound scientific

evidence regarding untreatibilty. Moreover, even if the diagnosis of juvenile psychopathy was a powerful tool in predicting long-term potential for violence and reduced treatment response, Edens et al. (2001) posit that the use of the diagnosis is far from morally neutral. As a consequence, they conclude that the use of psychopathy measures in a juvenile justice setting violates the ethical principles of 'social responsibility' and 'doing no harm.' Confirming these concerns, an experimental study of Vidal and Skeem (2007) demonstrated that juvenile probation officers (n=204) viewed both abused and psychopathic youth as highly challenging cases on a path toward adult criminality, but that they had greater hope and sympathy for abused than psychopathic youngsters. Furthermore, probation officers expected poorer treatment outcomes for psychopathic juvenile offenders, and were stricter, imposing rules and restrictions that were typically not enforced on other juvenile offenders (e.g. placement in correctional facilities). These observations illustrate how a diagnosis of juvenile psychopathy might result in the exclusion of juvenile offenders with psychopathic traits from therapeutic programs. Yet, the negative impact a diagnosis of psychopathy could possibly have on the lived experience and identity development of these juveniles is another ethical issue that still needs to be addressed.

THE CURRENT STUDY: RESEARCH QUESTIONS AND METHODOLOGY

RESEARCH QUESTIONS AND METHODS

The aim of this doctoral dissertation is to investigate the relationship between psychopathic traits and internalizing psychopathology, in particular anxiety, in juveniles. Second, in an indirect way we examine the lived experience of a psychiatric label in youth.

To investigate *the relationship between psychopathic traits and internalizing psychopathology* we follow a mixed method design (Creswell, Plano Clark, Gutmann, & Hanson, 2003) by combining both quantitative and qualitative research methods (see Table 2).

In Chapter Two, Three and Four we adhere a traditional, nomothetic perspective and use quantitative methods to address this relationship. As stated above, several scholars argue that the inconsistent findings concerning the relationship between negative affect and

psychopathy require additional research using multiple measures for each construct (i.e. psychopathy and internalizing psychopathology). We observed that few studies have addressed which *specific* psychopathic traits are associated with internalizing psychopathology and in what direction (i.e. positive or negative). This dissertation addresses these limitations by assessing psychopathic traits and internalizing psychopathology by means of different measurement methods. Moreover, we make use of both total psychopathy scores and scores on the separate psychopathy dimensions. Finally, we study the relationship between psychopathy and internalizing problems indirectly with respect to defense mechanisms. The research questions we address are as follows:

- Can the Youth Psychopathic Traits Inventory (YPI) and its short version (YPI-S) be used as a valid and reliable instrument for the measurement of psychopathic traits in youth?
- What is the relationship between the different dimensions of psychopathy and internalizing psychopathology?

  * For reasons mentioned in the introduction, we hypothesize that the Interpersonal and Affective dimensions of juvenile psychopathy are negatively related to symptoms of negative affect. On the other hand, the Lifestyle and Antisocial dimensions of psychopathy are positively related to symptoms of internalizing psychopathology. In addition, we hypothesize that these associations will be more strongly negative (or positive) with an interview measure for internalizing psychopathology, compared to self-report measures.

  * We also hypothesize that subgroups of youngsters with more psychopathic traits have less internalizing psychopathology than those with less psychopathic traits, and that this is especially true for those with high scores on the Interpersonal/Affective dimension of psychopathy. Those with high scores on the Lifestyle/Antisocial dimension of psychopathy are expected to have more internalizing problems.
- What is the relationship between psychopathic traits and defense mechanisms?

  * We hypothesize that higher levels of immature defense mechanisms are associated with higher levels of psychopathic traits in adolescents.

Subsequently, in Chapters Five and Six we adhere an ideographic perspective and use qualitative methods to address the relationship between juvenile psychopathy and

internalizing psychopathology. In the introduction we discussed that from a psychoanalytic perspective anxiety is related to and emerges within the relationship between an individual and his/her (interpersonal) context. As a consequence, in order to develop a psychoanalytically-based understanding of the nature and dynamics of an individual's anxiety or more broadly his/her emotional life, these should be studied within the context of his/her interpersonal relationships. Moreover, in order to develop a theory-consistent in-depth understanding of anxiety and interpersonal relations we take into account the meanings and motives people give to their own acts. This is the starting point for Chapters Five and Six. In these chapters we address the relationship between psychopathic traits and negative affect through an in-depth analysis of the affective and interpersonal experiences of juvenile delinquents with psychopathic traits. By means of a single case study and a thematic analysis of interview narratives of 15 juvenile delinquents, the following research questions are addressed:

- How are affects experienced by juvenile delinquents with psychopathic traits?
- How do (significant) others emerge within the narratives of juvenile delinquents with psychopathic traits?
- Which modes of functioning and interrelating are used by these juveniles to deal with (significant) others?

In our final chapter we investigate the impact that a psychiatric diagnosis might have on the lives of youngsters with a psychiatric label. We discussed in our introduction that a diagnosis of juvenile psychopathy is far from morally neutral in content and how it might result in the exclusion of juvenile offenders from therapeutic programs. We suggested that the effect that a diagnostic label of juvenile psychopathy has on the individual is another issue that must be addressed. As the adolescents in our referred sample were not made aware of their psychopathy score[6], it was not possible to address this issue in our study. Alternatively, in a sample of conduct disordered adolescents[7], we used the case example of Attention-Deficit Hyperactivity Disorder to examine the effects that diagnostic labels have on the lived experiences of juveniles.

Table 2

Research design

	The first cluster of research questions addresses: ▪ the relationship between psychopathic traits and internalizing psychopathology ▪ the way in which the method of measuring symptoms influences this relationship	**The second research question is:** How do (negative) affects emerge and how are they experienced within the interpersonal relationships of juvenile delinquents with psychopathic traits?	**The third research question is:** What effects do diagnostic labels and standardized treatment techniques have on the lived experience of juveniles?
Research paradigm & perspective	Post-positivistic Nomothetic	Constructivistic Ideographic	Constructivistic Ideographic
Research method	Quantitative: ▪ Confirmatory Factor Analysis ▪ Analyses of correlations ▪ Linear regression analyses	Qualitative: ▪ Thematic analyses of interview narratives ▪ Single Case study	Qualitative: ▪ Thematic analyses of interview narratives
Samples	▪ Community sample of adolescents (n = 1670) ▪ Referred sample of juvenile delinquents (n = 62)	Referred sample of juvenile delinquents	Mixed sample of conduct disordered youth with a diagnosis of ADHD
Chapter in dissertation	2, 3 & 4	5 & 6	7

PARTICIPANTS AND PROCEDURE

We used three different samples to address the research questions outlined above; a community sample of adolescents, a referred sample of juvenile delinquents and a 'mixed sample' of adolescents with conduct problems.

Community sample

The community sample (Chapters Two, Three, and Four) consisted of 1670 non-referred adolescents (57.8% girls) with a mean age of 14.63 years (*SD* = 1.83). The participants were recruited from 10 secondary schools (both rural and urban) in Flanders

(Belgium). In terms of type of education, 20.8% attended a special needs secondary school; 2.3% vocational; 9.2% technical and 67.8% a general secondary school. The data from 20 adolescents were excluded because of more than 5% of missing values for one or more measures, resulting in the final sample of 1670 participants.

Referred sample

The referred sample (Chapters Two, Three, and Five and Six) is composed of 62 male juvenile delinquents with a mean age of 15.71 years (*SD* = 1.23). The adolescents were recruited in two ways; (a) through referral by the juvenile court, and (b) through follow-up in a six-month residential treatment program for juvenile delinquents in Flanders. With regard to type of education, 12.9% attended a special needs secondary school; 66.1% vocational; 19.4% technical and 1.6% a general secondary school. The data from 4 adolescents were excluded because more than 5% of their YPI-S scores were missing, resulting in the final sample of 62 participants.

Participants recruited from the institution for juvenile delinquents were followed up for six months within the institution. For 34 of these participants we investigated (see Table 3) whether institutional misconduct and therapy progress were significantly associated with the amount of psychopathic traits[8]. There were no significant correlations between psychopathic traits and violent behavior[9] in the institution and serious violations of the institution rules[10] (e.g. committing offenses outside the institution in the outpatient phase, smuggling of prohibited goods). Minor violations[11] (e.g. missed appointment with the psychologist, rude table manners) and number of therapy relapses[12] (e.g. relapse to a lower level in the program) were only significantly correlated with the Lifestyle and Antisocial dimensions of the PCL:YV. Additionally, minor violations of the institution rules were significantly related to PCL:YV total scores.

Table 3

Correlations between scores on the Psychopathy Checklist: Youth Version (PCL:YV), Institutional Misconduct and Therapy progress

		PCL:YV					
	n	**Interpersonal**	**Affective**	**Lifestyle**	**Antisocial**	**PCL Tot-3** [a]	**PCL Tot-4** [b]
Institutional misconduct	34						
Minor violations		.17	.19	.42*	.52*	.34*	.41*
Serious violations		-.07	-.02	.24	.25	.07	.10
Violent behavior		-.09	-.06	.21	.18	.04	.10
Therapy Relapse		.11	.11	.41*	.48*	.28	.34

Note. [a]= summation of the Interpersonal, Affective and Lifestyle Factor (Cooke, 2001 model); [b] = summation of the 4 PCL:YV factors (Hare, 2003 model).

* = p < .05; ** = p < .01.

Furthermore, we re-consulted the court records (n=41) to determine the recidivism rates within a time period of 438 days after the release of each participant from the institution for juvenile delinquents. 63.4% of the participants reoffended and committed on average 6.79 (SD=7.13) new offenses within a time period of 438 days. There were no significant differences between the repeat offenders and the non-recidivists in terms of PCL:YV total and factor scores, except for the Antisocial Factor. Reoffenders had significantly higher scores on the Antisocial dimension of the PCL:YV, compared to non-reoffenders (t=2.54; df=39; p<.01). Additional descriptive characteristics for participants recruited from the institution for juvenile delinquents are presented in Table 4.

Mixed sample

The mixed sample (Chapter Seven) is composed of 17 youngsters with conduct problems. The participants were part of a qualitative research project about conduct disorders among children commissioned by the Flemish Children's Rights Commission in Belgium. Participants were recruited from two institutions: (1) a boarding school housing young people (aged 7 to 18 years old) with behavioral and emotional problems, mainly

following special education, and (2) an institution for delinquent adolescents (aged 14 to 18 years old). The average age of the participants in this study was 13.7 years. Fourteen participants had a clinical diagnosis of ADHD, the other 3 participants had a self-reported diagnosis of ADHD. Some participants had an additional diagnosis of a learning disability (n=3), an autistic spectrum disorder (n=3), a post-traumatic stress disorder (n =1) or an antisocial personality disorder (n=2). Five adolescents were also part of the referred sample. They all had an elevated score (M = 29.46; SD = 2.88) on the Psychopathy Checklist: Youth Version (PCL:YV). Most of the participants (n= 14) were taking or had been taking stimulants, most often Ritalin. Some participants took other psychotropic medications prior to the prescription of Ritalin, including antidepressants (n=1), antipsychotics (n=2) and hypnotics (n=2).

Table 4

Descriptive statistics for adolescents recruited from the institution for juvenile delinquents (n = 42)

Origin	% Belgian	23.8%
	% East-European	26.2%
	% North African	47.6%
	% Other	2.4%
Index offense	% Robbery/burglary/extortion with violence	33.3%
	% Robbery or burglary without violence	23.8%
	% Violence/Violent abuse	21.4%
	% Drug trafficking	9.5%
	% Uttering threats	2.4%
	% Traffic offense	2.4%
	% Illegal possession of weapons	2.4%
	% Fraud	2.4%
	% Arson	2.4%

MEASURES

Psychopathy

In both the community and referred sample psychopathic traits were assessed using the original Youth Psychopathic Traits Inventory (YPI; Andershed et al., 2001) and the YPI-Short Version (YPI-S; van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010)[13]. In the referred sample psychopathic traits were additionally assessed via ratings on the Psychopathy Checklist-Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003).

The *Youth Psychopathic Traits Inventory* (YPI; Andershed et al., 2001) is a 50-item self-report scale originally developed to measure psychopathic traits in adolescent community samples. Items are scored on a 4-point Likert scale ranging from 1 (does not apply at all) to 4 (applies very well). The YPI consists of ten subscales with five items each, clustered into three main factors or dimensions: the Grandiose-Manipulative or Interpersonal Dimension (GM subscales: Dishonest Charm, Grandiosity, Pathological Lying, and Manipulation), the Callous-Unemotional or Affective Dimension (CU subscales: Remorselessness, Unemotionality, and Callousness), and the Impulsive-Irresponsible or Behavioral Dimension (II subscales: Thrill-seeking, Impulsiveness, Irresponsibility). More recently, the Youth Psychopathic Traits-Short Version (YPI-S; van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010) was developed. The YPI-S contains 18 items that are also organized in three factors, but without sub-dimensions. Previous studies demonstrated adequate reliability and validity of the YPI-S in non-clinical populations (Colins, Noom, & Vanderplasschen, 2012).

The *Psychopathy Checklist: Youth Version* (PCL:YV; Forth, Kosson, & Hare, 2003) is an extension of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991 & 2003) designed to assess personality traits and behavioral features of psychopathy in adolescents. The PCL:YV rating is based on a semi-structured interview and court file data. Analogous to the PCL-R, it also consists of 20 items which are scored on a 3-point ordinal scale, ranging from 0 (‘definitely not present’) to 2 (‘definitely present’). The total score reflects the degree of psychopathic traits in the individual. Contrary to the use of the PCL-R in adults no cut-off score is used for the PCL:YV in adolescents (Forth et al., 2003).

Internalizing and externalizing psychopathology and alexithymia

The *Depression Anxiety Stress Scales-21* (DASS-21; Lovibond & Lovibond, 1995) is a short-version of the DASS and consists of three 7-item scales: Depression, Anxiety and Stress. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses automatic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale assesses difficulty in relaxing, nervous arousal, and being easily upset, irritable and impatient. Items are scored on a 4-point Likert scale ranging from 0 (did not apply to me at all) to 3 (applied to me very much) to describe negative emotional states experienced in the past week. In line with the study design of Willemsen & Verhaeghe (2012) the timeframe of the DASS-21 was altered to the past year. Several studies demonstrated good reliability and validity of the DASS-21 in both clinical and non-clinical populations (e.g. Antony, Cox, Enns, & Swinson, 1998; Crawford & Henry, 2003; Norton, 2007).

The *Positive and Negative Affect Schedule* (PANAS, Watson, Clark, & Tellegen, 1988) is a 20-item measure that compromises two primary 10-item dimensions of mood, one measuring Positive Affect (PA) and the other Negative Affect (NA). Items are scored on a 5-point Likert scale ranging from 1 (very slightly or not at all) to 5 (extremely) to indicate the extent to which they have experienced each particular affect within a specified time frame. Within this study participants were asked to rate how they feel in general. Previous studies demonstrated adequate reliability and validity of the PANAS (Crawford & Henry, 2004).

The *State-Trait Anxiety Inventory- form Y* (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is a 40-item self-report instrument to assess current symptoms of anxiety and a generalized disposition to be anxious. The STAI consists of two 20-item subscales. The State Anxiety Scale (S-Anxiety) measures the current state of anxiety, including subjective feelings of apprehension, tension, nervousness, worry, and arousal of the autonomic nervous system. Items are rated on a 4-point Likert scale, ranging from 1 (not at all) to 4 (very much so). The Trait Anxiety Scale (T-Anxiety) assesses more stable aspects of anxiety proneness. Participants are asked to rate the frequency of how they in general feel on a 4-point Likert scale, ranging from 1 (almost never) to 5 (almost always).

The *Beck Depression Inventory-II* (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item self-report instrument to measure severity of depressive symptomatology. The BDI-II assesses cognitive, affective, somatic and vegetative symptoms that correspond to DSM-IV criteria for diagnosing depressive disorders. Participants are asked to choose the statements that best reflect how they felt the past two weeks. Answer options include four increasing levels of severity with a range of 0 to 3. The BDI-II proves to be a reliable and valid instrument in both clinical and community samples (Beck et al., 1996).

The *Youth Self Report* (YSR; Achenbach & Rescorla, 2001; Verhulst & Van der Ende, 2001) is a 112-item questionnaire designed to assess a wide range of affective and behavioral problems experienced by adolescents during the past 6 months. Items are scored on a 3-point scale ranging from 0 (not true) to 2 (very often true). Factor analyses have identified 8 narrow-band subscales (i.e. Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, Aggressive Behavior) and 6 DSM-oriented scales (i.e. Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, Conduct Problems).

The *National Institute of Mental Health Diagnostic Interview Schedule for Children Version IV* (NIMH DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) was used to interview adolescents from the referred sample about past year symptoms of social phobia, simple phobia, panic disorder, agoraphobia, generalized anxiety disorder, posttraumatic stress disorder and major depressive disorder. The presence of symptoms was scored on a 3-point scale from 0 (absent) to 2 (present). Following the study design of Willemsen and Verhaeghe (2012) a dimensional score for past-year internalizing psychopathology was calculated by a summation of the following symptoms: (1) DSM-IV criteria A trough D of social phobia, (2) DSM-IV criteria A through D of simple phobia and the different types of simple phobia (e.g. animal, height), (3) the 13 symptoms of panic attack in the context of a panic disorder, (4) DSM-IV criteria A and B of agoraphobia and the different types of agoraphobia (e.g. train, tunnel), (5) the six somatic symptoms in the context of a generalized anxiety disorder, (6) the 17 symptoms of posttraumatic stress disorder and (7) the 9 symptoms of a major depressive disorder.

Alexithymia was measured by the 20-item version of the *Toronto Alexithymia Scale-20* (TAS-20; Taylor, Ryan, & Bagby, 1985) which consists of three subscales: difficulty identifying feelings (DIF), difficulty describing feelings (DDF) and externally oriented thinking (EOT). Each TAS-20 item is rated on a five-point Likert scale, with total scores ranging from 20 to 100. Several studies demonstrated adequate reliability and validity of the DASS-21 in both clinical and non-clinical populations (e.g. Bagby, Parker, & Taylor, 1994; Bagby, Taylor, & Parker, 1994; Meganck, Vanheule, & Desmet, 2008).

Defense mechanisms

The *Defensive Style Questionnaire-40* (DSQ-40; Andrews, Singh, & Bond, 1993) is a 40-item self-report scale to assess 20 defense mechanisms as described in the DSM-III-R (American Psychiatric Association, 1980). The DSQ-40 consists of three 2-item factors. Four defenses are related to the Mature factor: sublimation, humor, anticipation, and suppression. The Neurotic factor covers four defenses: undoing, pseudo-altruism, idealization, and reaction formation. Twelve defenses are related to the Immature factor: projection, passive-aggression, acting-out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, and somatization. Items are evaluated on a 9-point scale, with '1' indicating 'completely disagree' and '9' indicating 'fully agree.' The DSQ-40 proved to be a reliable and valid instrument in adolescent populations (Ruuttu et al., 2006).

OVERVIEW OF THE CHAPTERS

Chapter 2

The second chapter evaluates the psychometric properties of the Youth Psychopathic Traits Inventory (YPI) and the more recently developed YPI-Short Version (YPI-S) in the community and the referred sample of adolescents. More specifically, for both measures we examine the reliability, factor structure and measurement invariance across gender and type of education. Furthermore, the criterion and convergent validity of the YPI-S are addressed.

Chapter 3

The third chapter includes a quantitative study of the relationship between psychopathic traits and various measures of internalizing behavior, alexithymia and thought problems in the referred and community sample of adolescents. Psychopathic traits were assessed by means of the Youth Psychopathic Traits Inventory-Short Version (YPI-S). In the referred sample, psychopathic traits were additionally assessed by means of the Psychopathy Checklist: Youth Version (PCL:YV). To study the relationship between psychopathic traits and various measures of other psychopathologic problems, we follow a subgroup approach (cluster analysis) within the community sample, and a variable-oriented approach in the referred sample.

Chapter 4

In the fourth chapter we investigate the relationship between anxiety and juvenile psychopathy indirectly by exploring the role defense mechanisms play in the emergence of psychopathic personality traits in adolescents from a community sample. Psychopathic traits are measured by means of the Youth Psychopathic Traits Inventory-Short Version (YPI-S), defense mechanisms are measured with the Defensive Style Questionnaire (DSQ-40). We investigate which particular defense mechanism is associated with higher levels of psychopathic traits through linear regression analyses.

Chapter 5

In the fifth chapter we investigate a case study of a juvenile delinquent with an elevated score on the Psychopathy Checklist:YV (PCL:YV=32). We argued that in order to gain an in-depth understanding of the nature and dynamics of an individual's emotional life, we have to study his affective life within the context of his social bond with (significant) others. This assumption constitutes the starting point for the present case study. Through a detailed exploration of the boy's affective, interpersonal and antisocial life, we explore the psychodynamic and contextual processes that underlie his psychopathic behavior. We focus on the first-person perspective of this adolescent: Firstly, we explore how he experiences affects and emotions; secondly, we investigate how he relates to others; and finally we explore the status he attributes to his antisocial behavior and how this behavior emerges within his narratives.

Chapter 6

In Chapter Six we continue the project from the previous chapter. We study the presence/absence of anxiety, through an in-depth analysis of how 15 juvenile delinquents with psychopathic traits experience interpersonal relations and how inter-subjective dynamics are re-enacted in a therapeutic setting. Thematic analysis is used to identify and analyze the patterns that emerge in the therapeutic session narratives.

Chapter 7

In our seventh chapter we investigate the impact of psychiatric labels on the lived experiences of youth, by using the case example of Attention-Deficit Hyperactivity Disorder. Through a thematic analysis of interview narratives of 17 children with conduct problems, we explore how these youngsters experience their diagnosis, medical treatment and other standardized treatment interventions.

NOTES

1. Round table 1 (1949): “The psychopathic Delinquent Child”; Round table 2 (1950): “Psychopathic Behavior”; Round table 3 (1951): “A differential Study of Psychopathic Behavior in infants and Children.” These three round table discussions were retrospectively collected in one volume (see Karpman, 1956).
2. The PSD is a 20-item rating scale to measure psychopathy in children. It was modeled after the PCL-R (Hare, 1991) in such a way that each dimension designed by the PCL-R was also included in the PSD, unless it was irrelevant for children. The original PSD was later revamped into the Antisocial Process Screening Device (APSD; Frick & Hare, 2001)
3. The CPS is a parent/teacher-rated scale designed to assess psychopathy in late childhood and early adolescence. The 13-item CPS was derived from the Pittsburgh Youth study on 12–13-year-old boys and has a set of items that are similar to the behavioral items on the adult PCL–R (Hare, 1991). Confirmatory factor analysis (Lynam, 1997) revealed that the two-factor structure found to underlie the PCL-R (Hare, 1991) adequately fitted the CPS as well.
4. For a more detailed description of the dual deficit model, we refer to chapter 3 of this doctoral dissertation.
5. By way of illustration, a clause in the Mental Health Act of 1983 (English law) states that individuals with a psychopathic personality disorder may be excluded from some of the benefits available to other patients because on occasions they may be “untreatable” (Gunn, 2003).
6. For the sake of completeness, in our opinion labeling a young person with such a loaded diagnosis seems if only for ethical reasons not recommended.
7. According to Lynam (1997, 1998) these childeren who combine the symptoms of hyperactivity-impulsivity-attention problems (HIA) and conduct problems (CP) are most closely to resemble psychopathic adults. Together with other authors (e.g. Michonski & Sharp, 2010), we are very cautious with regard to Lynam's notion, but in the context of this dissertation “a light version” of Lynam’s “fledgling psychopathy” will be used to adress the issue of the impact of diagnostic labels on the lived experience of children.
8. Scores on the PCL:YV were calculated at the beginning of the 6-month program, and thus were not based on the participants behavior within the institution. The number of institutional misconducts and number of relapses to a lower level in the therapy program was calculated on the basis of official scoring lists of the institution (for each activity participants were scored on different parameters/compliance with the institution rules).

9. *Violent behavior* is a summation of the number of 'violent behavior' and the times a participant 'uttered threats' during the six-month program.
10. *Serious violations of the institution rules* involves major violations of the rules, such as escape from the institution, committing crimes outside the institution (e.g. burglary, robbery), smuggling of prohibited goods (e.g. drugs, mobile phones), falsification of weekly drug tests.
11. *Minor violations of the institution rules* involves smaller violations such as rude table manners, smoking a cigarette when it is not allowed, poor social skills, forgetting an appointment with the psychologist or an educator, rude table manners, and so on.
12. *Therapy relapse* is a summation of the times a participant relapses to a lower level in the 6-month program and the times a participant was sent on a time-out in another institution for juvenile delinquents.
13. The YPI-S data used in this study stem from an administration of the original 50-item YPI in both samples. Based on the results of our (factorial) validity analysis of both the YPI and the YPI-S, we concluded to use the YPI-S for further data analysis.

REFERENCES

Achenbach, T., & Rescorla, L. (2001). *Manual for ASEBA school-age forms & profiles.* Burlington: University of Vermont.

Andershed, H., Kerr, M., Stattin, H., & Levander, S. (2001). Psychopathic traits in non-referred youths: A new assessment. In E. Blaauw, & L. Sheridan (Eds.), *Psychopaths: Current international perspectives* (pp. 131-158). The Hague, The Netherlands: Elsevier.

Andrews, G., Singh, M., & Bond, M. (1993). The defence style questionnaire. *The Journal of Nervous and Mental Disease, 181*, 246-256.

Antony, M. M., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*, 176-181.

Bagby, R. M., Parker, J. D., & Taylor, G. J. (1994). The twenty-item Toronto Alexithymia Scale - I. Item selection and cross-validation of the factor structure. *Journal of Psychomatic Research, 3*, 23-32.

Bagby, R. M., Taylor, G. J., & Parker, J. D. (1994). The twenty-item Toronto alexithymia scale - II. Convergent, discriminant and concurrent validity. *Journal of Psychosomatic Research, 38*, 33-40.

Bary, C. T., Frick, P. J., DeShazo, T. M., McCoy, M. G., Ellis, M., & Loney, B. R. (2000). The importance of callous-unemotional traits for extending the concept of psychopathy to children. *Journal of Abnormal Psychology, 109*, 335-340.

Bauer, D. L., Whitman, L. A., & Kosson, D. S. (2011). Reliability and Construct Validity of Psychopathy Checklist: Youth Version Scores among Incarcerated Adolescent Girls. *Criminal Justice and Behavior, 10*, 965-987.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory: second edition manual.* San Antonio, TX: The Psychological Corporation.

Blackburn, R. (2011). On moral judgements and personality disorders. The myth of psychopathic personality revisited. *The British Journal of Psychiatry*, 505-512.

Brandt, J. R., Kennedy, W. A., Patrick, C. J., & Curtin, J. J. (1997). Assessment of psychopathy in a population of incarcerated adolescent offenders. *Psychological Assessment, 9*, 429-435.

Campbell, M. A., Porter, S., & Santor, D. (2004). Psychopathic Traits in Adolescent Offenders: An Evaluation of Criminal History, Clinical, and Psychosocial Correlates. *Behavioral Sciences and the Law, 22*, 23-47.

Cleckley, H. (1941). *The Mask of Sanity* (First Ed.). Saint Louis: The C.V. Mosby Company.

Cleckley, H. (1976). *The Mask of Sanity* (Fifth Ed.). Saint Louis: The C.V. Mosby Company.

Colins, O. F., Noom, M., & Vanderplasschen, W. (2012). Youth Psychopathic Traits Inventory-Short Version: A Further Test of the Internal Consistency and Criterion Validity. *Journal of Psychopathology and Behavioral Assessment, 4*, 476-486.

Cooke, D. J., & Michie, C. (1997). An item response theory analysis of the Hare Psychopathy Checklist - Revised. *Psychological Assessment, 9*, 3-14.

Cooke, D., & Michie, C. (2001). Refining the construct of psychopathy: Toward a hierarchical model. *Psychological Assessment, 13*, 171-188.

Corr, P. J. (2010). The psychoticism-psychopathy continuum: A neuropsychological model of core deficits. *Personality and Individual Differences, 48*, 695-703.

Corrado, R. R., Vincent, G. M., Hart, S. D., & Cohen, I. M. (2004). Predictive validity of the Psychopathy Checklist: Youth Version for general and violent recidivism. *Behavioral Sciences and the Law, 22*, 5-22.

Crawford, J. R., & Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): Normative data and latent structure in a large non-clinical sample. *British Journal of Clinical Psychology, 42*, 111-131.

Crawford, J. R., & Henry, J. D. (2004). The positive and negative affect schedule (PANAS): construct validity, measurement properties and normative data in a large non-clinical sample. *British Journal of Clinical Psychology, 43*, 245-265.

Creswell, J., Plano Clark, V., Gutmann, M., & Hanson, W. (2003). Advanced mixed methods research designs. In A. Tashakkori, & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioural research* (pp. 209-240). Thousand Oaks, CA: Sage.

de Botton, A. (2005). *Status Anxiety.* London: Penguin Books.

Dolan, M. C., & Rennie, C. E. (2007). Is juvenile psychopathy associated with low anxiety and fear in conduct-disordered male offenders. *Journal of Anxiety Disorders, 21*, 1028-1038.

Edens, J. F., Skeem, J. L., Cruise, K. R., & Cauffman, E. (2001). Assessment of "Juvenile Psychopathy" and Its Association with Violence: A Critical Review. *Behavioral Sciences and the Law, 19*, 2001.

Forth, A. E., Kosson, D., & Hare, R. D. (2003). *The Psychopathy Checklist: Youth Version.* Toronto, Ontario: Multi-Health Systems.

Forth, A. E. (1995). Psychopathy in adolescent offenders: Assessment, family background, and violence. *Issues in Criminological and Legal Psychology, 24*, 42-44.

Forth, A. E., Hart, S. D., & Hare, R. D. (1990). Assessment of of psychopathy in male young offenders. *Psychological assessment, 2*, 342-344.

Fowles, D. C., & Dindo, L. (2006). A dual-deficit model of psychopathy. In C. J. Patrick, *Handbook of psychopathy* (pp. 14-34). New York: Guildford Press.

Fowles, D. C. (1987). Application of a behavioral theory of motivation to the concepts of anxiety and impulsivity. *Journal of Research in Personality, 21*, 417-435.

Freud, S. (1978 [1926d]). Inhibitions, symptoms, and anxiety. In *Standard Edition* (Vol. 20, pp. 75-175). London: Hogarth.

Frick, P. J., Lilienfeld, S. O., Ellis, M., Loney, B., & Silverthorn, P. (1999). The association between anxiety and psychopathy dimensions in children. *Journal of Abnormal Child Psychology, 27*, 383-392.

Frick, P. J. (1998). Callous-Unemotional traits and conduct problems: applying the two-factor model of psychopathy to children. In D. J. Cooke, A. E. Forth, & R. D. Hare (Eds.), *Psychopathy: Theory, Research and Implications for Society* (pp. 161-188). Dordrecht/Boston/London: Kluwer Academic Publishers.

Frick, P. J. (2002). Juvenile psychopathy from a developmental perspective: Implications for construct development and use in forensic assessments. *Law and Human Behavior, 26*, 247-253.

Frick, P. J., & Hare, R. D. (2001). *Antisocial Process Screening Device.* Toronto, ON: Multi Health Systems.

Frick, P. J., & Marsee, M. A. (2006). Psychopathy and Developmental Pathways to Antisocial Behavior in Youth. In C. J. Patrick (Ed.), *Handbook of Psychopathy* (pp. 353-374). New York: The Guilford Press.

Frick, P. J., O'Brien, B. S., Wootton, J. M., & McBurnet, K. (1994). Psychopathy and Conduct Problems in Children . *Journal of Abnormal Psychology, 103*, 700-707.

Frick, P. J., Stickle, T. R., Dandreaux , D. M., Farell, J. M., & Kimonis, E. R. (2005). Callous-unemotional traits in predicting the severity and stability of conduct problems and delinquency. *Journal of Abnormal Child Psychology, 33*, 471-488.

Gray, J. A. (1979). A neuropsychological theory of anxiety. In C. E. Izard (Ed.), *Emotions in personality and psychopathology.* New York: Plenum Press.

Gray, J. A. (1976). The Behavioural Inhibition System: A possible substrate for anxiety. In M. P. Feldman, & Broadhurst (Eds.), *Theoretical and experimental bases of the behaviour therapies* (pp. 3-41). London: Wiley.

Gray, J. A. (1978). The neuropsychology of anxiety. *British Journal of Psychiatry, 69*, 417-434.

Gunn, J. (2003). Psychopathy: An Elusive Concept with Moral Overtones. In T. Millon , E. Simonsen , M. Birket-Smith, & R. D. Davis, *Psychopathy: Antisocial, Criminal, and Violent Behavior* (pp. 32-39). New York: The Guilford Press.

Hare, R. D. (1991). *The Hare Psychopathy Checklist - Revised Manual.* Toronto: Multi-Health Systems.

Hare, R. (2003). *The Hare Psychopathy Checklist-Revised* (2nd ed.). Toronto: Multi-Health Systems.

Hipwell, A. E., Pardini, D. A., Loeber, R., Sembower, M., Keenan, K., & Stouthamer-Loeber, M. (2007). Callous-Unemotional Behaviors in Young Girls: Shared and Unique Effects Relative to Conduct Problems. *Journal of Clinical Child & Adolescent Psychology, 36*, 293-304.

Karpman, B. (1959). *Symposia on Child and Juvenile Delinquency. Presented at the American Orthopsychiatric Association.* Washington, D.C.: Psychodynamics Monograph Series.

Kosson, D. S., Cyterski, T. D., Steuerwald, B. L., Neumann, C., & Walker-Matthews, S. (2002). The reliability and validity of the Psychopathy Checklist: Youth Version in non-incarcerated adolescent males. *Psychological Assessment, 14*, 97-109.

Kubak, F. A., & Salekin, R. T. (2009). Psychopathy and Anxiety in Children and Adolescents: New insights and Developmental Pathways to Offending. *Journal of Psychopathology and Behavioral Assessment, 31*, 271-284.

Lilienfeld, S. O., & Penna, S. (2001). Anxiety sensitivity: relations to psychopathy, DSM-IV personality disorder features, and personality traits. *Journal of anxiety Disorders, 15*, 367-393.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the depression anxiety stress Scales.* Sydney: Psychology Foundation.

Lykken, D. T. (1957). A study of anxiety in the sociopathic personality. *Journal of Abnormal and Social Psychology, 55*, 6-10.

Lynam, D. R. (1996). Early identification of chronic offenders: Who is the fledgling psychopath? . *Psychological Bulletin, 120*, 209-234.

Lynam, D. R. (1997) Pursuing the psychopath: capturing the fledgling psychopath in a nomological net. *Journal of Abnormal Psychology, 106,* 425–438.

Lynam, D. R. (1998). Early identification of the fledgling psychopath: Locating the psychopathic child in the current nomenclature. *Journal of Abnormal Psychology, 107*, 566-575.

McCord, W., & McCord, J. (1956). *Psychopathy and Delinquency.* New York: Grune & Stratton.

Meganck, R., Vanheule, S., & Desmet, M. (2008). Factorial Validity and Measurement Invariance of the 20-item Toronto Alexithymia Scale in Clinical and Nonclinical Samples. *Assessment, 15,* 36-47.

Michonski, J. D., & Sharp, C. (2010). Revisiting Lynam's notion of the "fledgling psychopath": are HIA-CP children truly psychopathic-like? *Child and Adolescent Psychiatry and Mental Health, 4*, 24-33.

Norton, P. J. (2007). Depression Anxiety and Stress Scales (DASS-21): Psychometric analysis across four racial groups. *Anxiety, Stress, & Coping, 20*, 253-265.

Patrick , C. J., Bradley, M. M., & Lang, A. R. (1993). Emotions in the criminal psychopath: startle reflex modulation. *Journal of Abnormal Psychology, 102*, 82-92.

Patrick, C. J. (1994). Emotion and psychopathy: startling new insights. *Psychophysiology, 31*, 319-330.

Ruuttu, T., Pelkonen, M., Holi, M., Karlsson, L., Kiviruusu, O., Heilä, H., et al. (2006). Psychometric properties of the defence style questionnaire (DSQ-40) in adolescents. *Journal of Nervous & Mental Disease, 194*, 98-105.

Salekin, R. T., Leistico, A. R., Trobst, K. K., Schrum, C. L., & Lochman, J. E. (2005). Adolescent psychopathy and personality theory - the interpersonal circumplex: Expanding evidence of a nomological net. *Journal of Abnormal Child Psychology, 33*, 445-460.

Salekin, R. T., & Lynam, D. R. (2010). Child and Adolescent Psychopathy. In R. T. Salekin, & D. R. Lynam, *Handbook of Child and Adolescent Psychopathy* (pp. 399-420). New York: The Guilford Press.

Salekin, R. T., Neumann, C. S., Leistico, A.-M. R., Dicicco, T. M., & Duros, R. L. (2004). Psychopathy and Comorbidity in a Young Offender Sample: Taking a Closer Look At Psychopathy's Potential Inportance Over Disruptive Behavior Disorders. *Journal of Abnormal Psychology, 113*, 416-427.

Schmidt, F., McKinnon, L., Chatta, H. K., & Brownlee, K. (2006). Concurrent and Predictive Validity of the Psychopathy Checklist: Youth Version Across Gender and Ethnicity. *Psychological Assessment, 18*, 393-401.

Sevecke, K., & Kosson, D. S. (2010). Relationships of Child and Adolescent Psychopathy to Other Forms of Psychopathology. In R. T. Salekin, & D. R. Lynam (Eds.), *Handbook of Child and Adolescent Psychopathy* (pp. 284-315). New York: The Guilford Press.

Sevecke, K., Lehmkuhl, G., & Krischer, M. K. (2009). Examining relations between psychopathology and psychopathy dimensions among adolescent female and male offenders. *European Journal of Child and Adolescent Psychiatry, 18*, 85-95.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, Differences From Previous Versions, and Reliability of Some Common Diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 28-38.

Skeem, J. L., & Cauffman, E. (2003). Views of the downward extension: comparing the youth version of the psychopathy checklist with the youth psychopathic traits inventory. *Behavioral Sciences & the Law, 21*, 737-770.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory.* Palo Alto, CA: Consulting Psychologists Press.

Stafford, E., & Cornell, D. G. (2003). Psychopathy scores predict adolescent inpatient aggression. *Assessment, 10*, 102-112.

Taylor, G. J., Ryan, D., & Bagby, R. M. (1985). Toward the development of a new self-report alexithymia scale. *Psychotherapy and Psychosomatics, 44*, 191-199.

Toupin, J., Mercier, H., Dery, M., Cote, G., & Hodgins, S. (1996). Validity of the PCL-R for adolescents. In D. J. Cooke, A. E. Forth, J. P. Newman, & R. D. Hare (Eds.), *Issues in criminological and legal psychology: No. 24, International perspectives on psychopathy* (pp. 143-145). Leicester, UK: British Psychological Society.

van Baardewijk, Y., Andershed, H., Stegge, H., Nilsson, K. W., Scholte, E., & Vermeiren, R. (2010). Development and Tests of Short Versions of the Youth Psychopathic Traits Inventory and the Youth Psychopathic Traits Inventory-Child Version. *European Journal of Psychological Assessment, 26*, 122-128.

Vasey, M., Kotov, R., Frick, P., & Loney, B. (2005). The latent structure of psychopathy in youth: A taxometric investigation. *Journal of Abnormal Child Psychology, 33*, 411-429.

Verhaeghe, P. (2004). *On being normal and other disorders. A manual for clinical psychodiagnostics.* New York: Other Press.

Verhulst, F., & Van der Ende , J. (2001). *Handleiding voor de CBCL/6-18, YSR, en TRF (Dutch manual for CBCL/6-18, YSR, and TRF).* . The Netherlands: Erasmus Universiteit Rotterdam.

Vidal, S., & Skeem, J. L. (2007). Effect of Psychopathy, Abuse and Ethnicity on Juvenile Probation Officers' Decision-Making and Supervison Strategies. *Law and Human Behavior, 31*, 479-498.

Walker, J. L., Lahey, B. B., Russo, M. F., Frick, P. J., Christ, M. A., McBurnett, K., et al. (1991). Anxiety, inhibition, and conduct disorder in children: relations to social impairment. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 187-191.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063-1070.

Willemsen, J., & Verhaeghe, P. (2012). Psychopathy and internalizing psychopathology. *International Journal of Law and Psychiatry, 35*, 269-275.

Appendix 1: Items and their corresponding factors in the different models of the Psychopathy Checklist-Revised and the Psychopathy Checklist: Youth Version

	ADULT PSYCHOPATHY	Two -factor model (Hare, 1991)	Three-factor model (Cooke, 2001)	Four-factor model (Hare, 2003)
	Items	**Factor 1 (F1):** Interpersonal/ Affective or "Selfish, callous and remorseless use of others" **Factor 2 (F2):** Social Deviant Lifestyle	**Factor 1 (F1):** Arrogant and Deceitful Interpersonal Style **Factor 2 (F2):** Deficient Affective Experience **Factor 3 (F3):** Impulsive and Irresponsible Behavioral style	**Factor 1 (F1):** Interpersonal **Factor (F2):** Affective **Factor 3 (F3):** Lifestyle **Factor 4 (F4)** Antisocial
1.	Glibness/superficial charm	F1	F1	F1
2.	Grandiose sense of self-worth	F1	F1	F1
3.	Stimulation seeking	F2	F3	F3
4.	Pathological lying	F1	F1	F1
5.	Conning/manipulative	F1	F1	F1
6.	Lack of remorse or guilt	F1	F2	F2
7.	Shallow affect	F1	F2	F2
8.	Callous/lack of empathy	F1	F2	F2
9.	Parasitic lifestyle	F2	F3	F3
10.	Poor behavioral control	F2	/	F4
11.	Promiscuous sexual behavior	Total score only	/	Total score only
12.	Early behavior problems	F2	/	F4
13.	Lack of realistic long-term goals	F2	F3	F3
14.	Impulsivity	F2	F3	F3
15.	Irresponsibility	F2	F3	F3
16.	Failure to accept responsibility	F1	F2	F2
17.	Many short-term relationships	Total score only	/	Total score only
18.	Juvenile delinquency	F2	/	F4
19.	Revocation of conditional release	F2	/	F4
20.	Criminal versatility	Total score only	/	F4

	JUVENILE PSYCHOPATHY	Two -factor model (e.g. Brandt , Kennedy, Patrick, & Curtin, 1997; Forth, 1995)	Three-factor model (e.g. Forth , Kosson, & Hare, 2003)	Four-factor model (e.g. Forth et al. 2003)
	Items	These factor models reflect the factor solutions for the PCL-R as explained left in this table.		
1.	Impression management	F1	F1	F1
2.	Grandiose sense of self-worth	F1	F1	F1
3.	Stimulation/ sensation seeking	F2	F3	F3
4.	Pathological lying	F1	F1	F1
5.	Manipulation for Personal Gain	F1	F1	F1
6.	Lack of remorse or guilt	F1	F2	F2
7.	Shallow affect	F1	F2	F2
8.	Callous/lack of empathy	F1	F2	F2
9.	Parasitic orientation	F2	F3	F3
10.	Poor anger control	F2	/	F4
11.	Impersonal sexual behavior	Total score only	/	Total score only
12.	Early behavior problems	F2	/	F4
13.	Lack of goals	F2	F3	F3
14.	Impulsivity	F2	F3	F3
15.	Irresponsibility	F2	F3	F3
16.	Failure to accept responsibility	F1	F2	F2
17.	Unstable interpersonal relationships	Total score only	/	Total score only
18.	Serious criminal behavior	F2	/	F4
19.	Serious violation of Conditional Release	F2	/	F4
20.	Criminal versatility	Total score only	/	F4

2

THE YOUTH PSYCHOPATHIC TRAITS INVENTORY: FACTORIAL VALIDITY AND MEASUREMENT INVARIANCE ACROSS GENDER AND SCHOOL TYPE[1]

This study evaluates the psychometric properties of the Youth Psychopathic Traits Inventory (YPI) and the more recently developed YPI-Short Version (YPI-S) in a community (N = 1670) and a referred sample (N = 62) of adolescents. Confirmatory factor analysis supports the three-factor structure of the YPI-S for the community sample, for boys and girls, and for students from both Special Secondary Education and General Secondary Education separately. For the proposed three-factor structure of the YPI, a less adequate fit was observed. Measurement invariance of the YPI-S is confirmed across gender and education. In both samples, relations between the YPI-S and relevant criterion variables (e.g. self-reported offending) are generally in line with our predictions. Non-significant to moderate correlations were found between conceptually corresponding subscale scores of the YPI-S and the Psychopathy Checklist: Youth Version.

[1] This chapter is based on De Ganck, J., Willemsen, J. & Vanheule, S. (submitted). The Youth Psychopathic Traits Inventory: Factorial Validity and Measurement Invariance across Gender and School Type. *Assessment.*

INTRODUCTION

To gain insight into the etiology of psychopathy, research has increasingly focused on psychopathic traits in children and adolescents (Farrington, 2005). There is accumulating evidence that psychopathic traits in both referred and non-referred youth manifest in a similar way to those of adults, particularly in terms of factor structure (e.g. Kosson, et al., 2013; Veen, Stevens, Andershed, Raaijmakers, Doreleijers, & Vollebergh, 2011) and positive associations with a variety of relevant criterion variables. Similar to the conceptualization of psychopathy in adults, juvenile psychopathy is usually defined through a constellation of either three (Cooke & Michie, 2001) or four (Hare, 2003) inter-related dimensions: (1) an arrogant and deceitful interpersonal style; (2) a callous and unemotional affective experience; (3) an impulsive and irresponsible behavioral style, and (4) antisocial tendencies. Moreover, much research into both adult and adolescent samples has shown similar positive relationships between psychopathic features and relevant external variables, such as conduct disorders (e.g. Forth & Burke, 1998; Frick, Bodin, & Barry, 2000; Kotler & McMahon, 2005), hyperactive behavior and problems with concentration (e.g. Colins, Noom, & Vanderplasschen, 2012; Dolan & Rennie, 2007; Hare, 1996; Lynam, 1996; Veen, et al., 2011), substance use (e.g. Forth & Burke, 1998; Hillege, Das, & de Ruiter, 2010 ; Mailloux, Forth, & Kroner, 1997; Sevecke, Lehmkuhl, & Krischer, 2008), instrumental or pro-active aggression (e.g. Fanti, Frick, & Georgiou, 2009; Flight & Forth, 2007; Fite, Stoppelbein, & Fabiano, 2009 ; Vitacco, Neumann, Caldwell, Leistico, & Van Rybroeck, 2006) and general delinquent behavior (e.g. Veen et al., 2011).

Along with this increased interest in juvenile psychopathy, several self-report measures have been developed as less time intensive alternatives to the Psychopathy Checklist: Youth Version (PCL:YV; Forth , Kosson, & Hare, 2003), a measure that is considered as the golden standard in the assessment of psychopathic traits in youth. The Youth Psychopathic Traits Inventory (YPI: Andershed, Kerr, Stattin, & Levander, 2001) is one such commonly used self-report instrument. The scale was designed primarily to overcome the problems intrinsic to the measurement of psychopathic traits through self-report, given the presumed deceitful nature of individuals with psychopathic traits as well as their lack of personal insight. By measuring psychopathic features indirectly and by framing them as

abilities, Andershed et al. (2001) aimed to avoid problems associated with response distortion and social desirability. The main objective of the YPI is to measure core personality traits (i.e. Grandiose-Manipulative (GM), Callous-Unemotional (CU) and Impulsive-Irresponsible (II) understood as dimensions of psychopathy), rather than antisocial behavioral characteristics related to psychopathy. As such, the YPI is based on the three-factor conceptualization of psychopathy (Andershed et al., 2001; Cooke & Michie, 2001), in which antisocial and criminal behavior (e.g. criminal versatility, sexual promiscuity, etc.) are understood as epiphenomena of psychopathy, rather than essential components of the construct.

Several studies have addressed the psychometric properties of the YPI, including internal consistency, factorial and convergent validity, and measurement invariance. While previous research generally claims that the YPI is internally consistent, only marginal attention has been paid to certain low internal consistencies, particularly in relation to the Callous-Unemotional scales and their sub-dimensions. By convention, several authors recommend a Cronbach alpha cut-off of .70 for acceptable internal consistency (Bland & Altman, 1997; DeVellis, 2003; George & Mallery, 2003; Nunnally & Bernstein, 1994). However, the mean inter-item correlation (MIC) can be considered as a more eligible indicator of internal consistency than the coefficient alpha, as it is independent of the number of items (Clarck & Watson, 1995). MIC values in the range of .15 to .50 are considered adequate, and values between .20 and .40, optimal (Briggs & Cheek, 1986; Clarck & Watson, 1995; Nunnally & Bernstein, 1994). In previous studies Cronbach's alpha for the YPI Total score and the YPI Interpersonal and Behavioral dimension was approximately .70 in both community and referred samples (α ranging from .70 - .93, with the exception of α = .68 for the Behavioral dimension in the study of Andershed, Hodgins and Tengström (2007)). On the other hand, several studies have reported unacceptable and poor α values for the Affective dimension and subscales and for some of the Interpersonal and Behavioral subscales. However, in all studies, the MIC values were largely optimal, except for the CU scale and Unemotional subscale in the study of Poythress et al. (2006). For a detailed overview of the internal consistency of the YPI see Appendix A and B.

Additionally, several studies tested the fit of the three-factor model of the YPI with confirmatory factor analysis (CFA). In general, most fit indices suggest an acceptable fit of this model to the data among both female and male, referred and non-referred adolescents

and among different ethnic groups (see Appendix C). However, a recurring problem with these studies is the use of parcel-based CFA. One of the advantages of using parcels as indicators for latent variables is that CFA can be done with smaller samples as it reduces the number of parameters that have to be estimated in a model (MacCallum, Widaman, Zhang, & Hong, 1999). For instance, if we take the ratio of subjects to each free parameter as 10:1 as a rule of thumb, in order to fit the three factor model onto the 50 items of the YPI the estimation of 103 parameters is required, i.e. a sample size of 1030. In contrast, a CFA with ten parcels requires the estimation of 23 parameters, i.e. a sample size of 230 subjects. However, parceling is only recommended when parceled items can be shown to be strictly uni-dimensional and when structural relations between latent variables are the focus of inquiry, not the measurement model itself (Bandalos & Finney, 2001). In previous YPI factor analytic studies these conditions proved to be problematic: both in the design of the YPI and previous CFA studies the assumption of uni-dimensionality was not examined (Colins et al., 2012).

According to Colins et al. (2012) the more recent, short version of the YPI (YPI-S; van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010), which offers a less time-consuming assessment of psychopathic traits, can indirectly solve the improper use of item parceling in CFA, as the 18 items of the YPI-S can be grouped into three factors without subscales. However, only two studies have addressed the internal consistency and factorial validity of the YPI-S (Colins et al., 2012; van Baardewijk et al., 2010). Several fit indices confirm the theoretical three-factor structure of the YPI-S. However, in both studies the Cronbach's alphas for the Behavioral dimension and in one study the Cronbach's alpha for the Affective dimension (Colins et al., 2012) are slightly below the recommended criterion value of .70, while all MIC values are still in the optimal range (see Appendix D).

Moreover, only a limited number of studies have evaluated measurement invariance of the YPI and the YPI-S. The results of two studies suggest factorial invariance of the YPI (Ručević, 2010) and the YPI-S (Colins at al., 2012) across gender. Furthermore, factorial invariance was found for the YPI on comparisons across ethnic majority and ethnic minority groups in an incarcerated sample in the Netherlands (Veen at al., 2011) and across age (Colins at al., 2012).

Finally, studies that have investigated the convergent validity between the YPI and the PCL:YV have yielded mixed results, with correlations between the corresponding factor

scores of the YPI and the PCL:YV ranging from non-significant to moderate (e.g. Andershed at al., 2007; Cauffman, Kimonis, Dmitrieva, & Monahan, 2009; Dolan & Rennie, 2006b; Skeem & Cauffman, 2003). To our knowledge, no studies have examined the convergent validity between the YPI-S and PCL:YV.

The purpose of this study is not only to further evaluate the psychometric properties of the YPI, but also to test the more time-efficient YPI-S in both a large, heterogeneous community sample of adolescents and a small referred sample of male juvenile offenders. Taking into account the limitations of previous research, the first aim of the present study is to examine the *factorial validity* of the YPI and the YPI-S in the large community sample. First, the three-factor model of the YPI is tested by using items as manifest variables. Next, the three-factor model of the YPI-S is tested. The second aim is to further examine the *measurement invariance* of both instruments across significant groups within the community sample; i.e. gender and different types of education. The third aim of this study is to evaluate the *internal consistency* of the YPI and the YPI-S. As few studies have examined the relationship between the YPI-S and relevant correlates, the fourth aim of this study is to further explore the *criterion validity* of the scores of the YPI-S by examining associations with self-reported antisocial behavior, conduct problems and hyperactivity. The fifth and final aim of this study is to assess the *concurrent validity* of the YPI-S by investigating its relations with the PCL-YV in a small referred sample of adolescent delinquents.

METHOD

Participants

Two types of samples of juveniles were used in this study. The first sample (community sample) consisted of 1670 non-referred adolescents (57.8% females) with a mean age of 14.63 years (*SD* = 1.83). The participants (response rate: 99.2%) were recruited from 10 secondary schools (both rural and urban) in Flanders (Belgium). In terms of type of education, 20.8% attended special needs secondary education; 2.3% vocational; 9.2% technical and 67.8% general secondary education. The data from 20 adolescents were

excluded because more than 5% of their YPI scores were missing, resulting in a final sample of 1670 participants.

The second sample (referred sample) is composed of 62 male adolescent delinquents with a mean age of 15.71 years (*SD* = 1.23). The adolescents were recruited in two ways; (a) through referral by the juvenile court, and (b) through follow-up in a six-month residential treatment program for juvenile delinquents in Flanders. With regard to type of education, 12.9% attended special needs secondary education; 66.1% vocational; 19.4% technical and 1.6% general secondary education. The data from 4 adolescents were excluded because more than 5% of their YPI scores were missing, resulting in the final sample of 62 participants[1].

Procedure

The study was approved by the Institutional Review Board of the Faculty of Psychology and Educational Sciences at Ghent University. Participants took part in the study on a voluntary basis, were informed about the overall purpose of the research project and gave their informed consent to be involved in the study. All participants completed a demographic survey and a set of questionnaires about internalizing problems, externalizing problems and delinquent behavior. The focus of this study is on the latter two. In the community sample, questionnaires were completed in the classroom under the supervision of the first author and/or a trained Masters student. For the referred sample, assessment took place at the adolescent's home or at the institution for juvenile offenders.

Measures

The *Youth Psychopathic Traits Inventory* (YPI; Andershed at al., 2001) is a 50-item self-report scale originally developed to measure psychopathic traits in adolescent community samples. Items are scored on a 4-point Likert scale ranging from 1 (does not apply at all) to 4 (applies very well). The YPI consists of ten subscales with five items each, clustered into three main factors or dimensions: the Grandiose-Manipulative or Interpersonal Dimension (GM subscales: Dishonest Charm, Grandiosity, Pathological Lying, and Manipulation), the Callous-Unemotional or Affective Dimension (CU subscales: Remorselessness, Unemotionality, and Callousness), and the Impulsive-Irresponsible or

Behavioral Dimension (II subscales: Thrill-seeking, Impulsiveness, Irresponsibility). More recently, the Youth Psychopathic Traits-Short Version (YPI-S; van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010) was developed. The YPI-S contains 18 items that are also organized in three factors, but without sub-dimensions.

The *Psychopathy Checklist: Youth Version* (PCL:YV; Forth et al., 2003) is a downward extension of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991 & 2003) designed to assess personality traits and behavioral features of psychopathy in adolescents. The PCL:YV rating is based on a semi-structured interview and court file data. Similar to the PCL-R, it also consists of 20 items which are scored on a 3-point ordinal scale, ranging from 0 ('definitely not present') to 2 ('definitely present'). The total score reflects the degree of psychopathic traits in the individual. Contrary to the PCL-R in adults no cut-off score is used for the PCL:YV in adolescents (Forth, Kosson, & Hare, 2003). In the current study internal consistencies were good for the Interpersonal Facet (α = .77; MIC = .45), the Affective Facet (α = .78; MIC = .48) and for the Lifestyle Facet (α = .78; MIC = .41). Alpha for the Antisocial Facet (α = .66; MIC = .28) was slightly below the criterion value of .70, however the MIC was between the recommended range of .15 to .50. Additionally, inter-rater reliability as determined by the intraclass correlations coefficient (absolute agreement) for a single rating, using a two-way random effects model, was 0.89 for the Interpersonal Facet, 0.87 for the Affective Facet, 0.75 for the Lifestyle Facet, 0.85 for the Antisocial Facet and 0.97 for the PCL:YV total score[2]. As such, according to the criteria of Landis and Koch (1977), inter-rater reliability proved to be excellent for all facets and the PCL:YV total score.

The *Youth Self Report* (YSR; Achenbach & Rescorla, 2001; Verhulst & Van der Ende, 2001) is a 112-item questionnaire designed to assess a wide range of affective and behavioral problems experienced by adolescents during the past 6 months. Items are scored on a 3-point Likert scale ranging from 0 (not at all) to 2 (very often). The YSR yields 8 empirically derived syndrome scales and 6 DSM-oriented scales. This study examined 3 syndrome scales (e.g. Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior) and 3 DSM-oriented scales (e.g. Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems). In the current study internal consistency was good for the following scales: Rule-Breaking Behavior (α = .82; MIC = .26); Aggressive

Behavior (α = .82; MIC = .23); Attention Deficit/Hyperactivity Problems (α = .73; MIC = .28); and Conduct Problems (α = .85; MIC = .30). Although the MIC of all scales are in the .15 to .50 range, alphas were lower for the scales Attention Problems (α = .58; MIC = .17); and Oppositional Defiant Problems (α = .58; MIC = .23).

For *Self-Reported Offending and Anti-Social Behavior* we mainly used the categories used in the original study of Andershed et al. (2001). Participants were asked to indicate how many times they were involved in a range of antisocial acts over the past year, namely: *property offenses* (e.g. shoplifting); *serious property offenses* (e.g. burglary); *violent offences* (e.g. making threats); *serious violent offences* (e.g. extreme physical violence); *vandalism* (e.g. destroying public property); *truancy*; *use of illegal drugs; dealing illegal drugs and sexual offenses*[3]. Additionally, similar to the original study of Andershed et al. (2002) *delinquent versatility* was calculated by the number of different antisocial acts in which the participants had engaged during the past year.

Overview of Statistical Analysis

CFAs were conducted using Lisrel 8.71 (Jöreskog & Sörbom, 1993). Maximum likelihood estimation was used to fit the three-factor model for the total sample, for different education types (i.e. GSE and SSE), and for boys and girls. Correlations between the latent variables were permitted and the error covariances between the observed variables were zero. Since the chi-square test statistic (χ^2) is highly dependent on sample size, the goodness of fit was evaluated based on several other fit indices, namely: the root mean square error of approximation (RMSEA; Steiger, 1990), the standardized root mean square residual (SRMR; Hu & Bentler, 1999), the comparative fit index (CFI; Bentler, 1990), the goodness-of-fit index (GFI; Jöreskog & Sörbom, 1989), and the adjusted goodness-of-fit index (AGFI; Jöreskog & Sörbom, 1989). The following criterion values were used as standards for an acceptable fit: χ^2/df ratio of 2 or less, CFI and GFI values exceeding .90; SRMR below .09; RMSEA lower then .06 and AGFI value exceeding .85 (Browne & Cudeck, 1993; Hu & Bentler, 1999; Jöreskog & Sörbom, 1993).

Measurement invariance was tested with the CFI-value (Chueng & Rensvold, 2002). The hypothesis of invariance was accepted if the difference in CFI (ΔCFI) between a hypothetical model (H1), in which all factor-loadings were equal across groups, and an unconstrained multi-group model (H0), was smaller than or equal to .01.

Internal consistency of the YPI and YPI-S total score and (sub)scales was investigated by means of both the Cronbach's alpha coefficient and the mean inter-item correlations (MIC). Cronbach's alpha coefficients of less than .60 are considered poor, marginal from .60 to .69, acceptable from .70 to .79, and good if exceeding .80 (Barker, Pistrang, & Elliott, 2002). MIC values in the range of .15 to .50 can be considered adequate, and between .20 and .40 optimal (Briggs & Cheek, 1986; Clarck & Watson, 1995; Nunnally & Bernstein, 1994).

Convergent and criterion validity were examined using Pearson correlations between the YPI-S total score and subscales with self-reported offending and anti-social behavior in both samples, and psychopathic traits in the referred sample. According to Dancy and Reidy's (2004) categorization Pearson correlation coefficients between .1 and .3 are weak, between .4 and .6 moderate, and between .7 and .9 strong.

RESULTS

Descriptive statistics psychopathic traits [4]

The mean scores (M) and standard deviations (SD) for the YPI-S total score and scales can be found in Table 1. For the community and referred sample the mean YPI-S total score was 32.06 and 36.44 respectively. Participants from the referred sample scored significantly higher on all YPI-S facet and total scores than participants from the community sample. Boys in the community sample scored significantly higher on all YPI-S facet and total scores than girls. Students from Special Secondary Education (SSE) scored significantly higher than students from General Secondary Education (GSE), except for the GM facet score.

Table 1

Mean (M) and Standard Deviations (SD) for the YPI-S

	n	YPI-S	Possible Range	M	SD	t	df
Total Samples: Community versus Referred							
Community	1670	Total	0-72	32.06	7.56		
Referred	62			36.44	8.52	4.45**	1730
Community	1670	GM	0-24	10.47	3.62		
Referred	62			11.50	4.20	2.19*	1730
Community	1670	CU	0-24	9.21	3.02		
Referred	62			10.90	3.81	3.46*	63.886
Community	1670	II	0-24	12.39	3.07		
Referred	62			14.03	3.39	4.14**	1730
Community: Girls versus Boys							
Girls	965	Total	0-72	30.16	6.78		
Boys	705			34.67	7.78	12.35**	1388.82
Girls	965	GM	0-24	9.66	3.32		
Boys	705			11.58	3.73	10.88**	1410.45
Girls	965	CU	0-24	8.36	2.54		
Boys	705			10.37	3.24	13.66**	1286.73
Girls	965	II	0-24	12.14	3.04		
Boys	705			12.73	3.08	3.88**	1668
Community: GSE versus SSE							
GSE	1132	Total	0-72	31.39	7.19		
SSE	347			33.79	8.35	4.84**	512.86
GSE	1132	GM	0-24	10.41	3.55		
SSE	347			10.63	3.93	.93	530.03
GSE	1132	CU	0-24	8.74	2.84		
SSE	347			10.47	3.21	8.96**	522.96
GSE	1132	II	0-24	12.23	2.91		
SSE	347			12.70	3.47	2.27*	504.07

Note. YPI-S = Youth Psychopathic Traits Inventory-Short Version; GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive –Irresponsible Factor; GSE = General Secondary Education; SSE = Special Secondary Education.

*: $p < .05$; **: $p < .001$

Factorial Validity and Measurement Invariance

CFA was used to evaluate the factor structure of the YPI and the YPI-S. The model tested for the YPI assumes that the instrument consists of ten subscales (five items each), clustered into three second-order factors. The model tested for the YPI-S assumes that the 18 items load on three latent factors. Fit indices for the YPI and for the YPI-S are shown in Table 2. The results indicate that the model-fit of the YPI factor model was sub-optimal: the value of the RMSEA is above .06, and the values of two other fit indices (i.e. GFI and AGFI) are below the cut-off for good fit. Moreover, this model has a poor fit for both boys and girls, and for students from General Secondary Education (GSE) and Special Secondary Education (SSE) separately. The model-fit of the YPI-S factor model was excellent: all fit indices meet the cut-off criteria. Furthermore, this model has a good fit for both boys and girls, and for both students from GSE and from SSE.

Subsequently, measurement invariance of the YPI and the YPI-S factor models was tested across gender, and across two types of education (GSE and SSE). For the YPI factor model, we observed that across boys and girls, the ΔCFI between the hypothetical model (CFI H1 =.924) and the unconstrained multi-group model (CFI H0 =.926) is smaller than .01. Furthermore, across students from GSE and SSE we found ΔCFI =.001 (CFI H0=.930 AND CFI H1=.931). For the YPI-S, we observed that across boys and girls, the ΔCFI between the hypothetical model (CFI H1 =.951) and the unconstrained multi-group model (CFI H0 =.951) is smaller than .01. Furthermore, across students from GSE and SSE we found ΔCFI =.001 (CFI H0=.959 AND CFI H1=.958). These results indicate that measurement invariance can be assumed across gender and type of education, for both the YPI and the YPI-S.

Table 2

Fit Indices for CFA of the three-factor model

Model	n	χ^2	df	RMSEA	SRMR	CFI	GFI	AGFI
YPI (items)								
Total sample	1670	7750.4	1172	.07	.06	.94	.81	.79
Boys	705	3767.2	1172	.06	.06	.93	.80	.78
Girls	965	5130.7	1172	.07	.06	.92	.80	.78
GSE	1132	6546.8	1172	.07	.06	.93	.78	.76
SSE	347	2263.4	1172	.06	.06	.94	.76	.72
YPI-short version								
Total sample	1670	717.1	132	.05	.06	.96	.95	.94
Boys	705	364.2	132	.05	.06	.95	.95	.93
Girls	965	445.8	132	.05	.06	.95	.95	.94
GSE	1132	554.5	132	.05	.06	.96	.95	.93
SSE	347	199.1	132	.04	.06	.97	.94	.92

Note. χ^2 = Chi-square; df = degrees of freedom; RMSEA = Root Mean Square Error of Approximation; SRMR = Standardized Root Mean Square Residual; CFI = Comparative Fit Index; GFI = Goodness of Fit Index; AGFI = Adjusted Goodness of Fit Index, GSE = General Secondary Education; SSE = Special Secondary Education.

The items of the YPI and their standard loadings on the three factors for the total community sample are displayed in table 3. Item loadings range from .28 to .71. Table 4 presents the items of the YPI-S and their standardized loadings on the three factors for the total community sample. Item loadings range from .35 to .77, except for the fifth YPI-S item ('skipping school') which shows a rather small loading of .19, meaning that this item explains only 3.6% of the variance of the II-factor[5].

The latent factors of the YPI factor model are moderately to strongly correlated: $r_{CU\text{-}GM}$ = .69, $r_{II\text{-}GM}$ = .76, and $r_{II\text{-}CU}$ = .62. The latent factors of YPI-S factor model are moderately correlated, further confirming the validity of the three factor model for the YPI-S: $r_{CU\text{-}GM}$ = .60, $r_{II\text{-}GM}$ = .47, and $r_{II\text{-}CU}$ = .35.

Table 3

Standardized factor loadings for the three-factor-model of the Youth Psychopathic Traits Inventory (*n*=1670)

YPI item	Description	GM	CU	II
YPI 6	It's easy for me to charm and seduce others to get what I want from them.	.58		
YPI 33	Pretty often I act charming and nice, even with people I don't like, in order to get what I want.	.57		
YPI 14	I have the ability to con people by using my charm and smile.	.67		
YPI 38	When I need to, I use my smile and my charm to use others.	.66		
YPI 27	When someone asks me something, I usually have a quick answer that sounds believable, even if I've just made it up.	.58		
YPI 10	I'm better than everyone on almost everything.	.47		
YPI 37	I'm more important and valuable than other people.	.54		
YPI 41	I am destined to become a well-known, important and influential person.	.55		
YPI 19	I have talents that go far beyond other people's.	.45		
YPI 30	The world would be a better place if I were in charge.	.49		
YPI 43	Sometimes I find myself lying without any particular reason.	.47		
YPI 24	Sometimes I lie for no reason, other than because it's fun.	.51		
YPI 50	I've often gotten into trouble because I've lied too much.	.46		
YPI 47	I like to spice up and exaggerate when I tell about something.	.52		
YPI 7	It's fun to make up stories and try to get people to believe them.	.55		
YPI 15	I am good at getting people to believe me when I make something up.	.67		
YPI 31	To get people to do what I want, I often find it efficient to con them.	.68		
YPI 11	I can make people believe almost anything.	.66		
YPI 46	It has happened that I've taken advantage of (used) someone in order to get what I want.	.60		
YPI 20	It's easy for me to manipulate people.	.71		
YPI 44	To feel guilty and remorseful about things you have done that have hurt other people is a sign of weakness.		.55	
YPI 8	I have the ability not to feel guilt and regret about things that I think other people would feel guilty about.		.49	
YPI 28	When someone finds out about something that I've done wrong, I feel more angry than guilty.		.45	
YPI 48	To feel guilt and regret when you have dome something wrong is a waste of time.		.59	
YPI 21	I seldom regret things I do, even if other people feel that they are wrong.		.55	
YPI 2	I usually feel calm when other people are scared.		.35	
YPI 36	What scares other usually doesn't scare me.		.44	
YPI 25	To be nervous and worried is a sign of weakness.		.54	
YPI 45	I don't let my feelings affect me as much as other people's feelings seem to affect them.		.46	
YPI 39	I don't understand how people can be touched enough to cry by watching things on TV or movie.		.51	

(table continues)

YPI 12	I think that crying is a sign of weakness, even if no one sees you.	.53	
YPI 17	When other people have problems, it is often their own fault. Therefore one should not help them.	.46	
YPI 35	I often become sad or moved by watching sad things on TV or film.	.29	
YPI 49	I usually become sad when I see people crying or being sad.	.28	
YPI 23	It's important to me not to hurt other people's feelings.	.31	
YPI 01	I like to be where exciting things happen.		.47
YPI 22	I like to do things just for the thrill of it.		.61
YPI 42	I like to do exciting and dangerous things, even if it is forbidden or illegal.		.67
YPI 29	I get bored quickly by doing the same thing over and over.		.39
YPI 04	I get bored quickly when there is too little change.		.36
YPI 03	I prefer to spend my money right away rather than save it.		.41
YPI 26	If I get the chance to do something fun, I do it no matter what I had been doing before.		.46
YPI 32	It often happens that I do things without thinking ahead.		.55
YPI 18	It often happens that I talk first and think later.		.49
YPI 09	I consider myself as a pretty impulsive person.		.48
YPI 05	I have probably skipped school or work more than most other people.		.36
YPI 40	I often don't/didn't have my school or work assignments done on time.		.50
YPI 13	If I won a lot of money in the lottery I would quit school or work and just do things that are fun.		.38
YPI 16	I have often been late to work or classes in school.		.45
YPI 34	It has happened several times that I have borrowed something and the lost it.		.41

Note. YPI = Youth Psychopathic Traits Inventory; GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible Factor.

Table 4

Standardized factor loadings for the three-factor-model of the Youth Psychopathic Traits Inventory-Short version (*n*=1670)

YPI item	YPI-S item	GM	CU	II
YPI 14	04. I have the ability to manipulate people.	.71		
YPI 15	05. I am good at getting people to believe me when I make something up.	.63		
YPI 19	08. I have talents that go far beyond other people's.	.45		
YPI 20	09. It's easy for me to manipulate people.	.74		
YPI 38	14. When I need to, I use my smile and charm to use others.	.68		
YPI 41	16. I am destined to become a well-known important and influential person.	.68		
YPI 12	03. I think that crying is a sign of weakness even if no on sees you.		.57	
YPI 17	17. When other people have problems, it is often their own fault. Therefore one should not help them.		.45	
YPI 25	10. To be nervous and worried is a sign of weakness.		.59	
YPI 39	15. I don't understand how people can be touched enough to cry by watching things on TV or movie.		.49	
YPI 44	17. To feel guilty & remorseful about things you have done that have hurt other people is a sign of weakness		.59	
YPI 45	18. I don't let my feelings affect me as much as other people's feelings seem to affect them.		.56	
YPI 05	01. I have probably skipped school or work more than most other people.			.19
YPI 09	02. I consider myself as a pretty impulsive person.			.54
YPI 18	07. It often happens that I talk first and think later.			.71
YPI 29	11. I get bored quickly by doing the same thing over and over.			.36
YPI 32	12. It often happens that I do things without thinking ahead.			.77
YPI 34	13. It has happened several times that I have borrowed something and the lost it.			.35

Note. YPI = Youth Psychopathic Traits Inventory; YPI-S = Youth Psychopathic Traits Inventory-Short Version; GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible Factor

Internal consistency

Cronbach's alpha coefficients and mean inter-item correlations for the YPI and the YPI-S total and factor (sub)scales are shown in Table 5. For the YPI-S, in both samples, Cronbach's alphas for the YPI-S total score and the GM scale (interpersonal dimension) exceeded the .70 criterion. Alpha scores for the CU and II scales proved to be marginal. In the SSE sample alpha scores for the CU scale were poor (α = .59). For the YPI, in both

samples, most alpha scores for the subscales Remorselessness, Unemotionality, Callousness, Thrill-Seeking, Impulsivity and Irresponsibility did not exceed the .70 criterion.

In both samples, the MIC values for the YPI-S total score and all dimensions were largely optimal. In general, the MIC values for the YPI total score and (sub)dimensions were adequate to optimal, apart from the sub-dimensions Dishonest Charm (MIC = .54) and Manipulativeness (MIC = .52) in the referred sample, and apart from the sub-dimension Callousness in the referred (MIC = .13), GSE (MIC = .13), and SSE (.14) sample. Moreover, in the SSE sample the MIC for the CU scale was not in the recommended range (MIC = .10). In general, the MIC values for the CU and GM scales were better for the YPI-S than for the YPI.

Criterion Validity

Table 6 presents the correlation coefficients between the YPI-S total and facet scores and various forms of self-reported antisocial behavior and externalizing psychopathology (YSR-scores). In the community sample, we found significant positive correlations between the scores on nearly all measures of externalizing and antisocial behavior and the YPI-S total and factor scores. The correlation between Attention Problems and CU factor scores, and between sexual offenses and the II factor scores were non-significant. By and large, the strongest correlations were found between the YPI-S total and factor scores and violent offences, serious violent offences, conduct problems and delinquent versatility. Similar correlations were found for boys, girls, and for students from GSE and SSE separately (details available upon request). Strong correlations were also found between the YPI-S total and the II-factor scores and the various forms of self-reported externalizing psychopathology (i.e. YSR-scores).

In the referred sample, only involvement in violent and serious violent offenses was significantly and positively correlated with YPI-S total and factor scores. The absent correlation between YPI-S and sexual offenses was due to the fact that none of the juvenile delinquents reported sexual offenses.

Table 5

Cronbach's Alpha and Mean Inter-Item Correlations for the YPI and the YPI-S

		Community Sample										Referred	
		TOT[a]		GSE[b]		SSE[c]		Girls[d]		Boys[e]		Sample[f]	
		α	MIC	α	MIC	α	MIC	α	MIC	α	MIC	α	MIC
YPI	DCH	.79	.44	.80	.45	.76	.39	.80	.45	.76	.39	.85	.54
	GRA	.77	.42	.80	.45	.73	.36	.74	.38	.76	.40	.79	.43
	LY	.75	.38	.76	.14	.76	.40	.75	.39	.72	.35	.71	.34
	MAN	.74	.36	.74	.37	.74	.36	.71	.33	.73	.35	.84	.52
	REM	.67	.29	.69	.32	.51	.17	.62	.25	.68	.30	.68	.30
	UNE	.61	.24	.64	.26	.48	.16	.54	.20	.57	.21	.73	.35
	CAL	.61	.23	.63	.14	.47	.14	.53	.18	.50	.17	.41	.13
	THR	.67	.29	.71	.33	.62	.25	.68	.30	.63	.26	.69	.31
	IMP	.66	.28	.65	.27	.68	.30	.68	.30	.63	.26	.70	.33
	IRR	.60	.25	.58	.24	.56	.22	.59	.24	.57	.23	.58	.23
	Total	.93	.20	.93	.21	.92	.19	.92	.18	.92	.18	.92	.18
	GM	.91	.33	.91	.33	.91	.33	.90	.32	.90	.29	.90	.31
	CU	.79	.21	.81	.24	.62	.10	.72	.16	.77	.19	.80	.21
	II	.81	.22	.80	.22	.80	.21	.82	.23	.78	.19	.81	.23
YPI-S	Total	.82	.21	.82	.21	.81	.19	.81	.19	.81	.19	.80	.18
	GM	.79	.39	.80	.40	.79	.38	.79	.38	.77	.36	.81	.42
	CU	.69	.27	.71	.30	.59	.19	.63	.23	.66	.25	.69	.25
	II	.64	.22	.65	.22	.63	.22	.67	.24	.60	.19	.60	.21

Note. TOT = Total Community Sample; GSE = General Secondary Education; SSE = Special Secondary Education; Total = Total score of the Youth Psychopathic Traits Inventory; MIC = Mean Inter-Item Correlation; GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible factor; YPI = Youth Psychopathic Traits Inventory; YPI-S = YPI-Short Version; Dch = Dishonest Charm; Gra = Grandiosity; Ly = Lying; Man = Manipulation; Rem = Remorselessness; Une = Unemotional; Cal = Callousness; Thr = Thrill-seeking; Imp = Impulsive; Irr = Irresponsible; α = Cronbach Alpha; MIC = Mean inter-item correlation

[a] :n = 1670; [b] :n = 1132; [c] :n = 347; [d] :n = 965; [e]: n = 705; [f]: n = 62

Table 6

Pearson's correlations between YPS-S dimensions, and different measures of self-reported antisocial behavior and externalizing psychopathology in the total community sample and the referred sample

	Community Sample (*n* =1518)				Referred Sample (*n* = 59)			
	TOT	GM	CU	II	TOT	GM	CU	II
Self-Reported Offending								
(Andershed et al., 2001)								
Property offenses	.33**	.32**	.15**	.28**	.11	-.03	.17	.13
Serious property offenses	.29**	.23**	.24**	.20**	.13	.02	.22	.06
Violent offences	.41**	.37**	.26**	.31**	.38**	.31*	.26*	.28*
Serious violent offences	.44**	.37**	.32**	.33**	.50**	.43**	.38**	.31*
Vandalism	.33**	.28**	.25**	.25**	.21	.20	.15	.13
Use of illegal drugs	.25**	.21**	.14**	.21**	.09	.14	-.08	.16
Dealing illegal drugs	.20**	.15**	.14**	.17**	.06	.18	.04	-.11
Sexual offenses	.12**	.11**	.08**	.04	//	//	//	//
Truancy	.30**	.23**	.21**	.27**	.11	.06	.05	.14
Delinquent versatility	.47**	.38**	.36**	.35**	.32	.29	.11	.33
YSR [a]								
Attention Problems	.30**	.19**	.08	.43**	//	//	//	//
Rule-Breaking Behavior	.44**	.37**	.28**	.33**	//	//	//	//
Aggressive Behavior	.40**	.30**	.19**	.42**	//	//	//	//
AD/H Problems	.43**	.26**	.15**	.58**	//	//	//	//
OD Problems	.36**	.28**	.21**	.34**	//	//	//	//
Conduct Problems	.44**	.34**	.31**	.36**	//	//	//	//

Note. TOT= Total score; GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible factor; AD/H = Attention Deficit/Hyperactivity; OD = Oppositional Defiant.

[a]: n = 336 (127 SSE and 209 GSE)

** : < .01 level; *: <.05 level

Convergent Validity

Correlations between the YPI-S and PCL-YV (table 7) were non-significant to moderate (range: -.04 to .38). The strongest, and conceptually relevant correlation was between the interpersonal factors of both the YPI-S and the PCL:YV. Additionally, there was

a weak, but significant correlation between the conceptually linked YPI-S total score and the PCL:YV total scores. The II-factor of the YPI did not significantly correlate with any of the PCL factors, nor the PCL:YV total score. The CU factor of the YPI did not significantly correlate with the corresponding Affective factor of the PCL:YV, but was significantly associated with the Antisocial Behavior factor of the PCL:YV.

Table 7

Correlations between the YPI and YPI-Short Version: Factors and Total Scores in the referred sample (*n* = 62)

	YPI-S			
	GM	**CU**	**II**	**YPI-S total**
PCL:YV				
Interpersonal Factor	**.38****	.25	.06	.32*
Affective Factor	.16	**.23**	.13	.23
Behavioral Factor	-.04	.15	**.23**	.14
Total of Three-Factor Model	.19	.25	.17	**.27***
Antisocial Behavior Factor	.09	.28*	.21	.25
PCL:YV total	.20	.29*	.17	.30*

Note: YPI-S = Youth Psychopathic Traits-Short Version; PCL:YV = Psychopathy Checklist: Youth Version; GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible factor. Conceptually corresponding variables are in bold.

** : p <.01; *: p <.05

DISCUSSION

A major limitation in previous factor analytic studies on the YPI has been the use of parcel-based CFA, without addressing the assumption of the unidimensionality of the YPI subscales. In order to address this limitation, the present study tested the three-factor model of the YPI by using the 50 items of the YPI as manifest variables and including the 10 YPI subscales as relevant first-order factors. Our findings indicate that this factor model has a sub-optimal fit for the total community sample, for both boys and girls separately, and for

both students from General Secondary Education (GSE) and Special Secondary Education (SSE) separately. On the other hand, and in line with van Baardewijk et al. (2010) and Colins at al. (2012), the results of the CFA supported the three factor structure of the more recently developed YPI-S for the total community sample, for boys and girls separately, and for GSE-pupils and SSE-pupils separately. Tests of *measurement invariance* indicated that the factor models of both the YPI and YPI-S are invariant across gender and across different types of education (i.e. GSE and SSE), suggesting that the interpretation of the meaning of affective, interpersonal and behavioral psychopathy-like characteristics is the same across samples.

Significant results were found for the relationship between psychopathic traits (as measured by the YPI-S) and gender and type of secondary education. In line with previous YPI-S and PCL:YV studies (e.g., Colins et al., 2012; Forth, Brown, Hart, & Hare, 1996) males in the community sample scored higher on psychopathic traits than females. The results indicate that pupils from SSE score higher on psychopathic traits than pupils from GSE, except for GM psychopathic features. In addition, participants of the referred sample scored significantly higher on psychopathic traits than participants from the community sample.

Our review of previous studies has indicated that there is a considerable problem with the internal consistency of the YPI Callous-Unemotional (CU) Scale and CU Subscales in particular. While in the study of van Baardewijk et al. (2010), the short version of the YPI proved to be a reliable instrument, in our study the alphas for the CU and II YPI-S scales were rather marginal (ranging from .59 to .71). On the other hand, all MIC values indicated that the YPI-S can be considered a reliable instrument. For the YPI, the alphas for several CU and II subscales were poor across different samples (GSE, SSE, girls and boys), which were accompanied by several less optimal MIC values. In general, compared to the YPI, the MIC values for the CU and GM scale were more optimal for the YPI-S. Taken together, these findings indicate that the YPI-S has a better internal consistency than the YPI.

Moreover, in our study the *criterion validity* of the YPI-S was supported. In line with previous research (e.g. Colins et al., 2012) in the community sample, nearly all concurrent associations between the YPI-S total and factor scores and various measures of antisocial and externalizing behavior were significant. Similar results were found for boys, girls, and for students from GSE and SSE separately. In the referred sample the YPI-S total and factor scores were only concurrently associated with violent and serious violent offenses, but not with less severe antisocial behavior. Surprisingly, there were no significant concurrent

associations between the YPI-S total and facet scores and delinquent versatility. This may be caused by the fact that the referred sample consisted mainly of juvenile repeat offenders with an extensive judicial and social care history, and less of first time offenders.

Finally, we explore the convergent validity of the YPI-S and the PCL:YV in a referred sample of adolescents. In line with previous studies with the original version of the YPI (e.g. Chauhan, Ragbeer, Burnette, Oudekerk, Reppucci, & Moretti, 2012; Dolan & Rennie, 2006) correlations between the total and factor scores of both measures ranged from non-significant to moderate. Comparable to previous studies with the YPI (e.g. Cauffman et al., 2009; Skeem & Cauffman, 2003), the strongest concurrent association was found between the interpersonal factor scores of both the YPI-S and the PCL:YV.

The results of the current study should be interpreted in light of limitations that should be addressed in future research. First, this study is limited by its cross-sectional design, excluding causal interpretations of the relationships between psychopathic features and various forms of antisocial and externalizing behavior. Second, all YPI-S data in this study were obtained from the administration of the long version of the YPI, as we also wanted to investigate the three-factor structure model of the original version of the YPI. Third, although this study was the first to investigate the convergent validity of the YPI-S in a referred sample, the sample size was too small to draw robust conclusions. Moreover, the referred sample mainly composed of persistent juvenile offenders. Future research with the YPI-S should include more heterogeneous samples of both frequent and first time juvenile offenders. Finally, the current study only examined the association between YPI-S scores and different measures of externalizing and antisocial behavior. Future validity studies with the YPI-S should include other relevant criterion variables, such as internalizing psychopathology.

Despite these limitations the present study has several strengths. First, because of the large community sample size, it was possible to test the three-factor model of the YPI by using the items as manifest variables. Secondly, the current study is the first of its kind to explore the convergent validity of the YPI-S in a referred sample of adolescents. Finally, the current study included pupils from special needs secondary education, and was the first to explore differences in the number of psychopathic traits across type of education. The findings indicate that the YPI-S is a valid and internally consistent instrument to assess psychopathic traits in this group of pupils as well.

NOTES

1. For each measure separately, series mean replacement was used in case of ≤ 5% missing item scores, in both the community sample and the referred sample.
2. Inter-rater reliability was conducted independently by a clinical psychologist, who received specialist training in PCL:YV assessment and rating. Inter-rater reliability was calculated for 18 of the 62 PCL:YV's available in this study.
3. In the original study of Andershed et al. (2001) 'truancy'; 'dealing illegal drugs' and 'sexual offenses' were not included as separate categories.
4. Because factor analysis yielded the best model fit for the YPI-S, further statistical analyses were performed on the YPI-S data only. Therefore, we only display the descriptive statistics for the YPI-S.
5. Colins et al. (2012) also report a low factor loading for this item.

REFERENCES

Achenbach, T., & Rescorla, L. (2001). *Manual for ASEBA school-age forms & profiles.* Burlington: University of Vermont.

Andershed, H., Hodgins, S., & Tengström , A. (2007). Convergent validity of the Youth Psychopathic Traits Inventory (YPI): Association with the Psychopathy Checklist: Youth Version (PCL:YV). *Assessment, 14*, 144-154.

Andershed, H., Kerr, M., Stattin, H., & Levander, S. (2001). Psychopathic traits in non-referred youths: initial test of a new assessment tool. In E. Blaauw, & L. Sheridan (Eds.), *Psychopaths: Current international perspectives* (pp. 131-158). The Hague: Elsevier.

Bandalos, D. L., & Finney, S. J. (2001). Item parceling issues in structural equation modeling. In G. A. Marcoulides & R. E. Schumacker (Eds.), *Advanced structural equation modeling: New developments and techniques.* Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in Clinical Psychology (2nd ed.).* Chichester, England: John Wiley & Sons, LTD.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*, 238-246.

Bland, J., & Altman , D. (1997). Statistics notes: Cronbach's alpha. *British Medical Journal, 314*, 572.

Briggs, S. R., & Cheek, J. M. (1986). The role of factor analysis in the development and evaluation of personality scales. *Journal of Personality, 54*, 106-148.

Browne, M. W., & Cudeck, R. (1993). Alternative ways of assessing fit. In K. A. Bollen, & J. S. Long (Eds.), *Testing structural equation models* (pp. 136-162). Newbury Park, CA: Sage.

Byrne, B. M. (1994). *Structural equation modeling with EQS and EQS/windows.* Thousand Oaks, CA: Sage Publications.

Campbell, M. A., Doucette, N. L., & French, S. (2009). Validity and Stability of the Youth Psychopathic Traits Inventory in a Nonforensic Sample of Young Adults. *Journal of Personality Assessment, 91*, 584-592.

Cauffman, E., Kimonis, E. R., Dmitrieva, J., & Monahan, K. C. (2009). A Multimethod Assessment of Juvenile Psychopathy: Comparing the Predictive Utility of the PCL:YV, YPI, and NEO PRI. *Psychological Assessment, 21*, 528-542.

Chabrol, H., & Saint-Martin, C. (2009). Psychopathic Traits and Suicidal Ideation in High-School Students. *Archives of Suicide Research, 13*, 64-73.

Chabrol, H., van Leeuwen, N., Rodgers, R. F., & Gibbs, J. C. (2011). Relations between self-serving cognitive distortions, psychopathic traits, and antisocial behavior in a non-clinical sample of adolescents. *Personality and Individual Differences, 51, 887-892.*

Chauhan, P., Ragbeer, S. N., Burnette, M. L., Oudekerk, B., Reppucci, N. D., & Moretti, M. M. (2012). Comparing the Youth Psychopathic Traits Inventory (YPI) and the Psychopathy Checklist-Youth Version (PCL:YV) Among Offending Girls. *Assessment, XX(X)*, 1-14.

Chen, F. F. (2005). Testing measurement invariance of second-order factor models. *Structural Equation Modeling, 12*, 471-492.

Chueng, G. W., & Rensvold, R. B. (2002). Evaluating goodness-of-fit indexes for testing measurement invariance. *Structural Equation Modeling, 9*, 233-255.

Clarck, L. A., & Watson, D. (1995). Constructing validity: Basic Issues in Objective Scale Development. *Psychological Assessment, 7*, 309-319.

Colins, O. F., Noom, M., & Vanderplasschen, W. (2012). Youth Psychopathic Traits Inventory-Short Version: A Further Test of the Internal Consistency and Criterion Validity. *Journal of Psychopathology and Behavioral Assessment, 4*, 476-486.

Colins, O. F., Vermeiren, R., De Bolle, M., & Broeckaert, E. (2012). Self-reported psychopathic-like traits as predictors of recidivism in detained male adolescents. *Criminal Justice and Behavior, 39*, 1421-1435.

Cooke, D., & Michie, C. (2001). Refining the construct of psychopathy: Toward a hierarchical model. *Psychological Assessment , 13*, 171-188.

Dancey, C., & Reidy, J. (2004). *Statistics without maths for psychology: using SPSS for windows.* London: Prentice Hall.

Declercq, F., Markey, S., Vandist, K., & Verhaeghe, P. (2009). The Youth Psychopathic Trait Inventory: factor structure and antisocial behaviour in non-referered 12-17-year olds. *Journal of Forensic Psychiatry & Psychology, 20*, 577-594.

Decuyper, M., Colins, O. F., De Clercq, B., Vermeiren , R., Broeckaert, E., Bijtebier P, et al. (2013). Latent Personality Profiles and the Relations with Psychopathology and Psychopathic Traits in Detained Adolescents. *Child Psychiatry & Human Development, 44*, 217-232.

DeVellis, R. (2003). *Scale development: theory and applications.* Thousand Oaks, CA: Sage.

Dolan, M. C., & Rennie, C. E. (2006a). Reliability, validity, and factor structure of the Swedish Youth Psychopathic Trait Inventory in a UK sample of conduct disordered boys . *Journal of Forensic Psychiatry & Psychology, 17*, 217-229.

Dolan, M. C., & Rennie, C. E. (2006b). Psychopathy Cheklist: Youth Version and Youth Psychopathic Trait Inventory: A comparison study. *Personality and Individual Differences, 41*, 779-789.

Dolan, M. C., & Rennie, C. E. (2007). The relationship between psychopathic traits measured by the Youth Psychopathic trait Inventory and psychopathology in a UK sample of conduct disordered boys. *Journal of Adolescence, 30*, 601-611.

Fanti, K. A., Frick, P. J., & Georgiou, S. (2009). Linking callous-unemotional traits to instrumental and non-instrumental forms of aggression. *Journal of Psychopathology & Behavior Assessment, 31*, 285-298.

Farrington , D. P. (2005). The importance of child and adolescent psychopathy. *Journal of Abnormal Child Psychology, 33*, 489-497.

Fite, P. J., Stoppelbein, L., & Fabiano, G. A. (2009). Confirmatory factor analysis of the Antisocial Process Screening Device with a clinical impatient population. *Assessment, 16*, 103-114.

Flight, J. I., & Forth , A. E. (2007). Instrumentally violent youths: The roles of psychopathic traits, empathy, and attachment. *Criminal Justice & Behavior, 34*, 739-751.

Forsman, M., Lichtenstein, P., Andershed, H., & Larsson, H. (2008). Genetic Effects Explain the Stability of Psychopathic Personality From Mid- to Late Adolescence. *Journal of Abnormal Psychology, 117*, 606-617.

Forth , A. E., Kosson, D., & Hare, R. D. (2003). *The Psychopathy Checklist: Youth Version.* Toronto, Ontario: Multi-Health Systems.

Forth, A. E., & Burke, H. C. (1998). Psychopathy in adolescence: Assessment, violence, and developmental precursors. In D. J. Cooke, A. E. Forth, & R. D. Hare (Eds.), *Psychopathy: Theory, research, and implications for society* (pp. 205-230). Dordrecht: Kluwer.

Forth, A. E., Brown, S. L., Hart, S. D., & Hare, R. D. (1996). The assessment of psychopathy in male and female noncriminals: Reliability and validity. *Personality and Individual Differences, 20*, 531-543.

Frick, P. J., Bodin, S. D., & Barry , C. T. (2000). Psychopathic traits and conduct problems in community and clinic-referred samples of children: Further development of the psychopathy screening device. *Psychological Assessment, 12*, 382-393.

George, D., & Mallery, P. (2003). *SPSS for Windows step by step: A simple guide and reference - 11.0 update* (4th ed.). Boston: Allyn & Bacon.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist (2nd ed.).* Toronto, ON: Multi Health Systems.

Hare, R. D. (1996). Psychopathy: A clinical construct whose time has come. *Criminal Justice and Behavior, 23*, 25-54.

Hare, R. (1991). *Manual for the Hare Psychopathy Checklist-Revised.* Toronto: Multi-Health Systems.

Hare, R. D. (2003). *Hare Psychopathy Checklist (2nd ed.).* Toronto, ON: Multi Health Systems.

Hart, S. D., Forth, A. E., & Hare, R. D. (1991). The MCM-II as a measure of psychopathy. *Journal of Personality Disorders, 5*, 318-327.

Hillege, S., Das, J., & de Ruiter, C. (2010). The Youth Psychopathic traits Inventory: Psychometric properties and its relation to substance use and interpersonal style in a Dutch sample of non-referred adolescents. *Journal of Adolescence, 33*, 83-91.

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indices in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling, 6*, 1-55.

Jöreskog, K. G., & Sörbom, D. (1989). *LISREL 7: A guide to the program and applications (2nd ed.).* Chicago: SPSS.

Jöreskog, K. G., & Sörbom, D. (1993). *Lisrel 8: Structural Equation Modeling with the SIMPLIS command language.* Chicago: SSI Scientific Software International.

Kimonis, E. R., Frick, P. J., Cauffman, E., & Goldweber, A. (2012). Primary and secondary variants of juvenile psychopathy differ in emotional processing. *Development and Psychopathology, 24*, 1091-1103.

Kline, R. B. (1998). *Principles and practice of structural equation modeling.* New York: Guilford.

Kosson, D. S., Neumann, C. S., Forth, A. E., Salekin, R. T., Hare, R. D., Krischer, M. K., et al. (2013). Factor Structure of the Hare Psychopathy Checklist: Youth Version (PCL:YV) in Adolescent Females. *Psychological Assessment, 25*, 71-83.

Kotler, J. S., & McMahon, R. J. (2005). Child psychopathy: Theories, measurement, and relations with the development and persistence of conduct problems. *Clinical Child and Family Psychology Review, 8*, 291-325.

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*, 159-174.

Larsson, H., Andershed, H., & Lichtenstein, P. (2006). A Genetic Factor Explains Most of the Variation in the Psychopathic Personality. *Journal of Abnormal Psychology, 115*, 221-230.

Lynam, D. R. (1996). Early identification of chronic offenders: Who is the fledging psychopath? *Psychological Bulletin, 120*, 209-234.

MacCallum, R. C., Widaman, K. F., Zhang, K. F., & Hong, S. (1999). Sample size in factor analysis. *Psychological methods, 4*, 84-99.

Mailloux, D. L., Forth, A. E., & Kroner, D. G. (1997). Psychopathy and substance use in adolescent male offenders. *Psychological Reports, 80*, 529-530.

Nijhof, K. S., Vermulst, A., Scholte, R. H., van Dam, C., Veerman, J. W., & Engels, R. C. (2011). Psychopathic Traits of Dutch Adolescents in Residential Care: Identifying Subgroups. *Journal of Abnormal Child Psychology, 39*, 59-70.

Nunnally, J., & Bernstein, L. (1994). *Psychometric theory.* New York: McGraw-Hill Higher, INC.

Nyström, M. B., & Mikkelsen, F. (2013). Psychopathy-Related Personality Traits and Shame Management Strategies in Adolescents. *Journal of Interpersonal Violence, 28*, 519-537.

Poythress, N., Dembo, R., Wareham, J., & Greenbaum, P. (2006). Construct validity of the youth psychopathic traits inventory (YPI) and the antisocial process screening device (APSD) with justice-involved adolescents. *Criminal Justice and Behavior, 33*, 26-55.

Roose, A., Bijttebier, P., Claes, L., Lilienfeld, S. O., De Fruyt, F., & Decuyper, M. (2012). Psychopathic Traits in Adolescence and the Five Factor Model of Personality. *Journal of psychopathology and behavioral assessment, 34*, 84-93.

Roose, A., Bijtebier, P., Claes, L., & Lilienfeld, S. O. (2011). Psychopathic traits in adolescence: Associations with the revised Reinforcement Sensitivity Theory systems. *Personality and Individual Differences, 50*, 201-205.

Ručević, S. (2010). Psychopathic Personality Traits and Delinquent and Risky Sexual Behaviors in Croation Sample of Non-Referred Boys and Girls. *Law and Human Behavior, 34*, 379-391.

Saint-Martin, C., & Chabrol, H. (2010). Contribution of psychopathic traits to delinquent behaviors in a sample of high-school male students. *Encephale-Revue de Psychiatrie Clinique Biologique et Therapeutique, 36*, 155-158.

Salekin, R. T., Debus, S. A., & Barker, E. D. (2010). Adolescent Psychopathy and the Five Factor Model: Domain and Facet Analysis. *Journal of Psychopathology and Behavioral Assessment, 32*, 501-514.

Salihovic, S., Kerr, M., Ozdemir, M., & Pakalniskiene, V. (2012). Directions of Effects between Adolescent Psychopathic Traits and Parental Behavior. *Journal of Abnormal Child Psychology, 40*, 957-969.

Seals, R. W., Sharp, C., Ha, C., & Michonski , J. D. (2012). *Journal of Personallity Assessment, 94*, 232-243.

Sevecke, K., Lehmkuhl, G., & Krischer, M. K. (2008). Attention-deficit hyperactivity disorder and personality disorders in treated in-patient and incarcerated adolescents. *Praxis der Kinderpsychologie und Kinderpsychiatrie, 57*, 641-661.

Sherman, E. D., Lynam, D. R., & Heyde, B. (2014). Agreeableness accounts for the factor structure of the Youth Psychopathic Traits Inventory. *Journal of Personality Disorders, 28*, 262-280.

Skeem, J. L., & Cauffman, E. (2003). Views of the downward extension: Comparing the youth version of the psychopathy checklist with the youth psychopathic traits inventory. *Behavioral Sciences and the Law, 21*, 737-770.

Steiger, J. H. (1990). Structural model evaluation and modification: An interval estimation approach. *Multivariate Behavioral Research, 25*, 173-180.

Uzieblo, K., Verschuere, B., Van den Bussche , E., & Crombez, G. (2010). The Validity of the Psychopathic Personality Inventory-Revised in a Community Sample. *Assessment, 17*, 334-346.

van Baardewijk, Y., Andershed, H., Stegge, H., Nilsson, K. W., Scholte, E., & Vermeiren, R. (2010). Development and tests of short versions of the youth psychopathic traits inventory and the youth psychopathic traits inventory-child version. *European Journal of Psychological Assessment, 26*, 122-128.

Vaughn, M. G., DeLisi, M., Beaver, K. M., Wexler, J., Barth, A., & Fletcher, J. (2011). Juvenile Psychopathic Personality Traits are Associated with Poor Reading Achievement. *Psychiatric Quarterly, 82*, 177-190.

Veen, V. C., Stevens, G. W., Andershed , H., Raaijmakers, Q. A., Doreleijers, T. A., & Vollebergh, W. A. (2011). Cross-ethnic generalizability of the three-factor model of psychopathy: The Youth Psychopathic Traits Inventory in an incarcerated sample of native Dutch and Moroccan immigrant boys. *International Journal of Law and Psychiatry, 34*, 127-130.

Verhulst, F., & Van der Ende , J. (2001). *Handleiding voor de CBCL/6-18, YSR, en TRF (Dutch manual for CBCL/6-18, YSR, and TRF).* The Netherlands: Erasmus Universiteit Rotterdam.

Vitacco, M. J., Neumann, C. S., Caldwell, M. F., Leistico, A., & Van Rybroeck, G. J. (2006). Testing factor models of the Psychopathy Checklist - Youth Version and their association with instrumental aggression. *Journal of Personality Assessment, 87*, 74-83.

Walsh, Z., Allen, L. C., & Kosson , D. S. (2007). Beyond social deviance: substance use disorders and the dimensions of psychopathy. *Journal of personality disorders, 21*, 273-288.

Wareham, J., Dembo, R., Poythress, N. G., Childs, K., & Schmeidler, J. (2009). A Latent Class Factor Approach to Identifying Subtypes of Juvenile Diversion Youths Based on Psychopathic Features. *Behavioral Sciences & the Law, 27*, 71-95.

Appendix A: Internal Consistency of the Youth Psychopathic Traits Inventory in non-referred samples

Community / Non-referred Samples		YPI scales				YPI subscales									
		GM	**CU**	**II**	**TOT**	**DCH**	**GRA**	**LY**	**MAN**	**REM**	**UNE**	**CAL**	**THR**	**IMP**	**IRR**
Study	**Sample**	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)
Sherman et al., 2014	466 undergraduate students: 50% ♂	.92	.92	.93	NA	.79	.76	.74	.81	.76	.70	.61	.63	.68	.71
Nyström & Mikkelsen, 2013	196 high school students: 96 ♂; 100 ♀	.86	.80	.75	.74	NA									
Salihovic, Kerr et al., 2012	875 high school students: 464 ♂; 411 ♀														
	▪ Time 1	.83	.76	.77	NA	NA									
	▪ Time 2	.89	.88	.79	NA	NA									
	▪ Time 3	.87	.86	.77	NA	NA									
	▪ Time 4	.87	.86	.75	NA	NA									
Roose et al., 2012	152 high school students; all ♂	.80	.83	.90	NA	NA									
Seals, Sharp et al., 2012	171 non-referred children and adolescents; all ♂	.91	.83	.85	NA	NA									
Chabrol et al., 2011	972 high school students: 594 ♂, 378 ♀	NA	NA	NA	.81	NA									
Vaughn, DeLisi et al., 2011	432 middle school students	.86	.71	.83	.91	NA									
Roose, Bijtebier et al., 2011	830 high school students	.90 (.31)	.80 (.21)	.84 (.26)	.92 (.19)	NA									
Ručević, 2010	706 non-referred youth: 226 ♂; 480 ♀	.82 (.51)	.77 (.48)	.73 (.40)	NA NA	NA NA									
	▪ 226 ♂	.84	.75	.74	NA	NA									
	▪ 480 ♀	.77	.78	.73	NA	NA									

(table continues)

Study	Sample	GM	CU	II	TOT	DCH	GRA	LY	MAN	REM	UNE	CAL	THR	IMP	IRR
Uzieblo et al. 2010	672 participants from a community sample	.91	.79	.83	.91	NA									
Saint-Martin et al. , 2010	155 non-referred adolescents	.90	.81	.77	NA	NA									
Hillege et al., 2010	728 adolescents - secondary education														
	▪ 341 ♂	.84	.66	.71	.70	.76	.82	.70	.78	.68	.51	. 32	. 62	.60	.60
	▪ 387 ♀	.82	.60	.78	.74	.78	.74	.76	. 78	.63	.60	.52	.71	.72	.62
Van Baardewijk et al., 2010	Sample 1: 2105 adolescents; 49 % ♂	.91	.82	.83	.93	NA									
	Sample 2: 2159 adolescents; 49% ♂	.91	.81	.82	.93	NA									
Chabrol et al., 2009	312 high-school students: 132 ♂, 145 ♀	.90	.81	.77	NA	NA									
Declercq et al., 2009	536 adolescent high school students														
	▪ 235 ♂	.91	.80	.80	.91	.78	.74	.73	.80	.55	.72	.56	.61	.69	.62
	▪ 301 ♀	.90	.72	.80	.90	.80	.68	.75	.76	.53	.53	.55	.70	.67	.57
Campbell et al., 2009	Introductory psychology students														
	▪ Sample 1: 217 students	.85	.75	.74	.93	NA									
	▪ Sample 2: 111 students	.86	.78	.66	.92	NA									
Forsman et al., 2008	1480 twin pairs:														
	▪ Time 1: ♂ – age 16	.83	.64	.76	NA	NA									
	▪ Time 1: ♀ – age 16	.81	.63	.77	NA	NA									
	▪ Time 2: ♂ – age 19	.83	.71	.70	NA	NA									
	▪ Time 2: ♀ – age 19	.81	.67	.71	NA	NA									
Larsson et al., 2006	2198 adolescent twins: ♂ - ♀	.82	.66	.76	NA	.79	.70	.74	.77	.70	.63	.58	.73	.68	.68

Note. GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible Factor; TOT = total YPI; Dch = Dishonest Charm; Gra = Grandiosity; Ly = Lying; Man = Manipulation; Rem = Remorselessness; Une = Unemotional; Cal = Callousness; Thr = Thrill-seeking; Imp = Impulsive; Irr = Irresponsible; NA = Data Not Available

Appendix B: Internal Consistency of the Youth Psychopathic Traits Inventory (YPI) in clinical and incarcerated samples

Clinical-referred & Incarcerated Samples		YPI scales				YPI subscales									
		GM	CU	II	TOT	DCH	GRA	LY	MAN	REM	UNE	CAL	THR	IMP	IRR
Study	**Sample**	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)	α (MIC)
Decuyper et al., 2013	342 detained minors: 172 ♂, 170 ♀	.93	.77	.86	.93	NA									
Colins, Vermeiren et al., 2012	223 detained minors, all ♂	.88	.73	.85	.92	NA									
Chauhan et al., 2012	122 adolescent offenders, all ♀	.92	.72	.85	.92	.83	.57	.86	.81	.56	.54	.48	.79	.71	.62
Kimonis, Frick et al., 2012	165 adolescent offenders: all ♂	.89	.71	NA	.90	NA									
Veen, Stevens et al., 2011	299 adolescents incarcerated , all ♂	.87	.73	.84	NA	NA									
	▪ 158 native Dutch adolescents	.87	.80	.83	NA	NA									
	▪ 141 Maroccan adolescents	.87	.61	.80	NA	NA									
Nijhof et al, 2011	214 youths referred to residential care: 113 ♂, 101 ♀	NA	NA	NA	NA	Ranging from .65 to .80, with α = .52 for Callousness									
Salekin, Debus et al. 2010	145 adolescent offenders 145: 68.8% ♂, 31.2 ♀	.90	.74	.85	92	NA									
Cauffman et al., 2009	1170 serious juvenile offenders, all ♂	Ranging from .73 to .91			.93	Ranging from .60 to .91									
Wareham et al., 2009	165 juvenile offenders; 86 ♂, 79 ♀	.91	.57	.82	NA	NA									
Andershed et al., 2007	162 adolescents referred to a clinic for substance misuse: 92 ♀, 70 ♂	.82 (.54)	.81 (.58)	.68 (.41)	.87 (.40)	.84 (.50)	.73 (.35)	.76 (.39)	.83 (.50)	.73 (.35)	.63 (.25)	.61 (.24)	.66 (.28)	.65 (.27)	.61 (.24)
Dolan & Rennie, 2006a	152 incarcerated conduct disordered adolescents, all ♂	NA	NA	NA	NA	.64	.65	.78	.78	.53	.56	.45	.67	.65	.56
Poythress et al., 2006	165 juvenile delinquents : 52% ♂ - 48% ♀	.91 (.33)	.57 (.09)	.82 (.23)	.92 (.20)	.80 (.45)	.69 (.32)	.75 (.38)	.82 (.49)	.64 (.27)	.64 (.26)	.36 (.09)	.68 (.29)	.65 (.27)	.65 (.27)
Skeem & Cauffman, 2003	160 serious adolescent offenders: all ♂	.90	.77	.83	.92	.82	.61	.84	.85	.77	.68	.49	.71	.70	.66

Note. GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible Factor; TOT = total YPI; Dch = Dishonest Charm; Gra = Grandiosity; Ly = Lying; Man = Manipulation; Rem = Remorselessness; Une = Unemotional; Cal = Callousness; Thr = Thrill-seeking; Imp = Impulsive; Irr = Irresponsible; α = Cronbach Alpha; MIC = Mean inter-item correlation; NA = Information Not Available

Appendix C. Fit Indices for CFA of the three-factor model: a review of YPI studies using item parceling and YPI-S studies

Criterion values for acceptable fit (Brown & Cudeck, 1993; Byrne, 1994; Hu & Bentler, 1999; Kline, 1998)		χ^2	df	**RMSEA** **< .06**	**SRMR** **<.09**	**CFI** **>.90**	**GFI** **>.90**	**AGFI** **>.85**	**NNFI** **>.90**	**NFI** **>.90**	**TLI** **>.90**	**Measurement Invariance**
Study	**Sample**											
Veen, Stevens, et. al, 2011	299 incarcerated adolescents: 158 Dutch, 141 Marrocon ♂	95.399	NA	.057	.052	.961						MI across ethnic groups
Nijhof, et. al, 2011	214 youths referred to residential care: 113 ♂, 101 ♀	103.34	32	.10	NA	.91	NA	NA	NA	NA	NA	NA
Ručević, 2010	706 non-referred:											
	• 226 ♂	65.99	32	.061	NA	.98	NA	NA	.97	NA	NA	MI across gender
	• 480 ♀	94.21	32	.062	NA	.96	NA	NA	.95	NA	NA	
Cauffman et al., 2009	1170 serious juvenile offenders, all ♂	NA	NA	.09	NA	.95	NA	NA	NA	.93	NA	NA
Wareham et al., 2009	165 juvenile offenders; 86 ♂, 79 ♀	NA	NA	.00	NA	1.00	.000	NA	NA	NA	1.00	NA
Declercq et al., 2009	536 adolescent high school students											
	• 235 ♂	72.99	32	.074	NA	.94	.95	.91	NA	NA	NA	NA
	• 301 ♀	75.51	32	.067	NA	.96	.95	.92	NA	NA	NA	
	• 277 12-13 years old	38.89	32	.04	NA	.98	.94	.90	NA	NA	NA	
	• 139 14-15 years old	43.36	32	.05	NA	.98	.93	.88	NA	NA	NA	
	• 120 16-17 years old	67.94	32	.09	NA	.91	.90	.83	NA	NA	NA	
Larsson et al., 2006	2198 adolescent twins											
	• 1099 ♂	233.98	32	.08	NA	.98	NA	NA	.99	NA	NA	NA
	• 1226 ♀	282.77	32	.08	NA	.98	NA	NA	.98	NA	NA	
Poythress et al., 2006	163 juvenile delinquents : ♂ - ♀	78.19	32	.094	NA	.936	NA	NA	NA	NA	.910	NA

Note. χ^2 = Chi-square; df = degrees of freedom; RMSEA = Root Mean Square Error of Approximation; SRMR = Standardized Root Mean Square Residual; CFI = Comparative Fit Index; GFI = Goodness of Fit Index; AGFI = Adjusted Goodness of Fit Index; NNFI = Non-Normed Fit Index; NFI = Normed Fit Index; TLI = Tuckler Lewis Index; NA = Not Available; MI = Measurement Invariance.

Appendix D: Internal Consistency of the Youth Psychopathic Traits Inventory-Short Version (YPI-S)

Community samples		YPI Scales			
		GM	**CU**	**II**	**TOT**
Study	**Sample**	α (MIC)	α (MIC)	α (MIC)	α (MIC)
Colins et al., 2012	768 high school students: 45.4% ♂, 54.6% ♀	.76 (.35)	.66 (.25)	.66 (.24)	.78 (.28)
van Baardewijk et al., 2010	Sample 1: 2105 adolescents; 49 % ♂	.79	.75	.68	.85
	Sample 2: 2159 adolescents; 49% ♂	.81	.81	.68	.83

Note. GM = Grandiose-Manipulative Factor; CU = Callous-Unemotional Factor; II = Impulsive-Irresponsible Factor; TOT = total YPI; α = Cronbach Alpha; MIC = Mean inter-item correlation

3

PSYCHOPATHIC TRAITS, INTERNALIZING BEHAVIOR, ALEXITHYMIA, AND THOUGHT PROBLEMS IN A COMMUNITY AND REFERRED SAMPLE[1]

The current study investigates the relationship between psychopathic traits and various measures of internalizing behavior, alexithymia, and thought problems in a referred (n=62) and community sample (n=1670). Psychopathic traits were assessed by means of the Youth Psychopathic Traits Inventory-Short Version (YPI-S). In the referred sample, psychopathic traits were additionally assessed by means of the Psychopathy Checklist: Youth Version (PCL:YV). In the community sample, cluster analysis of YPI-S scores revealed five groups that differed significantly in terms of externalizing behavior. Contrary to our expectations, the psychopathic-like group scored higher on different measures of internalizing problems. In line with our hypotheses, the impulsive-irresponsible group showed significantly more difficulties in identifying emotions, and cluster groups with higher levels of psychopathic traits showed significantly more thought problems. In the referred sample, the behavioral dimension of the YPI-S and YPI-S total scores were significantly correlated with measures of anxiety, but not with depression. Moreover, the lifestyle factor of the PCL:YV was significantly related to self-reported stress and internalizing psychopathology. Juvenile psychopathic traits, as measured by both the YPI-S and the PCL:YV, were not significantly related with an interview measure of internalizing psychopathology.

[1] This chapter is based on De Ganck, J. & Vanheule, S. (submitted). Psychopathic Traits, Internalizing Behavior, Alexithymia, and Thought Problems in a Community and Referred Sample. *Personality and Individual Differences.*

INTRODUCTION

While several authors express reticence relative to extend the psychopathy construct to adolescents (e.g. Skeem & Cauffman, 2003), a growing body of literature suggests that 'juvenile psychopaths' are characterized by a constellation of interrelated affective (e.g. grandiosity, manipulation), interpersonal (e.g. callousness, unemotionality) and behavioral (e.g. irresponsibility, impulsivity) characteristics, similar to adults (e.g. Vasey, Kotov, Frick, & Loney, 2005). Moreover, research indicates that both adult and juvenile delinquents with psychopathic traits share many other characteristics, such as persistent and violent patterns of antisocial and offending behavior and an increased risk of recidivism (e.g. Forth & Burke, 1998; Salekin, 2008; Spain, Douglas, Poythress, & Epstein, 2004). Based on these findings together with preliminary evidence for the effective treatment of youth with psychopathic traits (Caldwell, McCormick, Umstead, & Van Rybroek, 2007; Hawes & Dadds, 2005), several authors have recommended developing reliable and time-efficient measures that could identify high-risk juveniles (e.g. Andershed, Kerr, Stattin, & Levander, 2001; Frick, 2002). Recently, the Youth Psychopathic Traits Inventory-Short version (YPI-S; van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010) was developed to that end. Research demonstrates the factorial validity of the YPI-S and has investigated its convergent validity with several relevant correlates, in particular conduct problems, hyperactivity, substance abuse, and offending behavior (van Baardewijk at al., 2010; Colins, Noom, & Vanderplasschen, 2012). However, in these YPI-S studies little or no attention was paid to the relationship between psychopathic traits and other types of adolescent psychopathology, such as negative emotionality. Numerous scholars have argued that the relationship between juvenile psychopathy and internalizing disorders needs further investigation (e.g. Sevecke & Kosson, 2010). Therefore, the present study uses the YPI-S to investigate the relationship between psychopathic traits and various types of internalizing problems, alexithymia and thought problems.

Psychopathy and internalizing problems

Several authors argue that psychopathy and internalizing psychopathology are mutually exclusive. Cleckley (1976) contends that there are no valid signs of depression, psychoneurotic symptoms (e.g. anxiety), nervousness, or shame and guilt in psychopathy. In addition, according to Lykken (1957) psychopaths are characterized by a high degree of fearlessness in relation to the potentially adverse consequences of their acts. However, findings on the relationship between psychopathy and internalizing psychopathology are mixed, especially in child and adolescent populations (Kubak & Salekin, 2009; Sevecke, Lehmkuhl, & Krischer, 2009). Some studies suggest a negative relationship between juvenile psychopathy and internalizing problems (e.g. Skeem & Cauffman, 2003), while others support the idea that psychopathy and depression/anxiety are positively associated, or orthogonal constructs (e.g. Frick, Lilienfeld, Ellis, Loney, & Silverthorn, 1999; Salekin, Leistico, Neumann, DiCicco, & Duros, 2004).

These seminal theories, and to some extent the associated mixed psychometric evidence, have been recuperated in the dual deficit model of psychopathy (Corr, 2010; Fowles & Dindo, 2006). This model integrates the two-factor model of psychopathy (Hare, 1991) with Gray's Reinforcement Sensitivity Theory of personality (RST; Gray, 1976, 1978, 1979). The revised RST (Gray & McNaughton, 2000; Corr, 2010) hypothesizes that three neuropsychological systems are responsible for regulating human behavior, emotion and learning. The *Behavioral Activation System* (BAS) is activated by appetitive and potentially rewarding stimuli, causing the individual to approach the stimulus. The *fight-flight-freeze-system* (FFFS) is related to fear and is activated by aversive stimuli, causing avoidance behavior in the individual. According to Carver and White (1994), the BAS is composed of three subsystems: Reward-Responsiveness (i.e., the degree to which reward leads to positive emotions), Drive (i.e., the active pursuit of appetitive goals), and Fun-Seeking (i.e., the impulsive engagement in potentially rewarding acts). The *Behavior Inhibition System* (BIS) is responsible for the resolution of goal-conflict, for example when the BAS and FFFS are activated simultaneously. The BIS is implicated in the process that generates eventually the subjective experience of anxiety. In sum, the dual deficit theory (Corr, 2010; Fowles & Dindo, 2006) argues that the Interpersonal/Affective dimension of psychopathy[1] (Hare, 1991) is linked to a weak BIS and weak FFFS, and thus associated with low anxiety and low fear. On the other hand, it is argued that the Lifestyle/Antisocial dimension of psychopathy[2]

(Hare, 1991) is related to an overactive BAS or an inability to regulate approach behavior. According to the dual deficit model of psychopathy, the Lifestyle/Antisocial dimension of psychopathy is positively associated with anxiety and fear. This could be explained by the observation that impulsive and externalizing individuals are more exposed to and 'suffer' more from the negative consequences of their risky but rewarding acts (Willemsen & Verhaeghe, 2012). In addition, Corr (2010) stated that psychopathy in general is related to a dysfunctional BIS. Roose, Bijttebier, Claes, & Lilienfeld (2011) have examined the association between the three factors of psychopathy (Cooke & Michie, 2001) and the revised RST systems (Corr, 2010; Fowles & Dindo, 2006) in a community sample of adolescents. The Callous-Unemotional (CU) Factor was negatively associated with FFFS (fear), BIS (Anxiety) and BAS (Reward responsiveness). The association between CU and FFFS seemed to be mediated by the BIS. The Grandiose-Manipulative (GM) Factor was positively related to BAS (Drive and Reward-Responsiveness). The Impulsive-Irresponsible (II) factor was positively related to BAS (Drive and Fun-Seeking).

Psychopathy and Alexithymia

Some authors have argued that the mixed findings of the relationship between psychopathy and internalizing symptoms could be understood from the hypothesis that alexithymia is the underlying problem that causes psychopathic symptoms in an individual (Berenbaum, 1996). However, empirical evidence concerning the relationship between psychopathy and alexithymia is by no means robust. In a study of Pham, Ducro, & Luminet (2010) criminal psychopaths had significantly lower scores on inter alia the Toronto Alexithymia Scale (TAS; Taylor, Ryan, & Bagby, 1985) than non-psychopaths. Moreover, the affective dimension of psychopathy, in particular, was negatively related to alexithymia. In a sample of female inmates, Louth, Hare, & Linden (1998) found no significant correlation between PCL-R and TAS total scores, but the impulsive-irresponsible factor of the PCL-R was significantly related to difficulties in identifying feelings. In line with this, some studies indicate that there is a positive correlation between alexithymia and secondary psychopathy (Lander, Lutz-Zois, Rye, & Goodnight, 2012; Ridings, 2011).

Psychopathy and Psychosis

Although Cleckley (1976) contends that psychopaths are usually free from signs or symptoms of psychosis, several authors within the psychoanalytic tradition support this association. Congruent with the theory of Lacan (1955-56; 1962-63), Biagi-Chai (2012) argues that the diagnosis of psychopathy possibly conceals an underlying psychotic functioning. Meloy (2001, 2004) also refers to psychotic symptomatology in psychopathic individuals, which has been further confirmed by prevalence studies (e.g. Coid & Ullrich, 2011).

PRESENT STUDY

The aim of this study is two-fold. First, we investigate the association between psychopathic traits and internalizing psychopathology, alexithymia, and thought problems in both a community and referred sample. In the referred sample, we also examine whether these associations are dependent on the type of measurement used, i.e., interviews versus self-report. We hypothesize that youngsters with more psychopathic traits have less internalizing psychopathology than those with less psychopathic traits, and that this is especially the case for those with high scores on the Interpersonal/Affective dimension of psychopathy. We also hypothesize that those with high scores on the Lifestyle/Antisocial dimension of psychopathy will have higher levels of internalizing psychopathology. Finally, we hypothesize that youngsters with more psychopathic traits have more difficulties identifying feelings and more thought problems.

Study 1: Community sample

Within the community sample we followed a subgroup approach. First, through cluster analysis we investigated whether the YPI-S was able to identify a group of adolescents characterized by high scores on all three dimensions of the YPI-S. We subsequently examined whether this psychopathic-like group differs significantly from other subgroups on measures of internalizing psychopathology, alexithymia, and (psychotic) thought problems.

Based on previous research with the Youth Psychopathic Traits Inventory (YPI) and the YPI-Short Version (e.g. Andershed et al., 2001; Colins et al., 2012; Skeem & Cauffman,

2003), we expected to find at least four distinct groups: (1) a *normal* control group scoring low or average on all three dimensions of the YPI-S, (2) an *impulsive-irresponsible*, non-psychopathic group scoring high on the behavioral dimension of the YPI-S, but relatively low or average on the other two dimensions, (3) a *callous-unemotional* group scoring high on the affective dimension of the YPI-S, but relatively average to low on the other facets of the YPI-S, and (4) a *psychopathic-like* group scoring relatively high on all dimensions of the YPI-S. Since the YPI-S was developed to identify a high-risk group of adolescents, in order to validate the pertinence of our clusters, we first verified whether the psychopathic-like group was significantly different from other groups in terms of externalizing problems. If the cluster analysis yielded the expected four groups, it was further hypothesized that, compared to other groups (a) the *psychopathic-like* and the *callous-unemotional* groups would have significantly lower scores on self-reported measures of internalizing psychopathology, (b) the *impulsive-irresponsible* group would have more difficulties identifying emotions, and (c) the *psychopathic-like* group would show higher scores on thought problems related to psychosis.

Study 2: Referred sample

Within the referred sample we followed a variable-oriented approach. To this end, we investigated the association between the different facets of psychopathy and several measures of internalizing psychopathology and alexithymia. We subsequently examined whether the strength and significance of the associations with internalizing psychopathology are dependent of the type of measurement used. Based on previous research, we hypothesized that (a) the interpersonal (i.e. Grandiose-Manipulative) and affective (i.e. Callous-Unemotional) dimensions of psychopathy would be negatively associated with different measures of internalizing psychopathology, and (b) the behavioral (i.e. Impulsive-Irresponsible) dimension would be positively associated with different measures of internalizing psychopathology. We also hypothesized that (c) the behavioral dimension of psychopathy would be positively associated with difficulties in identifying emotions (alexithymia).

METHOD

PARTICIPANTS

The community sample (study 1) consisted of 1670 non-referred adolescents (57,8% girls) with a mean age of 14.63 years (*SD* = 1.83). The participants were recruited from 10 secondary schools (both rural and urban) in Flanders (Belgium). In terms of type of education, 20.8% attended a special needs secondary school; 2.3% vocational; 9.2% technical and 67.8% a general secondary school. The data from 20 adolescents were excluded because more than 5% of their YPI-S scores were missing, resulting in the final sample of 1670 participants[3].

The referred sample (study 2) is composed of 62 male juvenile delinquents with a mean age of 15.71 years (*SD* = 1.23). The adolescents were recruited in two ways; (a) through referral by the juvenile court, and (b) trough follow-up in a six-month residential treatment program for juvenile delinquents in Flanders. With regard to type of education, 12.9% attended a special needs secondary school; 66.1% vocational; 19.4% technical and 1.6% a general secondary school. The data from 4 adolescents were excluded because more than 5% of their YPI-S scores were missing, resulting in the final sample of 62 participants[3].

PROCEDURE

The study was approved by the Institutional Review Board of the Faculty of Psychology and Educational Sciences at Ghent University. Participants were informed about the overall purpose of the research project and gave informed consent to be involved in the study. All participants completed a demographic survey and a set of questionnaires about internalizing and externalizing problems. In the community sample, questionnaires were completed in the classroom under supervision of the first author and/or a trained Masters student. Different classes were administered different sets of self-report measures, as it was not possible, for reasons of time investment, for each student to fill in the full battery of questionnaires. For the referred sample, assessment took place at the adolescent's home or at the institution for juvenile offenders.

MEASURES[4]

Psychopathy

In both samples, psychopathic traits were measured using the Youth Psychopathic Traits Inventory-Short Version (YPI-S; van Baardewijk et al., 2010)[5]. In the referred sample psychopathic traits were additionally assessed via ratings on the Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003).

The *YPI-S* (van Baardewijk et al., 2010) is an 18-item version of the original Youth Psychopathic Traits Inventory (YPI; Andershed et al., 2001) developed to measure the number of psychopathic traits in adolescents. In accordance with the three-factor conceptualization of psychopathy (Cooke & Michie, 2001; Cooke, Michie, & Skeem, 2007), the YPI-S items are organized in three 6-item subscales; i.e. a Grandiose-Manipulative (GM), a Callous-Unemotional (CU) and an Impulsive-Irresponsible (II) dimension. Items are scored on a 4-point Likert scale, ranging from 1 ('does not apply at all') to 4 ('applies very well'). Previous studies demonstrated adequate reliability and validity of the YPI-S in non-clinical populations (Colins et al., 2012). For the present study, in the community sample, Cronbach's alphas were acceptable to good for the YPI-S GM and CU dimensions and for the YPI-S total score (range α = .69 - .82), but marginal for the II dimension (α = .64). In the referred sample, Cronbach's alphas were acceptable to good for the YPI-S GM and CU dimensions and for the YPI-S total score (range α = .69 - .81), but marginal for the II dimension (α = .60). In both the community and referred sample, all mean inter-item correlations (MIC) were in the adequate range of .15 to .50, which indicates internal consistency (Briggs & Cheek, 1986; Clarck & Watson, 1995; Nunnally & Bernstein, 1994).

The *Psychopathy Checklist: Youth Version* (PCL:YV; Forth et al., 2003) is an extension of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991 & 2003) designed to assess personality traits and behavioral features of psychopathy in adolescents. The PCL:YV rating is based on a semi-structured interview and court file data. Analogous to the PCL-R, it also consists of 20 items which are scored on a 3-point ordinal scale, ranging from 0 ('definitely not present') to 2 ('definitely present'). The total score reflects the degree of psychopathic traits in the individual. Contrary to the use of the PCL-R in adults, no cut-off score is used for the PCL:YV in adolescents (Forth et al., 2003). In our study, the inter-rater reliability as

determined by the intraclass correlations coefficient (absolute agreement) for a single rating, using a two-way random effects model, was .89 for the Interpersonal Facet, .87 for the Affective Facet, .75 for the Lifestyle Facet, .85 for the Antisocial Facet and .97 for the PCL:YV total score[6], which indicates excellent inter-rater reliability (Landis & Koch, 1977).

Internalizing psychopathology and thought problems

The *Depression Anxiety Stress Scales-21* (DASS-21; Lovibond & Lovibond, 1995) is a short-version of the DASS and consists of three 7-item scales: Depression, Anxiety and Stress. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses automatic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale assesses difficulty in relaxing, nervous arousal, and being easily upset, irritable and impatient. Items are scored on a 4-point Likert scale ranging from 0 ('did not apply to me at all') to 3 ('applied to me very much') to describe negative emotional states experienced in the past week. In line with the study design of Willemsen & Verhaeghe (2012) the timeframe of the DASS-21 was altered to the past year. Several studies demonstrated good reliability and validity of the DASS-21 in both clinical and non-clinical populations (e.g. Antony, Cox, Enns, & Swinson, 1998; Crawford & Henry, 2003; Norton, 2007). For the present study, in the community sample Cronbach's alpha as an index of internal consistency was acceptable for all DASS-21 scales (α for Depression = .79; α for Anxiety = .71; α for Stress = .76), and good for the DASS-21 total scale (α = .88). In the referred sample Cronbach's alphas were good for the DASS-21 Stress scale and the Total score (α for Stress = .80; α for Total scale = .88), but marginal for the Depression and Anxiety scales (α for Depression = .56; α for Anxiety = .66). In both the community and referred sample, all MIC values were in the adequate range.

The *Positive and Negative Affect Schedule* (PANAS; Watson, Clark, & Tellegen, 1988) is a 20-item measure that compromises two primary 10-item dimensions of mood, one measuring Positive Affect (PA) and the other Negative Affect (NA). Items are scored on a 5-point Likert scale ranging from 1 ('very slightly or not at all') to 5 ('extremely') to indicate the extent to which they have experienced each particular affect within a specified time frame.

Within this study participants where asked to rate how they feel in general. Previous studies demonstrated adequate reliability and validity of the PANAS (Crawford & Henry, 2004). For the present study, in the community sample, Cronbach's alpha was good for both the PA scale (α = .80) and the NA scale (α =.82). In the referred sample Cronbach's alpha was adequate for the PA scale (α = .71) and good for the NA scale (α = .80). In both the community and referred sample, all MIC values were in the adequate range.

The *State-Trait Anxiety Inventory- form Y* (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) is a 40-item self-report instrument to assess current symptoms of anxiety and a generalized disposition to be anxious. The STAI consists of two 20-item subscales. The State Anxiety Scale (S-Anxiety) measures the current state of anxiety, including subjective feelings of apprehension, tension, nervousness, worry, and arousal of the autonomic nervous system. Items are rated on a 4-point Likert scale, ranging from 1 ('not at all') to 4 ('very much so'). The Trait Anxiety Scale (T-Anxiety) assesses more stable aspects of anxiety proneness. Participants are asked to rate the frequency of how they generally feel on a 4-point Likert scale, ranging from 1 ('almost never') to 5 ('almost always'). For the present study, in the community sample, Cronbach's alpha was good for both the S-Anxiety scale (α = .91) and for the T-Anxiety scale (α = .86). In the referred sample Cronbach's alphas were good for the S-Anxiety scale (α = .92) and for the T-Anxiety scale (α = .86). In both samples, all MIC values were in the adequate range.

The *Beck Depression Inventory-II* (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item self-report instrument to measure severity of depressive symptomatology. The BDI-II assesses cognitive, affective, somatic and vegetative symptoms that correspond to DSM-IV criteria for diagnosing depressive disorders. Participants are asked to choose the statements that best reflect how they felt the past two weeks. Answer options include four increasing levels of severity with a range of 0 to 3. The BDI-II proves to be a reliable and valid instrument in both clinical and community samples (Beck, Steer, & Brown, 1996). For the present study, Cronbach's alphas for the BDI scale were good for both the community sample (α =.83), and the referred sample (α =.83). In both samples, all MIC values were in the adequate range.

The *Youth Self Report* (YSR; Achenbach & Rescorla, 2001; Verhulst & Van der Ende, 2001) is a 112-item questionnaire designed to assess a wide range of affective and behavioral problems experienced by adolescents during the past 6 months. Items are scored on a 3-point scale ranging from 0 ('not true') to 2 ('very often true'). Factor analyses have identified 8 narrow-band subscales and 6 DSM-oriented scales. The present study examined 1 syndrome scale (i.e. Thought Problems) and 3 DSM-oriented scales (i.e. Affective Problems, Anxiety Problems and Somatic Problems). Additionally, we included the total score for Externalizing Problems, which is a summation of the syndrome scales Rule-Breaking Behavior and Aggressive Behavior. For the current study, Cronbach's alphas were good for both Affective Problems (α =.80) and Externalizing Problems (α =.89); acceptable for both Thought Problems (α = .78) and Somatic Problems (α =.76), and marginal for Anxiety Problems (α =.65). All MIC values were in the adequate range.

The *National Institute of Mental Health Diagnostic Interview Schedule for Children Version IV* (NIMH DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) was used to interview adolescents from the referred sample about past year symptoms of social phobia, simple phobia, panic disorder, agoraphobia, generalized anxiety disorder, posttraumatic stress disorder and major depressive disorder. The presence of symptoms was scored on a 3-point scale from 0 (absent) to 2 (present). Following the study design of Willemsen & Verhaeghe (2012) a dimensional score for past year internalizing psychopathology was calculated by a summation of the following symptoms: (1) DSM-IV criteria A trough D of social phobia, (2) DSM-IV criteria A trough D of simple phobia and the different types of simple phobia (e.g. animal, height), (3) the 13 symptoms of panic attack in the context of a panic disorder, (4) DSM-IV criteria A and B of agoraphobia and the different types of agoraphobia (e.g. train, tunnel), (5) the six somatic symptoms in the context of a generalized anxiety disorder, (6) the 17 symptoms of posttraumatic stress disorder and (7) the 9 symptoms of a major depressive disorder.

Alexithymia

Alexithymia was measured by the 20-item version of the *Toronto Alexithymia Scale-20* (TAS-20; Taylor et al., 1985) which consists of three subscales: difficulty identifying

feelings (DIF), difficulty describing feelings (DDF) and externally oriented thinking (EOT). Each TAS-20 item is rated on a five-point Likert scale, with total scores ranging from 20 to 100. Several studies have demonstrated adequate reliability and validity of the TAS-20 in both clinical and non-clinical populations (e.g. Bagby, Parker, & Taylor, 1994; Bagby, Taylor, & Parker, 1994; Meganck, Vanheule, & Desmet, 2008). For the present community sample Cronbach's alpha was good for the DIF subscale (α = .82), adequate for the Total scale (α = .75), but poor for the EOT (α = .42) and DDF (α = .57) subscales. In the referred sample, Cronbach's alphas were nearly acceptable to excellent for the TAS DIF and DDF subscales and total scale (range α = .67 - .90), but poor for the EOT subscale (α = .41). All MIC values were in the adequate range, except for the EOT (MIC = .08) and Total scale (MIC = .13) in the community sample.

ANALYSIS

Statistical analyses were carried out in SPSS version 22.0. In the community sample, *cluster analysis* was applied to the three factor scores of the YPI-S. Ward's (1963) method was used to generate subgroups for further analysis. Ward's method is an agglomerative hierarchical clustering procedure often used in social science research (Aldenderfer & Blashfield, 1984). It uses an analysis of variance (ANOVA) approach to evaluate distances between clusters, maximizing between-group differences and minimizing within group differences (Kauffman & Rousseeuw, 2005). Additionally, we conducted a k-means cluster analysis, both to test the reliability of the cluster solution derived by Ward's method and to reduce the risk of cluster misassignment (Blashfield & Aldenderfer, 1988; Lorr, 1983). The k-means procedure is a non-hierarchical technique that starts from a user-specified value of k which indicates the number of clusters (Lorr, 1983). Each cluster has an initial centroid and objects are allocated to the nearest centroid. Clusters' centroids are updated and cases may be relocated. This procedure is repeated until all cases are duly classified to a cluster and there is no change in the k means. For each measure separately, group comparisons were made by means of multivariate analysis of variance (MANOVA) and one-way ANOVA[7]. Significant MANOVAs and ANOVAs were followed by independent sample t-tests for

pairwise comparison of the different clusters on measures of externalizing behavior, internalizing psychopathology, alexithymia, and thought problems.

In the referred sample, Pearson correlations were used to investigate the relationship between psychopathy scores (YPI-S, PCL:YV) and various measures of internalizing psychology (DASS-21, STAI, PANAS, BDI, DISC-IV) and alexithymia (TAS-20). According to Dancy and Reidy's (2004) categorization Pearson correlation coefficients between .1 and .3 are weak, between .4 and .6 moderate, and between .7 and .9 strong.

RESULTS

STUDY 1: COMMUNITY SAMPLE

Cluster analyses

Hierarchical cluster analysis using Ward's method was performed to classify cluster groups based on YPI-S scores. Five different cluster groups were retained on the basis of the analysis of the dendrogram, the variance ratio criterion, and the conceptual interpretability of the cluster solutions. To further evaluate the validity of this five cluster solution a k-means cluster analysis (with k=5) was performed. The overall agreement of both procedures of cluster assignment was 80%, and also the kappa statistic of .74 (t = 57.22, $p < .0001$) indicated a substantial agreement on the assignment of cases to groups between both techniques (McGinn, Wyer, Newman, Keitz, Leipzig, & Guyatt, 2004). Table 1 illustrates the standardized (z-scores) YPI-S facet scores for the 5 cluster groups generated by Ward's method. The participants in cluster 1 (*n*=652), the *Normal,* non-psychopathic group, have relatively low scores on all three YPI-S dimensions. The second group of adolescents (*n*=287), the *Callous-Unemotional* (CU) group, has a high level of callous and unemotional traits, but has relatively low levels of other psychopathic characteristics. The third cluster (*n*=313), the *Grandiose-Manipulative* (GM) group has a relatively high score on the Grandiose-Manipulative factor of the YPI-S, and average scores on the other YPI-S dimensions. Adolescents in the fourth group (*n*=201), the *Impulsive-Irresponsible* (II) group, have high scores on the Behavioral dimension of the YPI-S, and relatively lower scores on the other two YPI-S subscales. The final group (*n*=217), *the Psychopathic-like* group, has the most

extreme profile with high scores on all three YPI-S dimensions. To further validate the relevance of our clusters, the groups were compared in terms of YSR-externalizing behavior. A one-way ANOVA test indicated significant group differences in terms of externalizing psychopathology: $F_{(4,331)} = 3.096$, $p<.05$. On average, the *Psychopathic-like* group showed significantly more externalizing behavior than all other cluster groups. Compared to the other cluster groups, the *Normal* group scored significantly lower on externalizing problems (table 2).

Table 1

Cluster groups (Ward's method): mean z-scores on YPI-S dimensions

	Clusters					
	(1) NORMAL group	(2) CU group	(3) GM group	(4) II group	(5) PSYCHOPATHIC Group	
YPI-S	(*n* = 652)	(*n* = 287)	(*n* = 313)	(*n* = 201)	(*n* = 217)	*F*(4, 1665)
ID	-.68	-.13	.60	-.45	1.78	906.49**
AD	-.55	1.05	-.27	-.65	1.26	567.67**
BD	-.74	.02	.05	1.00	1.19	447.80**

Note. YPI-S = Youth Psychopathic Traits Inventory-Short Version; ID = Interpersonal (Callous-Unemotional) Facet of the YPI-S; AD = Affective (Grandiose-Manipulative) Facet of the YPI-S; BD = Behavioral (Impulsive-Irresponsible) Facet of the YPI-S; CU = Callous-Unemotional; GM = Grandiose-Manipulative; II = Impulsive-Irresponsible.

**: $p < .001$

Cluster differences on Internalizing psychopathology

Table 2 provides the descriptive statistics and pairwise group comparisons for internalizing psychopathology.

In regard to the *DASS-21*, on average the psychopathic-like group showed the highest total and scale scores. Significant differences across the five cluster groups were observed through MANOVA based on the 3 DASS-21 scales with Wilks' Lambda = .88, $F_{(12, 4054)} = 16.65$, $p<0.001$. Independent-samples t-tests indicated that, compared with the *Normal* group, the *Psychopathic-like* group scored significantly higher on Depression (t=5.12; df=291.154; p <.001), Anxiety (t=6.00; df=276.55; p<.001), Stress (t=10.56; df=270.549; p<.001), and Total Internalizing Psychopathology (t=8.62; df=281.26; p< .001). Compared with the *GM* group,

the *Psychopathic-like* group scored significantly higher on Anxiety (t=3.05; df=363.04; p <.01), Stress (t=4.79; df=374.417; p<.0001) and Total Internalizing Psychopathology (t=3.97; df=385.195; p< .001). The *CU* group scored significantly higher on Depression (t=5.37; df=446.078; p< .001), Anxiety (t=4.65; df=425.57; p<.001), Stress (t=5.62; df=409.737; p<.0001) and Total Internalizing Psychopathology (t=6.00; df=416.17; p<.0001), compared with the *Normal* group. The *CU* group scored significantly lower on Stress compared with the *II* group (t=-3.37; df=440; p<.01) and the *Psychopathic-like* group (t= -5.12; df=399.219; p <.0001).

In terms of the 3 *DSM-oriented scales of the YSR,* one-way ANOVA tests only indicated significant group differences for Anxiety: $F_{(4,331)}$ = 3.595, p<.01. Subsequent independent-samples t-tests indicated that the *II* group scored significantly higher on the Anxiety scale, compared to both the *Normal* (t=3.00; df=70.608; p<.01) and the *Psychopathic-like* group (t= 2.97; df=76.557; p<.01).

Concerning the *STAI*, no significant differences were observed across the five cluster groups through MANOVA based on the 2 STAI scales, with Wilks' Lambda = .96, $F_{(8, 536)}$=16.65, *p*=.134. Similarly, regarding the *PANAS,* two one-way ANOVA tests yielded no significant differences between groups on positive affect ($F_{(4,242)}$ = 1.782; df=4,242; p=.133) and negative affect ($F_{(4,242)}$ = .333; df=4,242; p=.856). Additionally, for the *BDI*, a one-way ANOVA test indicated no significant differences between clusters ($F_{(4,269)}$ = 2.165, df=4,269, p=.073).

Cluster differences on Alexithymia

Regarding alexithymia (Table 3), significant differences across the five cluster groups were observed through a MANOVA based on the 3 TAS-20 scales with Wilks' Lambda = .96, $F_{(12, 2220.077)}$ = 3.18, p<.001. In addition, a one-way ANOVA also indicated significant group differences for the TAS-20 total score ($F_{(4,841)}$=2.675, p<.05). Subsequent independent-samples t-tests indicated that the *II* group on average demonstrated more difficulties in identifying feelings (DIF), compared to the *Normal* (t=3.92; df=431; p<.001) and the *CU* group (t=2.80; df=237; p<.01). The *II* group also had significantly higher mean TAS-20 total scores compared with the *Normal* group (t=2.881; df=431;p<.01).

Table 2

Means (SDs) of the five clusters on Externalizing and Internalizing Psychopathology and Thoughts Problems

		Cluster groups					
		(1) NORMAL	(2) CU	(3) GM	(4) II	(5) PSYCHOPATHIC-like	Pairwise group comparisons Independent-Sample t-test [(a)]
DASS-21	**Range**	**(*n*=605)**	**(*n*=258)**	**(*n*=292)**	**(*n*=184)**	**(*n*=200)**	
Depression	0-42	8.84 (7.42)	12.01 (8.17)	10.70 (8.11)	12.13 (8.33)	12.48 (9.11)	1<2,3,4,5
Anxiety	0-42	8.01 (6.37)	10.48 (7.43)	9.74 (6.78)	11.59 (6.97)	11.94 (8.51)	1<2,3,4,5 5>3; 4>3
Stress	0-42	11.02 (6.65)	14.25 (8.15)	14.68 (7.66)	16.86 (7.87)	18.48 (9.23)	5>1,2,3 1<2,3,4; 2,3<4
Total	0-126	27.88 (17.38)	36.75 (20.86)	35.12 (19.46)	40.60 (19.52)	42.90 (22.55)	1<2,3,4,5 5>2,3; 4>3
STAI	**Range**	**(*n*=93)**	**(*n*=47)**	**(*n*=52)**	**(*n*=38)**	**(*n*=44)**	**PWG comparison**
S-Anxiety	20-80	37.12 (9.79)	37.99 (10.71)	37.42 (10.18)	39.21 (13.95)	36.68 (8.97)	No significant differences
T-Anxiety	20-80	40.66 (9.87)	40.40 (8.33)	42.73 (9.98)	45.51 (11.18)	40.40 (9.38)	
YSR	**Range**	**(*n*=114)**	**(*n*=57)**	**(*n*=63)**	**(*n*=48)**	**(*n*=54)**	**PWG comparison**
Affective Problems	0-26	4.97 (4.04)	6.29 (5.08)	5.97 (4.12)	6.96 (4.53)	5.63 (3.79)	No significant differences
Anxiety Problems	0-12	2.72 (1.97)	3.23 (2.76)	3.44 (2.24)	3.98 (2.61)	2.69 (1.61)	1,5<4
Somatic Complaints	0-14	2.33 (2.44)	3.02 (2.88)	3.10 (2.58)	3.40 (2.77)	2.57 (2.70)	No significant differences
Thought Problems	0-24	3.89 (3.45)	5.77 (4.46)	5.83 (3.97)	5.56 (4.21)	6.07 (3.95)	1<2,3,5
Externalizing Behavior	0-64	9.07 (6.44)	13.89 (8.27)	15.33 (8.17)	13.40 (7.25)	20.06 (11.55)	1<2,3,4,5 5>2,3,4
PANAS	**Range**	**(*n*=84)**	**(*n*=36)**	**(*n*=50)**	**(*n*=39)**	**(*n*=38)**	**PWG comparison**
PA	10-50	32.68 (6.02)	31.67 (6.45)	33.36 (5.59)	32.16 (6.99)	35.05 (5.67)	No significant differences
NA	10-50	20.89 (5.66)	21,5278 (6.45)	21,5566 (6.62)	21,5128 (6.99)	20,2368 (5.66)	
BDI	**Range**	**(*n*=92)**	**(*n*=47)**	**(*n*=53)**	**(*n*=38)**	**(*n*=44)**	**PWG comparison**
	0-63	11.19 (8.09)	11.94 (7.33)	12.27 (8.65)	14.96 (9.20)	14.74 (9.59)	No significant differences

Note. YPI-S = Youth Psychopathic Traits Inventory-Short Version; DASS-21 = Depression Anxiety Stress Scale-21; STAI = State-Trait Anxiety; S-Anxiety = State-Anxiety; T-Anxiety = Trait-Anxiety; YSR = Youth Self Report; PANAS = Positive and Negative Affect Scale; PA = Positive Affect; NA = Negative Affect; BDI = Beck Depression Inventory: CU = Callous-Unemotional; GM = Grandiose-Manipulative; II = Impulsive-Irresponsible; PWG = Pairwise Group

[(a)] = Statistical details available on request

Cluster differences on Thought problems

Table 2 provides the descriptive statistics and pairwise group comparisons for YSR-Thought problems. A one-way ANOVA test indicated significant mean scale score differences between groups for Thought problems: $F_{(4,331)} = 4.62$, $p<.01$. Subsequent independent-samples t- tests indicated that the *Normal* group scored significantly lower on Thought problems, compared to the *CU* (t=-2.79; df=90.558; p<.01), the *GM* (t=-3.38; df=175; p=.001), and the *Psychopathic-like* group (t=-3.65; df=166; p=.000).

Table 3

Means (SDs) of the five clusters on Alexithymia

		Cluster groups					
		(1) NORMAL	(2) CU	(3) GM	(4) II	(5) PSYCHOPATHIC -like	Pairwise group comparisons Independent-Sample t test [(a)]
TAS-20	**Range**	**(*n*=333)**	**(*n*=139)**	**(*n*=109)**	**(*n*=165)**	**(*n*=100)**	
DIF	7-35	15.64 (5.94)	16.15 (5.61)	17.10 (6.00)	18.34 (6.43)	17.18 (6.12)	4>1,2
DDF	5-25	13.53 (3.99)	13.83 (3.66)	13.57 (3.76)	13.75 (3.88)	13.24 (3.92)	No significant differences
EOT	8-40	22.78 (4.19)	23.98 (4.62)	23.18 (4.47)	23.25 (4.73)	23.48 (5.59)	No significant differences
Total	20-100	51.95 (10.35)	53.96 (10.45)	53.85 (10.20)	55.35 (10.40)	53.90 (11.56)	4>1

Note. CU = Callous-Unemotional; GM = Grandiose-Manipulative; II = Impulsive-Irresponsible; TAS-20 = Toronto Alexithymia Scale-20; DIF = difficulty identifying feelings; DDF = difficulty describing feelings; EOT = externally oriented thinking.

[(a)] = Statistical details available on request

STUDY 2: REFERRED SAMPLE

Pearson correlations between the YPI-S and PCL:YV total and facet scores with various forms of internalizing psychopathology for the referred sample are presented in table 4. We observed several significant, positive correlations between the YPI-S total and subscale scores with different measures of self-reported internalizing psychopathology. The YPI-S Total score, and the Interpersonal (GM) and Behavioral dimension (II) of the YPI-S are significantly related (range r: .27-.40) to Difficulties in Identifying Feelings, Total amount of alexithymia (TAS-20), and Trait-Anxiety (STAI). Additionally, moderate to strong positive correlations (range r: .45 - .62) were observed between the YPI-S total score, and the Behavioral dimension (II) of the YPI-S with anxiety, stress, and total amount of internalizing psychopathology (DASS21). The Affective dimension (CU) of the YPI-S is weak, but significantly related to Positive Affect (PANAS). There are no significant correlations between the YPI-S total and subscale scores with Depression (DASS-21 and BDI), Negative Affect (PANAS), and Difficulties Describing Feelings, and Externally Oriented Thinking (TAS-20).

The PCL:YV Total scores, and the Interpersonal and Affective factor of the PCL:YV are significantly and positively related to Difficulties in Describing Feelings (TAS-20). Moreover, strong positive correlations were observed between the Lifestyle factor of the PCL:YV and Stress and Total Internalizing Psychopathology (DASS-21). In addition, the PCL:YV Total-3 factor score was significantly correlated with Stress (DASS-21). None of the PCL:YV and YPI-S factor and Total scores were significantly associated with the interview measure of Total Internalizing Psychopathology (DISC).

Table 4

Pearson correlations between psychopathic traits and measures of internalizing psychopathology and alexithymia

			YPI-S				PCL:YV					
		n	GM	CU	II	Total	F1	F2	F3	F4	TOT3	TOT4
TAS-20	DIF	60	.27*	. 18	.40**	.40**	.05	.09	.00	.03	.05	.02
	DDF	60	.25	.04	.19	.23	.30**	.30*	.19	.06	.31*	.28*
	EOT	60	-.09	.01	-.04	-.06	-.12	-.04	.08	.11	-.03	.01
	Total	60	.28**	.15	.36**	.37**	.11	.17	.11	.10	.15	.14
DASS-	Depression	60	-.01	.12	.25	.16	-.02	-.15	-.05	-.17	-.08	-.14
21	Anxiety	60	.24	.25	.49**	.45**	.13	-.01	.06	-.01	.08	.03
	Stress	60	.23	.23	.62**	.54**	.19	.25	.66**	.11	.27*	.22
	Total	60	.20	.20	.55**	.47**	.13	.12	.61**	.00	.13	.07
PANAS	PA	55	.16	.31*	-.01	.22	.12	.09	.12	.24	.14	.22
	NA	55	.09	-.07	.22	.11	.09	.14	.13	-.01	.15	.09
STAI	S-Anxiety	56	.21	.07	.11	.19	.11	.00	.04	-.02	.07	.02
	T-Anxiety	56	.29*	.06	.32*	.31*	.20	.15	.06	-.12	.17	.06
BDI		56	.14	.04	.17	.16	.14	.12	.06	.05	.12	.08
DISC		53	.20	.04	.05	.11	.20	-.01	.11	-.11	.13	.04

Note. YPI-S = Youth Psychopathic Traits Inventory-Short Version; CU = Callous-Unemotional; GM = Grandiose-Manipulative; II = Impulsive-Irresponsible; PCL:YV : Psychopathy Checklist: Youth Version; F1 = Interpersonal Factor; F2 = Affective Factor; F3 = Behavioral Factor; F4 = Antisocial Factor; TOT3 = Total score based on three-factor model; TOT4 = Total score based on four-factor model; TAS-20 = Toronto Alexithymia Scale-20; DIF = difficulty identifying feelings; DDF = difficulty describing feelings; EOT = externally oriented thinking; DASS-21 = Depression Anxiety Stress Scale-21; PANAS = Positive and Negative Affect Scale; PA = Positive Affect; NA = Negative Affect; STAI = State-Trait Anxiety Inventory; S-Anxiety = State-Anxiety; T-Anxiety = Trait-Anxiety; YSR = Youth Self Report; BDI = Beck Depression Inventory, DISC = Diagnostic Interview Schedule for Children Version IV; PCL:YV : Psychopathy Checklist: Youth Version.

** = $p < .01$, * = $p < .05$

DISCUSSION

The aim of this study was to investigate the relationship between psychopathic traits and various forms of internalizing psychopathology, alexithymia, and thought problems in a community and referred sample of adolescents. We hypothesized that youngsters with more psychopathic traits have less internalizing psychopathology than those with less psychopathic traits, and that this is particularly the case for those with high scores on the Interpersonal/Affective dimension of psychopathy. Those with high scores on the Lifestyle/Antisocial dimension of psychopathy were expected to have more internalizing psychopathology. We also hypothesized that youngsters with more psychopathic traits have more difficulties identifying feelings and more thought problems.

In our community sample, several surprising results were found concerning cluster group differences in terms of internalizing psychopathology. Contrary to our hypotheses, both the Psychopathic-like and the Callous-Unemotional group scored significantly higher on Depression, Stress, Anxiety and Total internalizing psychopathology (DASS-21), compared to the normal group. Moreover, compared to the Grandiose-Manipulative group, the Psychopathic-like group also scored significantly higher on Anxiety, Stress, and Internalizing psychopathology. These significant group differences in terms of anxiety were not observed in relation to the STAI, another scale that measures anxiety. A possible explanation for this could be that the Anxiety scale of the DASS-21 contains more items that assess the autonomic arousal and skeletal musculature effects (e.g. trembling hands, palpitations) associated with anxiety, whereas more items of the STAI assess the subjective experience of anxiety (e.g. I 'feel' safe).

Moreover, and in line with our hypotheses, the Callous-Unemotional group scored significantly lower on Stress than the Impulsive-Irresponsible group. Also in accordance with our hypotheses, the Impulsive-Irresponsible group scored significantly higher on the YSR Anxiety scale, compared to both the Normal and the Psychopathic-like group. In relation to mean scores on the PANAS, and the BDI no significant differences between groups were observed.

Regarding alexithymia, the findings were more in line with our expectations. On average, the Impulsive-Irresponsible group demonstrated more difficulties in identifying feelings, compared to both the Normal and the Callous-Unemotional group. Moreover, the

Impulsive-Irresponsible group had significantly higher Total alexithymia scores, compared to the Normal group. Also in line with our hypotheses, compared to the Normal group, the Psychopathic-like, the Callous-Unemotional, and the Grandiose-Manipulative group demonstrated more thought problems.

Findings in the referred sample, confirmed several of our hypotheses, but also exhibited some surprising trends, comparable to the findings in the community sample. In line with our expectations, the Behavioral dimension of the YPI-S was significantly related to STAI Trait-Anxiety, and DASS-21 Anxiety, Stress, and Total amount of Internalizing psychopathology. Similarly, the Lifestyle factor of the PCL:YV was significantly and strongly correlated to DASS-21 Stress and Total Internalizing psychopathology. However, contrary to our expectations, we found no negative correlations between, the Callous-Unemotional dimension of the YPI-S and the Interpersonal and Affective subscales of the PCL:YV, and Internalizing Psychopathology. These findings challenge the idea of the *unemotional psychopath*.

Furthermore, we observed significant positive associations between the Interpersonal dimension of the YPI-S on the one hand, and Difficulties in Identifying Feelings and Total scores for alexithymia on the other hand. PCL:YV total scores, and the Interpersonal and Affective factor of the PCL:YV were significantly related to Difficulties in Describing Feelings (alexithymia). In addition, the YPI-S total score was positively related to DASS-21 Anxiety, Stress, and Total scores for Internalizing psychopathology. Analogously, strong correlations were found between the PCL:YV Total 3-factor score and DASS-21 Stress. To some extent, these results are in line with a previous study of Vahl, Colins, Lodewijks, Markus, Doreleijers, & Vermeiren (2013), which found a positive relationship between the interpersonal dimension of the YPI-S and anxious/depressed feelings. There were no significant correlations between YPI-S total and facet scores and depression, negative affect, difficulties in describing feelings, and externally oriented thinking. Notably, there were no significant correlations between PCL:YV, nor YPI-S factor and total scores, with internalizing psychopathology as measured by the DISC interview. Again, this contradicts the idea that youngsters with high psychopathy scores experience less internalizing problems.

These results should be interpreted in light of certain limitations. First, this study was limited by its use of a cross-sectional design, excluding causal interpretations of the relationships between psychopathic features and various measures of internalizing

problems, alexithymia and thought problems. Second, the referred sample was mainly composed of persistent juvenile offenders. This group may not be representative of the majority of adolescent offenders. Future research with the YPI-S should include more heterogeneous samples of both frequent and first time delinquents. Moreover, the sample size of the referred sample was too small to draw robust conclusions. Finally, the use of self-report measures may have confounded the relationship between psychopathy and different measures of psychopathology because of three reasons: (a) the deceptive nature of individuals with psychopathic traits renders self-report measures particularly vulnerable[8], (b) it may also be problematic to ask individuals who have never experienced internalizing problems to (self-)report their absence (Lilienfeld & Fowler, 2006), (c) it has been argued that questionnaires on anxiety and depression tend to measure general distress instead of particular symptoms of anxiety and depression (Coyne, 1994).

Taking into account these limitations and the inconsistent findings of this study, some provisional conclusions and suggestions for future research can be formulated. Overall, this study confirms the classical positive relation of psychopathy with externalizing behavior. On the other hand, hypotheses concerning the association of psychopathy and (an absence of) internalizing psychopathology were not confirmed. Based on self-report measures we found a moderate trend for a positive relationship between psychopathic traits and different measures of internalizing problems (or possibly general distress). Based on interview measures, juvenile psychopathy and internalizing psychopathology were not related. These results suggest that the supposed absence of anxiety and depression in juveniles diagnosed with 'psychopathy' might not hold. Future research should use indirect and implicit measures of anxiety and depression as well as qualitative research designs to address this issue. In addition, our findings suggest that despite some similarities, the affective problems typical for juvenile psychopathy cannot be equated with alexithymia. Since thought problems were significantly more pronounced in cluster groups with more psychopathic features, future research should investigate the possible relationship between psychopathy and latent psychosis in greater detail.

NOTES

1. Related to the concept of primary psychopathy (see Karpman, 1941, 1948; Lykken, 1995).
2. Related to the concept of secondary psychopathy (see Karpman, 1941, 1948; Lykken, 1995).
3. For each measure separately, series mean replacement was used in case of ≤ 5% missing item scores, in both the community sample and the referred sample.
4. Internal consistency was investigated by means of both the Cronbach's alpha coefficient and the mean inter-item correlations (MIC). The MIC is considered to be a more eligible indicator of the internal consistency than the coefficient alpha, as it is independent of the number of items (Clarck & Watson, 1995). Cronbach's alpha coefficients of less than .60 are considered poor, marginal from .60 to .69, acceptable from .70 to .79, and good if exceeding .80 (Barker, Pistrang, & Elliott, 2002). MIC values in the range of .15 to .50 can be considered adequate, and between .20 and .40 optimal (Briggs & Cheek, 1986; Clarck & Watson, 1995; Nunnally & Bernstein, 1994)
5. The YPI-S data used in this study stem from an administration of the original 50-item YPI in both samples. Based on the results of our (factorial) validity analysis of both the YPI and the YPI-S, we concluded to use the YPI-S for further data analysis.
6. A clinical psychologist, who received specialist training in PCL:YV assessment and rating, conducted inter-rater reliability independently. Inter-rater reliability was calculated for 18 of the 62 PCL:YVs available in this study.
7. Because of rather small sample sizes of the different cluster groups, group comparisons were also conducted using nonparametric Kruskal-Wallis tests, followed by post-hoc pairwise comparisons. The results of these tests showed the same trends as those obtained from (M)ANOVA and independent-samples t-tests.
8. The problem of face validity was addressed in the development of the YPI (Andershed et al., 2001) by framing items in a more positive and less transparent way.

REFERENCES

Achenbach, T., & Rescorla, L. (2001). *Manual for ASEBA school-age forms & profiles.* Burlington: University of Vermont.

Aldenderfer, M. S., & Blashfield, R. K. (1984). *Cluster analysis. Sage University Paper Series on Quantitative Applications in the Social Sciences, series no 07-044.* Beverly Hills, CA: Sage Publications.

Andershed, H., Kerr, M., Stattin, H., & Levander, S. (2001). Psychopathic traits in non-referred youths: A new assessment tool. In E. Blaauw, & L. Sheridan (Eds.), *Psychopaths: Current international perspectives* (pp. 131-158). The Hague, The Netherlands: Elsevier.

Antony, M. M., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*, 176-181.

Bagby, R. M., Parker, J. D., & Taylor, G. J. (1994). The twenty-item Toronto Alexithymia Scale - I. Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research, 3*, 23-32.

Bagby, R. M., Taylor, G. J., & Parker, J. D. (1994). The twenty-item Toronto alexithymia scale - II. Convergent, discriminant and concurrent validity . *Journal of Psychosomatic Research, 38*, 33-40.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in Clinical Psychology (2nd ed.).* Chichester, England: John Wiley & Sons, LTD.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory: second edition manual.* San Antonio, TX: The Psychological Corporation.

Berenbaum, H. (1996). Childhood abuse, alexithymia, and personality disorder. *Journal of Psychosomatic research, 41*, 585-595.

Biagi-Chai, F. (2012). *Serial Killers. Psychiatry, Criminology, Responsibility.* New York: Routledge.

Blashfield, R. K., & Aldenderfer, M. S. (1988). The methods and problems of clusteranalysis. In J. R. Nesselroade, & R. B. Cattell (Eds.), *Handbook of multivariate experimental psychology* (pp. 447-474). New York, NY: Plenum.

Briggs, S. R., & Cheek, J. M. (1986). The role of factor analysis in the development and evaluation of personality scales. *Journal of Personality, 54*, 106-148.

Caldwell, M., McCormick, D., Umstead, D., & Van Rybroek, G. (2007). Evidence of treatment progress and therapeutic outcomes among adolescents with psychopathic features. *Criminal Justice and Behavior, 34*, 573-587.

Carver, C. S., & White, T. L. (1994). Behavioral inhibition, behavioral activation, and affective responses to impending reward and punishment: The BIS/BAS scales. *Journal of Personality and Social Psychology, 67*, 319-333.

Clarck, L. A., & Watson, D. (1995). Constructing validity: Basic Issues in Objective Scale Development. *Psychological Assessment, 7*, 309-319.

Cleckley, H. (1976). *The mask of sanithy (5th ed.) .* St.Louis, MO: Mosby. .

Coid, J., & Ullrich, S. (2011). Prisoners with psychosis in England and Wales: Diversion to psychiatric inpatient services? *International Journal of Law and Psychiatry, 34*, 99-108.

Colins , O. F., Noom, M., & Vanderplasschen, W. (2012). Youth Psychopathic Traits Inventory-Short Version: A Further Test of the Internal Consistency and Criterion Validity. *Journal of Psychopathology and Behavioral Assessment, 34*, 476-486.

Cooke, D. J., Michie, C., & Skeem, J. (2007). Understanding the structure of the psychopathy checklist-revised: an exploration of methodological confusion. *British Journal of Psychiatry supplements, 49*, s39-s50.

Cooke, D., & Michie, C. (2001). Refining the construct of psychopathy: Toward a hierarchical model. *Psychological Assessment, 13*, 171-188.

Corr, P. J. (2010). The psychoticism-psychopathy continuum: A neuropsychological model of core deficits. *Personality and Individual Differences, 48*, 695-703.

Crawford, J. R., & Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): Normative data and latent structure in a large non-clinical sample. *British Journal of Clinical Psychology, 42*, 111-131.

Crawford, J. R., & Henry, J. D. (2004). The positive and negative affect schedule (PANAS): construct validity, measurement properties and normative data in a large non-clinical sample. *British Journal of Clinical Psychology , 43*, 245-265.

Dancey, C., & Reidy, J. (2004). *Statistics without maths for psychology: using SPSS for windows .* London: Prentice Hall.

Forth, A. E., & Burke, H. C. (1998). Psychopathy in adolescence: assessment, violence, and development precursors. In D. Cook, A. Forth, & R. Hare (Eds.), *Psychopathy: Theory, Research, and Implications for Society* (pp. 205-230). Dordrecht: Kluwer.

Forth, A., Kosson, D., & Hare, R. (2003). *The Hare Psychopathy Checklist: Youth Version.* Toronto: Multi-Health Systems, inc.

Fowles , D. C., & Dindo, L. (2006). A dual-deficit model of psychopathy. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 14-34). New York: Guildford Press.

Frick, P. J. (2002). Juvenile psychopathy from a developmental perspective: Implications for construct development and use in forensic assessments. *Law and Human Behavior, 26*, 247-253.

Frick, P. J., Lilienfeld, S. 0., Ellis, M., Loney, B., & Silverthorn, P. (1999). The association between anxiety and psychopathy dimensions in children. *Journal of Abnormal Child Psychology, 27*, 383-392.

Gray, J. A., & McNaughton, N. (2000). *The neuropsychology of anxiety: An enquiry into the functions of the septohippocampal system* (2nd ed.). Oxford: Oxford University Press.

Gray, J. A. (1979). A neuropsychological theory of anxiety. In C. E. Izard (Ed.), *Emotions in personality and psychopathology.* New York: Plenum Press.

Gray, J. A. (1976). The Behavioural Inhibition System: A possible substrate for anxiety. In M. P. Feldman, & Broadhurst (Eds.), *Theoretical and experimental bases of the behaviour therapies* (pp. 3-41). London: Wiley.

Gray, J. A. (1978). The neuropsychology of anxiety. *British Journal of Psychiatry, 69*, 417-434.

Hare , R. D. (1991). *Hare Psychopathy Checklist-Revised (PCL-R).* Torronto, ON: Multi Health Systems.

Hare, R. D. (1980). A research scale for the assessment of psychopathy in criminal populations. *Personality and Individual Differences , 1*, 111-119.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist-Revised (2nd ed.).* Torronto, ON, Canada: Multi-Health Systems.

Hare, R. (1991). *Manual for the Hare Psychopathy Checklist-Revised.* Toronto: Multi-Health Systems.

Hawes, D. J., & Dadds, M. R. (2005). The treatment of conduct problems in children with callous-unemotional traits. *Journal of Consulting and Clinical Psychology, 73*, 737-741.

Karpman, B. (1941). On the need of seperating psychopathy into two distinct clinical types: the symptomatic and the idiopathic . *Journal of Criminal Psychopathology, 3*, 112-137.

Karpman, B. (1948). The myth of the psychopathic personality. *American Journal of Psychiatry, 104*, 523-534.

Kauffman, L., & Rousseeuw , P. J. (2005). *Finding groups in data: An introduction to cluster analysis.* New York, NY: Wiley-Interscience.

Kubak, F., & Salekin, R. (2009). Psychopathy and anxiety in children and adolescents: New insights on developmental pathways to offending. *Journal of Psychopathology and Behavioral Assessment, 31*, 271-284.

Lacan, J. (1993 [1955-56]). *The Seminar 1955-1956, Book III, The Psychosis.* New York and London: W.W. Norton.

Lacan, J. (2002 [1962-63]). *The Seminar of Jacques Lacan: Book X. L'angoisse/Anxiety, 1962-63.* (T.b. Manuscripts, Trans.). Karnac Books.

Lander, G. C., Lutz-Zois, C. J., Rye, M. S., & Goodnight, J. A. (2012). The differential association between alexithymia and primary versus secondary psychopathy. *Personality and Individual Differences, 52*, 45-50.

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*, 159-174.

Lorr, M. (1983). *Cluster analysis for social scientists.* San Francisco: Jossey-Bass.

Louth, S. M., Hare, R. D., & Linden, W. (1998). Psychopathy and alexithymia in female offenders. *Canadian Journal of Behavioural Science/Revue Canadienne des sciences du comportment, 30*, 91-98.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the depression anxiety stress Scales.* Sydney: Psychology Foundation.

Lykken, D. T. (1957). A study of anxiety in the sociopathic personality. *Journal of Abnormal and Social Psychology, 55*, 6-10.

Lykken, D. T. (1995). *The antisocial personalities* . Hillsdale, NJ: Lawrence Erlbaum Associates.

McGinn, T., Wyer, P. C., Newman, T. B., Keitz, S., Leipzig, R., & Guyatt, G. (2004). Tips for learners of evidence-based medicine: Measures of observer variability (kappa statistic). *Canadian Medical Association Journal, 171*, 1369-1373.

Meganck, R., Vanheule, S., & Desmet, M. (2008). Factorial Validity and Measurement Invariance of the 20-item Toronto Alexithymia Scale in Clinical and Nonclinical Samples. *Assessment, 15,* 36-47.

Meloy, J. R. (2001). *The Mark of Cain.* Hillsdale, New Jersey: The Analytic Press.

Meloy, J. R. (2004). *The psychopathic mind: Origins, dynamics, and treatment.* Lanham, MD: Rowman & Littlefield.

Norton, P. J. (2007). Depression Anxiety and Stress Scales (DASS-21): Psychometric analysis across four racial groups. *Anxiety, Stress, & Coping, 20*, 253-265.

Nunnally, J., & Bernstein, L. (1994). *Psychometric theory.* New York: McGraw-Hill Higher, INC.

Pham, T. R., Ducro, C., & Luminet, O. (2010). Psychopathy, Alexithymia and Emotional Intelligence in a Forensic Hospital. *International Journal of Forensic Mental Health, 9*, 24-32.

Ridings, L. E. (2011). *Emotional Deregulation and Borderline Personality Disorder: Explaining the Link Between Secondary Psychopathy and Alexithymia.* Doctoral dissertation: University of Dayton.

Roose, A., Bijttebier, P., Claes, L., & Lilienfeld, S. O. (2011). Psychopathic traits in adolescence: Associations with the revised Reinforcement Sensitivity Theory Systems. *Personality and Individual Differences, 50*, 201-205.

Salekin , R. T., Leistico, A. M., Neumann, C. S., DiCicco, T. M., & Duros, R. L. (2004). Psychopathy and comorbidity in a young offender sample: taking a closer look at psychopathy's potential importance over disruptive behavior disorders. *Journal of Abnormal Psychology, 113*, 416-427.

Salekin, R. (2008). Psychopathy and recidivism from mid-adolescence to young adulthood: Cumulating legal problems and limiting life opportunities. *Journal of Abnormal Psychology, 117*, 386-395.

Sevecke, K., & Kosson, D. S. (2010). Relationships of child and adolescent psychopathy to other forms of psychopathology. In R. T. Salekin , & D. R. Lynam (Eds.), *Handbook of child & adolescent psychopathy* (pp. 284-314). New York: The Guilford Press.

Sevecke, K., Lehmkuhl, G., & Krischer, M. K. (2009). Examining relations between psychopathology and psychopathy dimensions among adolescent female and male offenders. *European Child and Adolescent Psychiatry, 2*, 85-95.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, Differences From Previous Versions, and Reliability of Some Common Diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 28-38.

Skeem, J. L., & Cauffman, E. (2003). Views of the Downward Extension: Comparing the Youth Version of the Psychopathy Checklist with the Youth Psychopathic traits Inventory. *Behavioral Sciences and the Law, 21*, 737-770.

Spain, S. E., Douglas, K. S., Poythress, N. G., & Epstein, M. (2004). The relationship between psychopathic features, violence and treatment outcomes: the comparison of three youth measures of psychopathic features. *Behavioral Sciences and the Law, 22*, 85-102.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory.* Palo Alto, CA: Consulting Psychologists Press.

Taylor, G. J., Ryan, D., & Bagby, R. M. (1985). Toward the development of a new self-report alexithymia scale. *Psychotherapy and Psychosomatics, 44*, 191-199.

Vahl, P., Colins, O. F., Lodewijks, H. P., Markus, M. T., Doreleijers, T. A., & Vermeiren, R. R. (2013). Psychopathic-like traits in detained adolescents: clinical usefulness of self-report. *European Child and Adolescent Psychiatry* , DOI 10.1007/s00787-013-0497-4.

van Baardewijk, Y., Andershed, H., Stegge, H., Nilsson, K. W., Scholte, E., & Vermeiren, R. (2010). Development and Tests of Short Versions of the Youth Psychopathic Traits Inventory and the Youth Psychopathic Traits Inventory-Child Version. *European Journal of Psychological Assessment, 26*, 122-128.

Vasey, M., Kotov, R., Frick, P., & Loney, B. (2005). The latent structure of psychopathy in youth: A taxometric investigation. *Journal of Abnormal Child Psychology, 33*, 411-429.

Verhulst, F., & Van der Ende , J. (2001). *Handleiding voor de CBCL/6-18, YSR, en TRF (Dutch manual for CBCL/6-18, YSR, and TRF).* The Netherlands: Erasmus Universiteit Rotterdam.

Ward, J. H. (1963). Hierarchical grouping to optimize an objective function. *Journal of the American Statistical Association, 58*, 236-244.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063-1070.

Willemsen, J., & Verhaeghe, P. (2012). Psychopathy and internalizing psychopathology. *International Journal of Law and Psychiatry, 35*, 269-275.

4

PROTECTING THE SELF: THE RELATIONSHIP BETWEEN DEFENSE MECHANISMS AND PSYCHOPATHIC TRAITS IN NON-REFERRED ADOLESCENTS[1]

The study examines the role defense mechanisms play in the emergence of psychopathic personality traits in adolescents from a community sample (n=261). Psychopathic traits were measured by means of the Youth Psychopathic Traits Inventory – Short version (YPI-S), defense mechanisms were measured with the Defensive Style Questionnaire (DSQ-40). Multivariate regression analysis revealed that higher levels of psychopathic traits were associated with higher levels of immature defenses (acting out, isolation, dissociation, splitting and rationalization) and lower levels of a neurotic defense mechanism (undoing).

[1] This chapter is based on De Ganck, J. & Vanheule, S. (submitted). Protecting the Self: The Relationship between Defense Mechanisms and Psychopathic Traits in Non-Referred Adolescents. *Journal of Adolescence.*

INTRODUCTION

While a substantial amount of literature indicates that defense mechanisms play an important role in personality disorders, empirical research into the defense mechanisms associated with psychopathy is scarce. Psychopathy is defined by a constellation of interpersonal (e.g. grandiosity, manipulation), affective (e.g. callousness, unemotionality), and behavioral (e.g. irresponsibility, impulsivity) characteristics (Cleckley, 1976; Cooke & Michie, 2001, Hare, 1998). From a clinical perspective, numerous authors have argued that psychopathy is typically marked by a lack of internalizing psychopathology, such as depression and anxiety (e.g., Cleckley, 1976; Karpman, 1941). However, based on clinical work with imprisoned addicts, Vaillant (1975) is more careful in making such a claim. He argues that the psychopath's "incapacity" to experience anxiety and/or depression should be interpreted in terms of defense processes rather than a deficiency. More recently, Nørbech, Crittenden, and Hartmann (2013) drew similar conclusions based on an in-depth analysis of an Adult Attachment Interview and Rorshach data of a male criminal with a psychopathic personality profile. They suggest that psychopathic individuals may indeed experience feelings such as agony and anxiety, and that the alleged absence of such feelings should be understood in terms of self-protective strategies. More specifically, their case study illustrates that there is no deficiency, but a *deactivation* of this individual's inner feelings and a *denial* of his fear and vulnerability. These function as defensive strategies to protect the self in the face of perceived danger. Meloy (2001 & 2004) also theorized the idiosyncratic role that defense mechanisms play in the psychopathic process. Based on his research with antisocial and psychopathic adults (Gacono & Meloy, 1994), he postulates that there is a predominance of immature or preoedipal defenses in psychopathy, indicating that most often the defense mechanisms of devaluation, denial, dissociation, splitting, omnipotence, and projective identification come to the fore.

The current study aims to investigate the psychodynamics underlying psychopathic traits in terms of defensive processes in adolescents. We hypothesize that higher levels of immature defense mechanisms will be associated with higher levels of psychopathic traits in adolescents, and test whether the cluster of psychopathic defense mechanisms that Meloy (2001; 2004) described explains most of the variance in psychopathic personality traits. If the

first hypothesis holds true, but the second not, we explore whether another subset of defense mechanisms could be considered typical of psychopathy.

METHOD

Participants

The sample consisted of 261 non-referred adolescents (58.6% girls) between 12 and 17 years old (*M* = 13.74, *SD* = 1.65). The participants were recruited from a secondary school in Flanders (Belgium). In terms of type of education, 13.88% followed technical and 86.2% general secondary education. The study was approved by the Institutional Review Board of the Faculty of Psychology and Educational Sciences at Ghent University. Participants took part in the study on a voluntary basis, were informed about the overall purpose of the research project and gave their informed consent to be involved in the study.

Measures

The *Youth Psychopathic Traits Inventory-Short Version* (YPI-S: van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010) is an 18-item version of the original Youth Psychopathic Traits Inventory (YPI; Andershed, Kerr, Stattin, & Levander, 2002) developed to measure the amount of psychopathic traits in adolescents. In accordance with the three-factor conceptualization of psychopathy (Cooke & Michie, 2001; Cooke, Michie, & Skeem, 2007;), the YPI-S items are organized in three 6-item facets; i.e. a Grandiose-Manipulative (GM), a Callous-Unemotional (CU) and an Impulsive-Irresponsible (II) dimension. Items are scored on a 4-point Likert scale ranging from 1 (does not apply at all) to 4 (applies very well). Previous studies demonstrated adequate reliability and validity of the YPI-S in non-clinical populations (Colins , Noom, & Vanderplasschen, 2012).

The *Defensive Style Questionnaire-40* (DSQ-40: Andrews, Singh, & Bond, 1993) is a 40-item self-report scale to assess 20 defense mechanisms as described in the DSM-III-R (American Psychiatric Association, 1980). The DSQ-40 consists of three factors. Four defense mechanisms are related to the Mature factor: sublimation, humor, anticipation, and suppression. The Neurotic factor covers four defense mechanisms: undoing, pseudo-altruism, idealization, and reaction formation. Twelve defense mechanisms are related to

the Immature factor: projection, passive-aggression, acting-out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, and somatization. Items are evaluated on a 9-point Likert scale, with '1' indicating 'completely disagree' and '9' indicating 'fully agree.' The DSQ-40 proved to be a reliable and valid instrument in adolescent populations (Ruuttu et al., 2006). For the purpose of our study, the Immature Factor of the DSQ-40 was subdivided in two Immature defense clusters. The first Immature cluster ('Immature – Meloy') is a summation of the defenses devaluation, denial, dissociation, splitting, and projection. The second ('Immature – Other') is a summation of the other Immature DSQ-40 defenses.

Plan of Data Analysis

Data were analyzed using SPSS 22. Multiple linear and stepwise linear regression analyses (Cohen, Cohen, West, & Aiken, 2003) were performed to assess the power of defensive mechanisms in predicting psychopathic traits.

RESULTS

Multiple linear regression

Multivariate linear regression analysis[1] (Table 1) was conducted to evaluate whether immature defense mechanisms predicted psychopathic traits while controlling for mature and neurotic defense mechanisms.[2] Four clusters of defense mechanisms were used as predictor variables; the DSQ-40 Mature and Neurotic factor, and the two Immature Factors ('Immature – Meloy' and 'Immature – Other'). The linear combination of predictor variables was significantly related to psychopathic traits, $F(4,256) = 31.705$, $p<.001$. The multiple correlation coefficient was .58, indicating that approximately 33% of the variance in psychopathic traits can be accounted for by the overall model. Additionally, significant positive beta coefficients were observed for Meloy's subset as well as for other immature defense styles, with higher levels of immature defenses associated with higher levels of psychopathic traits. The unique variance explained by these two predictors, as indexed by the squared semi-partial correlations, was approximately 2% and 10% respectively. The

score for neurotic defenses was also a significant predictor, with lower levels of neurotic defense associated with higher levels of psychopathic traits. The unique variance explained by this predictor was 7%.

Table 1

Multivariate linear regression analysis of defense mechanisms predicting psychopathic traits

Defenses	***B***	**SE**	**β**	**sr^2**	**F (4,256)**	**R^2**
					31.705	.331
Constant	21.690	1.989				
Mature	.050	.044	.063	.058		
Neurotic	-.220**	.042	-.297**	-.269		
Immature – psychopathic ('Meloy')	.104*	.038	.186*	.139		
Immature – non-psychopathic ('Other')	.197**	.032	.439**	.314		

Note. sr^2 = squared semi-partial correlation

*: $p < .01$; **: $p < .001$

Stepwise linear regression

As the results of the previous multiple linear regression indicated that the cluster of immature defenses as described by Meloy (2001; 2004) was a significant, but not a unique predictor of psychopathic traits, a stepwise multivariate linear regression[1] was conducted with all 20 DSQ-40 defenses as possible predictors. The retained prediction model[3] contained six predictors, and was reached in six steps with no variables removed (Table 2). The model was statistically significant, F(6,254) = 24.300, p<.001, and accounted for approximately 37% of the variance in psychopathic traits. Significant positive beta coefficients were demonstrated for 'acting out', 'isolation', 'dissociation', 'splitting' and 'rationalization', with higher levels of these immature defenses associated with higher levels of psychopathic traits. The unique variance explained by these immature defenses was 11%, 4%, 3%, 1% and 1% respectively. 'Undoing' was also a significant predictor, with lower levels of this neurotic defense associated with higher levels of psychopathic traits. The unique variance explained by this predictor was 3%.

Table 2

Stepwise multivariate linear regression analysis of defense mechanisms predicting psychopathic traits

Defenses		*B*	SE	β	R^2	R^2 change	sr^2	F (6,254)	R^2
								24.300	.365
Constant		19.706	1.679						
Acting out	Step 1	.598**	.090	.358**	.207	.207	.331		
Isolation	Step 2	.351**	.085	.212**	.261	.054	.206		
Dissociation	Step 3	.320**	.096	.177**	.305	.044	.167		
Undoing	Step 4	-.332**	.091	-.185**	.340	.035	-.183		
Splitting	Step 5	.216*	.100	.116*	.354	.014	.108		
Rationalization	Step 6	.217*	.103	.107*	.365	.011	.105		

Note. sr^2 = squared semi-partial correlation

*: $p < .05$; **: $p < .001$

DISCUSSION

The present findings from a nonclinical adolescent sample demonstrate that higher levels of psychopathic traits are significantly associated with higher levels of immature defenses and lower levels of neurotic coping strategies. The prediction that the particular constellation of immature defenses (i.e. devaluation, denial, dissociation, splitting, and projective identification) as described by Meloy (2001; 2004) would explain most of the variance in psychopathic traits, was only partially confirmed. More particularly we observed that approximately 37% of the variance in psychopathic characteristics was accounted for by the five immature defenses (acting out, isolation, dissociation, splitting and rationalization), of which dissociation and splitting were also described by Meloy, and by the neurotic defense undoing. Higher levels of psychopathic traits were associated with higher scores for the five immature defensive styles and lower levels of undoing.

Defense mechanisms are unconscious psychological processes (mental operations and interpersonal behavior) that protect the individual against an excess of anxiety and protect the self against internal and external threat (American Psychiatric Association, 2000; Cooper, 1998; Vaillant, 1994). Following this definition, our findings suggest that an experience of anxiety might be associated to psychopathic traits. Indeed, the current finding that, in this sample, 37% of the variance in psychopathic traits is accounted for by a set of

immature and neurotic defenses goes against the idea that psychopathic individuals are free from anxiety and fear.

Therefore, future research should study in greater detail whether and/or how psychopathic unemotionality and callousness could be understood in terms of coping mechanisms as a defense against danger. As self-reports usually indicate that individuals with high scores for psychopathy report low levels of anxiety, which could indicate splitting and dissociation, indirect and implicit measures of anxiety, as well as qualitative research designs should be included when studying this question.

NOTES

1. All assumptions (linearity, normality, homoscedasticity) for linear regression were met. Using Cook's Distance no multivariate outliers were detected. Collinearity statistics, Tolerance and Variance Inflation Factor (VIF), were acceptable, suggesting that the different predictors were not multicollinear.
2. The Immature Factor of the DSQ-40 was subdivided in two Immature defense clusters. The first Immature cluster ('Immature – Meloy') is a summation of the defenses devaluation, denial, dissociation, splitting, and projection. The second ('Immature – Other') is a summation of the other DSQ-40 defenses.
3. To validate our prediction model, several stepwise regression analyses were conducted on random subsamples of the full community sample. Results of these stepwise regression analyses are best reflected in the retained model.

REFERENCES

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.).* Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text rev.).* Washington, DC: Author .

Andershed , H., Kerr, M., Stattin, H., & Levander, S. (2001). Psychopathic traits in non-referred youths: initial test of a new assessment tool. In E. Blaauw, & L. Sheridan (Eds.), *Psychopaths: current international perspectives* (pp. 131-158). The Hague: Elsevier.

Andrews, G., Singh, M., & Bond, M. (1993). The defence style questionnaire. *The Journal of Nervous and Mental Disease, 181*, 246-256.

Cleckley, H. R. (1976). *The mask of sanity (5th ed.).* St. Louis, MO: Mosby.

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences.* London: Lawrence Eribaum Associates.

Colins , O. F., Noom, M., & Vanderplasschen, W. (2012). Youth Psychopathic Traits Inventory-Short Version: a further test of the internal consistency and criterion validity. *Journal of Psychopathology and Behavioral Assessment, 34*, 476-486.

Cooke, D. J., Michie, C., & Skeem, J. (2007). Understanding the structure of the psychopathy checklist-revised: an exploration of methodological confusion. *British Journal of Psychiatry supplements, 49*, s39-s50.

Cooke, D., & Michie, C. (2001). Refining the construct of psychopathy: Toward a hierarchical model. *Psychological Assessment, 13*, 171-188.

Cooper, S. H. (1998). Changing notions of defence within psychoanalytic theory. *Journal of Personality, 66*, 947-964.

Gacono, C., & Meloy, J. R. (1994). *Rorschach Assessment of Aggressive and Psychopathic Personalities.* Hillsdale, New Jersey: Lawrence Erlbaum Associates .

Hare, R. D. (1998). Psychopathy and its nature: Implications for mental health and criminal justice systems. In T. Millon, E. Simonsen, M. Birkert-Smith, & R. D. Davis (Eds.), *Psychopathy: Antisocial, criminal and violent behavior* (pp. 188-212). New York: Guilford.

Karpman, B. (1941). On the need for seperating psychopathy into two distinct clinical types: Symptomatic and idiopathic. *Journal of Criminology and Psychopathology, 3*, 112-137.

Meloy, J. R. (2001). *The Mark of Cain.* Hillsdale, New Jersey: The Analytic Press.

Meloy, J. R. (2004). *The psychopathic mind: Origins, dynamics, and treatment.* Lanham, MD: Rowman & Littlefield.

Nørbech, P. C., Crittenden, P. M., & Hartmann, E. (2013). Self-Protective Strategies, Violence and Psychopathy: Theory and a Case Study. *Journal of Personality Assessment, 95*, 571-584.

Ruuttu, T., Pelkonen, M., Holi, M., Karlsson, L., Kiviruusu, O., Heilä, H., et al. (2006). Psychometric properties of the defence style questionnaire (DSQ-40) in adolescents. *Journal of Nervous & Mental Disease, 194*, 98-105.

Vaillant, G. E. (1994). Ego mechanisms of defence and personality psychopathology. *Journal of Abnormal Psychology, 103*, 44-50.

Vaillant, G. E. (1975). Sociopathy as a human process: A viewpoint. *Archives of General Psychiatry, 32*, 178-183.

van Baardewijk, Y., Andershed, H., Stegge, H., Nilsson, K. W., Scholte, E., & Vermeiren, R. (2010). Development and tetst of short versions of the Youth Psychopathic Traits Inventory and the Youth Psychopathiv Traits Inventory-Child Version. *European Journal of Psychological Assessment, 26*, 122-128.

5

THE SADNESS IN HIS EYES: ENCOUNTERS WITH A JUVENILE DELINQUENT WITH PSYCHOPATHIC TRAITS[1]

Popular and scientific definitions of psychopathy are far from neutral and tend to engender stereotypical thinking. Strong images are often associated with this forensic concept, including the idea that the psychopath is a social predator or a cold-blooded beast. Such metaphors affect our ability to gain unbiased insight into how emotions and social relations are experienced by individuals with psychopathic traits, and to situate the status of their criminal acts. What is often ignored in the current approach to psychopathy is the psychodynamic and contextual embedment of the individual's psychopathic behavior. Through a detailed study of the affective, interpersonal and antisocial life of an adolescent male with marked psychopathic traits, this single case study aims to delineate the clinical picture, exploring the psychodynamic and contextual processes that underlie the adolescent's psychopathic behavior. Based on our case material, we suggest that the antisocial behavior and the so-called 'incapacities' in emotional and interpersonal life thought to be characteristic of the psychopathic individual, represent defensive processes rather than 'deficiencies.'

[1] This chapter is based on De Ganck, J. & Vanheule, S. (submitted). The Sadness in his Eyes: Encounters with a Juvenile Delinquent with Psychopathic Traits. *The Journal of Forensic Psychiatry & Psychology*.

INTRODUCTION

He who fights with monsters should be careful lest he thereby become a monster.
And if thou gaze long into an abyss, the abyss will also gaze into thee.
— Nietzsche, *Beyond Good and Evil* (1886)

The way in which psychopathy is portrayed in both scientific texts and popular culture is far from neutral. Indeed, as a scientific and clinical construct it has always been the subject of considerable debate (Arrigo & Shipley, 2001; Hare, 1996). A general discussion that insists to this day is whether psychopaths can be considered as having a mental disorder or simply considered *evil individuals*. Much discussion has also been generated by its repeatedly changing nomenclature and unclear diagnostic criteria (Arrigo & Shipley, 2001; Hervé, 2007). In this study we start from Hare's (2003 & 2011) concept of psychopathy, defined as a severe and stable disorder of the personality that consists of four dimensions: (1) an arrogant, deceitful *interpersonal* style, (2) a defective *affective* life, (3) an impulsive-irresponsible, and (4) a socially deviant *lifestyle.* Hare developed a 20-item instrument known as the Psychopathy Checklist-Revised[1] (Hare, 1991, 2003: PCL-R; Hare & Neumann, 2008), which is designed to assess these four dimensions[2]. Today, the PCL-R is considered to be the "gold standard" for assessing psychopathy (Acheson, 2005; Hare, 1991, 2003).

On the *interpersonal* level, psychopaths are considered to be glib-tongued, superficial, narcissistic, grandiose, egocentric, deceptive, and manipulating (Hare, 2003; Hare & Neumann, 2008, 2009). Meloy (1988) and Hare (2011) describe the reptilian-like and predatory gaze of the psychopath that leaves most people uncomfortable, "almost as if they feel like potential prey in the presence of a predator" (Hare 2011, p. 200):

> *Psychopaths* are social predators who charm, manipulate, and ruthlessly plow their way through life, leaving a broad trail of broken hearts, shattered expectations and empty wallets. Completely lacking in conscience and in feelings for others, they selfishly take what they want and do as they please, violating social norms and expectations without the slightest sense of guilt or regret (Hare 2011, p. 200).

In the same vein, the psychopath's *affective* life is often portrayed in terms of profound callousness and a general poverty of emotion. Although not explicitly included in the current diagnostic criteria of Hare's Psychopathy Checklist (Hare, 2003), psychopaths are considered to have little disposition for experiencing psychoneurotic symptoms or negative affect, such as depression, fear and anxiety, the latter symptoms considered as the driving force of conscience (Hare, 2011). In other words, psychopathic individuals are considered to be conscienceless; experiencing no empathy, guilt or remorse and accepting no responsibility for their actions. It is often suggested that they cannot form close emotional bonds with others and are incapable of experiencing love (Cleckley, 1976; Hare, 2011; Hare & Neumann, 2008, 2009; Lykken, 1957).

These interpersonal and affective characteristics are thought to be associated with a *socially aberrant way of living*, marked by an excessive need for excitement and impulsive, irresponsible and rule-violating behavior. Their lack of guilt, fear and empathy, their incapacity for close relationships, together with their grandiosity and egocentricity almost pave the way for antisocial and criminal behavior (Hare & Neumann, 2009; Porter, 2007). Indeed, a consistent body of research indicates that psychopathy is a risk factor for antisocial conduct[3], institutional maladjustment, recidivism and violence (e.g., Hare, 2006; Hare & Neumann, 2009; Leistico, Salekin, DeCoster, & Rogers, 2008). Undoubtedly, for this reason psychopathy ought to be the most important psychological construct within the criminal justice system (Harris, Skilling, & Rice, 2001). The image of the psychopath as a dangerous "beast of prey" is reflected in several studies which indicate that persons with psychopathic traits are more prone to engage in instrumental or predatory violence (e.g., Cornell, Warren, Hawk, Stafford, Oram & Pine, 1996; Hare, 2003; McDermott, Quanbeck, Busse, Yastro, & Scott, 2008; Vitacco, Neuman, Caldwell, Leistico, & Van Rybroek, 2006). Some authors even assert that psychopathy and predatory aggression are virtually interchangeable notions (e.g., Declercq, 2008).

Conversely, several authors argue that these descriptive textbook definitions and popular conceptions of psychopathy are illusionary and mythical (e.g., Blackburn, 1988; Vaillant, 1975) and reflect nothing more than a social construct, readily accepted by the population at large (Federman, Holmes, & Jacob, 2009). Parker and colleagues (1995) argue that the demarcation of a psychiatric concept, such as psychopathy, can actually create cases that correspond with the expectations associated with it. In this respect, a reality that

matches the concept is constructed, reinforcing the belief that psychopathy is indeed a discrete and natural kind (Vanheule, 2012). Following this line of reasoning, it is not implausible that diagnostic categories, such as psychopathy, engender stereotypical thinking, where the observation of one characteristic, such as frequent norm violation, is assumed to be associated with other characteristics, such as having a poor affective life. Metaphors like that of the psychopath as a social predator or a reptilian beast fuel such stereotypical thinking and tend to distort our perception of individuals labeled as psychopaths.

It can be argued that the current definition and diagnosis of psychopathy barely transcends the descriptive level and, thus, lacks a conceptual framework to explain the underlying psychological and social processes of psychopathic behavior. Indeed, as Rabinovitch (1959) states: “Diagnosis on a purely descriptive level, without regard to the child’s thought content and inner life, is really no diagnosis at all” (p. 57). What is often ignored is the psychodynamic and contextual embedment of an individual’s psychopathic behavior. Following Kagan (2012), psychological assessment should always be related to contextual factors, such as gender, ethnicity, age and development, social class and cultural background.

In this study, we present the single case of a male adolescent, we call him Obrad, who fulfills Hare’s (2003) criteria for a diagnosis of psychopathy (Forth, Kosson, & Hare, 2003). Through a detailed exploration of the adolescent’s affective, interpersonal and antisocial life, we aim to delineate the clinical picture, exploring the psychodynamic and contextual processes that underlie his psychopathic behavior. We focus on the first-person perspective of the adolescent: Firstly, we explore how affects and emotions are experienced by this young man; Secondly, we investigate how he relates to others; and finally, we explore what status is attributed to his antisocial behavior and how this behavior emerges within his narratives.

METHOD

We first met Obrad at age 16 in the context of a research project on psychopathic traits in adolescent delinquents, which took place in an institution for juvenile delinquents in Belgium. He stayed in this institution for 9 months in total. The research project was approved by the Institutional Review Board of the Faculty of Psychology and Educational Sciences at Ghent University. The young man was informed about the overall purpose of the project, i.e. research on the affective, interpersonal and lifestyle characteristics of juvenile delinquents. He gave his informed consent to participate in the project and, with his permission, all interviews were audio-recorded and used for research and publishing purposes. The interviews took place on a voluntary and weekly basis in the institution itself. In total, 32 interviews were conducted by the first author during the 9 months that he was under the guardianship of the institution. The Hare Psychopathy Checklist: Youth Version (Forth et al., 2003: PCL:YV) was also administrated by the interviewer, who received specialist training prior to doing so[4]. The adolescent obtained a very high total score of 32 on the PCL:YV. All interviews were transcribed. The names of the adolescent, other people and places have been changed to ensure anonymity.

CASE STUDY

Life history and previous psychosocial guidance

Obrad is a 19-year-old adolescent who grew up in an east-European country until the age of ten. When he was five years old, war broke out in his home country and for six months he, his parents and his two older brothers lived in the basement of their house, seeking shelter from the daily bombings. As soon as his mother had accumulated enough petrol, she and her sons fled to Belgium, where they stayed for four months. They then returned home. When Obrad was eight years old, his father killed a family friend during a party on the terrace of their house. Obrad witnessed this murder. His mother took the three children and ran away in the middle of the night, but returned the next day. Both parents subsequently denied what had happened the night before. When Obrad was ten years old,

his father was charged with murder. When this took place, Obrad began to ditch school to avoid harassment from the other children. The family of the victim threatened to avenge the murder by killing one of his father's three sons. Once again, Obrad's mother fled to Belgium with her sons due to the persistent reprisals. Obrad's father was subsequently convicted and imprisoned in the family's home country. In jail, he soon entered a privileged half-open regime[5], being able to continue his artistic work and frequently enjoys penitentiary leave[6] outside of the prison. Having arrived in Belgium at the age of ten, Obrad didn't see his father again for five years, when he visited him in jail. During his imprisonment, Obrad's father repeatedly violated the prison terms: e.g. smuggling in a cell phone and not returning to the prison after penitentiary leave.

Between the ages of five and ten, Obrad was treated for seizures. Once he arrived in Belgium he went into counseling on a voluntary basis due to the traumatic events he had experienced and his problematic family situation. When he was 11 years old, he was referred to a social institution for one year because his mother couldn't manage his behavioral problems any longer. Between the ages of 11 to 18, he almost continuously lived in residential childhood settings and institutions for juvenile delinquents as a result of committing several crimes (e.g., stealing cars, joyriding, assault and injury, dealing drugs, arson, and burglary). He currently resides in a prison for adult offenders due to a variety of fraud offences and for violating his parole. In judicial and (earlier) therapeutic reports, he is described as a manipulative, cold, and emotionless individual, unable to describe his feelings. He is also described as secretive, closed-mouthed, aggressive and very therapy resistant. In earlier therapeutic programs he refused to talk about his family history, past traumatic life events or current drug abuse, and when he is asked to do so, he often responds aggressively.

Affective life: A masquerade of coldness, not a mask of sanity

During the initial meetings with Obrad, he informed the interviewer that his mother and educators encourage him to talk more openly about his affective life, but he is not willing to do so. On several occasions he stated that feelings must be kept hidden to avoid *being vulnerable to the intentions of others*:

> I don't show my feelings. I want to keep them to myself. Other people will only abuse it. Or they will try to… (…) That's one of the reasons why I don't show my feelings; why I keep them to myself. Others might want to help me (…). But I don't want that. (…) I don't feel like talking and I don't want to hear things that I don't like. (…) One of my educators once told me: "I see a lot of sadness in your eyes." Yes, I was feeling sad and angry, but I refuse to talk about it. I try to mask my feelings. (…) That's why I always say there's nothing wrong with me.

Obrad repeatedly spoke about the need "to keep" feelings inside. This statement may seem to suggest a lack of a profound and varied affective life, one of the core psychopathic characteristics. Despite his so called "unwillingness" or "inability" to express his feelings, different emotions (e.g., love and happiness, shame and guilt, anxiety and fear, despair and sadness) surface as the interviews unfold in time. For example, when Obrad talks about interactions with his girlfriend or with his father as a child, we don't meet a cold person, but discern feelings of *affection, love and true happiness*:

> I just really love my girlfriend. I had to wait seven months to start a relationship with her, because she already had a boyfriend. (…). What I like about her is that she wants a serious relationship, she doesn't want to fool around with other boys every time she gets sick of a relationship. She has a beautiful personality, that's what I really appreciate about her. She's sweet to me, she's beautiful.

> When I was still a very little child I hid under my bed and always looked at my father, how he was reading his newspaper. Then he looked up from behind his newspaper and looked back at me lying under my bed. From that moment on, he called me "little mouse". Yes, "my (with great emphasis) little mouse!" I felt so happy.

During several sessions he spoke about the *admiration* he felt as a child for his father who, being an artist, had decorated the family home. Every time Obrad goes on holiday to his home country, he returns to the family home to take pictures hoping that it will revive good childhood memories. This house often appears in many of Obrad's drawings.

Although Obrad seemed capable of experiencing and expressing several positive affects, most of the interviews clearly indicated an incapacity to express and endure negative emotions, particularly in relation to his parents. Whenever he attempted to express something of these negative feelings, Obrad would immediately shift with apparent ease onto positive feelings about the same theme, and in a manner that seemed as though his previous statements hadn't been verbalized at all, they were nonexistent. For example, every time he expressed anger, disappointment or fear concerning his father's power, he almost immediately continued by saying something very positive about him. This mechanism of *extreme dissociation or radical splitting* between negative and positive affective expressions are sharp transitions that often seemed strange or illogical for the interviewer. For example, this radical switch from negative to positive affects is illustrated in Obrad's description of the first meeting he had with his father, when he visited him in prison for the first time at the age of 15. As we can see below, at first Obrad verbalizes his fear and mistrust towards the aggressive nature of his father, but while describing this fear, Obrad's speech falters. Instead of elaborating this emotionally charged disclosure, Obrad suddenly switches tone and describes his father as someone who likes doing nice things with his family. This reflects a certain splitting with respect to his father:

> I told him: "If you would ever lay a finger on me!" Then he said: "I am your father, I would never harm you. (…) When you speak these words, (…) it feels like I am not your father." This is how it felt to the both of us. He doesn't make me feel like I have a real father, because I haven't seen him for five years**.** [**RADICAL SPLITTING**] He often takes us out, when he's home, and we're bored. "Let's go shopping, let's go swimming, let's hit the town," he'll say. That's what he's like.

Psychopaths are considered to have little tendency for experiencing negative affect, which could explain such splitting. However, in Obrad's case we are more likely to interpret this splitting as an inability to cope with negatively charged situations, rather than a mere lack of negative affect. Indeed, Obrad was overwhelmed by negative affect at certain moments; moments which he clearly found difficult to endure. During several interviews, this difficulty came to the fore and Obrad would cope either by laughing off feelings of sadness, pain or anger or by rationalizing painful situations: "I'd rather laugh my ass off, than be angry or sad." When asked to speak about his feelings around the dangerous events[7] in

his past, he often replied: “sometimes you're lucky, sometimes you’re not,” “what has happened, has happened,” or “accidents just happen.” This incapacity to endure negative affect also seemed to be present in Obrad’s relatives, as suggested in Obrad’s description of other family members. For example, when Obrad spoke about how he lost his grandfather, he said: “My grandfather knew he was dying and called us on Christmas Eve: ‘I will die within a few hours. (…), but you shouldn’t let your head (spirit) drop into a somber mood. (…) You mustn’t let this fuck up the party.’”

In line with common theoretical assumptions related to psychopathy, Obrad stated that, with regard to his life in general, he is *free of fear*. He is only afraid when he has to appear in front of the judges and when his father is angry, aggressive, stressed or unpredictable. Often he relativizes his fear of his father by specifying it as just a “little” fear or as “not really” being afraid of him:

> I know my father is strict, but fair. He sometimes shouts. (...) Yes, I'm afraid of him. (…) I don’t exactly know what’s permissible or not with him. That's what frightens me. But if I do good things for him, he’s nice to me.

However, halfway into the overall interview phase, Obrad acknowledged two life events in which he felt *real anxiety*. His descriptions of these events are rather fragmented and hard to follow. The first story refers to the fear he experienced during a survival weekend in the context of a time-out project for juvenile delinquents. At night in the woods, he would sit in a tree with another youngster. At one point he saw a “pair of legs” passing by and he became overwhelmed with anxiety. Obrad could not explain this phenomenon; the only thing he could say about it was that he was sure it wasn’t a wild boar, or a fox, or bird. In the second story he began by describing a stormy night and the appearance of a cat on the window sill of the third floor of his parental house, and then immediately switched to the description of a bloody scene and trees[8]. Both events appeared to have an alienating effect on Obrad, who failed to construct a coherent narrative around them. He defined the anxiety he experienced as follows: “I experience anxiety if I ... If I have no clue. As if things are an enigma to me. You don’t know where it comes from. (...) There’s no reason why it happens (...).”

Also *shame and guilt* were not altogether absent in Obrad's narratives. On the one hand, while he didn't deny the gravity of his violent acts, emotions of *shame and guilt* towards his (unknown) victims were absent, which seems to fit the stereotype of the psychopath as a conscienceless creature. With regard to the consequences of his acts for his victims, he stated, for example: "I don't know if it should bother me." Moreover, Obrad seemed to be completely unable to explain what motivates his criminal behavior:

> These are difficult questions. (...) I don't know. (...) It's difficult to talk about my criminal acts, because it is hard to think about it again. It's difficult to talk about the facts. What happened, just happened. (…) It's not difficult to talk about the facts, but to explain in detail how I feel about it is.

On the other hand, feelings of guilt and shame did appear during our meetings, specifically in relation to his older brother. Several of Obrad's statements revealed his sense of responsibility for the well-being of his brother. He feels guilt when his brother isn't doing well, for instance, when he was unable to prevent his brother's drug abuse. Feelings of guilt also emerge in relation to the repeated battles he has with his older brother, since this violates a rule highly valued by Obrad: "Brothers do not fight." Such examples indicate that Obrad does actually hold on to moral and ethical principles. He argues that other people don't understand why they fight and that it is often his older brother that starts the fight when things get out of hand. Mostly, he says, he does not respond to his brother's taunts, unless the scene unfolds in front of his girlfriend:

> I feel guilty towards my big brother, just really guilty. (...) Normally I don't fight with my brother, even though he often grabs me and beats me up. I never had the feeling that I would hit him. But at that moment I had to do it. (...) I'm thinking how I should apologize to my brother. That really preoccupies me. (...) I would never hit my own brother. (...) but at that moment I was not thinking of my brother, but of my girlfriend who was there the whole time: [I thought] 'What is she thinking?' 'What is she seeing?' 'Is she crying or is she afraid?'. I saw my brother's fist coming my way. I ducked and looked at my girlfriend. She ran away, crying. Then I really got angry (firmly)! Because I…because…because you just do not do that!

Despite his tendency towards psychical splitting in relation to the experience or expression of negative affect, nearing the end of our series of sessions, Obrad began to express feelings of *despair*, *sadness*, and *pain* and spoke about two incidents involving suicidal thoughts. Both incidents were a reaction to the threats of Obrad's mother to send him back to an institution for juvenile delinquents. On the first occasion, he took his mother's sleeping pills from the bathroom cabinet… "because I had nothing to lose." It was difficult for him to swallow the pills. When his mother entered the bathroom, he changed his mind and went out for a walk. He added that his mother was worried afterwards. A couple of weeks later the thought of suicide re-emerged, and once again he made an appeal to his mother, taking her pillbox and walking through the house with it for a while: "I wanted to do it. But ... but at that moment I was really shaking. I was even too angry to swallow the pills. Then I threw them away and just went outside." Even though Obrad succeeded to resume daily life in a normal way after these events, his suicidal thoughts gradually seemed to be more deeply rooted than they had at first. For example, in one of our final sessions, it became clear that the lyrics of a rap song he wrote do not describe the suicidal thoughts of his friend, but his own. A part of his song goes as follows:

> You're waiting for death. You're afraid to go, but you keep yourself strong. You kiss your family goodbye. It will be alright. Don't cry. You have to express your feelings, wherever you are. I express them on different beats. (…) I will take you to a boy. He has lost interest in life. He was forever on pills to counteract the pain. His life in this world wasn't worth living. (…) He was bullied at school. He could not take it anymore. (…) I said, ignore those people (…) come on, don't behave like a boy of eleven. (…) I got the message that he hanged himself. My eyes closed. My tears were too wet, too wet to dry. (…) Why should you suffer fatigue and pain? The grief of people, where is the medicine? (…) Scientists make efforts, but is it to find? I do not know. (...) You got one thing and that is hope, even though this sounds so cheap.

Overall it was apparent that Obrad does experience a range of affects and emotions, which contrasts with the popular notion of the psychopath as a cold-blooded beast. Whereas Obrad initially seemed unable to speak about his feelings, he does appear to *experience feelings* and was certainly able to verbalize them as the rapport between he and the interviewer developed over time. While Obrad clearly experienced a spectrum of

negative feelings, including shame and guilt, sadness, pain, anxiety and fear, any narratives that incorporated both positive *and* negative emotions revealed extreme dissociation or radical splitting. This might be a result of the trauma he has experienced in his life, but also coheres with the split manner in which his parents managed issues in their own lives, including the murder committed by his father (e.g., Glassman, 1988; Kramer, de Roten, Perry & Despland, 2013). Whereas the initial standard screening for psychopathy (using the PCL:YV) revealed that a wide range of emotions was absent in Obrad, our interviews and the relational context that developed over time brought us to conclude that different emotions were clearly present. As illustrated above, these emotional experiences were embedded in Obrad's close interpersonal relationships. Below, we focus on Obrad's interpersonal life in more detail.

Interpersonal life: The enigmatic others and the semblance of authority

In one of our final encounters, Obrad stated that he felt as though he was the plaything of other people's intentions and actions: "I'm like a Play Station game to other people, they move their joystick all over me." Several interviews revealed Obrad's *basic distrust* in relation to the motives of (significant) others and his mistrust towards the integrity of (representatives of) the law.

This basic distrust was clearly expressed in relation to his parents, whose words and actions were constantly ambiguous to him. For instance, on the evening his father went before the court regarding his possible amnesty, Obrad spontaneously asked for a consultation with the first author. This was the first time that he talked about his father's murder case. He also explicitly expressed his sense of vulnerability in terms of trusting other people. Even though Obrad witnessed the murder, over the course of the following years his parents continued to deny what had happened: "It was just a game." Only after a couple of years did his mother vaguely inform him about the murder: "It was just an accident within the context of partying and drinking," to which she added that he was forbidden to talk about this to anyone. Furthermore, to date his father has never spoken honestly about the reason why he's in jail[9]:

> I didn't have much confidence in my father. He will never be honest. I asked him: "Why are you in prison?" His first story (...) was that he went to the pharmacy by car. We used to have a little dog. He had left the dog in the car, and the police said that the window should be left open when a dog is inside the car. Then there was also a story about pills and black marketing. According to my father that's the reason why he is in prison.

Obrad's mother encourages him to have confidence in his father, but for Obrad his parents' words and motives are ambiguous. He argues that the words of his father do not affect him because his life is marked by the absence of his father. Obrad wonders how he can meet the demand of his father to stay straight, as his father has done far worse things than the relatively minor offenses Obrad has committed. He questions his father's reproach over Obrad's smuggling of mobile phones into the institution and disobeying his conditional release, since his father did exactly the same. The possible release of his father frightens him, as his threatening and criminal behavior could potentially resume. However, what worries him the most is his suspicion of his mother's involvement in these matters. During his last visit to his home country he discovered guns in the house, but instead of openly asking his mother about them, he just quietly observed the way she deals with these weapons. Her concealment of his father's weapons simply feeds his distrust:

> I don't care if my father becomes threatening and things go wrong again. That's not the only thing that frightens me. (…) I found big and small weapons at home. (…) So my mother is involved again, she has begun to hide my father's weapons and stuff. That's what I can't agree with.[10]

Hence, trust in significant others seems to be absent. In Obrad's view, people occupying a particular social position (father, mother, girlfriend, representatives of the law,...) seem to be wearing "a mask of sanity," which may well hide their true selfish or malevolent intentions. Consequently, the trustworthiness of the other is something that needs to be repeatedly tested in reality, for example: "I do trust my girlfriend, cause till now she hasn't stolen anything from me." Similarly, at the beginning of our series of meetings, the confidentiality of our relationship was often tested. For example, by asking the interviewer what she would do if she knew he had smuggled a cell phone into the institution. The interviewer always referred to the formal agreement made at the beginning

of the working alliance that everything remains confidential, except if his life or that of other people could be in danger. In that case, the interviewer would intervene because she is obliged to do so by law. Related to this, Obrad continuously observes the behavior of other people, speculating as to whether they are deceiving him. He even states that he possesses a good knowledge of human nature and that he has a kind of direct access to the main traits of other people:

> My psychologist in institution X wasn't someone I could talk to. With you it is different. If I see someone I can immediately unravel his character: that's someone you can talk to, that's someone who will really listen to you. The first time I saw Jason[11] I immediately knew he was very strict, that he really enjoys making fun of other people.

Obrad also says that he is most sensitive to how representatives and authority figures deal with the law. Even though he recognizes the need for the law in society, since "otherwise, there would be total chaos," he has no confidence in it. He cites myriad examples: he refers to how easy it is to bribe the police in East-Europe, how he was once acquitted by a drunk judge, how he often witnessed an abuse of power in various institutions, etc.:

> The law…it is normal that the law applies to everyone. And of course the law must be obeyed. But not everyone does that, even the police. They are the principal representatives of the law, so to speak... Nonetheless, they also break the law.

Despite his fundamental distrust of others, over the years Obrad has managed to build trusting relationships with a few educators and judicial assistants. However, in the end he has always radically and unexpectedly terminated these relationships, precisely at the moment a strong appeal is made to his subjectivity:

> My first counselor from juvenile court, he was a good person. He gave me ...well he told me: "I've defended you too much." And he was right, he always stood up for me against the opinion of the judge. He always gave me many opportunities. (…) I really had a good relationship with him. (…) But I violated the trust in our relationship. (…) Now I regret that I ruined our relationship.

Within these relationships, the other is not perceived as bad, but Obrad could not tolerate the intimacy or closeness that developed in such relationships. His problem with intimacy was also illustrated by the way he spoke about his imprisonment: “Sometimes I think it would be easier if nobody from the outside, nobody who loves me, would come to visit me in prison. Sometimes I no longer want to see anybody from outside.” However, this radical distancing does not mean that there is no object permanence or social bond, as he repeatedly returns to the confidant after several years. Obrad could not account for these acts of both distancing and seeking reconciliation: “After three years I went back to that institution. I don’t know why. Just because there was an educator with whom I had a very good relationship and who I wanted to see back.”

In the previous section, we discussed how Obrad’s (apparent) incapacity to express emotions is embedded in his relational life. One stereotypical belief about individuals classified as psychopathic is that within interpersonal relationships they assume the position of a social predator, hunting for innocent prey. Our observations suggest that the metaphor of the psychopath as a “beast of prey” is flawed and that the overall assumption that individuals with psychopathic traits are incapable of object love or sustaining social bonds with others may be overly simplistic. Obrad’s position in relation to the intentions of significant others, authority figures, and representatives of the law is characterized by basic distrust. On the other hand, Obrad was able to build trusting relationships with a number of social workers and educators. He even voluntarily returns to his confidants later in life. However, his fundamental distrust, together with his recalcitrance in intimate relationships makes it difficult for Obrad to take on a subjective position in social bonds. Considered from Obrad’s perspective, *he* is the one who is at risk of falling prey to the ambiguous motives of other people.

Antisocial life: Becoming a person by acting…as a criminal

Obrad’s criminal acts seem to serve different functions. On the one hand, Obrad performs instrumental offenses that yield personal profit, money, excitement, etc. These are antisocial acts indicative of a certain indifference towards others, and fit the classic picture of psychopathy. On the other hand, Obrad also tends towards other types of behavior: antisocial behavior in response to a basic distrust in others, and antisocial behavior that

emerges when a demanding other comes too close. In both constellations, Obrad reacts by embracing the idea of being a criminal. This idea seems to provide the sense of identity he cherishes.

Every time longed-for objectives are soon to be realized (e.g., his final release from the institution, transition to the next phase in his criminal trial, professional opportunities related to his talents, etc.) Obrad performs 'unexplainable' and peculiar criminal offences that yield new punishments. This dynamic coheres with Cleckley's indication that psychopaths have a tendency to exhibit *inadequately motivated antisocial behavior* (Cleckley, 1976). For example, one day he failed to appear in court, even though he had been guaranteed that he would be acquitted. Obrad claimed that he didn't trust the words of the representative of the court, and fled to his Eastern-European home country. He also behaves in various antisocial ways that prevent him from being 'liberated,' examples of which are numerous, ranging from ostentatiously talking about his smuggled mobile phone in the institution just before his release, taking an alternative bus route that will cause him to arrive to the institution late, and taunting the police, to violating the rules of the institution just prior to his final release:

> It was the last day at the institution. (...) The holidays started, so we were allowed to go home. I had to leave anyway. My final day. I was packing my stuff. (...) Normally you're not allowed to smoke cigarettes there. But that day I was smoking in my room, yes. My educators said: "What are you doing?!" (...) I didn't have to come back to the institution anyway. (...) Then I started to smash everything in my room to bits.

These acts seem to sabotage the objectives he seemingly longed for. In one session, Obrad questioned his relapses and stated: "When I cause mischief others say: 'You are not allowed to do that.' Then I regret what I did, but two minutes later I take a swing again." In one way or another, he experiences difficulty at precisely the moment he is to be released, when the label of "criminal" would no longer apply to him. Indeed, things often go wrong when he returns to his family home when his detention is complete. In one interview, he complained that at home they live too close to each other and as a result the situation often gets out of hand. Close bonds with others seem to have an overwhelming effect on him, prompting him to react with violence. As our meetings evolved over time it became apparent that Obrad *identifies with being a virile and aggressive young man and a criminal*.

It seems that he needs such a label to assert his identity in relation to others. When he arrived in Belgium at the age of ten, children at school began to call him a criminal, and as an adolescent he began to adopt various nicknames, ranging from “karate kid” to denominations meaning “immigrant” or “foreigner.” Obrad cherished these nicknames. One day, Obrad’s mother insisted that he should go to the army’s open house. It was her wish that he, like his father, applied as a candidate for the army or the navy. At first Obrad was not interested. Afterwards he said that he was impressed by the military practices and that he felt good when he was allowed to handle a gun. What attracted him to the army was the potential for violence. He repeatedly suggests that others can’t imagine how aggressive he actually is, and that he is even afraid that his temper will take over again the moment he gets released. Concerning his imprisonment, he claims he doesn’t really feel uncomfortable living in detention, quite the contrary; he feels at ease among other “delinquents.” This indicates that his behavior is not as unmotivated as it first seems: by acting in antisocial ways, Obrad actively constructs an identity where he can affirm who he is in relation to others whose intentions are obscure to him. Furthermore, this idea of being a criminal seems to enable Obrad to make bonds with others that also identify with such an image. Indeed, he described the periods during which he committed many crimes with his friend Jonathan as “the good times.” He mentioned that he prefers to talk Slavic rather than Dutch, as the Slavic language is the language of the illegals, it is the language of the street:

> I prefer to speak Slavic. (...) No matter how you look at it, if I know 13 people from East-Europe, then almost all of them are illegals. (...) Talking like an illegal. (...), talking with the accent of a foreigner. I also talk that way, don’t I?

However, towards the end of our meetings, Obrad distanced himself somewhat from the image of being a criminal or illegal, embodied by the figure of his father. This developed together with an ability to speak more openly during our sessions:

> In the beginning I didn’t want to say everything to you, for example when you asked me questions about my father. I didn’t want to talk about it. But because you so often said: “You can say anything here, but you’re not obliged to.” I know now that I can tell you anything. That it remains all confidential, and that my words can stay between us. But some things…it’s better that no-one knows. But I know I can’t keep

> it to myself forever. It's not because my father is a criminal that I am like my father. It's not because my father is smart, that I am smart.

Obrad's difficulties in taking a subjective position (other than that of being a criminal) is also expressed at another level. Even though he is talented in different ways (e.g., he is very skilled in drawing, playing football and emceeing) he often keeps these talents hidden from others, partly because others might want something from him. The demands of others largely prove to be unbearable:

> Other people don't think I am accomplished, because I never show them what I am capable of. (…) For example in football, I will never demonstrate… (hesitating)…that I am quite good in playing football. (…) Same with drawing. I draw, but I don't show my sketches to everyone. (…) Because then everyone would ask: "Do you want to draw this or that for me?" No, I do not feel like it. (…) I don't know why but I just don't want to show it to others.

During our sessions, Obrad often spoke of the importance of writing and singing rap songs; among other things it helps him to relax and to express his feelings and thoughts. He spoke with admiration about some acquaintances who are professionally involved with rap music and indicated that he would also want that. One day he was invited to write a rap song for a documentary project that took place in the institution for juvenile delinquents. He decided to join the project and enthusiastically started working on his rap song. On the day of the recording, however, he didn't show up for the appointment, switched off his phone and took flight. During one of the later interviews, he said that he didn't want to do the recording because he felt uncomfortable and inconvenienced by it after all.

In general, our observations demonstrate that Obrad's antisocial actions and rule-violating behavior do not bear witness of an absence of emotions or affects, nor of a psychopath's presumed grandiosity and egocentricity. Much of his antisocial behavior has a defensive function and aims to keep the distrusted other at bay, and the demanding other at a distance. Obrad's radical identification with aggressiveness and criminality has a separating function in that it keeps the enigmatic other at a distance. By identifying with the image of being a "criminal" and an "illegal" he protects himself against falling prey to others, whose intentions often seem ambiguous to him.

DISCUSSION

Starting from the idea that a descriptive diagnostic label, such as "psychopathy" may engender stereotypical thinking, the present case study focused on an adolescent with psychopathic traits and a significant history of antisocial behavior. The case material revealed that this individual could clearly experience a range of emotions and affects, and had the ability to engage in interpersonal relationships. The case material thus reveals several discrepancies between what an individual classified as having psychopathic traits actually lives through and our popular notions about psychopathy.

Firstly, our clinical observations shed light on the *presumed affective deficits* in psychopathy. Contrary to the notion that "true" emotions cannot be expected in individuals with this condition, we discerned a whole range of emotions in Obrad's narratives, ranging from love, happiness and admiration, to guilt, shame, fear, anxiety and pain. At the beginning of the interviews, Obrad seemed to avoid expressing emotional experiences, as other people's intentions were experienced as ambiguous to him. However, as conversations between Obrad and the interviewer unfolded over time and a trusting relationship developed, a wide spectrum of both positive and negative emotions emerged. We find it remarkable that in our initial diagnostic interview[12] *guilt and shame* were absent, while in the later interviews these emotions were clearly present. We suggest that the frequently used instrument to measure this construct, the Psychopathy Checklist of Hare, misses the complexity of the individual's emotional life. Moreover, common beliefs that a psychopath is free of fear, anxiety and other (negative) affect, sets up a certain expectation in those who interview them, making them biased in their observations. Assumptions concerning the absence of emotions may lead to an interviewing style that prompts the interviewee to actually *conceal* what he lives through. In other words, the manner in which a subject represents himself depends largely on the manner in which he is received.

We also found it remarkable that at moments Obrad experienced and expressed negative affect (e.g., anxiety, pain, or sadness), he would immediately and almost seamlessly switch to another narrative containing opposite affective qualities, indicating radical splitting. Following Porter (1996), this might be associated with the traumatic events of Obrad's past. Porter (1996) suggests that the shallow affect and the dissociation of emotions in psychopathic individuals might be mechanisms acquired to cope with trauma and

environmental threats. We argue that such splitting or dissociation may be indicative of a specific *defense or coping mechanism* rather than an *absence* of emotion and affect. This viewpoint is in line with the theory of George Vaillant (1975), in which *psychopathy* is interpreted as a *human process*. According to Vaillant the psychopath's "incapacity" to experience both anxiety and depression represent defensive processes rather than "inability." One of the reasons psychopaths *"conceal"* their anxiety could be that they themselves have experienced an intolerance to expressions of tension or anxiety in the family constellation. In our case study, Obrad's radical dissociation in expressing negative emotions cohered with the split manner in which other family members coped with emotions and problems in their lives. Moreover, Vaillant (1975) suggests that often the psychopath's anxiety and tension are invisible and concealed from others, including mental health professionals: the author states that we are often blind to the psychopath's anxiety because the psychopath has managed to project or transfer his anxiety to us. It is demonstrated in literature that the presumed deceptive and manipulative characteristics in individuals with psychopathic traits evoke mistrust, suspicion, and hostile counter-transferential reactions in clinicians working with psychopathic individuals (Seto & Quinsey, 2006). These counter-transferential reactions possibly cloud a more profound understanding of the complexity of the affective life of an individual with psychopathic traits.

At the *interpersonal* level, the psychopath is often portrayed as a "social predator" or a "beast of prey." Our observations lead us to question this depiction. From Obrad's perspective, he is the one in danger of falling prey to *other people's ambiguous desires and motives*. This coheres with his *basic distrust* of others and his general sense that (representatives of) the law bear witness of mere semblance and inadequacy. This is in line with research on 'hostile attribution bias' and aggression (Dodge 1980, 1986, 2006; Crick & Dodge, 1994). According to social information-processing (SIP) models of children's social adjustment, behavioral responses in social situations are a function of a set of processing steps that are believed to operate outside consciousness, including the encoding of social cues, clarification of goals, response access or construction, response decision, and behavioral enactment (Crick & Dodge 1994, 1996; Dodge, 1986). Aberrant processing at the level of one of these consecutive steps may result in aggression (Dodge, 1986). One such divergent pattern of social information-processing which has been found to be implicated in the development and persistence of aggression in children is the *hostile attribution bias* or

hostile attribution of intent. This bias involves processing at the interpretation step of the SIP-model (Crick & Dodge, 1996). Notwithstanding certain inconsistent research findings (e.g., Dodge, Laird, Lochman, & Zelli, 2002; Dodge, Lochman, Harnish, Bates & Pettit, 1997; Matthys, Cuperus & van Engeland, 1999), numerous studies indicate that aggressive or delinquent children and adolescents have a tendency to attribute hostile and malicious intentions to others, especially within the context of ambiguous situations with negative outcomes (e.g., Dodge, 1980; Dodge & Frame, 1982; Dodge, Price, Bachorowski & Newman, 1990; Guerra & Slaby, 1989; Lochman & Dodge, 1994; Steinberg & Dodge, 1983). If children demonstrate a tendency to interpret the other's intentions as hostile or harmful to the self, the likelihood that these children will respond aggressively increases. This type of aggression may be interpreted as a retaliation or defense against a threatening other, and is thus rooted in anxiety (Crick & Dodge1996). This *hostile attribution of intent* also holds for other target groups who frequently display aggressive and antisocial behavior, including individuals with psychopathic traits. Serin (1991) and Vitale, Newman, Serin & Bolt (2005) used hypothetical, provocative clinical vignettes to examine the attributional styles of male offenders. Both studies found a positive association between hostile attribution style and psychopathy, as measured by the PCL-R. While Hare (1991) suggests that psychopaths view the world as antagonistic and untrustworthy, this perspective seems to neglect the overall embedment of the individual in his/her broader social dynamics. From our point of view, the theories of Lévi-Strauss and Jacques Lacan offer a more robust conceptual framework to understand Obrad's basic distrust (Lacan 1955-56, 1959; Lévi-Strauss, 1949, 1958; Vanheule, 2011). For Lévi-Strauss social groups, such as a family, have an underlying elementary structure, which consists of positions (e.g. mother - father - child) that function according to rules relating to what they can and can't do. Indeed, via language we attribute positions to individuals and at the same time unconsciously follow laws and rules of exchange. With this symbolic structure, the actions of others are, to an extent, predictable for the individual. Obrad's social world does not appear to be structured in this way, as other people within his social system *do not* appear to occupy clear positions or behave according to lawful principles. For this reason, other people's motives and desires in relation to Obrad emerge as an *enigma* for him. This is clearly illustrated by the ambiguous position Obrad's mother occupies in the family system in general and towards her son in particular. On the one hand, she denounces her son's criminal behavior, but on the other hand, she helps him to escape

from prison, whereupon she proceeds to threaten to have him imprisoned again. Obrad's mother's desires and intentions towards him remain ambiguous. In Lacanian terms it could be said that in Obrad's world interrelations between people and the rules governing his social system are so vague that he resides in an extremely unpredictable world. This renders him helpless in relation to others and brings him to counter-react with violence (Vanheule & Hauser, 2008). Obrad lacks the code to crack the riddle of the other's desire, or the signifier that would signify the other's intentions. Indeed, no clear position can be attributed to either his mother or his father, and no stable law seems to determine their actions. This undermines the experience of the symbolic order and opens up the realm of the psychotic experience, in which the subject has to deal with a 'mad' other (Lacan, 1959; Regnault, 1995; Vanheule, 2011, p. 50-80). Indeed, the motives and intentions of others remain enigmatic for Obrad and thus he cannot endure close social bonds in which his subjectivity is addressed, often resulting in a radical termination of the relationship. When others get close to him they gradually become unpredictable, and, as a result, Obrad recreates a safe distance qua violence. This "incapacity" to endure intimate relationships in psychopathy was also observed by Vaillant (1975, p. 181) who states: "Close relationships arouse anxiety in them. Terrified of their own dependency, of their very 'grievance', and of their fantasies of mutual destruction they either flee relationships or destroy them." Obrad's alternating tendency towards radical distancing and seeking rapprochement in intimate relationships are a magnification of the problem of human intimacy as such. In that way, Obrad doesn't appear as a social predator, but as a porcupine searching for the proper distance that will enable him to endure interpersonal intimacy, as described in Schopenhauer's (1851) Hedgehog dilemma:

> One cold winter's day, a number of porcupines huddled together quite closely in order through their mutual warmth to prevent themselves from being frozen. But they soon felt the effect of their quills on one another, which made them again move apart. Now when the need for warmth once more brought them together, the drawback of the quills was repeated so that they were tossed between two evils, untill they had discovered the proper distance from which they could best tolerate one another. (…) The mean distance which they finally discover and which enables them to endure being together, is politeness and good manners. Whoever does not keep to this, is told in England to 'keep his distance' (p.651-652).

In contrast with the solution of Schopenhauer's porcupines to the problem of intimacy in terms of a reciprocal "politeness" and "good manners," for Obrad no such conventional answers enable him to articulate his existence and identity in relation to others. Time and again, we observed that if other people came too close or if Obrad was invited to reflect on his own existence and to take on a subjective position, he responds by committing a *criminal or antisocial act*. The status of these acts go beyond their presumed instrumental function or predatory motives. During our sessions, the importance for Obrad to hide behind a mask of aggressiveness and criminality became apparent. For example, his preference to speak the language of the illegals, the great importance attached to his self-image during his antisocial behavior, the nicknames he adopts to masquerade something of his aggressiveness and masculinity, and his feeling of ease when imprisoned among other offenders, etc. To some extent, Obrad's extreme *identification with the image* of the "criminal" and the "illegal" enables him to position himself as a subject in a social bond with others. His radical identification with "aggressiveness" and "illegality" seems to provide him with the sense of *being* someone. Instead of being overwhelmed and intimidated by the enigma of the other, Obrad's passing to the act enables him to proactively assert his identity. This identity qua criminal has both a separating and identity lending function: it enables him to keep the enigmatic (desire of the) other at a distance, and at the same time to come into existence and "apprehend himself on the imaginary plane" (Lacan, 1955-56, p. 204). This is perhaps one of the reasons he feels at ease when he is imprisoned; his position within the regime of the institution is clear, namely that of a "criminal" among other "criminals." In that way, for Obrad, life in detention seems to offer a "symbolic" framework in which he is no longer the prey of others, whose intentions he cannot grasp.

The present case study has certain limitations. Fonagy (2003, 2004) describes a lack of mentalization in individuals with psychopathic traits; while they can read the thoughts of others, for example researchers and clinicians, this 'mindreading' capacity is not accompanied by an empathic component. Moreover, Hare (1991) warns us of the psychopath's tendency to feed researchers and clinicians with socially desirable answers. As our case study is primarily based on Obrad's narratives, the reliability of our findings might be put into question. However, collateral information provided by educators in the institution and informal discussions with Obrad's mother and girlfriend did not contradict

Obrad's testimonies. In this context, it is also noteworthy that one year after our final interview, Obrad contacted the first author with the request for psychological counseling. At that time, he had been acquitted of further prosecution, thus indicating there was no instrumental motive behind this request. This may suggest that the previously observed emotions in Obrad were authentic and not driven by deception. Moreover, in a juridical report that was filed after the interviews by an independent institution, Obrad makes reference to the trustful bond he had with the first author of this study.

Based on our encounters with Obrad we would like to end with a suggestion for both clinical research on psychopathy and clinical work with psychopathic individuals. In today's conceptualization of psychopathy the presumed "inabilities" and "deficits" on the affective, interpersonal and behavioral level are entirely situated *within* the psychopathic individual, without reference to his or her socio-cultural context. This negative, descriptive conceptualization of psychopathy engenders stereotypical thinking, often accompanied by therapeutic pessimism. Our case study illustrated, however, that it was possible to develop a trusting relationship with Obrad over time. Through this rapport between the adolescent and the first author, it became apparent how the adolescent's affective, interpersonal and behavioral problems were clearly embedded in his family constellation and his broader social context. We argued that Obrad's so-called affective and interpersonal "incapacities" and behavioral problems represent (to some extent "deficient," but relatively normal) defense mechanisms**.** We believe these defense mechanisms allowed him to "exist" in relation to others and were not merely indicative of **"**incapacities**."** It is therefore essential to focus on the *social context* of an individual's problems and on the subject-other relationship in order to grasp the complexity of each case. Following Nietzsche, he who seeks monsters, will likely find them, but should realize that these monsters are perhaps his own creations.

NOTES

1. The initial Psychopathy Checklist (Hare, 1980) consisted of 22 items.
2. The PCL-R items are: (1) Glib/superficial charm; (2) Grandiose sense of self-worth; (3) Need for stimulation; (4) Pathological lying; (5) Conning/manipulative; (6) Lack of remorse or guilt; (7) Shallow affect; (8) Callous/lack of empathy; (9) Parasitic lifestyle; (10) Poor behavior controls; (11) Promiscuous sexual behavior; (12) Early behavioral problems; (13) Lack of realistic long-term goals; (14) Impulsivity; (15) Irresponsibility; (16) Failure to accept responsibility of own actions; (17) Many short-term marital affairs; (18) Juvenile delinquency; (19) Revocation of conditional release; and (20) Criminal versatility. The PCL-R rating is based on a semi-structured interview and file data. Each item is scored on a 3-point ordinal scale: definitely not present (0), partially present (1), or definitely present (2). Total scores can range from 0 to 40 and represent the degree to which the individual corresponds with the prototypical psychopath. A score of 30 is recommended as a cut-off for a diagnosis of psychopathy (Acheson, 2005; Hare, 1991, 2003).
3. Because of its correlation with antisocial conduct, psychopathy is often confused with Antisocial Personality Disorder (APD) as defined by the Diagnostical and Statistical Manual of Mental Disorders (DSM IV & 5). Although there are some overlapping characteristics between APD and the concept of psychopathy, the relation between the two entities is asymmetric: “most of the psychopaths also meet the criteria for APD, but most of those with APD are not psychopaths” (Hare 1996, p. 31). That is because the diagnosis of APD is based largely on antisocial behavior and to a lesser degree on affective and interpersonal components as described in Hare’s psychopathy construct.
4. The PCL:YV is a downward extension of the PCL-R designed to assess personality traits and behavioral features of psychopathy in adolescents. Analogous to the PCL-R, it also consists of 20 items which are scored on a 3-point ordinal scale. The total score, ranging from 0 to 40, reflects the degree of psychopathic traits in the individual. Contrary to the use of the PCL-R in adults no cut-off score is used for the PCL:YV in adolescents (Forth et al., 2003).
5. After a few years in full detention, Obrad’s father obtained the exceptional permission to alternate between staying a week in prison and a week at home.
6. Penitentiary leave is a sentencing format that allows the inmate to go home for the weekend or to go on leave outside prison for a fixed period of time.
7. For example when he talks about witnessing of people dying, or how he and his family narrowly escaped being killed by a bombardment, or how he prevented his brother’s murder.
8. It is noteworthy that the way Obrad talks about this second event resembles the way he talks about the murder committed by his father.

9. Towards the end of our series of meetings, Obrad explicitly stated that after all these years he finally wants to hear the truth from the mouth of his father.
10. During this session Obrad spoke about how his mother was lying to the police about Kalashnikovs and other weapons in the house. The ambiguous position that Obrad's mother occupies is also demonstrated on another level. On the one hand, she would move heaven and earth to have her son set free; she lies to the police, conceals Obrad's undiscovered crimes, helped him avoid detention on two occasions, and so on. But once Obrad is released, she repeatedly threatens to have him sent back to the institution. Often she declares to the police and social workers that she is afraid of (the delinquent behavior of) her son, only to withdraw these formal statements afterwards: "There must have been a miscommunication." When judges or policemen confront Obrad with his mother's statements it is hard for him, and simply reinforces his belief in the unreliability of the court system: "They say my mother is afraid of me. They're a lying. My mother would never say such things. My mother and I have a good relationship."
11. An educator.
12. PCL:YV

REFERENCES

Acheson, S. K. (2005). Review of the Hare Psychopathy Checklist-Revised, 2nd edn. In R. A. Spies & B. S. Plake (Eds.), *The Sixteenth Mental Measurements Yearbook* (pp. 429- 31). Lincoln, NE: Buros Institute of Mental Measurements.

Arrigo, B. A., & Shipley, S. (2001). The Confusion Over Psychopathy (I): Historical Considerations. *International Journal of Offender Therapy and Criminology, 45*, 325-344.

Blackburn, R. (1988). On moral judgments and personality disorders. The myth of psychopathic personality revisited. *The British Journal of Psychiatry, 153,* 505-512.

Cleckley, H. (1976). *The Mask of Sanity* (Fifth Edition). Saint Louis: The C.V. Mosby Company.

Cornell, D. G., Warren, J., Hawk, G., Stafford, E., Oram, G., & Pine, D. (1996). Psychopathy in instrumental and reactive violent offenders. *Journal of Consulting and Clinical Psychology, 64*, 783-790.

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information-processing mechanisms in children's social adjustment. *Psychological Bulletin, 115,* 74-101.

Crick, N. R., & Dodge, K. A. (1996). Social information processing mechanisms in reactive and proactive aggression. *Child Development, 67,* 993-1002.

Declercq, F. (2008). Affectief en predatorisch geweld: persoonlijkheidsstructuren en dynamieken. In F. Declercq (Ed.), *Seksuele, geweld- en levensdelicten* (pp. 87-114). Leuven/Voorburg: Acco.

Dodge, K. A. (1980). Social cognition and children's aggressive behavior. *Child Development, 51,* 162-170.

Dodge, K. A. (1986). A social information processing model of social competence in children. In M. Perlmutter (Ed.), *Minnesota Symposium on Child Psychology: Vol.18. Cognitive perspectives on children's social and behavioral development* (pp.77-125). Hillsdale, NJ: Erlbaum.

Dodge, K. A. (2006). Translational science in action: Hostile attributional style and the development of aggressive behavior problems. *Development and Psychopathology, 18,* 791-814.

Dodge, K. A., & Frame, C. L. (1982). Social cognitive biases and deficits in aggressive boys. *Child Development, 53,* 620-635.

Dodge, K. A., Laird, R., Lochman, J. E., & Zelli, A. (2002). Multidimensional latent-construct analysis of children's social information processing patterns: Correlations with aggressive behavior problems. *Psychological Assessment, 14,* 60-73.

Dodge, K. A., Lochman, J. E., Harnish, J. D., Bates, J. E., & Pettit, G. S. (1997). Reactive and proactive aggression in school children and psychiatrically impaired chronically assaultive youth. *Journal of Abnormal Psychology, 106,* 37-51.

Dodge, K. A., Price, J. M., Bachorowski, J., & Newman, P. (1990). Hostile Attributional Bias in Severely Aggressive Adolescents. *Journal of Abnormal Psychology, 99*, 385-392.

Federman, C., Holmes, D., & Jacob, J. D. (2009). Deconstructing the Psychopath: A critical Discursive Analysis. *Culture Critique, 72,* 36-65.

Fonagy, P. (2003). Towards a developmental understanding of violence. *The British Journal of Psychiatry, 183,* 190-192.

Fonagy, P. (2004). Early-Life Trauma and the Psychogenesis and Prevention of Violence. *Annals New York Academy of Sciences, 1036,* 181-200.

Forth, A., Kosson, D., & Hare, R. (2003). *The Hare Psychopathy Checklist: Youth Version.* Toronto: Multi-Health Systems, Inc.

Glassman, M. B. (1988). Intrapsychic Conflict Versus Developmenatl Deficit: A Causal Modeling Approach to Examining Psychoanalytic Theories of Narcissism. *Psychoanalytic Psychology, 5* (1), 23-46.

Guerra, N. G., & Slaby, R. G. (1989). Evaluative factors in social problem solving by aggressive boys. *Journal of abnormal Child Psychology, 17,* 277-289.

Hare R. D. (1980). A research scale for the assessment of psychopathy in criminal populations. *Personality and Individual Differences, 1,*111–19.

Hare, R. D. (1991). *Manual for the Hare Psychopathy Checklist-Revised*. Toronto: Multi-Health Systems.

Hare, R. D. (1996). Psychopathy: A Clinical Construct Whose Time Has Come. *Criminal Justice and Behavior, 23*(1), 25-54.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist-Revised* (2nd ed.). Toronto: Multi-Health Systems.

Hare, R. D. (2006). Psychopathy: A clinical and forensic overview. *Psychiatric Clinics of North America, 29* (3), 709-724.

Hare, R. (2011). *Without Conscience: The Disturbing World of the Psychopaths Among us.* (EPUB format). New York: Guilford Press.

Hare, R. D., & Neumann, C. S. (2008). Psychopathy as a Clinical and Empirical Construct. *Annual Review of Clinical Psychology, 4*, 217-246.

Hare, R. D., & Neumann, C. S. (2009). Psychopathy: Assessment and Forensic Implications. *The Canadian Journal of Psychiatry, 54*, 791-802.

Harris, G. T., Skilling, T. A., & Rice, M. E. (2001). The construct of psychopathy. In M. Tonry, & N. Morris (Eds.), *Crime and justice: An annual review of research* (pp. 197-264). Chicago: University of Chicago Press.

Hervé, H. (2007). Psychopathy Across the Ages: A History of the Hare Psychopath. In H.Hervé & J.C.Yuille (Eds.), *The Psychopath: Theory, Research and Practice* (pp. 31-55). Mahwah, New Jersey: Lawrence Erlbaum Associate Publishers.

Kagan, J. (2012). *Psychology's ghosts - the crisis in the profession and the way back.* New Haven and London: Yale University Press.

Kramer, U., de Roten, Y., Perry, J.C., & Despland, J.-N. (2013). Beyond splitting: Observer-rated defense mechanisms in Borderline Personality Disorder. *Psychoanalytic Psychology, 30* (1), 3-15.

Lacan, J. (1993 [1955-56]). *The Seminar 1955-1956, Book III, The Psychosis.* New York and London: W.W. Norton.

Lacan, J. (2006 [1959]). On a Question Prior to any Possible Treatment of Psychosis. In J. Lacan, & J. A. Miller (eds.), *Ecrits* (pp. 575-584). New York and London: W.W. Norton.

Leistico, A.-M. R., Salekin, R. T., DeCoster, J., & Rogers, R. (2008). A Large-Scale Meta-Analysis Relating the Hare Measures of Psychopathy to Antisocial Conduct. *Law and Human Behavior, 32*, 28-45.

Lévi-Strauss, C. (1949). *The Elementary Structures of Kinship.* Boston: Beacon Press.

Lévi-Strauss, C. (1958). *Structural Anthropology.* New York: Basic Books.

Lochman, J. E., & Dodge, K. A. (1994). Social-Cognitive Processes of Severely Violent, Moderately Aggressive, and Nonaggressive Boys. *Journal of Consulting and Clinical Psychology, 2,* 366-374.

Lykken, D. T. (1957). A study of anxiety in the sociopathic personality. *Journal of Abnormal and Social Psychology, 55*, 6-10.

Matthys, W., Cuperus, J. M., & van Engeland, H. (1999). Deficient social problem-solving in boys with ODD/CD, with ADHD, and with both disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 311-321.

Meloy, J. R. (1988). *The psychopathic mind: Origins, dynamics, and treatment*. Northvale, NJ: Aronson Inc.

McDermott, B. E., Quanbeck, C. D., Busse, D., Yastro, K., & Scott, C. L. (2008). The accuracy of risk assessment instruments in the prediction of impulsive versus predatory aggression. *Behavioral Sciences and the Law, 26*, 759-777.

Nietzsche, F. W. (1997 [1886]). *Beyond Good and Evil. Prelude to a Philosophy of the Future.* Dover: Thrift Editions.

Parker, I., Georgaca, E., Harper , D., McLaughlin, T., & Stowel-Smith, M. (1995). Representations of Madness. In I. Parker, E. Georgaca, D. Harper, T. McLaughlin, & M. Stowel-Smith (Eds.), *Deconstructing Psychopathology* (pp. 56-71). London: SAGE Publications Ltd.

Porter, S. (2007). Psychopathy and violent crime. In H. Hervé, & J. Yuille, *The psychopath: theory, research, and practice* (pp. 287-300). Mahwah (NY): Lawrance Erlbaum Associates, Inc.

Rabinovitch, R. D. (1959). The Concept of Primary Psychogenic Acathexis. In B. Karpman (Ed.), *Symposia on Child and Juvenile Delinquency, Presented at the American Orthopsychiatric Association* (pp.57-63). Washington, D.C.: Psychodynamics Monograph Series.

Regnault, F. (1995). The Name-of-the-Father. In R. Feldstein, B. Fink, M. Jaanus, *Reading Seminar XI: Lacan's Four Fundamental Concepts of Psychoanalysis* (pp. 75-76). Albany: State University of New York Press.

Schopenhauer, A. (2000 [1851]). *Parerga and Paralipomena, Volume 2, English translation* (Rev. ed.). (E. Payne, Trans.) Oxford: University Press.

Serin, R.C. (1991). Psychopathy and Violence in Criminals. *Journal of Inerpersonal Violence, 6*, 423-431.

Seto, M. C., & Quinsey, V. L. (2006). Toward the Future. Translating Basic Research into Prevention and Treatment Strategies. In C.J. Patrick (Ed.), *The Handbook of Psychopathy* (pp. 589-601). New York: The Guilford Press.

Steinberg, M. D., & Dodge, K. A. (1983). Attributional bias in aggressive adolescent boys and girls. *Journal of Social and Clinical Psychology, 1,* 312-321.

Vaillant, G. E. (1975). Sociopathy as a Human Process. *Archives of General Psychiatry, 32*, 178-183.

Vanheule, S. (2011). Foreclosure and Its Vicissitudes. In S. Vanheule, *The subject of psychosis: A Lacanian perspective* (pp. 50-80). Hampshire/New York: Palgrave Macmillan.

Vanheule, S. (2012). Diagnosis in the field of psychotherapy: A plea for an alternative to the DSM-5.x. *Psychology and Psychotherapy: Theory, Research & Practice, 85*, 128-142.

Vanheule, S., & Hauser, S. T. (2008). A narrative analysis of helplessness in depression. *Journal of the American Psychoanalytic Association,* 56, 1309-1330.

Vitacco, M. J., Neuman, C. S., Caldwell, M. F., Leistico, A., & Van Rybroek, G. J. (2006). Testing factor models of the psychopathy checklist: Youth Version and their association with instrumental aggression. *Journal of Personality Assessment, 87*, 74-83.

Vitale, J. E., Newman, J. P., Serin, R. C., & Bolt, D. M. (2005). Hostile Attributions in Incarcerated Adult Male Offenders: An exploration of Diverse Pathways. *Aggressive Behavior, 31,* 99-115.

6

"BAD BOYS DON'T CRY": INTERPERSONAL DYNAMICS AND TRANSFERENCE PROCESSES IN YOUNG OFFENDERS WITH PSYCHOPATHIC TRAITS[1]

Scientific research into the effective factors for the treatment of psychopathy is scarce. This is caused by a deeply rooted, but unfounded conviction that individuals with psychopathic traits are untreatable. Since therapy success largely depends on the efficacy of the therapeutic relationship, this study explores the kind of interpersonal and therapeutic relationship apparent in juvenile delinquents with psychopathic traits. Fifteen adolescents with psychopathic traits were followed-up over six months within an institution for juvenile delinquents. All interviews were coded via thematic analysis. Our findings indicated that feelings of threat, anxiety and basic distrust were the crucial emotions the juvenile delinquents experienced in relation to (significant) others. Moreover, different self-protective mechanisms to cope with the untrustworthy and threatening other were detected.

[1] This chapter is based on De Ganck, J. & Vanheule, S. (submitted). "Bad boys don't cry": Interpersonal Dynamics and Transeference Processes in Young Offenders with Psychopathic Traits. *Psychoanalytic Psychology.*

INTRODUCTION

With hard men intimacy is a thing of shame –
and something precious.
— Friedrich Nietzsche, *Beyond Good and Evil* (1886)

In recent decades scientific interest in the concept of psychopathy has strongly increased, partly due to the development of new assessment instruments, such as the Psychopathy Checklist (PCL; Hare, 1980; PCL-R; Hare, 2003). Remarkably, the diagnostic focus of new research does not appear to include questions around psychotherapy with this group. Indeed, individuals with a psychopathic personality profile are frequently thought of as untreatable, where it is virtually deemed impossible to reduce recidivism and antisocial behavior (e.g., Harris & Rice, 2007; Wong, 2000). However, critical studies (e.g., McGauley, Adshead, & Sarkar, 2007; Polaschek & Daly, 2013; Salekin, 2002) indicate that this therapeutic defeatism is not empirically grounded.

As psychotherapy research observes that the effectiveness of treatment is strongly determined by the quality of the therapeutic relationship (e.g., Konzag, Bandemer-Greulich, & Barhke, 2004; Luborsky, McLellan, Woody, & O'Brien, 1985; Roth & Fonagy, 2006) this study aims to explore how juvenile delinquents with psychopathic traits experience interpersonal relations and how intersubjective dynamics are re-enacted in a therapeutic setting. We therefore aim to answer three interrelated research questions:

a. How do (significant) others emerge within the narratives of adolescents with psychopathic traits?
b. Which modes of functioning and interrelating are used by these adolescents to deal with (significant) others?
c. How do these relationship patterns re-emerge within a therapeutic setting?

METHOD

Fifteen subjects were selected from a sample of 42 male juvenile delinquents involved in a research project on psychopathic traits in adolescent delinquents. All participants were recruited from a six-month residential treatment program for juvenile delinquents. The research project was approved by the Institutional Review Board of the Faculty of Psychology and Educational Sciences at Ghent University. Participants were selected based on their high scores on the Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003); i.e. PCL: YV ≥30 (M = 31.9; SD=1.7). The mean age of the participants was 15.3 years (SD=1.1). The PCL: YV rating is based on a semi-structured interview and file-data. It consists of 20 items that are scored on a 3-point ordinal scale: definitely not present (0), partially present (1), or definitely present (2). The total score, ranging from 0 to 40, reflects the degree of psychopathy.

On a voluntary basis, all participants engaged in individual psychotherapeutic sessions with the first author, who is a trained psychoanalytic therapist. All sessions took place in the institution, were audio-recorded and transcribed verbatim. On average participants engaged in 10.2 sessions (SD = 6.7). Thematic analysis (Braun & Clarke, 2006) was used to identify and analyze the patterns that emerged in the session narratives. In a first step the first author identified all narratives of interpersonal encounters, descriptions of significant others and of interpersonal dynamics within the therapeutic setting. In a second step, the authors located and discussed recurring patterns of the interpersonal relations across all participants. Consensus regarding the main themes between authors was reached. For the purpose of trustworthiness, an external researcher conducted independently a thematic analysis on all session narratives of six participants of the study. Similar themes were identified and no additional categories were created.

RESULTS

WHO IS THE OTHER TO THEM?

Common notions of psychopathy describe a somewhat fearless and hostile individual, where metaphors such as social predator (Meloy, 1988) and bull terrier (Lykken, 1995)

prevail. According to this assumption, we are at risk of falling prey to the psychopath's malevolent intentions. However, as our therapeutic sessions indicate, in the view of our participants the opposite is true. Indeed, the predominant recurring theme across the narratives of all 15 adolescents was that (significant) others are *fundamentally distrustful* antagonists that they must guard themselves from. This is illustrated by Lukas (session 10):

> Never underestimate a man and never give a man your trust. Wait and see (…) If you know someone for ten years, then you can tell him about 10% about yourself. Then, you observe. And if you can really (...) feel his heart, his soul… (…) then you can tell him another 30%. (...) There are people who'll immediately tell you everything about themselves. Then there's deception. They loved a girl, trusted her, and in retrospect they see she was actually a little whore. (...) And you too (…): "You should not trust anyone, miss."

Throughout the interviews, this "threatening other" appeared to be embodied in three different character types: (a) the malignant other; (b) the annoyingly different other; and (c) the taunting other. Below we describe these three characters and discuss how the maternal and paternal object frequently appears in the narratives around inter-subjective relationships of our participants.

The malignant other

The figure of an enigmatic, incomprehensible and threatening other was predominant in all participants' stories. As they fail to unravel what the other wants from them, basic distrust prevails (Vanheule 2011). Often, evil is perceived in the other's *gaze*, as illustrated by Bastian (session 5):

> I often lose control and get angry. (…) when someone looks at me with an evil gaze. Then you know his intentions are malicious, that he wants a fight. (…) Then everything turns black before my eyes (…). I lose control, I fight, (…) or destroy things. (…) It's the wicked gaze of the other.

Moreover, frequently *a demanding other who comes uncomfortably close* was experienced as malevolent. All participants expressed difficulties in enduring intimate relationships, both

with family members and (girl)friends. This seems to result from an inability to decode others' motives and a fear of losing control, as illustrated in the following fragments:

> I've never been in love. Being in love ... (...) I would not be able to stand it. (…) I would go crazy, lose control. Girls, they make you crazy. I couldn't stand the idea that I'd always want to be with her (Dennis, session 7).

> I don't know from what kind of mother and father I descend. (…) They are not the kind of people to mess with. (…) A man or a thief or an animal... An animal, when it's hungry it goes to its mother, right? To his own mother, not to cows or monkeys, right? A cow has a baby and the baby knows his mother because he needs to eat. This mother goes to the child, to stay close to the child, to give it warmth, to defend it (…). But this mother comes too close for comfort. The child needs freedom. So he has to go. He has to leave his mother, (…) because an animal knows who his mother is. I know who my mother is (Max, session 16).

Others are typically seen as predators to which they could fall victim; participants don't assume that inter-subjective relationships are regulated by social rules that safeguard those involved. In their view, words and laws are deceptive, which is why nothing coming from the other is taken for granted, as illustrated by David (session 7):

> People (…) cheat, they're hypocritical, their word is not to be trusted. (...). In this world... no-one is perfect. Everyone... even teachers, bank managers... they snort coke for example. You may not be aware of that (…) I mean… You think: that's a teacher, that's a doctor, a bank manager, a respectable man...(…) who works for a living, has a family… But then, you see them using coke, you know they're violent at home… (…) so you see how banks get robbed...The thieves know exactly (…) where the money is... They're tipped, miss, by those perfect men.

The annoyingly different other and the importance of the Ideal-Ego

While they do not have confidence in social rules and laws, they maintain a relation to others through an identification with an extremely masculine and aggressive ideal-ego. Through this virile imago they can transcend their experience of fear, as illustrated by Jonas (session 1);

> I'm a cold-blooded human being, just like my father, like my entire family. I once ate a hedgehog…its liver, its heart (…). I drank its blood and ate its flesh. Since that moment, I'm a cold-blooded man. I like to see blood. Since I drank its blood I'm cold-blooded and without fear. (…) Some people are always afraid, I'm not, I always laugh.

The identification with this masculine imago gives them a stable sense of identity, a sense of *being* someone. However, this identification is fragile and is at stake in every encounter with another that differs in some way (e.g., appearance, dealing with emotions, etc.) from this ideal-ego. As they don't believe that interpersonal relationships are regulated by social rules (Lacan 1966 [2006]), a confrontation with the "otherness of the other" proves to be threatening or frustrating. This often results in aggression because the ego is threatened, as illustrated by Dennis (session 5), who strongly adheres to the imago of "the bad guy that never cries":

- D.: I've never had that feeling of being sad or...(…) They can't hurt me or destroy me. Nobody, no Judge can break me, you must let them know this (…). I hate misery and people acting hopelessly... I hate it when people around me cry. I say "Shut up!"
- I.: Other people crying is unbearable for you?
- D.: I hate that, I get angry when they act hopelessly. Act like a man! A man doesn't cry.
- I.: Who says a man doesn't cry?
- D.: I do, I say to them: "A man does not cry, so why are you crying?" (…) Life is hard, so you have to be hard.

The taunting other and the narcissistic injury

The character of the taunting other involves a real individual that literally insults the ideal self-image of the adolescent or who offends one of the adolescent's significant others, particularly the mother. This usually causes an accumulation of tension and anger in the adolescent, due to the discrepancy that arises between the internal ideal self-image (or the ideal image of the (m)other) and narcissistic humiliation (Baumeister, Smart, & Boden 1996), as illustrated by Max (session 16):

> I don't know how to control myself. (…) People will provoke you. They'll say: "Your mother (…) is a faggot or a whore" (chuckle). They call me a loser. At school they do. The teachers do. (…) I can 't take it. I lose control.

The paternal and maternal other

Particular parent-child relationship patterns recurred with considerable frequency in the sessions with our participants. At first sight, basic distrust is not experienced towards the paternal and maternal other: e.g. "My family has made a great man of me, of course I trust them (Lukas, session 5)." Moreover, several adolescents in our study differentiate between their lives as delinquents in the outside world (which is conceived of as dangerous) and their lives as a son within their families (which is perceived as safe and reliable): e.g. "At home I trust everybody, but as soon as I'm in the outside world, everything is different (Caspar, session 12)." The paternal other is often described as a righteous, respectable, intelligent, but frequently gadabout man. The maternal other is often idealized as a kind of holy Madonna figure, as illustrated by Dennis and Jonas:

> My father means a lot to me. He's…someone important. A smart person, yes. Not an aggressor, a quiet man. He loves nature and jazz music (...) and opera. He listens to this kind of music when he's reading. (...) He's not violent. He doesn't use swear words against anyone. He's a proper man (Dennis, session 10).

> My mother and I never fight. (…) We have a strong bond. She means a lot to me. (…) It's normal that she's my life. She carried me for nine whole months, she's nourished me, and she's sweet. She always consoled me (…). She says: "Come here, don't cry"... Like that. By giving me kisses. On my forehead...where it hurts...Yes, by giving me kisses (Jonas, session 7).

However, a process of dissociation with regard to the image of the paternal other could be observed in most of the participants. For example, the image Dennis (session 10) outlines of his father as a respectable man is totally nullified in later statements describing a rather primitive image of an aggressive father:

> If I did something wrong as a child, my father would try to scare me by saying the police were coming to arrest me. It didn't bother me. Then he'd physically assault me or break my bones. (…) Then I got beaten up by him and I had to sleep in the basement as a punishment. I didn't understand that. (…) He was just angry because I used to fight and extort. (...) He'd say: "You shouldn't think no-one sees you, Dennis. You damage my good name" (Dennis, session 10).

Initially these different images of the parental other are dissociated from one another. Yet ultimately they become integrated when the adolescent believes in the legitimacy of a violent and brutal regulation: "How I feel when I got hit by my father? I deserve it. You get what you deserve. That's the way it goes." Correlatively, the idealized image of the mother is frequently violated, as illustrated by Max (session 6):

> In my family they never use violence, never! (…) Only 2 or 3 years ago, my father put a knife in my mother's neck (…) 6 cm deep or so. (…) It was dinnertime. My mother was (…) teasing my father. He got angry. (…) He didn't bring her to the hospital, he left her like that. (…) It doesn't matter, miss. (…) I said: "Give me the keys of your car. I'm going to take her to the hospital." My father answered: "No, you will stay here," "Ok, fine by me," I said. (…) What could I do? (…) And afterwards? I don't know, miss. I 'm not going to cry, otherwise my father could stab me in the face as well. (…) I said to my mother: "You shouldn't disturb dad when he comes home from work. He's a lot on his mind." She shouldn't nag him. I think my father was right. (…). If she was looking for trouble, then you can get trouble, right? I hate that too when people interrupt me when I am eating.

These examples illustrate that the identification with an aggressive ideal-Ego is passed through via an identification with the image of the paternal other, as is also illustrated by Lukas (session 10):

> Our culture passes it on…(…) If my father's a thief, I'm a thief. If my father's a businessman, I'm a businessman. If my mother's a whore, my sister's a whore. (…) I'm not saying my family are thieves or whores. (…) It amounts to that. The father teaches you whatever (…).

HOW DO THEY DEAL WITH THE OTHER?

The participants in our study developed several self-protective strategies to deal with an unreliable and hostile world. We were able to detect four recurring strategies to deal with a threatening other, which we discuss below.

Testing the reliability of the other, hic et nunc

A thorough examination of how others behave and deal with confidential information is a commonly used strategy for testing the reliability of the other, as illustrated by Lukas (session 10):

> Your heart is like a testament. You see and hear things, you observe people and then you can make a decision with your heart (…): "Yes, I can trust this person." (…) Sometimes you really don't know whether you can trust your heart or mind. So you stage things to see what will happen. (…) For example, you have your car keys in your pocket, but you say to your friend: "Oh no, I lost the keys of my new BMW." Then you leave your wallet with 1000 euros in it on the table, and watch what happens to your wallet when you go out looking for your keys.

Examples of this strategy were multiple. Some adolescents organized meetings with other gang members to check everyone's judicial declaration and to assess who is trustworthy and who is not. Others told a secret to a friend and then observed whether that friend kept the secret, etc.

Demonstrating that the world is a world of semblance

Another mechanism of escaping the menacing other is to demonstrate that a nonviolent law guaranteeing safety doesn't exist. By acting as an outlaw, they want to demonstrate that the world is just a world of pretense and appearances. On the one hand, they denounce the semblance in the world by repeatedly challenging and provoking (representatives) of the conventional law; e.g. racing past the police station with a stolen car, playing loud music; breaking into houses in broad daylight in such a way that passers-by would see them. On the other hand, they wanted to demonstrate the lack of a guaranteeing

law by inducing fear in the other. When anxiety is expressed in the other, they themselves seem to be able to traverse their own fears and emerge as a subject within the interpersonal scene, as illustrated by Alexander (session 8):

> When you do a robbery... it feels great. (…) First you're standing outside. I always listen to music first, otherwise I won't go in. (…) I lift myself in. (…) While I'm changing clothes outside, another boy goes in and asks the pharmacist for something from the back (…) and then we go in. (…) At that moment, outside, I feel stressed. (…) Then we're laughing. (…) I've got music in my ears and I'm singing along. I'm getting charged up. And then I go in. (…) Then I start to laugh, with a little bit of stress (chuckles), a little panic. (…) It just feels good. I don't know why. (…) The woman is in the back. When she returns and she sees us, she's gonna be scared, afraid. (…) That's the best feeling (laughing). Sorry...

Testing the sameness – otherness of the other

We commented above that a confrontation with the "otherness of the other" is threatening to the ego. Therefore, *the sameness or otherness* of the other is tested. The question that must be answered is as follows: "Are you like me?" If the other acts according to their own ideal image, they conclude that the other is reliable. In this way, it often happens that friendships are formed through fights or committing crimes together, as illustrated by Dennis and David:

> From childhood onwards (...) I beat up children when they asked me if I would be their friend. I kicked them in the face. (...) Some of them would cry, others wouldn't. Those who were able to endure the beating could enter my group. (...) My friend and I made these kids hard. We wouldn't tolerate it if they started to cry (Dennis, session 5).

> We met each other during a burglary. (...) We didn't know each other. We didn't wait until the streets were empty to break into houses. Showing off. He wasn't afraid of anyone. (...) After this burglary, we were always together, inseparable. Committing crimes together. (…) We didn't lack anything. (...) To trust someone means having no shortages (David, session 7).

Destruction of the other

The *destruction of the other*, whether literally or not, is the final mechanism in place to protect themselves against a deceiving other. Several fragments above illustrate this use of *violence*, for example, when the adolescent is narcissistically aggrieved. Another strategy is to live the life of a *lone wolf*: "No, I don't need any friends. I prefer to live on my own. I don't like to make new friends. (…) Then you have to learn to trust all those suckers again (…). I don't like to trust people" (Thomas, session 1). In different ways they do everything in their power to not become emotionally dependent on someone and often radically end (love) relationships out of fear of what love may bring:

> Being alone in this world. I think it's better to be on your own. (…) I often retreat, away from other people. (…) Taking care of my own. In life, I only loved my sister who died. She was blind, (….) She had a tumor in her eye. (…) I often pulled her leg. (…) when she walked down the hallway, I'd sneak up behind her without saying anything. She could feel my presence and ask if someone was there. I never answered and I knew she was scared (David, session 7).

HOW DOES THE OTHER EMERGE WITHIN THERAPY?

Within the therapeutic relationship it was the figure of the malignant other who played a predominant role. Several participants had difficulties keeping eye contact (e.g. "your stare is weird, stop looking at me" (David, session 1)), or to tolerate the intimacy that the therapeutic process often entails. Clinging to their image of impenetrability, most questions about emotional pain and fear were deflected by the participants, especially in the early sessions. For example, in response to the interviewer's question as to whether he had ever lost a friend in a fight, Dennis (session 12) answers: "No, no (hesitating)…It doesn't matter to me (sigh), miss. I am not used to talking about myself. It doesn't matter. Let's move on to the next question." Through the sessions it became clear that there is no absence of (negative) affects in these adolescents, but that they lack the skills to cope with strong emotions. In later sessions, Dennis talked about how he had lost some friends, but that he didn't know any other way of dealing with it than to deny his sadness and become angry and frustrated. Later he asked the therapist if she had ever lost someone and if she

could teach him different ways of dealing with grief and loss. Disclosure about their affective life was also inhibited by their difficulties trusting the therapist. Since regulations lack power for them, the confidentiality of the conversations was often doubted. In the beginning, several strategies were used to test the trustworthiness of the therapist and to keep her at a safe distance. For example, they tested how she dealt with confidential information, as illustrated by Max (session 6):

- M.: So you say I can trust you miss. It's not like that it'll suddenly emerge that you're not to be trusted? (...)

  — *Max puts his cell phone on the table in the therapy room, while residents of the institution are not allowed to keep their cell phone with them.*
- M.: Don't you have to ask me what my mobile is doing here? They didn't find it yesterday when there was a room inspection.
- I.: (…) I would like to ask you something. Why do you tell me all these things?
- M.: Every time when I come to you I remember what you said in the beginning, that all will stay confidential, that I can trust you. (…)
- I.: But why do you want to show me that you smuggled in your mobile?
- M.: Because you told me I can trust you. (…)
- I.: And now you want to test whether I'm a person you can trust?
- M.: Yeah. If they discover that I have my mobile, then I know it comes from you, Julie. (laughing) It's not something to laugh about. I'm bloody serious.

Another strategy of investigating the motives of the therapist was by provoking the arbitrariness of professional secrecy and a guaranteeing law, as illustrated by Alexander (session 11):

— *During the session the adolescent is toying with a broken pen. With the sharp point he is continuously reaching towards the wall, just nearly missing it.*

- A.: What would you do if I were to smudge your beautiful new wall?
- I.: Why would you do that?
- A.: Seriously, miss, what would you do if I were to smudge the wall? Would you go and tell the principal?
- I.: I think I would have to tell him, yes. The wall has just been painted.

- A.: Is that so? You'd tell him, huh? Is my life in danger then? I thought you would only speak if my life or somebody else's life was in danger. That was the rule, I thought.

Taking control by fear-inducing or violent strategies occurred a few times, but was not dominant throughout therapy, as illustrated in the following dialogue with Lukas (session 10):

- I.: But in court, they don't know you use a fake ID?
- L.: Not when Julie doesn't tell anyone.
- I.: I'm a psychologist, not a judge.
- L.: Are you sure, Julie? (…) Are you sure you have only one key in your pocket? That of this institution?
- I.: Do you think I also have the key to the courthouse?
- L.: I've already checked everything. (…) Don't be afraid. If I were to tell you your address, where you live, when you were born, where your sisters live, would you be scared then?

Physical violence was never used towards the interviewer. Occasionally violence was expressed verbally during the therapy, e.g., by using the name of the interviewer in some story boards of the Thematic Apperception Test: “The nail is on the floor and Julie falls. A six inch nail. It pierces thru her eye, right into her brain. And her mother has no child to live for anymore. She dies” (Lukas, session 12).

The figures of the annoyingly different and taunting other hardly played any role within the therapeutic relationship. Only two fragments depict an adolescent feeling offended by the questions of the therapist; "What do you think, miss, that I am a psychopath?" Only a few statements were related to the perception of “the otherness” of the interviewer; e.g. "Girls, like you," "You can’t understand that, miss, it’s not your kind of world." Occasionally the sameness - otherness of the therapist was examined, for example by asking her about her criminal background: “Miss, your boots…I know they are very expensive. How much did they cost, miss? I want to know. Where did you get them? On the black market? Illegally, right?” (Bastian, session 5). Initially, the otherness of the therapist could be a source of frustration and threat, but became more accepted as sessions progressed in time.

A positive therapeutic relationship was established with most of the adolescents through time. To a certain degree, they were willing to divulge most intimate affairs. In some adolescents a longing for a nonviolent way of *being* emerged, often combined with taking distance from the identification with a stern paternal object:

> My parents are dangerous, miss, especially my father. Give him a gun and he will shoot you. They don't reflect on what they do. (…) The moment he put the knife into my mother's back, I copied him. (…) But I'm not like my father (Max, session 16).

However, the therapeutic relationship generally remained fragile. For example, several adolescents asked for extra counseling sessions a long time after their release. What is noteworthy is that they often asked to delineate these extra sessions after a while. For example, one year after his release from the institution, David contacted the first author because of depressive symptoms following the death of a friend. He asked her for one therapeutic session, and only one. It's possible that they need to escape the vulnerability that the therapeutic process entails. The following interview fragment also illustrates that even though there is a foundation of trust between adolescent and therapist it is difficult for these adolescents to believe in the authenticity of words and relationships:

> Our lives will separate here, miss. (…) I'll remember this conversation and I'll be happy. But I know that you'll go home and that you won't remember this evening. I know it's your job. I'm grateful that I could come (…).

The moment the therapist is about to express that these conversations within the institution are not without significance for her, he continues:

> Miss, please don't say anything, don't say that you will remember this conversation (…) because then you're... It's fine as it is now...(David, session 7).

SOME FINAL REFLECTIONS ON TREATMENT POSSIBILITIES

Gaining insight into the underlying dynamics of psychopathic symptoms is undoubtedly a prerequisite to any form of therapy with this group. The analysis of our 15 cases clearly demonstrates that much of the psychopathic behavior is rooted in an

underlying anxious and hostile interpretation of the social world. Psychopathic behavior should be understood as a (deficient) self-protective strategy of managing this fearful position. Most therapies focus on eliminating psychopathic features and reducing of the risk of recidivism. Indeed, the prevention of reoffending is undoubtedly important. However, we argue that this can only be successful if the underlying anxiety and distrust in these adolescents is addressed. This group is not immune to painful experiences of grief, fear and self-doubt. However, their basic distrust inhibits their ability to express negative emotions and they do not possess adequate coping mechanisms to deal with affective life-events. Therefore, the main task of the therapist is to create a safe therapeutic environment. In our case, the guarantee of professional confidentiality was a necessary (but not sufficient) condition to this end. It is important to understand that for these adolescents we, as therapists, are a menace; to them we represent a deceitful and threatening society. To protect themselves against danger, professional confidentiality will be tested, lies will be told, inner feelings will be masqueraded, and fear-inducing strategies will be used. It is essential that this "testing" is tolerated by the therapist. For example, when it became clear that one of our participants had lied, we did not show anger or make lying a moral issue, but referred to the agreement that everything *could* be said within the therapy, including lies. We subsequently invited them to reflect on why it was necessary for them to lie. We also never put pressure on adolescents to talk about anything, including their criminal offenses. We stated from the outset that it was not the role of the psychologist (in contrast to the police or Juvenile Court) to uncover the truth behind their criminal offenses and in that way they were allowed to withhold whatever information they wished. Anytime they spoke openly about criminal offenses or violations of the rules in the institution, the therapist referred consistently to conventional laws that were violated, but not in a judgmental way. What is important in this is that the therapist behaved as an individual who was subject to these conventional laws as well. For example, the therapist took personal responsibility whenever she had violated certain social rules, e.g. by recognizing the adolescent's anger if she showed up late for a session. It was partly due to these small but human(izing) interventions that a positive therapeutic relationship was established. In our opinion, one of the main obstacles to a successful therapeutic relationship with individuals with psychopath traits is the fear of the therapist being fooled by these types of patients. Lacan is quite radical on this matter, however: "There is only one resistance, the resistance of the analyst.

The analyst resists when he doesn't understand what he is dealing with" (Lacan 1988 [1954-1955], p.228). To avoid a situation of countertransference, an open and non-judgmental attitude on the part of the therapist is required in order to unmask the psychological dynamics behind psychopathic behavior. With this manuscript, we hope to have contributed to this perspective.

REFERENCES

Baumeister, R., Smart, L., & Boden, J. M. (1996). Relation of Threatened Egotism to Violence and Aggression: The Dark Side of High Self-Esteem. *Psychological Review*, *103,* 5-33.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Forth, A., Kosson, D., & Hare, R. (2003). *The Hare Psychopathy Checklist: Youth Version.* Toronto: Multi-Health Systems, inc.

Hare, R. D. (1980). A research scale for the assessment of psychopathy in criminal populations. *Personality and Individual Differences, 1,* 111-119.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist-Revised (Second Ed.).* Torronto, ON, Canada: Multi-Health Systems.

Harris, G. T., & Rice, M. E. (2007). Psychopathy research at Oak Ridge: Skepticism overcome. In H. Hervé, & J. C. Yuille (Eds.), *The psychopath: Theory, research and practice* (pp. 57-75). Mahwah, NJ: Lawrence Erlbaum Associates.

Konzag, T. A., Bandemer-Greulich, U., & Barhke, U. (2004). Psychotherapeutic relationship and outcome in psychotherapy of personality disorders. *Zeitschrift fur Psychosomatische Medizin und Psychotherapie, 50,* 394-405.

Lacan, J. (1966 [2006]). Aggressiveness in Psychoanalysis. In B. Fink (Ed.), *Ecrits. The First Complete Edition in English* (pp. 83-101). New York: W.W.Norton & Company, Inc.

Lacan, J. (1988 [1954-1955]). *The Seminar of Jacques Lacan. Book II: The Ego in Freud's Theory and in the Technique of Psychoanalysis* (edited by J.A.Miller). Cambridge: University Press .

Luborsky, L., McLellan, A. T., Woody, G. E., & O'Brien, C. P. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42,* 602-611.

Lykken, D. (1995). An Animal Model: The Bull Terrier. In D. Lykken, *The Antisocial Personalities* (pp. 13-16). Hillsdale, New Jersey: Lawrence Erlbaum Associate, Inc.

McGauley, G., Adshead, G., & Sarkar, S. (2007). Psychotherapy of psychopathic disorders. In A. R. Felthous, & H. Sass (Eds.), *The international handbook of psychopathic disorders and the law* (pp. 449-466). Chichester, UK: Wiley.

Meloy, J. R. (1988). *The psychopathic mind: Origins, dynamics, and treatment.* Northvale, NJ: Aronson Inc.

Polaschek, D. L., & Daly, T. E. (2013). Treatment and psychopathy in forensic settings. *Aggression and Violent Behavior, 18,* 592-603.

Roth, A., & Fonagy, P. (2006). *What works for whom? A critical review of psychotherapy research.* New York: The Guilford Press.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism. Clinical lore or clinical reality? *Clinical Psychology Review, 22,* 79-112.

Vanheule, S. (2011). Foreclosure and Its Vicissitudes. In S. Vanheule, *The subject of psychosis: A Lacanian perspective* (pp. 50-80). Hampshire/New York: Palgrave Macmillan.

Wong, S. (2000). Psychopathic offenders. In S. Hodgins & R. Muller-Isberner (Eds.), *Violence, crime and mentally disordered offenders* (pp.87-112) Chichester: Wiley.

7

Troublesome Children or Children in Troubled Times: The Lived Experiences of Children Diagnosed with ADHD[1]

Attention-Deficit Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed disorders in children. However, little research is done into children's lived experiences with the ADHD diagnosis and corresponding treatment techniques. In this study narratives of 17 children and adolescents with ADHD were subjected to thematic analysis. Four main story lines were discerned. Firstly, the authors observed a process of pre-labeling by laymen and the exclusion of the child's voice in the assessment process. Secondly, this process of (pre)labeling implies a process of reification, whereby children start to identify with the label. This leads to self-stigmatization. Thirdly, the process of self-stigmatization proved to be connected with public stigmatization and social exclusion. Finally, participants perceived standardized treatment techniques as disciplining and alienating. Implications for research and practice are discussed.

[1] This chapter is based on De Ganck, J. & Vanheule, S. (under review). Troublesome Children or Children in Troubled Times: The Lived Experiences of Children Diagnosed with ADHD. *Ethos, Journal of the Society for Psychological Anthropology*

INTRODUCTION

> It is my wish for others to see me as a normal person, although there is no such thing as normality.
>
> —Ethan, 18-year old boy

The last few decades has seen a considerable increase in the number of children diagnosed with psychiatric disorders. This increasing number of diagnoses goes hand in hand with an exponential growth in the prescription of psychotropic medications (Thomas, Conrad, Casler, & Goodman, 2006). These diagnoses are usually given without the involvement and participation of the child. In this article we use the case example of Attention-Deficit Hyperactivity Disorder (ADHD) to examine the effects that diagnostic labels and standardized treatment techniques have on the lived experiences of children. More specifically, we examine narratives of 17 children and adolescents diagnosed with ADHD by exploring their attitudes towards the diagnostic process and the ADHD-label, and by mapping their subjective experiences with psychotropic medication and other treatment interventions.

ADHD: A MEDICAL CONDITION OR A SOCIAL CONSTRUCT?

From the mid-seventies until now Attention-Deficit Hyperactivity Disorder (ADHD) has become the most frequently diagnosed behavioral disorder in children and adolescents (Furman, 2009; Zimmerman, 2003). Some authors speak of a “real” ADHD epidemic, particularly in North America and other Western countries (Clarke, 2011; Stolzer, 2007; Timimi & Leo, 2009; Timimi & Taylor, 2004). The predominant explanations for the causation of this “epidemic” disorder are generally derived from a biomedical discourse. Within this biomedical framework ADHD is considered a medical condition in which some type of organic basis is postulated to account for the behavioral symptoms of hyperactivity, poor concentration and impulsivity (Conrad, 1977; Conrad, 2006). More specifically, the etiology of ADHD is often explained in terms of heredity and genetic factors (e.g., Biederman et al., 1992;

Biederman, 2005; Swanson et al., 2001; Waldman & Gizer, 2006; Wallis, Russell, & Muenke, 2008), imbalances in dopaminergic and noradrenergic systems (e.g., Biederman, 2005; Pliszka, McCracken, & Maas, 1996; Pliszka, 1998), or functional and structural brain abnormalities (e.g., Castellanos et al., 2002; Durston, 2003; Frodl & Skokauskas, 2012; Konrad & Eickhoff, 2010). Within the biomedical model, pharmacological treatment, particularly stimulant medications such as methylphenidate and dextroamphetamine, has become the dominant intervention in ADHD (Clarke, 2011; Furman, 2009; Searight & McLaren, 1998). Although a combination of pharmacological treatment and (behavioral) therapy is often recommended, several authors promote the superior effectiveness and benefits of the medication management of ADHD over psychosocial interventions (e.g., Spencer et al., 1996; Spencer, Biederman, & Wilens, 1998; Wilens, Biederman, & Spencer, 1998). These assumptions about the neurobiological substrates of ADHD and the promotion of psychotropic treatments are well-known and widely accepted by the general public through portrayals of ADHD in the written press (Clarke, 2011; Conrad & Potter, 2006; Danforth & Navarro, 2001; Horton-Salway, 2011; Norris & Lloyd, 2000; Schmitz, Filippone, & Edelman, 2003), education and support groups for ADHD patients and their relatives (Kean, 2009; Conrad & Potter, 2006) and even popular children songs (Batstra, 2012).

Contrary to what is generally accepted, until today no specific bio-neurological markers or medical tests for ADHD have been found, and, as stated by Sami Timimi and Jonathan Leo (2009, p.9), possibly never will be found:

> What most of the current ADHD 'experts' are reluctant to acknowledge to the general public is that, no matter what area of their research one chooses, whether it is genetics, neuroimaging, or chemical imbalances, the more studies they publish, the further away the goal of finding a biological marker to help with diagnosing children with ADHD seems to become. To account for an increasing list of disparate results, their answer has been to develop even more complicated theories about the biological basis of ADHD, but these theories can obscure only for so long a simpler possibility –that there may be no biological marker for ADHD.[1]

Alternatively, researchers argue that a psychiatric diagnosis, such as ADHD, is not necessarily an indicator of a natural condition, but is best understood as a cultural or social construct (e.g., Amaral, 2007; Caplan, 1995; Conrad, 2007; Conrad & Barker, 2010; Timimi & Radcliffe, 2005a, 2005b; Timimi & Taylor, 2004). Instead of assuming that the causes of ADHD reside *within* the diagnosed *individual* (i.e., *within* his 'broken' brain, defective genes or chemically imbalanced body and brain), social constructivists argue that a psychiatric diagnosis, such as ADHD, is created through sociopolitical negotiation processes among different "interest groups of theoreticians, researchers, clinicians, hospitals, clinics, and drug companies" (Kutchins & Kirk, 1997, p.37) and that the causes of the problems labeled as ADHD-symptoms are contextual, social, political and cultural, rather than objective and natural (Conrad & Barker, 2010; Timimi & Leo, 2009; Timimi & Taylor, 2004; Vanheule, 2012). There are two ways in which we can understand the contribution of the cultural and social context in the epidemic increase in ADHD diagnoses (Timimi, 2009, p. 133-159):

First of all there seems to be an alteration in the way we perceive and ascribe meaning to disruptive behavior (Timimi, 2009, p.134), combined with an increasing medicalization of so-called "disruptive" behavior in children. Medicalization is the process in which behavior, human problems or non-disease states become defined as medical problems or illnesses, whereby medicine and drug therapy are often invoked to socially control and treat them (e.g., Conrad, 1975, 1992, 2007; Conrad & Schneider, 1992; Searight & McLaren, 1998; Szasz, 2007). Children's "disruptive" behaviors (e.g. "the kid has ants in his pants", "he is noisy") which were previously perceived as normal and tolerable, now become clustered into "syndromes" ("the kid has ADHD"). Danforth and Navarro (2001, p.167) state:

> This medicalized approach to research tends to overlook the way that childhood disorders are social and linguistic products cofabricated within the complex construction and contestation of cultural codes, norms, and identities. A medicalized approach often fails to acknowledge that researchers who "discover" childhood disorders and professionals making diagnoses of those disorders operate within a constructive and contested

> discursive field of political and normative meanings about the lives of children.

In that way, ADHD is a hypothetical notion that is created via the discourse of psychology and medicine, and not a scientifically discovered disorder. It primarily aims at managing and controlling children's behavior considered in current times as socially unacceptable and unwanted (Amaral, 2007; Schubert, Hansen, & Rapley, 2005; Timimi & Radcliffe, 2005a).

Secondly there seems to be an amplification of ADHD-like behavior in children, which cannot be fully understood apart from the social-environmental context in which the behavior appears (Timimi, 2009, p.134). Although research into the possible environmental, social and psychological correlates of ADHD-like behavior is rare due to the dominant belief in the biomedical model (Cohen, 1993; Timimi & Radcliffe, 2005a), Timimi gives an overview of some possible environmental causes of ADHD-like behaviors, such as a busy family life and a reduced availability of fathers and mothers for their children during the day; changes in children's lifestyles and their increased exposure to electronic media; modern teaching methods in school that emphasize self-regulation, and so on (Timimi & Taylor; 2004, p.8; Timimi, 2009, p.134-140). Richard DeGrandpre (1999) interprets the emergence of ADHD-like behavior, such as restlessness, hyperactivity, and unsettledness, as the product of our increasingly ''rapid-fire culture" that is characterized by excitement and speed. Studies by Julian Ford and others (Briscoe-Smith & Hinshaw, 2006; Ford et al., 1999, 2000) indicate that psychosocial factors, such as a history of maltreatment, abuse and trauma, are associated with ADHD-like behavior. Nicky Hart and Louba Benassaya (2009) demonstrate that the distribution and incidence of ADHD-symptoms in British children is dependent on environmental factors, i.e. health inequality, social class, stressful life events, parents' education and race.

Regardless of these preliminary findings which indicate the existence of psychosocial and environmental correlates of ADHD, treatment often mainly has a biological focus through drug therapy. Although in biomedical discourse stimulant

and psychotropic treatment is frequently depicted as safe and effective, several authors express their concerns about the side effects and dangers of drug therapy. Peter Breggin (1999) and Grace Jackson (2009) decimated the disruptive effects of stimulant medication on children's growth and development, pointing out that psychostimulants produce a continuum of central nervous system toxicity resulting in a disruption of the formation of cartilage, white and gray matter, a dysregulation of endocrine function, a decreased capacity for neural plasticity in a brain region which is critical for learning and a limitation in the brain's capacity to respond to future experiences by reducing the experience-dependent growth of neuronal dendrites. Breggin adds that the sought-after clinical effects of psychostimulants (being less noisy, talking less to others, suppression of spontaneous behaviors, and so on) are in fact a direct expression of their toxicity, but are often perceived by parents and professionals as the beneficial effects of drug therapy. This developmental toxicity often seems to evolve towards obsessive/compulsive or perseverative activities, agitation and psychosis, apathy, social withdrawal, emotional depression and docility (e.g., Breggin, 1999; Breggin, 2001).

In stark contrast with the bulk of mainstream research on ADHD in children, few studies have explored children's experiences and feelings about their medication or diagnosis (Furman, 2009). Indeed, in scientific literature testimonials from children are scarce. This is all the more striking when compared to the number of case reports of adults with an ADHD diagnosis (e.g., Brod, Schmitt, Goodwin, Hodgkins, Niebler, 2012; Henry & Jones, 2011; Okie, 2006) and especially compared to the number of testimonials or ratings from family members and teachers living and working with "ADHD" children (e.g., Cronin, 2004; dosReis & Myers, 2008; Firmin & Phillips, 2009; Hansen & Hansen, 2006; Ho, Chien, & Wang, 2011; Kendall, 1998, 1999; Koro-Ljungberg & Bussing, 2009; Lin, Huang, & Hung, 2009; Lopes, Eloff, Howie, & Maree, 2009; Lopez, 2009; Moen, Hall-Lord, & Hedelin, 2011; Segal, 1998; Singh, 2003). Conducting a literature search on the Web of Science, we traced nine qualitative studies, almost all within nursing research, the main conclusions of which we summarize below.

THE LIVED EXPERIENCES OF CHILDREN DIAGNOSED WITH ADHD:

A CRITICAL REVIEW

Krueger and Kendall (2001) interviewed 11 white adolescents (13-19 years old, 8 males, 3 females), diagnosed with ADHD and all taking prescribed medication(s), about their experiences with and management of their ADHD diagnosis. Participants described themselves in terms of negative ADHD "symptoms", i.e. inadequacy in the female participants and anger and defiance in the male participants. ADHD related descriptions dominated these children's self-experience, resulting in what the authors refer to as an *ADHD-defined self*: "They were their ADHD and their ADHD was them" (Krueger & Kendall, 2001, p.65). Such identification with the ADHD disorder was also observed by Bitar (2004).

Drawing on her previous work, Kendall and colleagues, conducted another qualitative study in which they explored the experiences of 35 children and adolescents living with ADHD (aged 6 to 17 years, 26 boys and 13 girls) from diverse ethnical backgrounds (Kendall, Hatton, Beckett, & Leo, 2003). As in the previous study, the process of over-identification with the ADHD disorder was observed. Furthermore, participants described problems in thinking, learning and feeling, which they associated with having ADHD. Moreover they reported on both the *positive* (decreased hyperactivity; increased concentration; improvement of behavior and school performance) and *negative* effects (headaches; stomachaches; feelings of fear, shame and depression; unwanted changes in personality, depressive feelings) of taking the ADHD medication. With these data they conclude that "affected children and their families suffer from real problems and that biological treatments (i.e. medications) are often viewed as effective and helpful" (Kendall et al., 2003, p.126). The authors conclude that intervention should focus *on ADHD as an illness* and on the early detection of ADHD-like behavior.

These recommendations are similar to the ones made by Shattel, Bartlett and Tracie (2008) based on phenomenological interviews with 16 white college-enrolled young adults (aged 18 to 25 years, primarily female) who were asked to look back at their childhood experiences of ADHD. All participants recalled feelings of isolation,

being different, loneliness and being misunderstood by peers, teachers and parents. The feeling of being different became more apparent once participants became diagnosed and started (stimulant) treatment, indicating a clear stigmatizing effect of both the ADHD label and treatment. Although participants recalled a strong wish not to be identified in public as diagnosed with a disorder, the authors conclude: "to best help these children, pediatric and school nurses need to advocate for and identify creative strategies so that these children can become connected to a supportive peer group and supportive teachers" (Shattel et al., 2008, p.55). Not only do they make a plea for psycho-education for teachers and parents, but also for all children.

Additionally, Ilina Singh (2011) proposes a child-environment interaction model of the ADHD diagnosis. Drawing on semi-structured interviews about the social and moral dimensions of ADHD in more than 150 children (aged 9 to 14 years old), Singh (2011) describes the (stigmatizing) association between the ADHD diagnosis and uncontrolled anger and aggression in the context of aggressive situations. A loss of self-control and anger seem to differentiate diagnosed children, both to others and to themselves, whereby children with ADHD diagnoses are more likely to be involved in aggressive discussions, more often as a victim but also as a perpetrator. Notwithstanding the stigmatizing fusion of ADHD, anger and aggression, Singh (2011) argues that diagnosed children should not be seen as victims of their environment. More specifically, the intervention of friends, the moral obligations and the loyalty of the diagnosed children towards friends, and the exploitation of the ADHD stigma and mobilization of ADHD behaviors seem to foster self-control and prevention of engagement in fights.

Next to these studies on the experience of the ADHD diagnosis, a number of studies focused on the experiences of children with stimulant medication. One study (Meaux, Hester, Smith, & Shoptaw, 2006) explored the past and present experiences of 15 college students (aged 18 to 21 years old, 9 male and 6 female) all diagnosed with ADHD prior to college and all treated with stimulant medications. All participants described the *negative physiological side effects* (nausea, anorexia, increased thirst, insomnia, shakiness, fatigue and dry mouth) and *psychological side effects* (decrease of creativity, feelings of shame and irritability, emotional liability,

anger, anxiety, restlessness, depression, feeling zombie-like and loss of their own personality) of stimulants. Those who started stimulant medication early in life experienced more negative effects. Almost all benefits of taking medication were associated with academic performance. Participants also described abuse of stimulants for amelioration of academic performances in high school and college.

In a more recent study of Singh et al. (2010), in which 16 children (aged 9 to 14 years old, 14 male and 2 female) diagnosed with ADHD were interviewed through focus groups and individual interviews, the stigmatizing and negative effects of taking stimulant medication were not confirmed. Although side effects were commonly experienced by the participants, the authors highlight largely positive responses to medication (decrease in disruptive behavior and increase in concentration)[2] and argue that experiences of stigma were only related to the ADHD diagnosis itself and ADHD-like symptoms. These results complement a previous study by Singh (2007), in which she concludes, drawing on interviews with 25 children (aged 8 to 12 years old, 22 male and 3 female) with a diagnosis of ADHD, that stimulant drug treatment does not appear to undermine a child's understanding of personal authenticity. In addition to the studies cited above, Brinkman and colleagues (2012) interviewed 44 adolescents with ADHD (aged 13 to 18 years old) through focus groups about their contribution in medication treatment decisions. Next to the identification of both the benefits and side effects of stimulant treatment, several adolescents describe their involvement in discussions and management decisions with parents and medical practitioners as inadequate. Many adolescents portray themselves as being a silent spectator in the diagnostic process and denounce not being listened to by parents or doctors, as medicinal treatment was prolonged despite their objections.

Remarkably, in these qualitative studies, the vast majority of the authors seem to start from a biomedical perspective and conclude by promoting a combination of psycho-education, behavioral management, negotiation and communication techniques, and drug therapy. In our interpretation this is superfluous. These studies demonstrate the clear stigmatizing, alienating and health-threatening effects of the ADHD label and its pharmacological treatment. Moreover

there is preliminary evidence that children are not sufficiently listened to in the diagnostic process and in drug treatment decisions. Therefore we examined the lived experiences of children with ADHD diagnoses from an interpretative-constructivist point of view, and aimed at making conclusions that closely connect to children's actual experience.

DESCRIPTION OF OUR STUDY AND METHOD

Within this study we adhere to the assumption that human behavior cannot be understood without reference to the meanings and motives that people give to their acts (Guba & Lincoln, 1994). Meaning appears through a process of deep reflection and can be stimulated by an interactive dialogue between researcher and participant. Meaning and experiences of the behavioral problems, the diagnosis, and the standardized mental health treatment were explored through participant observation and in-depth interviewing.

The 17 participants considered in this article were part of a qualitative research project about behavioral disorders among children commissioned by the Flemish Children's Rights Commission in Belgium. Participants were recruited from two institutions: (1) a boarding school housing young people (aged 7 to 18 years old) with behavioral and emotional problems, mainly following special education, and (2) an institution for delinquent adolescents (aged 14 to 18 years old). The average age of the participants in this study was 13.7 years.

Fourteen participants had a clinical diagnosis of ADHD, the other 3 participants had a self-reported diagnosis of ADHD. Some participants had an additional diagnosis of a learning disability (n=3), an autistic spectrum disorder (n=3), a post-traumatic stress disorder (n =1) or an antisocial personality disorder (n=2). Most of the participants (n= 14) were taking or had been taking stimulants, most often Ritalin. Some participants took other psychotropic medications prior to the prescription of Ritalin, including antidepressants (n=1), antipsychotics (n=2) and hypnotics (n=2).

All parties (children, parents, institutions) were informed about the overall purpose of the project and gave their informed consent to be involved in the research. The research project was approved by the Ethical Commission of the Faculty of Psychology and Pedagogical Sciences of Ghent University. Through extensive participant observation prior to the interviews, a confidential relationship between child and researcher developed. Interviews took place at the participants' institutions (February – May 2011) and were audio-recorded for written transcription. The names of all participants have been changed to ensure anonymity.

The interview narratives were analyzed by means of thematic analysis (Braun & Clarke, 2006) whereby we focused on children's stories about their hyperactive or inattentive behavior, rather than on the descriptive characteristics of their behavior. We looked for recurring patterns of meaning or overall themes related to how the participants experience their diagnosis, medical treatment and other standardized treatment interventions. The method of thematic analysis allowed us to map both differences and similarities between individuals.

FOUR STORY LINES

Four story lines were identified through repetitious review of the narratives:

(1) a process of pre-labeling from which the voice of the child is excluded
(2) a process of identification with the label, which is accompanied by self-stigmatization
(3) a process of stigmatization by others and social exclusion
(4) a process of subjection to disciplinary treatment techniques

Pre-labeling and the exclusion of the child's voice

Several children in our study described a process previously described in scientific literature as "pre-labeling" (Conrad, 1976; Conrad, 2006) and "semi-formal labeling" (Rafalovich, 2004, 2005). These concepts refer to the process in which the disruptive or unruly behavior of a child becomes labeled as a medical problem by

non-medical persons who are not authorized to make diagnoses. From a social constructivist point of view Peter Conrad and Adam Rafalovich discern several phases in this process. In the case that parents and teachers fail to normalize, control or manage a child's problems or troubles through common remediating or rectifying pedagogical strategies, the child's disruptive behavior is no longer conceived of as idiosyncratic or a transitory problem but as presenting a more profound problem. At this point non-medical denominations become replaced by medical labels and more official "suspicions of the existence of medical condition" (Rafalovich, 2005) become uttered by laymen. In the formulation of these medical diagnoses the child's voice is often excluded.

One boy in our research powerfully described this transition from deviant behavior into a medical condition as follows: "They say we have a mental disturbance, because we disturb others". Rafalovich (2004, 2005) observed that the "suspicion" that leads to an ADHD diagnosis stems most often from (both academic and social) troubles in a school context, whereby teachers and school-based teams inform parents that their child probably has ADHD and urge parents to visit a medical practitioner, or even to start medical treatment. We also observed this, as shown in the testimonial of Joshua, an 18-year old boy:

> In kindergarten the teachers approached my mother. They said I was much busier than other children, that I was less concentrated and...I often had to stand in the corner of the classroom. I was easily distracted. At that time, ADHD was known as hyperkinetic or something like that. The teachers said: "We think he has ADHD". And it turned out to be true. That's the way the teachers explained it to my mother. And my mother she also has ADHD, huh.

Participants indicated that both within the process of pre-labeling by educators as in the diagnosis by a professional, their own experience and opinion about the so-called disruptive behaviors were not questioned, or included. Most of them stress that at the moment of (pre)labeling they themselves did not experience significant distress or disability, as illustrated by Joshua:

> I do not suffer from having ADHD, I do not notice it. It is mainly my environment that suffers from me being busy. Teachers in the classroom say: "You are going on overdrive". Whereas I don't see it myself. (…) Sometimes it is strange that other people notice it, and I don't. Then I ask myself: "What do I do wrong?" Then they say: "You are busy again". That is difficult for me that others observe something I don't realize. That's because of my ADHD probably?

The fact that it is not the children's own choice to seek professional help and that an "Ego-alien" label is actively forced upon them by both educators and professionals often results in feelings of resistance and not accepting the ADHD-diagnosis in adolescents. Participants also indicate that this "Ego-odd" label lacks a grasp of the uniqueness of each individual, as demonstrated in a testimonial of Royce, a 17-year-old boy:

> It is not correct that they say that I have a behavioral disorder. A behavioral problem means… If you look at it properly, my brother and I, we are different from each other in many respects. To my brother they say: "You have a behavioral disorder". But to me they would also say: "You have a behavioral disorder". No, reality is simply this way: everyone is different. Clear. Nobody can be perfect.

These feelings of disagreement and of being misunderstood are also compounded by the reprehensible ways in which a diagnosis is performed by the medical practitioner. Several participants indicated that they were not involved in the assessment process. Diagnoses were usually based on the parents' or teachers' opinions only, on a neurological examination by means of an electroencephalogram (EEG), or on the observation of the efficacy of prescribed stimulant medication. These findings are striking, given the fact that to-date no biological marker for ADHD has been found (Schubert, Hansen and Rapley 2005). Moreover, several participants remarked that their problems became too decontextualized during the evaluation process and that their opinion about the possible causes of their behavioral problems was rarely sought. Two illustrations of these questionable ways in which a diagnosis is set are given by Royce:

> And yes, doctors sometimes prescribe pills for people, for children, while they do not know the causes of the child's problem. Doctors simply immediately write down a diagnosis. I could not agree with that. They did not conduct any tests with me. They only formulated some questions and then they said: "Well, take some Dipiperon, uh some Ritalin".
>
> Ritalin made me active. When I had taken it, then I could no longer concentrate. In other people it sometimes has a paradoxical effect; it makes them tired and so on. The doctor said to me: "We'll see what effect the medication has on you. If it has an opposite effect on you, than we have to do something else". With me it had the opposite effect. So I could stop taking Ritalin.

Identification with the label and self-stigmatization

Associated with this process of labeling, several participants started to consider themselves as cases of ADHD, which implies a process of reification. After being forced by educators and professionals to take on board the initial "I-odd" label of ADHD (alienation), several participants started to identify themselves with the ADHD-label and disorder, as illustrated by Ethan, an 18-year old boy: "ADHD is who I am, I grew up with it". The ADHD diagnosis thus obtains a "master status" (Becker, 1963; Goffman, 1963) and starts functioning as a lens through which one's own actions are framed, leaving little space for alternative interpretations. Whereas in terms of the Diagnostic and Statistical Manual of Mental Disorders (DSM) ADHD only refers to a possible assemblage of hyperactive and inattentive behavioral characteristics, several participants used it to build a new identity, to present themselves to others, to interpret feelings and individual attributes and to give meaning to complex interpersonal actions. This bears witness of "reification" of diagnoses (Hyman, 2010), whereby labels such as ADHD are seen as entities with an objective reality, instead of serving as a merely descriptive diagnosis (Mirowsky & Ross, 1989). Furthermore, the reification of an ADHD diagnosis leads to self-stigmatizing practices in children being diagnosed.

In our study, the examples of this process of "reification" and of the ADHD label operating as a "master status" were multiple. Several participants equate the label of ADHD with their own *identity* and use it to present themselves to other people, as illustrated by Travis, a 12-year old boy:

> The diagnosis means a lot to me. Now I know that not everything is okay with my behavior and so on. Now I know that I sometimes live in my own world. Now I know who I am. I try as much as possible to intercept these things by simply not thinking too much about it.

Many children use the term ADHD to denominate *feelings or psychological* experiences within complex interpersonal relationships. While talking about an argument with his girlfriend, Sanches, a 16-year-old boy stated: "My girlfriend helps me with my problems. But often *she makes me ADHD*. For example, when she arrived one hour late at our appointment".

Young people diagnosed with the label also often interpret personality traits and personal talents, such as being a good sportsman, being creative, being jovial, or being passionate in life in terms of ADHD. Personal attributes such as creativity and being good at sports are no longer seen as properties of the individual, but as integral characteristics of ADHD. Joshua puts it as follows:

> Having ADHD is always useful (...). If you handle it well, it's just fun. In the first place, you always have energy, and secondly you're creative. And you hit upon ideas very easily. It's also easy for me to write poems. And if you don't have ADHD, you can have this too, but not all together.

Notwithstanding the fact that many people in the school and home environment of the child perceive ADHD as a disease, youngsters themselves normally do not, as illustrated in the narrative of Sanches:

> Some people say it is a disease. But I don't experience it as a disease myself. ADHD is ADHD. I mean, it would be a shame, if everyone ignored people with ADHD. I mean, there are so many people who have ADHD.

While ADHD is regularly associated with positive and valued characteristics, more often than not it constitutes a "spoiled identity" attached to the person being labeled (Goffman, 1963, p.19). Indeed, several children indicate that the label characterizes them as deviant. Although they do not think of ADHD as an illness, they associate having ADHD with being abnormal, acting strange, being bad and indecent, having an evil character and demonstrating other psychiatric attributes, such as paranoia and hysteria. They start to perceive themselves as deviates of social norms and expectations, as illustrated by Sanches:

> I want to pretend and act as if I were a decent guy. Decent guys go to bed early. They do not party, they just stay home and watch telly. Or they go cycling. It is just everything. They brush their teeth. I just want to be a normal guy. I want to prove to others that I am a normal guy, and not someone with a bad character.

This reification of the ADHD diagnosis in this sense leads to negative self-esteem. The experience of "being" abnormal or aberrant often goes along with enormous feelings of shame, distress and grief, as illustrated by Travis and Jonathan, a 13-year-old boy:

> I wish I did not have this behavioral disorder. That I could be normal, like most children, but yes…Sometimes it makes me sad. Not that I show it to other people. Actually I never show it to other people, but it is not easy to hide my grief. But I try to do my best. I try to put on a brave face.
>
> Have you already noticed that I am weird? I know that. Sometimes I forget that I have to control myself. Sometimes when they make me angry…really…sometimes when I get angry, when…(he sighs). And then it stops, and I have the bad feeling inside that I did not succeed in restraining myself.

Stigmatization by others and social exclusion

Feelings of shame and low self-esteem, as described above, are often connected to *public stigmatization* related to a diagnosis of ADHD. Public or societal

stigma refers to the stereotypical, prejudicial and discriminating beliefs and reactions the general public, both laymen and professionals, has upon people diagnosed with a mental disorder (Corrigan & Watson, 2002). *Self-stigmatization* occurs when the public stigma becomes internalized by the person being labeled, applying it to other people with a mental disorder (stereotype agreement) or to himself (self-concurrence), the latter often resulting in diminished self-esteem and self-efficacy (Corrigan & Watson, 2002; Corrigan, Watson, & Barr, 2006; Link, 1987). *Stereotypes* (beliefs) and *prejudices* (attitudes) about people with a mental health problem often imply that they are dangerous, violent, incompetent, as well as responsible and in control of the persistence of the disorder (Corrigan et al., 2000; Ben-zeev, Young, & Corrigan, 2010). These beliefs and attitudes often lead to discrimination, such as exclusion from opportunities in life (job, school), segregation, bullying and scapegoating (Ben-zeev et al., 2010; Link, 1987).

Most participants in our study talked about the negative effects of public stigmatization and described the label as a societal stamp for eternity, as stated by Sanches: “It is not good that they label my problems. It is like they put a stamp on you, saying that your behavior is bad. And you can’t get rid of it anymore, it sticks on you forever”. A majority of the participants did not want others, besides their parents and close friends, to know about their diagnosis because of the prejudice related to the label and the possible lack of empathy. Ezra, a 16-year-old boy expressed other people’s prejudice of “dangerousness” and “badness” as follows:

> It is good my parents are informed that I have a conduct disorder and ADHD. They know it now and they understand it. It turned out bad when the children from my class got acquainted with my diagnosis. They were saying to others that they had to be on their guard against me, because I have ADHD. I didn’t like that, because they didn’t know me. I couldn’t deal with that.

Once the diagnosis was known by others, participants felt it gave rise to negative stereotyping and a bad reputation with peers, and even teachers, as Travis said: “Once they knew what I had, I became the villain of the class”. Several adolescents

said that for teachers and peers the diagnosis of ADHD was associated with being stupid and the necessity to follow special education, with violent behavior, or being ill, as expressed by Matthew, a 14-year old boy: “I am being called names by the teacher all the time. He says: ‘you are not capable of learning. You’re an idiot’”. Ezra articulated the effects of communicating his diagnosis to others as follows:

> Children in my class said: "You’re sick". I replied to them: "I don’t have a disease". And all kinds of bullshit. Everyone in the class confronted me with me having ADHD, except one boy. I still keep in touch with him. He is a good friend of mine.

The majority of participants in our study reported being bullied and being called names, and worried about being left in the lurch by peers and friends. They stated that they became more and more isolated and separated from others, as expressed in the following narratives by Sanches and Ezra:

> The diagnosis gives me no benefits. I sometimes think: “How am I ever supposed to explain this to someone I know?” I imagine that they will immediately let me down. I always have that feeling. (…) If I have to tell someone about me, something they do not know or something serious, then I have a feeling they will abandon me. That is how I always feel.

> Sometimes classmates were friendly, because they assumed that saying wrong things to me would make me angry. But in the evening when school was finished and everyone was going home, they changed their tone, they raised their voice with me. They said rough things about me.

Conversely, only 4 out of the 17 children in our study with a psychiatric diagnosis of ADHD reported positive effects of their diagnosis in relation to others, that is, they can ask others to take the diagnosis into account. A few participants suggested that they sometimes used the “label” as an excuse for their performance and behavior, as expressed by Sanches:

> I am glad I know that I have ADHD. (…) I don't have to keep it secret from others any longer. It is the first thing I say when I meet new people. For example I always say to my bosses: "I have ADHD, so take it into account, will you". And they say: "I'm glad you told me". That's it.

However, other people's understanding of the child's problems often gets translated into isolating pedagogical interventions and a reduction of the child's accountability for his own behavior. In school the child diagnosed with ADHD often gets a separate place in the classroom or on the playground. These well intentioned pedagogical interventions often get interpreted by the youngsters in terms of social control, as expressed by Ezra: "In the classroom and playground teachers always kept me separate from others. I always had to stand close to the teachers. In fact, just to keep an eye on me".

Subjection to disciplinary treatment techniques

Recalling Ezra's testimonial, and taking into consideration previous reflections by Rafalovich (2001), the ways in which standardized treatment techniques of ADHD (behavioral modification and psychotropic treatment) are perceived by the children undergoing it may best be explained in terms of discipline through "dressage" and "imprints in the docile bodies" (Foucault, 2006, 2007; Rafalovich, 2001). The way in which ADHD is interpreted from a biomedical discourse and the way ADHD children are framed through the ADHD label and its reifications pave the way to normalizing and disciplining interventions by others (Rafalovich, 2001). Both behavior modification techniques and psychotropic treatment in ADHD could be interpreted as extensions of the *asylum disciplining*, described by Foucault (2006, 2007). Both techniques intervene on the surface of and in the "hyperactive" body that must be trained, manipulated, perfected and normalized. As such, discipline fabricates "docile bodies" (Foucault, 2007, p.188-196). Where the hyperactive child deviates from the vague field of compliance, as registered by the permanent supervision of educators and the medical gaze of medical practitioners, the child must be disciplined and normalized through dressage and the regimentation of its environment (Foucault, 2006, p.249). Behavioral contracts, token economies, point

systems and the assignment of a separate place in the playground or classroom –often used in the treatment of ADHD –are modern examples of such asylum discipline. The use of psychotropic drugs in the treatment of ADHD can also be seen as an extension of asylum discipline (Foucault, 2006, p.181): an "extension of the regime of discipline inside the patient's body". In reaction to these disciplinary actions, many children in our study protested, as will be illustrated below.

The majority of participants (14 out of 17) in our sample were taking or had been taking stimulant drugs, most often Ritalin. In most cases pharmaceutical treatment, together with some behavior modification techniques and pedagogical interventions in school (e.g. behavioral contracts, token economies, point-based systems, structural changes in the classroom), were the only treatments participants were familiar with. Only 3 participants in our sample received or were receiving counseling. When counseling was being phased, sometimes it became replaced by pharmaceutical treatment, as Travis testifies:

> I'm no longer going to a psychiatrist. When I discovered I had autism and ADHD, he suggested me having therapy every week. To talk about my week. To check if everything went okay. My problems improved very quickly that way. And then he said: "Ask your personal doctor to prescribe Ritalin, because your problems can come back". My mother gave it to me for a couple of months. But I almost never took the tablets and I stayed calm. Subsequently the doctor suggested I stop the medication, because there was a chance that Ritalin would make me aggressive.

About half of the participants in our study started psychotropic treatment in kindergarten or in the first years of primary school. One of the main themes present in the majority of participants' narratives was the pressure exerted by the environment to take medication. Many children did not want to take medication for various reasons (e.g. fear it will change their personality, shame, no confidence in the efficacy), but were often obliged to take it by teachers and parents. In the children's narratives it was striking how the environment, most often the teachers, endeavored to promote medication by highlighting only the positive effects

(behavioral control, more attention, better grades, less punishment, and so on) as illustrated by Sanches:

> At this moment I don't take medication, but the school encourages me to do so. (…) But I prefer not to take pills, you know. I want to stay myself. I don't want to be like that: lying on a table in the classroom and snoring. The teachers say to me: "Pills will help you, you will not feel like you are someone else. You will remain yourself". But I do not believe that, I have always claimed: "Pills make you someone else".

In a few cases medication was even administered without the knowledge or consent of the child, by using a cop or a lie, as illustrated in the following narrative of Matthew:

> My father gave me concentration pills, without telling me what it was. He asked me in the evening: "Do you want to drink something?" And then he crushed a pill in my drink. I did not want to take pills, so he did it like that. But I saw through that. Or he said: "Do you want some candy?" I said yes and then put it in my mouth. And then I pulled it out of my mouth and hide it under my pillow. Because I did not want to take pills. And then he found the pills under my pillow and he was really angry.

Children have their own critical ideas about why the environment attaches so much importance to taking stimulant drugs. First, participants said that adults no longer have time to listen and deal with children who are struggling. Troubled children become troublesome children and pills are an instant and ready-made solution to take this burden away. Matthew articulated it bluntly like this:

> I do not agree that children should swallow pills. I think that is inappropriate. Because those adults do not have time anymore to keep you calm. These children are recommended to take pills to make other people happy because pills make them calm down. I will not let them force me to take pills. To calm me down? All those pills I may as well...My mom said you should take those pills. And I said to myself: "Forget it!" And I said to her: "You know, I'll take a pill that causes me to die within ten minutes. Then you have no more

> trouble with me. Then you do not need to waste time calming me down, because I will be dead". Then my mother started to cry.

Secondly, a few participants clearly *criticized the increasing medicalization* of life problems. They argue that in current times too much confidence is placed in the efficacy of medication, as promoted by doctors and advertisements. The downside of this strong belief in pharmaceutical treatments for behavioral and emotional problems, the participants argue, is that people (can) no longer take responsibility for their own problems, as illustrated in the following example of Royce:

> People are too gullible. They give too much credence to pills and things like that. They put too much faith in doctors, television programs and commercials…That is something I can not put faith in. Pills are just pills, so…There are pills and there are painkillers. A painkiller is not the same as a pill to change your behavior…A behavior is just a behavior. You cannot modify behavior by means of a pill. It is only the person himself who can change his behavior. Pills cannot do that. You have to work on your behavior yourself. That's how I think about it.

The same boy wanted to prove his hypothesis that people give too much credence to biomedical explanations and treatments of behavioral problems by provoking a kind of placebo effect among teachers and parents. By simply pretending that he was taking Ritalin he succeeded in letting teachers and parents believe his behavior was improved, thanks to stimulant drugs –which he did not take:

> Every day I had to go to the nursing staff. Two, no three times a day I had to go to the nurse to take my Ritalin. But I have never taken these pills. I was just pretending I took those pills, putting them under my tongue. Nobody knew what I was up to. Then my mother and the teachers said: "He really calmed down since he takes those pills". I thought to myself: "I don't take those pills and now you tell me things are improving because of my medication". (...) I then explained this to my mother. I just wanted to prove that I don't need pills to calm down.

Although critical towards the medicalization of society, several other participants commented on the positive effects of psychotropic treatment as envisaged by professionals and other adults. The benefits of taking stimulant drugs were primarily related to the school environment, such as being able to study and learn, demonstrating less disruptive verbal and physical behavior, being more relaxed in the class room, being less noisy, being able to think before acting, being more focused and, ultimately, it being less likely that they would have to change schools. Parents and teachers approaching children more positively, appears to be another major advantage of taking medication, as described by Joshua:

> My ability to concentrate improved. I could stay quiet in class. And I always received positive comments from my teachers saying that I was sitting still and behaving obediently. The reactions of my teachers really made me happy. And so I continue to take those pills. It actually became a habit.

At the same time, all participants in our study, except one, testified to the negative side-effects of stimulant treatment. The illustrations ranged from rebound effects, increased aggression, insomnia, zombie-like and depressive feelings, reduction of creativity to loss of one's personality, listlessness, stigmatization by peers and teachers, feelings of shame and of being trapped in one's own body and world, and experiencing abdominal pain and headaches. Two examples from many illustrate this, as given by Rachid and Matthew, two 14-year old boys:

> These pills were not good for me. I was not myself. No, you had to see me. It was like I had been smoking cannabis. It was like I had taken drugs. At the school they declared me crazy. (...) I always felt dizzy.

> The pill keeps you calm. You start to feel dizzy. You don't do anything. But then, when the pill wears off, then all the aggression you've experienced that day, but have suppressed, comes up. The aggression at the moment the pill loses it force, is much worse than when I didn't take the pills.

Because of these side-effects several participants stated they want to stop stimulant drug treatment, but are forced to continue by educators and medical practitioners

because of the latter's overall belief in the benefits and necessity of biomedical treatment. Young people themselves are, nevertheless, creative in developing private and alternative ways of dealing with behavioral problems and other difficulties in life. These singular strategies of dealing with problems differ from youngster to youngster, ranging from telling their story to counselors and playing soccer or expressing themselves in creative activities, as illustrated by Joshua:

> Drawing and acting silly. Especially drawing. Making drawings for me is actually a good medication. It really calms me down. In my drawings, I can get rid of all my troubles. Sometimes it's expressed in my drawings…the chaos. Last year I was drawing in my diary from school all the time. But while I was doing that, I was at ease. Being focused on my drawing, the bustle and my troubles get absorbed in my drawing, and no longer reside in myself. I become silent and serene. So drawing is the perfect drug for me. Drawing is my Ritalin.

DISCUSSION

Instead of speaking of the "ADHD-child" from an expert point of view, in this study we explored the lived experiences of a sample of children and adolescents with an ADHD diagnosis, and thus discerned four main storylines. Through the narratives of participants being diagnosed with ADHD, it became apparent how educators play an active role in the medicalization and psychiatrization of their behavioral problems through a process of pre-labeling. Remarkably, our participants indicated that they were often (pre)labeled as mentally disordered and in need of medical evaluation and treatment, while they themselves did not experience significant distress or impairment. The implicit prerequisites formulated by the DSM-IV that something cannot be a disease because it is bad for society (Cooper, 2005, p.23) and that "a condition is only a disease if and only if it is a bad thing to have, those with the condition are unlucky, and the condition is at least medically treatable" (Cooper, 2005, p.4, p.22-44) apparently doesn't count for children, whose opinion is typically not sought when a diagnosis is made. Indeed, diagnostic

evaluation by a medical practitioner is often based solely on teacher and parent reports or on neurological examinations, without listening to the child's experiences. Participants in our study pointed out that their problems were overly decontextualized and that their opinions were insufficiently questioned during the diagnostic procedure, as also noted by Walker (1998, p.6): "Hyperactivity is not a disease. It's a hoax perpetrated by doctors who have *no idea what's really going on with these children*". Moreover, the exclusion of the child's voice goes against the Rights of the Child as formulated by the United Nations (1989, especially articles 3, 12 and 13)[3], which says that all actions in children start from the best interests of the child and that in all actions the child should have the right to freely formulate his opinion.

A question we can ask is why educators and professionals seek refuge in so-called biomedical statements and related diagnostic categories, without taking into account alternative interpretations. In quoting Balint (1957) and Broom and Woodward (1996), Peter Conrad and Deborah Potter (2006, p.103) argue that one of the positive effects of a medical diagnosis lies in the fact that it modifies an obscure and vague bunch of complaints and symptoms into a more understandable "organized illness" and that it provides the sufferer with an understanding of their problems. The lived experiences of children in our study prove this to be wrong. The ADHD label does not contribute to a child's insight into the content of his problems, nor does it endow children with an increased empowerment over their lives, quite the contrary, since the child's problems become decontextualized. Labeling has far-reaching alienating effects on the child being diagnosed, as it doesn't take into account the subjective experiences and the uniqueness of the child: "placing people in diagnostic categories treats them as objects and ignores the persons, or treats the persons as mere epiphenomena of the biological mechanism of their thoughts, feelings and actions" (Mirowsky & Ross 2002, p.153).

Forced to identify with a label that is "Ego-alien", the participants in our study started to develop a new "ADHD-identity", similar to an "ADHD-defined self" or a "distorted sense of self" as found in previous qualitative studies exploring the lived experiences of young people with ADHD (Bitar, 2004; Kendall et al., 2003; Krueger & Kendall, 2001). The ADHD-label and the child's identity become interchangeable

notions: “I don’t have ADHD, I am ADHD”. Through a process of reification the diagnostic label obtains a “master status”, through which the child presents himself to others[4] (“public identity”) and interprets all life events, psychological experiences and personal talents and shortcomings. This over-identification with the diagnosis prevents the child from looking for alternative explanations and solutions to life’s problems, and even from taking credit for personal achievements and talents. While ADHD may be associated with positive characteristics by the youngsters themselves, more often than not the ADHD-diagnosis implies *self stigma*, resulting in a damaged and diminished self-esteem. This self-stigmatization and damaged self-esteem are often the result of public or societal stigmatization, which are connected with prejudices (children with ADHD are bad, dangerous, ill,…) and segregation, such as becoming the black sheep or the villain, being scapegoated and ostracized from social events, being bullied and called names, not to mention being constantly supervised by educators.

These processes of over-identification, self- and societal stigmatization, might be interpreted as *contraindications for the use of psychiatric labels* in children. We agree with John Mirowky and Catherine Ross (2002, p.159-160) where they state:

> We do not need to label people as depressive, schizophrenics, or alcoholics in order to recognize that they feel bad, or their thoughts are disorganized and bizarre, or they have problems with alcohol. Certainly, we need to assess the type and extent of a person’s problems, but the assessment does not need to be categorical. A person does not have to be diagnosed to be helped. Just the opposite may be true. Once a person receives a label, such as “schizophrenic”, the diagnosis is treated as if it were the person’s preeminent trait. Often the rest of the person’s life and their other psychological problems are ignored.

Indeed, labels reinforce diagnostic myopia and draw attention away from social and cultural factors and personal experiences beyond overt behavioral symptoms. Diagnostic labeling disregards differences between children manifesting similar behavior and is not capable of representing the subjective authenticity of children’s lives, relationships, contexts, their history and their thoughts and feelings.

In contrast to previous qualitative studies on this topic, we do not make a plea for more psycho-education, nor for the promotion of an increased awareness of ADHD-related issues, quite the contrary as these "educating" activities will only make over-identification, self-stigma and public stigma more likely to occur. Given the many negative effects of a nomothetic and categorical diagnostic formulation, we argue for an ideographic approach in the diagnostic process. An ideographic (from the Greek, idios, one's own, and graphein, to describe) approach in diagnostic formulation rests on the constructivist assumption that "there exist multiple, constructed realities (…), rather than a single true reality. Reality (…) is subjective and influenced by the context of the situation, namely the individual's experience and perceptions, the social environment, and the interaction between the individual and the researcher" (Ponterotto, 2005, p.130). Instead of reducing children's problems to categorical diagnoses, an ideographic stance approaches each case as a *single case* to achieve "a thorough, interactive and contextualized understanding" (IGDA Workgroup WPA, 2003, p.s55) of the symptoms of the child.

Such ideographic diagnostic formulation is opposite to the standardized treatment approaches that are common in the treatment of ADHD. Besides experiencing positive effects, all participants in our study stress the many side-effects of stimulant drug treatment and the disciplining nature of standardized treatment. They complain about the over-medicalization in modern society and complain that pills are instant and ready-made solutions for adults who have no more time to listen to the story of the child having problems. This is consistent with a hypothetical indictment of Peter Breggin in which he states: "Drugs are only useful when we are focused on our needs as adults rather than on the needs of the child. Every time we drug a child, we are choosing our convenience and our peace of mind over the child's real needs" (Breggin, 2001, p.139). Interpreting the lived experiences of our participants, there is no single and simple treatment technique that is appropriate for every child, as each child is different and adds a different meaning to his behavioral problems. Therefore, in addition to an ideographic diagnostic evaluation, we argue for a single case approach to the treatment of so-called ADHD children. In an individualized approach, where *dialogue with the individual child* is emphasized, strategies that help regulate his emotions and behavior are *co-created*.

Instead of situating the problem in the child's broken brain or defective genes, we recommend a contextualized approach to his problems, by charting the life history of the child, the socio-cultural context in which he moves and his current relationships with significant others. In that way an authentic diagnosis (from the Greek: dia, thoroughly and completely; gignoskein, to come to know) can arise in a way that does not coincide with an objectified and universal evaluation or label, but underlines the subjectivity and uniqueness of each child. Actually, this treatment approach doesn't require much of a professional, besides the ability to listen well.

We conclude with an excerpt from a poem by a Dutch writer, Remco Campert (1970, our translation): "Resistance doesn't begin with big words, but with small acts. Like a storm with a rustle in the garden or a cat having a mad fit. (…) Asking yourself a question, with that begins resistance. And then asking that question to another". May the lived experiences of our participants and their small revolts against an increasing medicalization and normalization in society be an invitation to all of us to question whether the benefits of psychiatric labels and protocolized treatment in children are really worth the disadvantages.

NOTES

1. Several authors convincingly falsify the assumption of a neurobiological substrate for ADHD or of ADHD as a valid, objective medical condition by pointing out the methodological shortcomings of the impending scientific studies. For example, Jay Joseph (2000, 2009) disproves the alleged evidence for a genetic basis of ADHD derived from family, twin and adoption studies. The author argues that results from family and twin studies are greatly confounded by environmental factors and that twin studies are severely flawed by the facts ADHD diagnoses were not made blindly and because of the absence of information about the biological relatives of adoptees. Similarly, Lydia Furman (2008, 2009) concludes that results from genome-wide scan studies and candidate gene studies are often negative and far from conclusive. Finally, in reviewing neuroimaging studies David Cohen and Jonathan Leo (Cohen & Leo, 2004; Leo & Cohen, 2003; Leo & Cohen, 2009) demonstrate the evidence in favor of brain abnormalities causing ADHD to be invalid. One confounding factor in neuroimaging studies is the absence of reporting on prior psychotropic or stimulant treatment of the participants and the absence of comparing unmedicated ADHD subjects with controls.
2. Although the authors point out that these positive responses are possible due to selection bias.
3. Through non-involvement of the child's voice in the diagnostic process, the following rights of the child (United Nations 1989) are violated:
   - 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.' (art.3 §1)
   - 'State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.' (Art.12 §1)
   - 'The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kind, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's voice'. (Art.13 §1)

This argument was previously used by Brian Kean in his discussion of the case study of 'A boy who stops taking stimulants for "ADHD" (Cohen & Leo, 2002, p.203).

4. Peter Conrad and Deborah Potter (2006) refer to this as a diagnosis becoming a public identity.

REFERENCES

Amaral, O. B. (2007). Psychiatric Disorders as Social Constructs: ADHD as a case in Point. *The American Journal of Psychiatry, 164*, 1612.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition - Text Revision.* Washington, DC: American Psychiatric Association.

Balint, M. (1957). In *The Doctor, His Patient, and the Illness.* New York: International Universities Press.

Batstra, L. (2012). *Hoe voorkom je ADHD? Door de diagnose niet te stellen.* Amsterdam: Uitgeverij Nieuwezijds.

Becker, H. S. (1963). *Outsiders: Studies in the Sociology of Deviance.* New York: Free Press.

Ben-zeev, D., Young, M. A., & Corrigan, P. W. (2010). DSM-V and the stigma of mental illness. *Journal of Mental Health, 19*, 318-327.

Berger, P. L., & Luckman, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge.* New York: Anchor Books.

Biederman, J. (2005). Attention-Deficit/Hyperactivity Disorder: A Selective Overview. *Biological Psychiatry, 57*, 1215-1220.

Biederman, J., Faraone, S. V., Keenan, K., Benjamin , J., Krifcher, B., Moore, C., et al. (1992). Further Evidence for Family-Genetic Risk Factors in Attention Deficit Hyperactivity Disorder: Patterns of Comorbidity in Probands and Relatives in Psychiatrically and Pediatrically Referred Samples. *Archives of General Psychiatry, 49*, 728-738.

Bitar, P. M. (2004). *The self perceptions of adolescents with attention deficit hyperactivity disorder.* Duquesne University.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Breggin, P. R. (2001). *Talking Back to Ritalin: What Doctors Aren't Telling You About Stimulants and ADHD. Revised Edition.* Cambridge: Da Capo Press.

Breggin, P. R. (1999). Psychostimulants in the treatment of children diagnosed with ADHD: Risks and mechanism of action. *International Journal of Risk & Safety in Medicine, 12*, 3-35.

Brinkman, W. B., Sherman, S. N., Zmitrovich, A. R., Visscher, M. O., Crosby, L. E., Phelan, K. J., et al. (2012). In Their Own Words: Adolescent Views on ADHD and Their Evolving Role Managing Medication. *Academic Pediatrics, 12*, 53-61.

Briscoe-Smith, A. M., & Hinshaw, S. P. (2006). Linkages Between Child Abuse and Attention-Deficit/Hyperactivity Disorder in Girls: Behavioral and Social Correlates. *Child Abuse & Neglect, 30*, 1239-1255.

Brod, M., Schmitt, E., Goodwin, M., Hodgkins , P., & Niebler, G. (2012). ADHD burden of illness in older adults: a life course perspective. *Quality of Life Research, 21*, 759-799.

Broom, D. H., & Woodward, R. V. (1996). Medicalisation reconsidered: toward a collaborative approach to care. *Sociology of Health and Illness, 18*, 357-378.

Campert, R. (1970). Iemand stelt de vraag. *Betere tijden*. Amsterdam: De Bezige Bij.

Caplan, P. (1995). *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal.* Reading, MA: Addison-Wesley.

Castellanos , F. X., Lee , P. P., Sharp, W., Jeffries, N. O., Greenstein, D. K., Clasen, L. S., et al. (2002). Developmental Trajectories of Brain Volume Abnormalities in Children and Adolescents With Attention-Deficit/Hyperactivity Disorder. *American Medical Association, 288*, 1740-1748.

Clarke, J. N. (2011). Magazine portrayal of attention deficit/hyperactivity disorder (ADD/ADHD): A post-modern epidemic in a post-trust society. *Health, Risk & Society, 13*, 621-636.

Cohen, C. I. (1993). The Biomedicalization of Psychiatry: A Critical Overview. *Community Mental Health Journal, 29*, 509-521.

Cohen, D., & Leo, J. (2002). A Boy Who Stops Taking Stimulants for "ADHD": Commentaries on a Pediatrics Case Study. *Ethical Human Sciences and Services, 4*, 189-209.

Cohen, D., & Leo, J. (2004). An update on ADHD neuroimaging research. *The Journal of Mind and Behavior, 25*, 161-166.

Conrad, P. (1977). Situational Hyperactivity: A Social System Approach. *Journal of School Health, 47*, 280-285.

Conrad, P. (1975). The Discovery of Hyperkinesis: Notes on the medicalization of Deviant Behavior. *Social Problems, 23*, 12-21.

Conrad, P. (1976). *Identifying Hyperactive Children.* Toronto/London: Lexington Books.

Conrad, P. (2006). *Identifying Hyperactive Children: The Medicalization of Deviant Behavior. Expanded edition.* Hants: Ashgate Publishing Limited.

Conrad, P. (1992a). Medicalization and Social Control. *Annual Review of Sociology, 18*, 209-232.

Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Conditions.* Baltimore, Maryland: The John Hopkins University Press.

Conrad, P. (2006). Toward a Social System Approach to Hyperactivity: Situational Hyperactivity. In P. Conrad, *Identifying Hyperactive Children: The medicalization of Deviant Behavior* (pp. 77-85). Hants: Ashgate Publishing Limited.

Conrad, P., & Barker, K. K. (2010). The social construction of Illness: Key Insights and Policy Implications. *Journal of Health and Social Behavior, 51*, S67-S79.

Conrad, P., & Potter, D. (2006). Epiloque 2000: From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories. In P. Conrad, *Identifying Hyperactive Children: The Medicalization of Deviant Behavior. Expanded Edition* (pp. 101-125). Hants: Ashgate Publishing Limited.

Conrad, P., & Schneider, J. W. (1992). *Deviance and Medicalization: From Badness to Sickness. Expanded edition.* Philadelphia: Temple University Press.

Cooper, R. (2005). *Classifying Madness: A philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders.* Dordrecht, The Netherlands: Springer.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The Self-Stigma of Mental Illness: Implications for Self-Esteem and Self-Efficacy. *Journal of Social and Clinical Psychology, 25*, 875-884.

Corrigan, P. W., & Watson, A. C. (2002). The Paradox of Self-Stigma and Mental Illness. *Clinical Psychology - Science and Practice, 9*, 35-53.

Corrigan , P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., et al. (2000). Stigmatizing attributions about mental illness . *Journal of Community Psychology, 28*, 91-102.

Cronin, A. F. (2004). Mothering a child with hidden impairments. *American Journal of Occupational Therapy, 58*, 83-92.

Danforth, S., & Navarro, V. (2001). Hyper Talk: Sampling the Social Construction of ADHD in Everyday Language. *Anthropology & Education Quarterly, 32*, 167-190.

DeGrandpre, R. (1999). *Ritalin nation: Rapid-Fire Culture and the Transformations of Human Consciousness.* London: W.W. Norton & Co Ltd.

dosReis, S., & Myers, M. A. (2008). Parental attitudes and involvement in psychopharmacological treatment for ADHD: A conceptual model. *International Review of Psychiatry, 20*, 135-141.

Durston, S. (2003). A Review of the Biological Bases of ADHD: What Have We Learned From Imaging Studies? *Mental Retardation and Developmental Disabilities Research Reviews, 9*, 184-195.

Firmin, M. W., & Phillips , A. (2009). A Qualitative Study of Families and Children Possessing Diagnoses of ADHD. *Journal of Family Issues, 30*, 1155-1174.

Ford, J. D., Racusin , R., Ellis, C. D., Daviss, W. B., Reiser, J., Fleisher , A., et al. (2000). Child Maltreatment, other Trauma Exposure, and Posttraumatic Symptomatology among Children with Oppositional Defiant and Attention Deficit Disorders. *Child Maltreatment, 5*, 205-217.

Ford, J. D., Racusin, R., Daviss, W. B., Ellis, C. G., Thomas, J., Rogers , K., et al. (1999). Trauma exposure among children with oppositional defiant disorder and attention deficit-hyperactivity disorder. *Journal of Consulting and Clinical Psychology, 67*, 786-789.

Foucault, M. (2007). *Discipline, Toezicht en Straf (Nederlandse vertaling).* Groningen: Vertalerscollectief - Historische Uitgeverij.

Foucault, M. (2006). *Psychiatric Power: Lectures at the collège de France 1973-1974.* New York: Palgrave Macmillan .

Frodl, T., & Skokauskas, N. (2012). Meta-analysis of structural MRI studies in children and adults with attention deficit hyperactivity disorder indicates treatment effects. *Acta Psychiatrica Scandinavia, 125*, 114-126.

Furman, L. (2009). ADHD: What Do We Really Know? In S. Timimi, & J. Leo, *Rethinking ADHD: from brain to culture* (pp. 21-57). Hampshire & New York: Palgrave Macmillan.

Furman, L. (2008). Attention-Deficit Hyperactivity Disorder (ADHD): Does New Research Support Old Concepts. *Journal of Child Neurology, 23*, 775-784.

Goffman, E. (1963). *Stigma: Notes on the management of Spoiled Identity.* Englewood Cliffs, N.J: Prentice-Hall.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative Research* (pp. 105-117). Thousand Oaks, CA: SAGE Publications.

Hansen, D. L., & Hansen, E. H. (2006). Caught in a balancing act: Parents' dilemmas regarding their ADHD child's treatment with stimulant medication. *Qualitative Health Research, 16*, 1267-1285.

Hart, N., & Benassaya, L. (2009). Social Deprivation or Brain Dysfunction? Data and the Discourse of ADHD in Britain and North America. In S. Timimi, & J. Leo (Eds.),

Rethinking ADHD: from brain to culture (pp. 218-251). Hampshire & New York: Palgrave MacMillan.

Henry, E., & Jones , S. H. (2011). Experiences of Older Adult Women Diagnosed with Attention Deficit Hyperactivity Disorder. *Journal of Woman & Aging, 23*, 246-262.

Ho, S.-W. C., Chien, W. T., & Wang, L.-Q. (2011). Parents' perceptions of care-giving to a child with attention deficit hyperactivity disorder: An exploratory study. *Contemporary Nurse, 40*, 41-56.

Horton-Salway, M. (2011). Repertoires of ADHD in UK newspaper media. *Health, 15*, 533-549.

Hughes, E. C. (1945). Dilemmas and Contradictions of Status. *American Journal of Sociology, 50*, 353-359.

Hyman, S. E. (2010). The diagnosis of mental disorders: The problem of reification. *Annual Review of Clinical Psychology, 6*, 155-179.

IGDA Workgroup, WPA. (2003). IGDA.8: Ideographic (personalised) diagnostic formulation. *British Journal of Psychiatry, 182*, s55-s57.

Jackson, G. E. (2009). The Case against Stimulants. In S. Timimi, & J. Leo (Eds.), *Rethinking ADHD: from brain to culture* (pp. 255-286). London: Palgrave Macmillan.

Joseph, J. (2009). ADHD and Genetics: A consensus Reconsidered. In S. Timimi, & J. Leo (Eds.), *Rethinking ADHD: from brain to culture* (pp. 58-91). Hampshire & New York: Palgrave Macmillan.

Joseph, J. (2000). Not in Their Genes: A critical View of the Genetics of Attention-Deficit Hyperactivity Disorder. *Developmental Review, 20*, 539-567.

Kean, B. (2009). ADHD in Australia: The Emergence of Globalization. In S. Timimi, & J. Leo (Eds.), *Rethinking ADHD: from brain to culture* (pp. 169-197). New York : Palgrave Macmillan.

Kendall, J. (1998). Outlasting disruption: Process of reinvesting in families with ADHD children. *Qualitative Health Research, 8*, 839-857.

Kendall, J. (1999). Sibling accounts of ADHD. *Family Process, 38*, 117-136.

Kendall, J., Hatton, D., Beckett, A., & Leo, M. (2003). Children's Accounts of Attention-Deficit/Hyperactivity Disorder. *Advances in Nursing Science, 26*, 114-130.

Konrad, K., & Eickhoff, S. B. (2010). Is the ADHD Brain Wired Differently? A review on structural and Functional Connectivity in Attention Deficit Hyperactivity Disorder. *Human Brain Mapping, 31*, 904-916.

Koro-Ljungberg, M., & Bussing, R. (2009). The management of Courtesy Stigma in the Lives of Families With Teenagers With ADHD. *Journal of Family Issues, 30*, 1175-1200.

Krueger, M., & Kendall, J. (2001). Descriptions of Self: An Exploratory Study of Adolescents With ADHD. *Journal of Adolescent Psychiatric Nursing, 14*, 61-72.

Kutchins, H., & Kirk, S. (1997). *Making us crazy: DSM: The Psychiatric Bible and the Creation of Mental disorders.* New York: The Free Press.

Leo, J., & Cohen, D. (2009). A Critical Review of ADHD Neuroimaging Research. In S. Timimi, & J. Leo (Eds.), *Rethinking ADHD: from brain to culture* (pp. 92-129). Hampshire & New York: Palgrave Macmillan.

Leo, J., & Cohen, D. (2003). Broken brains or flawed studies? A critical review of ADHD neuroimaging research. *The Journal of Mind and Behavior, 24*, 29-56.

Lin, M.-J., Huang, X.-Y., & Hung, B.-J. (2009). The experiences of primary caregivers raising school-aged children with attention-deficit hyperactivity disorder. *Journal of Clinical Nursing, 18*, 1693-1702.

Link, B. G. (1987). Understanding Labeling Effects in the area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection. *American Sociological Review, 52*, 96-112.

Lopes, T., Eloff, I., Howie, S., & Maree, J. G. (2009). South African Teachers' Experiences of Children in their Classrooms who may have ADHD. *Journal of Psychology in Africa, 19*, 347-354.

Lopez, S. M. (2009). Difficulties of teachers in the identification of students with ADHD. *Revista Espanola de Pedagogia, 67*, 545-564.

Meaux, J., Hester, C., Smith, B., & Shoptaw, A. (2006). Stimulant Medications: A Trade-off? The Lived Experience of Adolescents With ADHD. *Journal for Specialists in Pediatric Nursing, 11*, 214-226.

Mirowsky, J., & Ross, C. E. (2002). Measurement for a Human Science. *Journal of Health and Social Behavior, 43*, 152-170.

Mirowsky, J., & Ross, C. E. (1989). Psychiatric Diagnosis as Reified Measurement. *Journal of Health and Social Behavior, 30*, 11-25.

Moen, O. L., Hall-Lord, M., & Hedelin, B. (2011). Contending and Adapting Every Day: Norwegian Parents' Lived Experience of Having a Child With ADHD. *Journal of Family Nursing, 17*, 441-462.

Norris, C., & Lloyd, G. (2000). Parents, professionals and ADHD: what the papers say. *European Journal of Special Needs Education, 15*, 123-137.

Okie, S. (2006). ADHD in adults. *New England Journal of Medicine, 354*, 2637-2641.

Pliszka, S. (1998). Comorbidity of attention-deficit/hyperactivity disorder with psychiatric disorder: An overview. *Journal of Clinical Psychiatry, 59*, 50-58.

Pliszka, S. R., McCracken, J. T., & Maas, J. W. (1996). Catecholamines in attention-defict hyperactivity disorder: Current perspectives. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 264-272.

Ponterotto, J. (2005). Qualitative research in Counseling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology, 52*, 126-136.

Rafalovich, A. (2001). Disciplining Domesticity: Framing the ADHD Parent and Child. *The Sociological Quarterly, 42*, 373-393.

Rafalovich, A. (2004). *Framing ADHD Children: A Critical Examination of the History, Discourse, and Everyday Experience of Attention Deficit/Hyperactivity Disorder.* US: Lexington Books .

Rafalovich, A. (2005). Relational Troubles and Semiofficial Suspicion: Educators and the Medicalization of "Unruly" Children. *Symbolic Interaction, 28*, 25-46.

Schmitz, M. F., Filippone, P., & Edelman, E. M. (2003). Social Representations of Attention Deficit/Hyperactivity Disorder, 1988-1997. *Culture & Psychology, 9*, 383-406.

Schubert, S., Hansen, S., & Rapley, M. (2005). 'There is no pathological test': More on ADHD as rhetoric. *The Journal of Critical Psychology, Counseling and Psychotherapy, 5,* 151-160.

Searight, H. R., & McLaren, A. L. (1998). Attention-Deficit Hyperactivity Disorder: The medicalization of Misbehavior. *Journal of Clinical Psychology in Medical Settings, 5*, 467-495.

Segal, R. (1998). The construction of family occupations: A study of families with children who have attention deficit/hyperactivity disorder. *Canadian Journal of Occupational Therapy, 65*, 286-292.

Shattell, M. M., Bartlett, R., & Rowe, T. (2008). "I Have Always Felt Different": The Experience of Attention-Deficit/Hyperactive Diorder in Childhood. *Journal of Pediatric Nursing, 23*, 49-57.

Singh, I. (2011). A disorder of anger and agression: Children's perspectives on attention deficit/hyperactivity disorder in the UK. *Social Science & Medicine, 73*, 889-896.

Singh, I. (2007). Clinical implications of ethical concepts: Moral self-understandings in children taking methylphenidate for ADHD. *Clinical Child Psychology and Psychiatry, 12*, 167-182.

Singh, I. (2003). Boys will be boys: Fathers' perspectives on ADHD symptoms, diagnosis, and drug treatment. *Harvard Review of Psychiatry, 11*, 308-316.

Singh, I., Kendall, T., Taylor, C., Mears, A., Hollis, C., Batty, M., et al. (2010). Young people's experience of ADHD and Stimulant Medication: A Qualitative Study for the NICE Guidelines. *Child and Adolescent Mental Health, 15*, 186-192.

Spencer, T. J., Biederman, J., & Wilens, T. (1998). Pharmacotherapy of ADHD with Antidepressants. In R. A. Barkley (Ed.), *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* (pp. 552-563). New York: The Guilford Press.

Spencer, T., Biederman, J., Wilens, T., Harding, M., O'Donell, D., & Griffin, S. (1996). Pharmacotherapy of Attention-Deficit Hyperactivity Disorder across the Life Cycle. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 409-432.

Stolzer, J. M. (2007). The ADHD epidemic in America. *Ethical Human Psychology, 9*, 109-116.

Swanson, J., Deutsch, C., Cantwell, D., Posner, M., Kennedy, J. L., Barr, C. L., et al. (2001). Genes and attention-deficit hyperactivity disorder. *Clinical Neuroscience Research, 1*, 207-216.

Szasz, T. (2007). *The Medicalization of Everyday Life: Selected essays.* Syracuse, New York: Syracuse University Press.

Thomas, C. P., Conrad, P., Casler, R., & Goodman , E. (2006). Trends in the Use of Psychotropic Medications Among Adolescents, 1994 - 2001. *Psychiatric Services, 57*, 63-69.

Timimi, S. (2009). Why diagnosis of ADHD has Increased so Rapidly in the West: A cultural Perspective. In S. Timimi , & J. Leo (Eds.), *Rethinking ADHD: from brain to culture* (pp. 133-159). New York: Palgrave Macmillan.

Timimi, S., & Leo, J. (2009). Introduction. In S. Timimi, & J. Leo (Eds.), *Rethinking ADHD: from brain to culture* (pp. 1-17). New York : Palgrave Macmillan.

Timimi, S., & Leo, J. (2009). *Rethinking ADHD.* New York: Palgrave Macmillan.

Timimi, S., & Radcliffe, N. (2005b). The rise and rise of ADHD. In C. Newnes, & N. Radcliffe (Eds), *Making and breaking of children's lives* (pp. 63-70). Ross-on-Wye: PCCS Books.

Timimi, S., & Radcliffe, N. (2005a). The rise and rise of attention deficit hyperactivity disorder. *Journal of Public Mental Health, 4*, 9-13.

Timimi, S., & Taylor, E. (2004). ADHD is best understood as a cultural construct. *The British Journal of Psychiatry, 184*, 8-9.

United Nations. (1989). *Convention on the Rights of the Child*. Retrieved juni 7, 2012, from Office of the United Nations High Commissioner for Human Rights: www2.ohchr.org/english/law/crc.htm part1

Vanheule, S. (2012). Diagnosis in the field of psychotherapy: A plea for an alternative to the DSM-5.x. *Psychology and Psychotherapy: Theory, Research and Practice, 85,* 128-142.

Waldman, I. D., & Gizer, I. R. (2006). The genetics of attention deficit hyperactivity disorder. *Clinical Psychology Review, 26*, 396-432.

Walker, S. (1998). *The Hyperactivity Hoax: How to Stop Drugging your Child and Find Real Medical Help.* New York: St. Martin's Press .

Wallis, D., Russell, H. F., & Muenke, M. (2008). Review: Genetics of Attention Deficit/Hyperactivity Disorder. *Journal of Pediatric Psychology, 33*, 1085-1099.

Wilens, T. E., Biederman, J., & Spencer, T. J. (1998). Pharmacotherapy of Attention Deficit Hyperactivity Disorder in Adults. *CNS Drugs, 9*, 347-356.

Zimmerman, M. L. (2003). Attention-deficit hyperactivity disorders. *Nursing Clinics of North America, 38*, 55-66.

8

GENERAL CONCLUSION AND DISCUSSION

In this final chapter, we summarize our findings and draw conclusions with regard to the relationship between psychopathic traits and internalizing psychopathology in juveniles. Both our qualitative and quantitative studies indicate that juvenile psychopathy and internalizing psychopathology are not mutually exclusive constructs. Moreover, based on our qualitative studies we venture to postulate that an underlying anxious position is at the heart of the emergence of psychopathic behaviour in adolescents. Furthermore, we debate the perils and pitfalls of diagnosing juvenile psychopathy. Implications for clinical-forensic practice, as well as the strengths and limitations of the present doctoral study are considered.

CONCLUSION

> Let us focus on the idea of irresponsibility. Is he irresponsible, the one who can not give a reason for his actions, the one who is not able to respond? The word 'responsibility' itself includes the word 'response' – both have the same root. Responsibility is the possibility to respond for oneself. If, for psychoanalysis criminology is so interesting, it is because it poses the question of whether mental illness should lead to the suspension of the subject of law.
>
> — Jacques-Alain Miller (2011, our translation)

The main objective of this doctoral dissertation was to study the relationship between psychopathic traits and internalizing psychopathology, in particular anxiety, in youth. In our introductory chapter we discussed how seminal theorists and clinicians defined both adult and juvenile psychopathy in terms of a remarkable absence of fear (Lykken, 1957), anxiety and psycho-neurotic symptoms, such as guilt, remorse and intra-psychic conflict (e.g Cleckley, 1976 ; Karpman, 1959 ; McCord & McCord, 1956). Several contemporary authors have recuperated these original ideas and claim that an absence of anxiety and fear (or startle) indeed are at the core of psychopathy (e.g. Corr, 2010 ; Fowles & Dindo, 2006 ; Patrick, 1994 ; Patrick, 2007; Patrick, Bradley, & Lang, 1993). On the other hand, our concise overview in the introduction of empirical studies investigating the relationship between internalizing psychopathology and juvenile psychopathy revealed inconsistent results (see also: Salekin & Lynam, 2010; Sevecke & Kosson, 2010). Within this dissertation we endeavored to address the limitations of previous empirical research by following a mixed method design, combining both quantitative and qualitative methods. In doing so, we used multiple measures for the assessment of both constructs under study and took into account the total psychopathy scores, as well as the scores on the separate psychopathy dimensions.

Furthermore, we debated in our introduction how the concept of juvenile psychopathy is far from moral neutral and how a diagnosis of psychopathy might result in exclusion processes. Within contemporary research, the potential for the negative impact

that a psychiatric label such as psychopathy may have on a youngster's identity development is rarely questioned. Related to this, this dissertation aimed to investigate the impact that a psychiatric label may have on the lived experiences of juveniles by using the case example of Attention-Deficit Hyperactivity Disorder.

OVERVIEW OF THE MAIN FINDINGS

In *Chapter 2* we investigated the reliability, factor structure and measurement invariance of both the Youth Psychopathic Traits Inventory (YPI; Andershed, Stattin, & Levander, 2002) and the more recently developed YPI-Short Version (YPI-S; van Baardewijk, Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010). Both self-report measures are based on the three factor conceptualization of psychopathy (Cooke & Michie, 2001), which includes a Grandiose-Manipulative (GM), a Callous-Unemotional (CU); and an Impulsive-Irresponsible factor (II). In general, the internal consistency of the subscales were better for the YPI-S than for the YPI. Confirmatory factor analysis (CFA) was used to evaluate the proposed three-factor structure of both the YPI and the YPI-S. CFAs supported the three-factor structure for the YPI-S in the community sample, for boys and girls, and for students from both Special Secondary Education (SSE) and General Secondary Education (GSE) seperately. The latent factors of the YPI-S factor model are moderately correlated, further confirming the validity of the three-factor model for the YPI-S. CFAs (using the YPI items as manifest variables) indicated that the model-fit of the YPI factor model was sub-optimal in the community sample (for boys and girls) and for students from SSE and GSE separately. For both the YPI and the YPI-S measurement invariance was confirmed across gender and type of education, suggesting that the interpretation of the meaning of affective, interpersonal and behavioral psychopathy-like characteristics was the same across samples. With regard to the convergent validity, two conceptually relevant correlations were found between the YPI-S and the PCL:YV. Moreover, the criterion validity of the YPI-S was confirmed, with several significant correlations between the YPI-S and different forms of antisocial and externalizing behavior in both samples. However, these correlations have only small to moderate effect sizes. Taken together, the findings indicated that the YPI-S could be used in

our subsequent studies as a valid and reliable instrument to measure psychopathic traits in juveniles.

In *Chapter 3*, we empirically tested the relationship between psychopathic traits, internalizing psychopathology (e.g. depression, anxiety and stress), alexithymia and thought problems in a community and referred sample of adolescents. In both samples psychopathic traits were measured by means of the YPI-S, and other psychopathological problems by means of a comprehensive battery of self-report measures. In the referred sample, psychopathic traits and internalizing psychopathology were additionally measured by means of the PCL:YV and a semi-structured interview respectively. In the community sample cluster analysis identified five subgroups that differed significantly from each other in terms of their specific constellation of psychopathic traits. The psychopathic-like group differed from the other groups on externalizing problems (i.e. rule-breaking and aggressive behavior), a variable that typically characterizes adult psychopathy as well. On the other hand, several of our findings ran counter to the traditional hypothesis that juvenile psychopathy is negatively related to internalizing psychopathology. In the community sample, compared to the normal and/or other groups, the psychopathic-like group scored significantly higher on DASS-21 depression, anxiety and stress, and psychotic-like thought problems. Similar observations were made in the referred sample, with all correlations between self-reported internalizing psychopathology and psychopathic traits being non-significant or positive. In addition, based on interview measures no relation between juvenile psychopathy and internalizing psychopathy was observed. These findings suggest that inconsistent results in previous studies may not reflect differences among measures, but most likely demonstrate that in juvenile psychopathy the hypothesis of a presumed absence of anxiety, depression and stress does not hold.

In *Chapter 4*, we indirectly tested the relationship between juvenile psychopathy and anxiety by studying defense mechanisms in a nonclinical sample of adolescents. We observed that approximately 37% of the variance in psychopathic traits was accounted for by five immature defenses (i.e. acting out, isolation, dissociation, splitting and rationalization) and by the neurotic defense ‘undoing.’ Higher levels of psychopathic traits were associated with higher scores on the five immature defensive styles and lower scores on undoing. Since defense mechanisms are unconscious psychological processes that protect

individuals against an overflow of anxiety and threat, the results of this study suggest that an experience of anxiety might indeed be associated with juvenile psychopathy.

In *Chapter 5*, we studied the complex relationship between juvenile psychopathy and negative affect through a qualitative study of the affective, interpersonal and antisocial life of a youngster with marked psychopathic traits (PCL:YV = 32). Our clinical interviews with this adolescent shed a more nuanced light on the presumed affective deficits in juvenile psychopathy. In contrast with the typical image of unemotional functioning and callousness, a range of emotions, such as guilt, shame, fear, anxiety and pain emerged as a trustful therapeutic relationship between adolescent and interviewer developed over time. Remarkably, in this juvenile, the experience and expression of negatively-charged conditions and life-events was accompanied by an apparent process of radical splitting or dissociation. It is argued that this process of splitting points to self-protective strategies, rather than to an absence of affects such as anxiety fear, and sadness. Moreover, the adolescent's social world didn't appear to be structured in a symbolic way, resulting in an extremely unpredictable world in which other people's desires and motives emerged as an enigma to him. His helplessness in relation to other people's intentions urged him to react with violence and to radically terminate intimate relationships. These antisocial acts can be interpreted as a defense against a threatening (i.e., enigmatic) other, and as such are rooted in an underlying anxious position.

In *Chapter 6* we continued the project that we had begun in *Chapter 5* by investigating the relationship between juvenile psychopathy and anxiety through an extensive qualitative study of the interpersonal lives of 15 juvenile offenders with psychopathic traits. The predominant theme across all narratives was that, from the viewpoint of these juveniles, they themselves are at risk of falling prey to fundamentally distrustful and deceitful (significant) others. Our findings demonstrated that in order to cope with these fundamentally unreliable and unpredictable others, several self-protective strategies are employed. For example, by deliberately testing of the reliability of the other or through fear-inducing strategies they attempt to escape the deceptiveness of the other. Our findings indicated that much of their psychopathic behavior is rooted in an underlying anxious position. We argued that in order for therapy to be successful this fundamentally anxious and distrustful position should be addressed.

In our final chapter, we addressed our second research objective by exploring the lived experiences of 17 children with a diagnosis of ADHD and associated treatment techniques. Our results indicated that a psychiatric diagnosis and its corresponding treatment procedures often induce alienating effects in the sense of the self and the social development of these children. Based on our results, it appeared that the voice of the child is often neglected in the assessment process. After a diagnosis is determined a process of reification generally begins, whereby a child begins to identify with the label itself. This often leads to self and public stigmatization and the commencement of various dynamics associated with social exclusion. Moreover, participants often perceived standardized treatment techniques as disciplining and alienating.

OVERALL CONCLUSION AND CRITICAL CONSIDERATIONS

FOR CLINICAL-FORENSIC PRACTICE

The mutual inclusiveness of juvenile psychopathy and anxiety

Both of our quantitative and qualitative studies indicated that juvenile psychopathy and internalizing psychopathology are *not* mutually exclusive constructs. On the contrary, based on self-report and interview measures, we found that psychopathic traits are unrelated or positively related to various forms of internalizing psychopathology. More specifically, our results did not confirm the hypothesized negative relationship between the core interpersonal and affective traits of psychopathy, and negative affect or affective disorders. As such, our findings contradict the classical idea of a general absence of emotional experiences, anxiety, fear and behavioral inhibition in juveniles meeting the diagnosis of psychopathy (Cleckley, 1976; Karpman, 1959; Lykken, 1957; McCord & McCord, 1956). Moreover, our findings provide no evidence for the existence of affective neuropsychological deficits in juvenile psychopathy as postulated by the dual deficit theory (Fowles, 1980; Fowles & Dindo, 2006).

On the other hand, our results are in line with a growing body of research that points to a positive relationship between psychopathic traits in juveniles and internalizing psychopathology (e.g. Bauer, Whitman, & Kosson, 2011; Kosson, Cyterski, Steuerwald, Neumann, & Walker-Matthews, 2002). Some authors claim that these positive relations

between juvenile psychopathic traits and internalizing psychopathology are due to direct and indirect associations with conduct disorders; i.e. it is argued that conduct disorders are associated with both psychopathic traits and internalizing psychopathology and that internalizing problems are common in adolescents with conduct disorders (e.g. Nijhof, Vermulst, Scholte, van Dam, Veerman, & Engels, 2011; Zoccolillo, Pickles, Quinton, & Rutter, 1992). However, in our opinion this explanation does not sufficiently cover the complex psychodynamics that seem to be at work in the case of juvenile psychopathy.

Based on our chapter on defense mechanisms and our qualitative studies, we venture to postulate that an underlying *anxious position is at the heart of the emergence of psychopathic behavior* in adolescents. Alluding to the idea of Alain de Botton, (2005), with which we opened this dissertation, in our opinion a vast majority of what is called 'juvenile psychopathy' is determined by how a person defends him/herself against anxiety, sadness and traumatic or negatively charged experiences. For example, both in Chapters 4 and 5 we found a relationship between psychopathic traits and the immature defense mechanisms of dissociation and splitting. Based on our clinical work, we reject the possibility that in initial interactions with a juvenile with marked psychopathic traits this anxious position will be disclosed and that he/she will reveal his/her anxieties. Self-disclosure requires much time, particularly in the case of traumatized individuals, and an individual's anxieties will only emerge when a relationship of trust is developed over time (Verhaeghe, 2004). Indeed, in Chapters 5 and 6 we argued that their fundamentally anxious position is concealed (even to themselves on a conscious level[1]) by a defensive mask of grandiosity and a pronounced identification with a primitive image of the virile, fearless, invulnerable and untouchable youngster/criminal. This is their robust self-protecting strategy that allows them to cope with and to survive in a fundamentally disingenuous social world. However, these self-protective strategies suggest the existence of an underlying anxiety of most rudimentary form; i.e. the helplessness of the individual in relation to the enigmatic intentions of significant others and his speechlessness (literally) in relation to past traumatic events and current negatively-charged situations (e.g. witnessing a murder, experiencing violence in the family constellation, losing a friend in ambiguous circumstances). One of our participants formulated it robustly, and in an almost Lacanian way: "I experience anxiety if I ... If I have no clue. As if things are an enigma to me" (Obrad).

The basic distrust and the accompanying defense mechanisms that, in our opinion, are at the heart of juvenile psychopathy tie in with previous conceptualizations and findings of other authors. For example, both Corval (2009) and Meloy (2004) describe how psychopathic individuals might experience persecutory anxiety, which resembles our observation of the juvenile psychopath who feels at risk of falling prey to others' malevolent intentions. Moreover, George Vaillant (1975) interpreted the supposed absence of anxiety and depressive symptoms in terms of defensive processes rather than in terms of affective deficiencies. More recently, a case study of a male psychopathic criminal by Nørbech, Crittenden, and Hartmann (2013) seems to provide additional empirical evidence for Vaillant's theory. These authors argue that the presumed lack of internalizing psychopathology, as well as the presence of dangerous behaviors in psychopaths should be interpreted in terms of self-protective strategies and as developmental outcomes of attempting to protect the self from a series of complex and severe dangers in childhood. More specifically, they thoroughly describe how, in their case, the individual did not lack feelings of agony or anxiety but *deactivated his own inner feelings and denied his own fear and vulnerability to protect the self in the face of danger.* Most interestingly, these authors report that they noticed an astonishing contrast between the individual's self-aggrandizing narrative around crime and violence during the PCL-R interview and his fragmented appearance on the Adult Attachment Interview and the Rorschach, which they interpreted as a partial breakdown of his psychopathic defense mechanisms. This note takes us to our next point, in which we critically consider the pitfalls of diagnosing 'juvenile psychopathy' according to contemporary conceptualizations of the construct and based on today's state of the art assessment instruments.

Perils and pitfalls of diagnosing juvenile psychopathy

During the second round table on child psychopathy, chaired by Karpman (1959), psychiatrist Rabinovitch critically formulated his concerns about the validity of the concept of 'psychopathic behavior' in children:

> *There is a fundamental difficulty in any attempt to discuss current views on psychopathic reactions in children because of the general lack of specificity in the meaning of the term 'psychopathic'.* At the outside I should like to question the

> validity of the term 'psychopathic behavior.' It is usually employed as a general designation for antisocial conduct or delinquency and as such is descriptive only. But at the same a diagnosis in terms of the child's personality is implied. This common usage has tended to cloud basis issues. *Diagnosis on a purely descriptive level, without regard to the child's thought content and inner life, is really no diagnosis at all.* When used descriptively *'psychopathic' provides no more insight into underlying psychological processes* than a listing of such acts as stealing, truancy or fire setting. It is obvious that a particular pattern of behavior *may stem from widely psychological causes and may be seen in children presenting diverse clinical pictures.* (Karpman, 1959, p.57, our italics)

Half a century later hardly anything has changed in this respect, quite the opposite. It can be argued that the current conceptualization and diagnosis of psychopathy barely transcends the descriptive level, and, thus lacks a conceptual framework to explain the underlying psychological and social processes of psychopathic behavior[2]. Based on the findings of our qualitative studies (Chapters 5 and 6) we underscore the importance of debating some of the pitfalls that come with this descriptive conceptualization of psychopathy. First, Hare's conceptualization of psychopathy, and the Psychopathy Checklists in particular, focuses to a great extent on the '*absence*' of a particular phenomenon (e.g., the absence of a wide spectrum of profound emotions, the lack of guilt, remorse and empathy, the absence of deep emotional bonds, and so on). However, the 'non-appearance' of phenomena does not equate to their 'absence.' This was clearly illustrated in our case study in which a wide spectrum of affects emerged as the sessions with the juvenile progressed over time.

Second, in Hare's conceptualization of psychopathy the repetitive engagement in antisocial behavior is a clear indication of the absence of guilt and remorse. Our qualitative studies demonstrate that this is a questionable line of reasoning. For example, our case study indicated that feelings of guilt, shame and regret were not absent, but nonetheless insufficient to prevent future antisocial behavior due to the status these acts have in the juvenile's life. As discussed in Chapters 5 and 6, for these youngsters the world doesn't seem to be structured in a symbolic way, leaving them helpless in relation to the enigmatic intentions of others. In line with Lacan (1993 [1955-56]) we believe that in order to apprehend themselves on the imaginary plane they sharply identify with the primitive, virile, and aggressive image of a cold-blooded, invulnerable, fearless young man/criminal. Among

other defense mechanisms, it is through the antisocial act and through aggression that they position themselves as a subject in relation to other human beings. As such, the absence of behavioral change isn't equivalent to an absence of guilt or conscience.

Furthermore, labeling a young delinquent with a diagnosis of juvenile psychopathy often leads to a short circuit in the exploration of the contextual embedment, subjective logic and signification of the adolescent's anti-social and asocial acts. Among other things, this might be an effect of using tautological assertions and erroneous deductions related to the diagnosis. For example, Hare (2011, p.170) claims: "While some assert that psychopathy is the result of attachment difficulties in infancy, I turn the argument around: In some children the very failure to bond is a symptom of psychopathy. It is likely that these children lack the capacity to bond readily, and that their lack of attachment is largely the result, not the cause, of psychopathy." This is an illogical argument in which the author appears to reify the psychopathy construct. Robert Hare is correct when he states that a failure to establish a social bond *is* a *symptom* of psychopathy (i.e., unstable interpersonal relationships are one of the diagnostic criteria of psychopathy). However, the problem of reification is evident when he argues that this failure to bond is *caused* by psychopathy, as psychopathy only refers to a possible constellation of descriptive characteristics and not to an entity characterized by an objective, organic or biological reality[3]. However, such widely used statements (e.g. 'his irresponsibility is attributable to his psychopathy,' 'his affect poverty is a result of his psychopathic personality profile,' or 'he mistreats animals because he is a fledgling psychopath,' and so on) may lead to clinical practice that lacks any search for the underlying socio-psychological dynamics of juvenile psychopathic behavior. Along with this, the juvenile delinquent may be prevented from taking effective responsibility for his own acts (as a consequence of the belief that 'he acts the way he acts because he is a juvenile psychopath'), as insightfully noted by Voruz and Yang (2012, p.2): "Effective responsibility, in the sense of a responsibility that produces subjective effects within the individual, is first and foremost a *response-ability*: an ability to account for one's actions in terms of a personal, specific causality, rather than a generic one."

Finally, in today's conceptualization of psychopathy the presumed 'inabilities' and 'deficits' on the affective, interpersonal and behavioral level are largely situated *within* the psychopathic individual (e.g. within his broken genes which still have to be discovered), without reference to his socio-cultural context. In this context, Federman, Holmes, and Jacob

(2009) remark that although Hare (2011) postulates that the psychopath's problems are constitutional, and not contextual (e.g. difficult attachment relations), he does not provide any evidence for how a child can become a psychopath all by himself. Further to this remark, our qualitative studies (Chapters 5 and 6), by contrast, demonstrated how the juveniles' affective, interpersonal and behavioral problems were clearly embedded in a complex family constellation and a broader social context, which they perceived as fundamentally hostile and distrustful. Our chapter on the relationship between defense mechanisms and psychopathic traits (Chapter 4) and our qualitative studies (Chapters 5 and 6) indicate that the juveniles' affective and interpersonal 'incapacities' and behavioral problems represent – to some extent 'deficient,' but human – defense mechanisms that enable them to cope with their anxiety and to 'exist' in relation to others, rather than 'inabilities.'

Our final concern relates to the communication of the diagnosis[4] to the person concerned, i.e. in first instance the delinquent juvenile[5]. Through the case example of Attention-Deficit Hyperactivity Disorder we illustrated in Chapter 7, the way in which children and adolescents tend to identify with the initial I-*odd psychiatric label* and the way in which the label begins to function as a lens through which their actions are framed, leaves little space for alternative interpretations. However, in the case of juvenile psychopathy the consequences of communicating such a diagnosis might have even more far-reaching and devastating consequences for the identity development of the youngster. As discussed in Chapters 5 and 6, youngsters with many psychopathic traits tend to identify themselves with the image of an often aggressive, extreme virile and invulnerable young man/criminal. Informing these youngsters that they have the characteristics of a 'fledgling psychopath' might only ratify and perpetuate this type of imaginary identification. It stands to reason that in these youngsters we need to seek out other ways to enable them to identify themselves and acquire more constructive mechanisms to cope with a disingenuous social world, than through identification with the image of a psychopathic delinquent.

If we are aware of the pitfalls related to the diagnosis of juvenile psychopathy, what is the added value of such a diagnostic category for clinical-forensic practice? Broadly speaking, two reasons for the use of this diagnosis can be put forward. First and foremost, we assume that a diagnosis of juvenile psychopathy can inform us about the risk of future delinquency and simultaneously about the dangerousness of the individual in society. Secondly, several authors suggest the need to identify high-risk groups of young delinquents

for the purpose of early treatment and rehabilitation. In the next sections, we will address the current, scientific state of affairs related to these two issues.

On being at risk of dangerous minds and the danger of the notion of dangerousness

The construct of psychopathy is closely related to the notion and/or the perception of dangerousness. Both specialist literature and popular media (for a critical discourse analysis, see: Paulsen, 2010) warn us to be on our guard against the malevolent, violent and dangerous intentions of psychopaths, "for if we can't spot them, we are doomed to be their victims both as individuals and as society" (Hare, 2011, p.19). Compared with non-psychopathic criminals, psychopaths are perceived or at least expected to act more dangerously; to be more difficult to handle within institutions; to commit more violent crimes; and to consciously exploit others' weaknesses (e.g. Cleckley, 1976 ; Hare, 1998, 2011). However, our findings (Chapter 1) did not confirm (or only partially) the expected relationships between psychopathic traits with institutional misconduct and risk of recidivism (as indicators of the general notion of 'dangerousness'). For example, in Chapter 1 we demonstrated that in our referred sample psychopathic traits[6] were unrelated to both serious violations of the institution rules and violent behavior in the institution. Minor violations of the institution rules (e.g. impolite table manners) were significantly related to the Lifestyle and Antisocial dimensions of psychopathy and total PCL:YV scores, but unrelated to the core Affective and Interpersonal characteristics. Moreover, there were no significant differences between those youngsters who re-offended after release from the institution an those who didn't relapsed in terms of PCL:YV total and factor scores, except for the Antisocial Factor of psychopathy. Reoffenders had significantly higher scores on the Antisocial dimension of psychopathy, compared to the non-reoffenders. On the other hand, self-reported psychopathic traits were significantly, but moderately related to self-reported *past* violent and serious violent offenses (Chapter 2). In general, these findings are consistent with ample research demonstrating, both in adult and adolescent samples, that there is indeed a (significant) correlation between psychopathy with past and future criminal behavior and risk of future violence towards others, but that *the explanatory and predictive power of an elevated psychopathy score is only limited* or moderate (e.g. Edens, Skeem, Cruise, & Cauffman, 2001; Leistico , Salekin, DeCoster, & Rogers, 2008). Indeed, in line with

our findings, previous studies in adult samples indicated that the *core psychopathic traits* (i.e. the Interpersonal and Affective characteristics) *are not decisive in the prediction of recidivism and institutional misconduct*, whereas the Antisocial dimension has more power in predicting future offenses and institutional misbehavior (e.g. Kennealy, Skeem, Walters, & Camp, 2010; Leistico et al., 2008; Walters, 2003).

Altogether, these findings bring us to conclude that there are ethical problems in using risk assessments or making long-term judicial decisions about a juvenile offender based exclusively on his total psychopathy score. This is also the main conclusion of Cooke and Michie's illuminating study (2010) on the limitations of the predictive utility of the PCL-R in individual cases. In a sample of 184 male prisoners, they empirically demonstrated how the prediction of future offending in an individual case cannot be achieved with any degree of confidence. For example, they showed that a PCL-R score of 30 was associated with a 45% risk of violent recidivism within 29 months. Examination of the 95% confidential intervals (CIs) for the estimate of the mean rate of reconviction indicated that for an average PCL-R score of 30, the 95% CI was 21-70%. At a group level this means, that 95% of the male prisoners with a PCL-R score of 30 have a risk of recidivism somewhere between 21% and 70%. However, at the level of the individual, Cooke and Michie (2010) also estimated the CIs for the likelihood that an individual would be reconvicted. The authors found that for an individual with a PCL-R score of 30 the 95% CI was 0-99.5%. This means that in 95% of the cases with a PCL-R score the risk of recidivism lies between 0% and 99.5%.

Taking into account the limited predictive validity of total psychopathy scores and of the separate psychopathy dimensions, further research is needed into other possible factors, besides psychopathy, that can predict and thus prevent future violence or criminal offenses. An additional problem, in our opinion, is that to date we lack a robust conceptual framework concerning *how* to understand the complex relationship between psychopathic traits and antisocial conduct. In our qualitative studies (Chapters 5 and 6) we attempted this. For example, we discussed that the youngster's passing to the antisocial act might *also* have a separating and identity lending function, as it enables him to keep an enigmatic and distrustful other at a safe distance. Furthermore, we want to express our reticence regarding the use of the term 'dangerousness' in the context of (juvenile) psychopathy. There is no doubt that some individuals with psychopathic traits are dangerous, both to themselves and society, but the concepts of psychopathy and dangerousness are definitely not

interchangeable as our findings illustrate. Moreover, we agree with Saleem Shah (1981) who suggests that there are dangers or pitfalls inherent to the use of the notion of "dangerousness" because the term is not morally neutral, it is too vague and, as such, it is open to misinterpretation:

> Notions of 'dangerousness' are closely related to particular value systems, as well as philosophical, moral and ideological perspectives. Clearly the major values and sociopolitical process in a society will tend to determine what will be perceived, defined, and officially labeled as dangerous, and how conditions and behaviors so labeled will be handled. However, the term 'dangerousness' is rather vague and often receives surplus meanings and varying interpretations. Indeed it has been suggested that, like beauty, dangerousness lies in the eye of the beholder" (p. 235).

Additionally, the association between psychopathy and the notion of dangerousness is quite likely unconscious, and as such might have unintended, but negative consequences for clinical or psychotherapeutic work with delinquents with psychopathic traits. As illustrated in Chapter 7, people with a psychiatric diagnoses often experience public or societal stigmatization (Corrigan & Watson, 2002). Certain stereotypes (and prejudice) about people with a diagnostic label often carry the idea they are dangerous, violent, as well as responsible and in control of the perseverance of the disorder (Corrigan et al., 2000; Corrigan , Watson, & Barr, 2006). This often leads to discrimination, such as social exclusion, social segregation, bullying, and scapegoating (Ben-zeev, Young, & Corrigan, 2010; Link, 1987). In the case of psychopathy, it is demonstrated in literature that the deceptive and manipulative characteristics assumed in individuals with psychopathic traits evoke mistrust, suspicion, and hostile counter-transferential reactions in clinicians working with them (Seto & Quinsey, 2006). This brings us to our final point of consideration: the 'state of the art' of the treatment of delinquents with psychopathic traits.

Pursuing the juvenile psychopath to cure him or to control his antisocial symptoms?

As stated above, a growing number of authors urge for the development of reliable and time-efficient assessment instruments to identify high-risk groups of juvenile offenders for the purpose of early treatment and rehabilitation (e.g. Andershed et al., 2002). Our

psychometric study (Chapter 2) indicated that the YPI-S is promising to that end. However, research into the treatment modalities for psychopathy is almost non-existent, both at the child and the adult level, when compared to the high number of validity studies and studies into the relationship between psychopathy and risk of recidivism. Moreover, a therapeutic pessimism and nihilism still prevails, with many authors claiming that psychopathy is an untreatable condition or others even suggesting that therapy may improve a psychopath's criminal strategies and may worsen his psychopathic characteristics (e.g. Harris & Rice, 2006; Suedfeld & Landon, 1978). However, there is little empirical evidence to support this therapeutic pessimism. For example, based on a review of 42 studies (including several old case studies, quasi-experimental designs, and control studies), Salekin (2002) found that on average 62% of the psychopathic patients benefitted from psychoanalytic, cognitive-behavioral or eclectic long-term and intensive individual therapy. Improvements were observed in different domains (often varying according to the type of therapy received); e.g. improvement of interpersonal relationships, maintaining a job, the emergence of feelings of remorse and guilt, decreased tendency to lie, etc.). In addition, based on a more recent review, Salekin, Worley and Grimes (2010) found that that the treatment of psychopathic youth appears promising. However, in our opinion, the scarce amount of current research into the effectiveness of treating juvenile psychopathy, focuses too much on treatment compliance and recidivism (Salekin, Worley, & Grimes, 2010; Salekin, Tippey, & Allen, 2012). Other possible positive therapeutic effects (e.g. the improvement of interpersonal relationships, an increased ability to express (negative) emotions or to cope in a more constructive way with negatively-charged life events, and so on) are often not taken into account. Today's therapy research, in its main focus on controlling antisocial symptoms, therefore provides little or no insight into what exactly could be effective in bringing about change at the level of the personality or the affective and interpersonal life of the youngster. Moreover, even though it is well known that the quality of the therapeutic relationship is one of the most powerful predictors of successful therapy (e.g. Roth & Fonagy, 2006), today's research on therapy efficacy barely explores what may contribute to the installation of such a trustful therapeutic alliance with a juvenile delinquent with psychopathic traits. In this context, the findings from our qualitative studies (Chapters 5 and 6) which demonstrate that these youngsters are afraid of falling prey to the malevolent and enigmatic intentions of others might be instructive for clinical practice and may offer ideas on how an effective

therapeutic relationship could be installed. Our qualitative studies suggest that a particular ethical position on the side of the therapist may be decisive for the installation of a trustful therapeutic alliance, i.e., the position of a non-judgmental listener, who refrains from understanding all too quickly, and as such gives response-ability to the subject.

LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FUTURE RESEARCH

Limitations of the present study

The studies presented in this dissertation have a number of limitations that should be addressed. Our quantitative studies (Chapters 2, 3 and 4) used a *cross-sectional design*, wherein causal interpretations of the relationships between psychopathic traits and various forms of antisocial, externalizing and internalizing psychopathology were not made. Moreover, in the community sample we only used self-report measures for the assessment of psychopathic traits, and different types of internalizing and externalizing psychopathology. Although there is evidence that the reliability and validity of self-report questionnaires for the assessment of psychopathology increases in adolescence (Kamphaus & Frick, 2002), the use of self-report measures may have confounded the relationship between psychopathy and different measures of psychopathology for three reasons: (a) the deceptive behaviors of individuals with psychopathic traits renders self-report measures particularly vulnerable, (b) it might be problematic to ask individuals who have never experienced internalizing problems to (self-) report on their absence (Lilienfeld & Fowler, 2006), and (c) it has been argued that questionnaires on anxiety and depression actually measure general distress instead of particular symptoms of anxiety and depression (Coyne, 1994). Future research could address these limitations by including parent and teacher ratings or interview-based measures, such as the Diagnostic Interview Schedule for Children (DISC).

Secondly, the *sample size of our referred sample* was too small to draw robust conclusions from our quantitative analysis (Chapters 1, 2 and 3). Moreover, although excellent inter-rater reliability was demonstrated for the Psychopathy Checklist: Youth

Version, we were not able to investigate the factor structure underlying this instrument due to the low number of observations. For the same reason we were not able to investigate the factor structure of the Youth Psychopathic Traits Inventory (YPI) and the YPI-Short Version (YPI-S) in the referred sample by means of Confirmatory Factor Analysis, unlike our large community sample. Future research should examine the psychometric properties of the YPI-S in large referred samples of adolescents.

Third, in the referred sample both the PCL:YV and DISC interviews were carried out by the same researcher. Although we didn't find the expected relationship between PCL:YV and DISC-scores, nevertheless this relationship may be the result of *rater bias*. However, we tried to avoid this problem by scoring the DISC twice (for n=15): our first rating was based on the score sheets that we completed during the interview itself, and the second rating by the same researcher, approximately one year later, was based on verbatim transcriptions of the DISC interviews done by Master's level students. A comparison of these two different ratings indicated that the assessment of internalizing psychopathology by means of the DISC was reliable.

Our fourth concern relates to the *generalizability and replicability of our findings*, in particular those in relation to our referred sample. This sample mainly consisted of persistent juvenile offenders. This group may not be representative of the majority of adolescent male offenders. Future research should include more heterogeneous samples of both frequent and first time offenders. Moreover, our findings cannot be generalized to female adolescent offenders. In relation to the replicability of our qualitative studies on psychopathy (Chapters 5 and 6), it should be noted that in qualitative research, a transference relation between the researcher and participants, and the emotional investment of the researcher, is essential to facilitate participants' ability to articulate their experiences (Braun & Clarke, 2006). In this respect, the findings of our qualitative studies are related to the position of the researcher towards his/her 'subject.' As mentioned before, our attitude towards the juvenile delinquents can be described as non-judgmental and empathic. Moreover, participants were at no time forced to speak, they were invited. If other researchers wish to replicate our studies in similar or different samples they should take into account the particular position that we took on in our studies.

Fifth, it could be argued that the psychopath's tendency to manipulate and to feed researchers and clinicians with socially desirable answers (Hare, 1991) might have weakened the reliability of our findings in the qualitative studies on psychopathy (Chapters 5 and 6). However, we do not believe that this was the case for several reasons. First and foremost, a number of our participants have contacted the researcher for further counseling, even at a time that they had been acquitted for further prosecution, thus indicating that there were no instrumental motives behind their request. Furthermore, we are aware that, especially at the beginning of the therapeutic process, participants told lies and as such could be deemed deceptive. However, it is important to note that these lies were related to the fact a trustful therapeutic alliance was not yet installed, as they themselves explained in later sessions. As discussed in Chapter 6, in that context we made no moral issue of telling lies. Third, the sessions were on a voluntary basis and participants were well aware that a participation in the research project could not in any way affect their juridical process or sentence, either positively nor negatively.

Sixth, in Chapter 4 we investigated the relationship between defense mechanisms and psychopathic traits in a non-referred sample of adolescents based on self-report measures. This study should be replicated in a referred sample of adolescents, and by means of both the YPI-S and the PCL:YV. Furthermore, defense mechanisms should be assessed using instruments other than self-report questionnaires alone.

Additional suggestions for future research

Our research provided us with several new questions that could be interesting starting points for future research and new initiatives in the study of juvenile psychopathy.

On several occasions we argue that in today's research the social and contextual embedment of an individual's psychopathic behavior is often neglected. Although we have attempted to study psychopathic behavior and characteristics within the context of interpersonal relationships (by taking into account the youngster's history, his family constellation, and so on), an in-depth study of the complex concept of (juvenile) psychopathy requires a more thorough socio-constructivist approach. Questions that we had to leave unanswered within the scope of this dissertation include: 'Is psychopathy a problem of an individual and/or is it a consequence of a certain zeitgeist and/or social context?'

'What is the relation between the emergence of psychopathic-like traits and cultural/ethnical background?' 'Are some cultures more prone to exhibit psychopathic-like traits as a consequence of a history of migration and war?' It would be interesting if scientists from diverse disciplines (e.g. ethicists, social workers, researchers in special education/orthopedagogics, psychologists, sociologists, philosophers, criminologists, historians, etc.) collaborated to obtain a more nuanced insight into the psychological and social dynamics underlying psychopathy.

In Chapter 3 we found significant relationships between psychopathic traits and thought problems. Moreover, several of our findings from our qualitative studies (e.g. the lack of a symbolic structuring of the juvenile's social world, the confrontation with an enigmatic other…) point to a possible relationship between psychopathy and an underlying psychotic functioning. This could be addressed in future research.

Next, during our clinical work several juveniles openly 'confessed' to offenses they had committed but were not known by the court/police. In Chapter 6 we interpreted these confessions in terms of reliability tests. An alternative interpretation could be that these confessions are effects of unconscious feelings of guilt. For example, Theodor Reik (1945), argues that because of unconscious guilt, criminals often leave clues that can lead to their identification or arrest. According to us, this could be an interesting starting point for future research, as it is generally assumed that psychopathic individuals are free from feelings of guilt.

Finally, we think that the time has come for more systematic research into the effectiveness of therapy with juvenile psychopaths. Single case studies and other qualitative research designs that offer in-depth contextualized insight into the therapeutic process are lacking in today's scientific literature on psychopathy.

A final suggestion for researchers and clinicians

To conclude, as researchers in the *humanities*, we want to make a plea for a more *humanizing* scientific study and treatment of these juvenile psychopaths. A plea for an ideographic scientific and clinical approach in which there is space for the juvenile to speak

about and grasp his own often diffuse story, where there is time for the youngster to discover and to *respond* according to his own subjective logic and take *responsibility* for his own (antisocial) acts. This is because it is precisely through an authentic encounter with these 'troublesome' youngsters that researchers and clinicians can see that they are primarily human beings, and that nothing human is really alien to them, not even anxieties. It is our hope that this dissertation will inspire other researchers and clinicians to "take this walk on the wild side." It will be an enriching journey, at least, this was definitely the case for me.

Julie De Ganck, June 2014

NOTES

1. For example, in Chapter 3, we found in the community sample that the psychopathic-like group scored significantly higher on an anxiety questionnaire (i.e. DASS-21) measuring mainly the autonomic arousal and skeletal musculature effects (e.g. trembling hands, palpitations) associated with anxiety. However, this elevated score was not reflected in scores on the STAI which assess to a greater extent the subjective experience of anxiety (e .g. 'I *feel* safe').
2. It is instructive to read Hare's (2011) "Without Conscience: The Disturbing World of the Psychopaths Among Us" to understand that his conceptualization of psychopathy is nothing more than an elaborated description of the 20 diagnostic criteria included in the PCL:R and PCL:YV. In other words, psychopathy as it is conceptualized to-date refers only to a possible assembly of affective, interpersonal, lifestyle and antisocial characteristics.
3. The same process of reification of descriptive categories was observed in the case of AHDH (Chapter 7).
4. It should be noted that in case of children or adolescents we cannot set a psychopathic personality diagnosis, we can only speak of a high number of psychopathic traits, or an elevated score on an instrument measuring psychopathic characteristics.
5. Based on our work in the clinical forensic field and our study of the judicial records of the delinquents in our referred sample, it is our *impression* that the assessment of psychopathic traits becomes more and more part of the diagnostic protocol in Youth Detention Centers. Moreover, these diagnostic reports are added to the official legal records of the youngsters. On one occasion, we witnessed how a young delinquent was confronted with his elevated scores on the PCL:YV during the course of a public hearing (own field notes, October 2011).
6. Total PCL:YV scores and scores on the individual dimensions.

REFERENCES

Andershed, K. M., Stattin, H., & Levander, S. (2002). Psychopathic traits in non-referred youths: initial test of a new assessment tool. In S. Blaauw (Ed.), *Psychopaths: current international perspectives.* The Hague: Elsevier.

Bauer, D. L., Whitman, L. A., & Kosson, D. S. (2011). Reliability and Construct Validity of Psychopathy Checklist: Youth Version Scores among Incarcerated Adolecent Girls. *Criminal Justice and Behavior, 10*, 965-987.

Ben-zeev, D., Young, M. A., & Corrigan, P. W. (2010). DSM-V and the stigma of mental illness. Journal of Mental Health, 19, 318-327.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Cleckley, H. (1976). *The Mask of Sanity* (Fifth Ed.). Saint Louis: The C.V. Mosby Company.

Cooke, D., & Michie, C. (2001). Refining the construct of psychopathy: Toward a hierarchical model. *Psychological Assessment, 13*, 171-188.

Cooke , D. J., & Michie, C. (2010). Limitations of diagnostic precision and predictive validity in the individual case: A challenge for forensic practice. *Law and Human Behavior, 34*, 259-274.

Corrigan , P. W., & Watson, A. C. (2002). The Paradox of Self-Stigma and Mental Illness. *Clinical Psychology - Science and Practice, 9*, 35-53.

Corrigan , P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., et al. (2000). Stigmatizing attributions about mental illness . *Journal of Community Psychology, 28*, 91-102.

Corrigan , P. W., Watson, A. C., & Barr, L. (2006). The Self-Stigma of Mental Illness: Implications for Self-Esteem and Self-Efficinacy. *Journal of Social and Clinical Psychology, 25*, 875-884.

Corr, P. J. (2010). The psychoticism-psychopathy continuum: A neuropsychological model of core deficits. *Personality and Individual Differences, 48*, 695-703.

Corval, P. (2009). *Violence, psychopathie et socioculture.* Paris: L'Harmattan.

Coyne, J. C. (1994). Self-report distress: Analog or ersatz depression? *Psychological bulletin, 116*, 29-45.

de Botton, A. (2005). *Status Anxiety.* London: Penguin Books.

Edens, J. F., Skeem, J. L., Cruise, K. R., & Cauffman, E. (2001). Assessment of "Juvenile Psychopathy" and Its Association with Violence: A Critical Review. *Behavioral Sciences and the Law, 19*, 53-80.

Federman, C., Holmes, D., & Jacob, J. D. (2009). Deconstructing the Psychopath: A Critical Discursive Analysis. *Cultural Critique, 72*, 36-65.

Fowles, D. C., & Dindo, L. (2006). A dual-deficit model of psychopathy. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 14-34). New York: Guildford Press.

Fowles, D. C. (1980). The three arousal model: Implications of Gray's two-factor learning theory for heart rate, electrodermal activity, and psychopathy. *Psychophysiology, 17*, 87-104.

Hare, R. D. (1991). *Manual for the Hare Psychopathy Checklist-Revised*. Toronto: Multi-Health Systems.

Hare, R. (1998). Psychopaths and Their Nature: Implications for the Mental Health and Criminal Justice Systems. In T. Millon, E. Simonson, M. Birket-Smith, & R. Davis (Eds.), *Psychopathy: Antisocial, Criminal, and Violent Behavior.* New York: Guilford Press.

Hare, R. (2011). *Without Conscience: The Disturbing World of the Psychopaths Among us* (EPUB format). New York: Guilford Press.

Harris, G. T., & Rice, M. E. (2006). Treatment of psychopathy: A review of empirical findings. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 555-572). New York: Guilford.

Hawes, D. J., & Dadds, M. R. (2005). The treatment of conduct problems in children with callous-unemotional traits. *Journal of Consulting and Clinical Psychology, 73*, 737-741.

Kamphaus, R. W., & Frick, P. J. (2002). *Clinical assessment of children's personality and behavior* (Second Ed.). New York, NY: Allyn & Bacon.

Karpman, B. (1959). *Symposia on Child and Juvenile Delinquency. Presented at the American Orthopsychiatric Association.* Washington, D.C.: Psychodynamics Monograph Series.

Kennealy, P. J., Skeem, J. L., Walters, G. D., & Camp, J. (2010). Do core interpersonal and affective traits of PCL-R psychopathy interact with antisocial behavior and desinhibition to predict violence. *Psychological Assessment, 22*, 569-580.

Kosson, D. S., Cyterski, T. D., Steuerwald, B. L., Neumann, C., & Walker-Matthews, S. (2002). The reliability and validity of the Psychopathy Checklist: Youth Version in non-incarcerated adolescent males. *Psychological Assessment, 14*, 97-109.

Lacan, J. (1993 [1955-56]). *The Seminar 1955-1956, Book III, The Psychosis.* New York & London: W.W. Norton.

Leistico , A. M., Salekin, R. T., DeCoster, J., & Rogers, R. (2008). A Large-Scale Meta-Analysis Relating the Hare Mesaures of Psychopathy to Antisocial Construct. *Law and Human Behaviour, 32*, 28-45.

Lilienfeld, S. O., & Fowler, K. A. (2006). The self-report assessment of psychopathy: Problems, pitfalls, and promises. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 107-132). New York: Guildford Press.

Link, B. G. (1987). Understanding Labeling Effects in the area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection. *American Sociological Review, 52*, 96-112.

Lykken, D. T. (1957). A study of anxiety in the sociopathic personality. *Journal of Abnormal and Social Psychology, 55*, 6-10.

McCord, W., & McCord, J. (1956). *Psychopathy and Delinqency.* New York: Grune & Stratton.

Meloy, J. R. (2004). *The psychopathic mind: Origins, dynamics, and treatment.* Lanham, MD: Rowman & Littlefield.

Miller, J. A. (2011). Santé Mentale et Ordre Public. *Pipol News, 27*, 1-24.

Nijhof, K. S., Vermulst, A., Scholte, R. H., van Dam, C., Veerman, J. W., & Engels, R. C. (2011). Psychopathic Traits of Dutch Adolescents in Residential Care: Identifying Subgroups. *Journal of Abnormal Child Psychology, 39*, 59-70.

Norbech, P. C., Crittenden, P. M., & Hartmann, E. (2013). Self-Protective Strategies, Violence and Psychopathy: Theory and a Case Study. *Journal of Personality Assessment, 95*, 571-584.

Patrick , C. J., Bradley, M. M., & Lang, A. R. (1993). Emotions in the criminal psychopath: startle reflex modulation. *Journal of Abnormal Psychology, 102*, 82-92.

Patrick, C. J. (1994). Emotion and psychopathy: startling new insights . *Psychophysiology, 31*, 319-330.

Patrick, C. J. (2007). Getting to the heart of psychopathy. In H. Hervé, & J. C. Yuille (Eds.), *The psychopath: Theory, research, and practice* (pp. 207-252). New York: Lawrence Erlbaum Associates.

Paulsen, R. (2010). Mediated Psychopathy -A Critical Discourse Analysis of Newspaper Representations of Agression. *Kritike, 4*, 60-86.

Reik, T. (1945). *The Unknown Murderer.* New York: Prentice-Hall.

Roth, A., & Fonagy, P. (2006). *What works for whom? A critical review of psychotherapy research.* New York: The Guilford Press.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism: Clinical lore or clinical reality? *Clinical Psychology Review, 22*, 79-112.

Salekin, R. T., Tippey, J. G., & Allen, A. D. (2012). Treatment of conduct problem youth with interpersonal callous traits using mental models: Measurement of risk and change. *Behavioral Sciences and the Law, 30*, 470-486.

Salekin, R. T., & Lynam, D. R. (2010). Child and Adolescent Psychopathy: The Road Ahead. In R. T. Salekin, & D. R. Lynam (Eds.), *Handbook of Child and Adolescent Psychopathy* (pp. 399-420). New York: The Guilford Press.

Salekin, R. T., Worley, C., & Grimes, R. T. (2010). Treatment of Psychopathy: A Review and Brief Introduction to the Mental Model Approach for Psychopathy. *Behavioral Sciences and the Law, 28*, 235-266.

Seto, M.C., & Quinsey, V.L. (2006). Toward the Future. Translating Basic Research into Prevention and Treatment Strategies. In C.J. Patrick (Ed.), *The Handbook of Psychopathy* (pp. 589-601). New York: The Guilford Press.

Sevecke, K., & Kosson, D. S. (2010). Relationships of child and adolescent psychopathy to other forms of psychopathology. In R. T. Salekin, & D. R. Lynam (Eds.), *Handbook of child & adolescent psychopathy* (pp. 284-314). New York: The Guilford Press.

Suedfeld, P., & Landon, P. B. (1978). Approaches to treatment. In R. D. Hare, & D. Schalling (Eds.), *Psychopathic behavior: Approaches to research* (pp. 347-378). New York: Wiley.

Vaillant, G. E. (1975). Sociopathy as a human process: A viewpoint. *Archives of General Psychiatry, 32*, 178-183.

van Baardewijk, Y., Andershed, H., Stegge, H., Nilsson, K. W., Scholte, E., & Vermeiren, R. (2010). Development and tests of short versions of the youth psychopathic traits inventory and the youth psychopathic traits inventory-child version. *European Journal of Psychological Assessment, 26*, 122-128.

Verhaeghe, P. (2004). *On being normal and other disorders. A manual for clinical psychodiagnostics.* New York: Other Press.

Voruz, V., & Yang, S. (2012). Introduction: revisiting the question of madness. In F. Biagi-Chai, *Serial Kilers. Psychiatry, Criminology, Responsibility* (pp. 1-15). Abingdon, Oxon: Routledge/a GlassHouse book.

Walters, G. D. (2003). Predicting insitutional adjustment and recidivism with the Psychopathy Checklist factor scores: A meta-analysis. *Law and Human Behavior, 27*, 541-558.

Zoccolillo, M., Pickles, A., Quinton, D., & Rutter, M. (1992). The outcome of childhood conduct disorder: Implications for defining adult personality disorder and conduct disorder. *Psychological Medicine, 22*, 971-1086.

TERECHT OPSTANDIG: EEN EMPIRISCHE STUDIE NAAR DE AFFECTIEVE EN INTERPERSOONLIJKE DYNAMIEKEN VAN PSYCHOPAAT GEDRAG EN DE BELEVING VAN PSYCHIATRISCHE LABELS BIJ JONGEREN

Het grootste deel van wat we 'persoonlijkheid' noemen,
wordt gedetermineerd door hoe we onszelf
verdedigen tegen angst en zielenleed.
—Alain de Botton, *Status Anxiety* (2005, eigen vertaling)

DOELSTELLING VAN DE HUIDIGE STUDIE

Volgens de psychoanalyse is *angst* het basisaffect van de mens. Meer nog, het is door de primordiale angst dat een kind zich ontwikkelt, een taal en identiteit verwerft en uiteindelijk mens wordt *in relatie tot* andere mensen (Verhaeghe, 2004). Freud (1978 [1926d]) beschouwde de reactie van de mens tot extern gevaar en interne bedreiging (de eigen driften die een intern onevenwicht, onlust en pijn veroorzaken) als een prototype van angst. Door de biologische hulpeloosheid van het kind in relatie tot zijn eigen driften is hij genoodzaakt een appèl te doen op significante anderen om het intern evenwicht te herstellen en om te overleven. Angst verschijnt wanneer het antwoord van de ander ontbreekt of tekortschiet (Verhaeghe, 2004). Vanaf de geboorte van de mens, verschijnt angst dus binnen de relatie tussen individu en significante anderen.

Het is dan ook interessant op te merken dat één van de belangrijkste studieonderwerpen binnen het psychopathie onderzoek precies de angst, of eerder de studie naar de 'afwezigheid van angst' betreft. Verschillende vroegere grondleggers van het huidig psychopathieconcept poneerden dat psychopathie zowel bij volwassenen als bij jongeren gekarakteriseerd wordt door een opmerkelijke afwezigheid van angst, intrapsychisch conflict (Cleckley, 1976; Karpman, 1959; McCord & McCord, 1956) en vrees (Lykken, 1957). Deze vroege conceptualiseringen werden verder uitgewerkt en genuanceerd binnen recentere theorieën over de relatie tussen psychopathie en internaliserende psychopathologie (o.a. Corr, 2010; Fowles & Dindo, 2006; Patrick, 1994; Patrick, 2007 ;

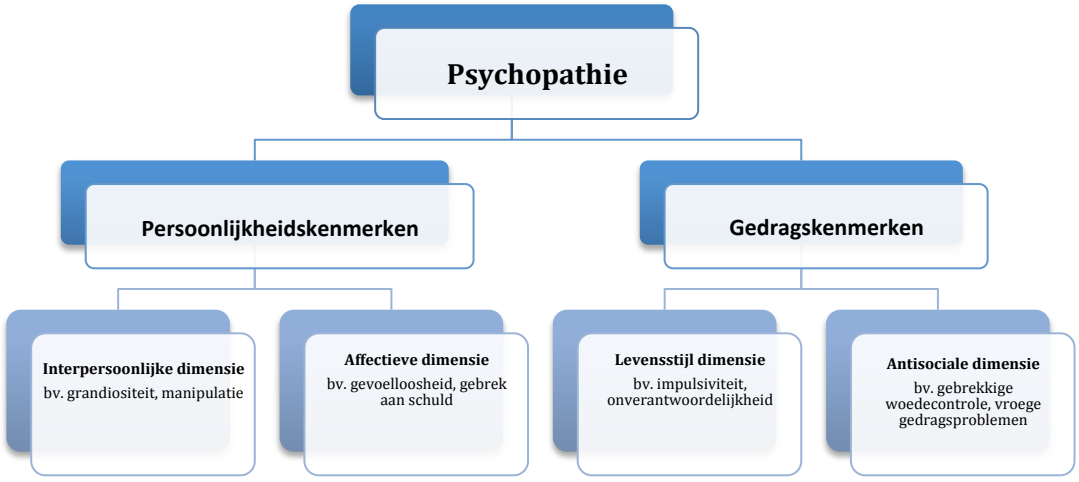
Patrick, Bradley, & Lang, 1993). Deze doctoraatsverhandeling sluit aan bij deze onderzoekstraditie en stelt de vraag naar het verband tussen psychopate trekken en internaliserende psychopathologie bij jongeren centraal. Bijkomend exploreren we indirect de potentiële impact van een diagnostisch label, zoals psychopathie, op de identiteitsontwikkeling van jongeren.

In ons introducerend hoofdstuk illustreerden we dat eerder empirisch onderzoek naar *de relatie tussen juveniele psychopathie en negatief affect* inconsistente resultaten opleverde (o.a. Salekin & Lynam, 2010; Sevecke & Kosson, 2010). Terwijl juveniele psychopathie doorgaans gedefinieerd wordt door een constellatie van drie (Cooke & Michie, 2001) of vier (Hare, 2003) met elkaar verbonden dimensies of factoren (zie Figuur 1), adresseerden slechts enkele studies hoe deze afzonderlijke dimensies van juveniele psychopathie geassocieerd zijn met internaliserende psychopathologie. Op basis van recente theorieën (o.a. Corr, 2010; Fowles & Dindo, 2006) kan echter verondersteld worden dat de Interpersoonlijke en Affectieve dimensies negatief gerelateerd zijn aan internaliserende psychopathie, terwijl de Levensstijl en Antisociale dimensies positief gerelateerd zouden zijn aan negatief affect. Voorafgaande studies adresseerden dit verschil doorgaans niet door het gebruik van totaalscores voor psychopathie. Bovendien gebruikten de meeste voorgaande studies zelfrapportage instrumenten voor minstens één van beide concepten (d.w.z. psychopathie en internaliserende psychopathologie). We merkten hierbij op dat beide aspecten (gebruik van totaalscores en gebruik van zelfrapportagematen) mogelijks de geobserveerde relatie tussen juveniele psychopathie en negatief affect beïnvloedden.

Binnen dit proefschrift hebben we getracht de beperkingen uit voorgaand onderzoek te adresseren door een mixed method ontwerp te hanteren, waarbij we kwantitatieve en kwalitatieve onderzoeksmethoden combineerden. Bovendien gebruikten we meerdere meetinstrumenten voor de beoordeling van zowel psychopate trekken als negatief affect. Tenslotte brachten we zowel de totale psychopathiescores als de scores op de afzonderlijke dimensies van psychopathie in rekening. Voor de studie van het verband tussen internaliserende psychopathologie en psychopate trekken gebruikten we twee steekproeven: (1) een niet-klinische steekproef van 1670 schoolgaande jongeren tussen 12 en 18 jaar, en (2) een klinische steekproef van 62 delinquente jongeren tussen 14 en 18 jaar.

Figuur 1

Schematische voorstelling van de verschillende dimensies van juveniele psychopathie



Bijkomend bediscussieerden we in ons introducerend hoofdstuk dat het concept van juveniele psychopathie een moreel beladen construct is, en hoe een diagnose van psychopathie mogelijks resulteert in sociale en andere uitsluitingsprocessen. Huidig onderzoek bestudeert echter nauwelijks de potentieel negatieve impact van dergelijk psychiatrisch label op de identiteitsontwikkeling van jongeren. Binnen dit proefschrift beoogden we daarom bijkomend de effecten van een psychiatrische diagnose op de geleefde ervaringen van jongeren te onderzoeken, aan de hand van het praktijkvoorbeeld van aandachtstekort-hyperactiviteitstoornis (ADHD). Voor het behandelen van deze onderzoeksvraag gebruikten we een heterogene steekproef die bestond uit 17 jongeren met gedragsproblemen en een zelf-gerapporteerde of klinische diagnose van ADHD. Deelnemers werden geselecteerd uit 2 instellingen: (1) een internaat voor jongeren met emotionele of gedragsproblemen, en (2) een instelling voor delinquente adolescenten.

OVERZICHT VAN DE BEVINDINGEN

In *hoofdstuk 2* onderzochten we de betrouwbaarheid, factor structuur en meetinvariantie van zowel de Youth Psychopathic Traits Inventory (YPI; Andershed, Kerr, Stattin, & Levander, 2002) als van de recentere YPI-Short Version (YPI-S ; van Baardewijk,

Andershed, Stegge, Nilsson, Scholte, & Vermeiren, 2010). Beide zelfrapportagevragenlijsten zijn gebaseerd op het drie-factoren model van psychopathie (Cooke & Michie, 2001) dat bestaat uit een Grandioos-Manipulatieve (GM), een Callous-Unemotional[1] (CU) en een Impulsief-Onverantwoordelijke factor (II). Globaal beschouwd, was de interne consistentie van de subschalen beter voor de YPI-S dan voor de YPI. We gebruikten Confirmatorische Factor Analyse (CFA) om de drie-factor structuur van de YPI en de YPI-S te evalueren. CFA's confirmeerden de drie-factor structuur van de YPI-S in de niet-klinische steekproef, voor jongens en meisjes, en voor leerlingen uit het Buitengewoon Onderwijs (BO) en het Algemene Secundair Onderwijs (ASO) afzonderlijk. De latente factoren van het YPI-S model waren moderaat gecorreleerd, wat verder evidentie oplevert voor de validiteit van het drie-factoren model voor de YPI-S. CFA (waarbij de YPI items als manifeste variabelen gebruikt werden) gaf aan dat de model fit voor het YPI factor model suboptimaal was in de niet-klinische steekproef. Voor zowel de YPI als de YPI-S bleek de factor structuur invariant voor jongens en meisjes enerzijds, en voor BO en ASO anderzijds. Met betrekking tot de convergente validiteit werden twee conceptueel relevante correlaties genoteerd tussen de YPI-S en de Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003). Tenslotte werd de criterium validiteit van de YPI-S bevestigd door verschillende significante correlaties tussen de YPI-S en verschillende vormen van externaliserend en antisociaal gedrag in zowel de klinische als niet-klinische steekproef. Deze bevindingen gaven aan dat de YPI-S in onze volgende studies kon gebruikt worden als een valide en betrouwbaar instrument om psychopate trekken te meten bij adolescenten.

Hoofdstuk 3 betrof een empirische, kwantitatieve studie naar de relatie tussen psychopate trekken, internaliserende psychopathologie (bv. depressie, angst en stress), alexithymie en gedachteproblemen in de klinische en niet-klinische steekproef van adolescenten. In beide steekproeven werden psychopate trekken gemeten aan de hand van de YPI-S, en andere psychopathologische problemen aan de hand van een uitgebreide testbatterij van zelfrapportagematen. In de steekproef van delinquente jongeren werden psychopate trekken en internaliserende psychopathologie bijkomend gemeten aan de hand van respectievelijk de PCL:YV en een semi-gestructureerd interview. Clusteranalyse identificeerde in de niet-klinische steekproef 5 subgroepen die significant van elkaar verschilden in termen van hun specifieke constellatie van psychopate trekken. De psychopathie-achtige groep verschilde van de andere groepen in termen van externaliserend

gedrag, een variabele die ook volwassen psychopathie karakteriseert. Anderzijds gingen verschillende van onze resultaten in tegen de traditionele hypothese dat juveniele psychopathie negatief geassocieerd is met negatief affect. In de niet-klinische steekproef scoorde de psychopathie-achtige groep bijvoorbeeld significant hoger dan de normale groep op DASS-21 depressie, angst en stress. We kwamen tot gelijkaardige bevindingen in de steekproef van delinquente jongeren, waarbij alle correlaties tussen zelfgerapporteerde internaliserende psychopathologie en psychopate trekken niet significant of positief waren. Tevens was de relatie tussen psychopate trekken en internaliserende psychopathologie niet significant wanneer we gebruik maakten van interview maten. Deze bevindingen suggereren dat de inconsistente resultaten uit voorgaande studies geen reflectie zijn van verschillen tussen meetinstrumenten, maar dat in het geval van juveniele psychopathie de hypothese van een vooronderstelde afwezigheid van angst, depressie en stress mogelijks niet standhoudt.

In *hoofdstuk 4* hebben we in de niet-klinische steekproef de relatie tussen juveniele psychopathie en angst indirect onderzocht via de studie van defensiemechanismen. We observeerden dat ongeveer 37% van de variantie in psychopate trekken verklaard werd door 5 immature defensiemechanismen (acting-out, isolatie, dissociatie, splitting en rationalisatie) en door het neurotisch defensiemechanisme 'tenietdoen'. Hogere scores op psychopathie (YPI-S) waren geassocieerd met hogere scores op de vijf immature defensiestijlen en een lagere score op 'tenietdoen'. Daar defensiemechanismen onbewuste psychische processen zijn die individuen beschermen tegen een teveel aan angst en bedreiging, suggereren de bevindingen van deze studie dat een ervaring van angst mogelijks geassocieerd is met juveniele psychopathie.

In *hoofdstuk 5* bestudeerden we de complexe relatie tussen juveniele psychopathie en negatief affect via een kwalitatieve studie van het affectieve, interpersoonlijke en antisociale leven van een jonge delinquent met een hoge psychopathiescore (PCL:YV = 32). Onze klinische interviews schetsten een meer genuanceerd beeld van de vooronderstelde affectieve deficits bij juveniele psychopathie. In tegenstelling tot het typisch beeld van affectkilte en gevoelloosheid, verscheen een waaier aan emoties, zoals schuld, schaamte, angst, vrees en emotionele pijn, naarmate een vertrouwensband zich ontwikkelde tussen adolescent en psycholoog. Het was opmerkenswaardig dat bij deze jongere de ervaring en uiting van negatief beladen omstandigheden en levensgebeurtenissen gepaard ging met een

proces van radicale splitting of dissociatie. We beargumenteerden dat dit proces van splitting wijst op de aanwezigheid van zelf-beschermende strategieën, eerder dan op een afwezigheid van angst, vrees en emotionele pijn. Bovendien bediscussieerden we dat de sociale wereld van de adolescent niet symbolisch gestructureerd leek te zijn en daardoor extreem onvoorspelbaar was. Zijn hulpeloosheid ten opzichte van de enigmatische verlangens en intenties van anderen spoorden hem aan tot gewelddadige acting-outs en het radicaal beëindigen van intieme interpersoonlijke relaties. Deze antisociale acten lijken dan ook geïnterpreteerd te kunnen worden in termen van een verdediging tegen een bedreigende, want enigmatische ander, en zijn op die manier geworteld in een onderliggende angstige positie van de adolescent.

In *hoofdstuk 6* onderzochten we het verband tussen juveniele psychopathie en angst via een uitgebreide kwalitatieve studie van de interpersoonlijke levens van 15 adolescente delinquenten met psychopate trekken. Het dominante thema over alle interview narratieven heen was dat vanuit het standpunt van deze jongeren zij zelf risico lopen ten prooi te vallen aan een fundamenteel onbetrouwbare en bedrieglijke (significante) ander. Onze bevindingen illustreerden dat deze jongeren verschillende zelf-beschermende strategieën gebruiken ten einde om te kunnen gaan met deze fundamenteel onbetrouwbare en onvoorspelbare ander. Zo pogen ze door het doelbewust testen van de betrouwbaarheid van de ander of door het gebruik van angst-inducerende strategieën te ontsnappen aan de bedrieglijkheid van de ander. Onze resultaten toonden aan dat een groot deel van hun psychopaat gedrag geworteld is in een onderliggende angstige positie. We beargumenteerden dan ook dat opdat therapie succesvol zou kunnen zijn, deze fundamenteel angstige en wantrouwende positie moet geadresseerd worden.

In ons *laatste hoofdstuk* beschouwden we onze tweede onderzoeksvraag via een kwalitatieve exploratie van de geleefde ervaringen van 17 kinderen en jongeren met een diagnose van ADHD en de bijbehorende behandelingsmethoden. Onze resultaten toonden aan dat een psychiatrische diagnose en de geassocieerde behandeling vaak aliënerende effecten ressorteert op het gebied van de identiteitsontwikkeling en sociale ontwikkeling van kinderen. Hierbij bleek de stem van de jongere vaak te worden genegeerd binnen het diagnostisch proces. Nadat een diagnose gesteld wordt, start veelal een proces van reïficatie waarbij de jongere zich begint te identificeren met het label. Dit leidt vaak tot zelf- en

publieke stigmatisering en sociale exclusieprocessen. Bovendien ervoeren verschillende deelnemers de gebruikelijke behandelmethoden als disciplinerend en bevreemdend.

ALGEMENE CONCLUSIES EN KRITISCHE BESCHOUWINGEN VOOR DE KLINISCH-FORENSISCHE PRAKTIJK

Het verband tussen juveniele psychopathie en angst

Zowel onze kwantitatieve als onze kwalitatieve studies toonden aan dat juveniele psychopathie en internaliserende psychopathologie elkaar niet uitsluiten. Zowel op basis van zelfrapportage vragenlijsten als op basis van interview-gebaseerde meetinstrumenten, observeerden we dat psychopate trekken niet of positief gerelateerd zijn aan verschillende vormen van internaliserende psychopathologie. Onze bevindingen bevestigden dus niet de veronderstelde negatieve relatie tussen de interpersoonlijke en affectieve dimensies van psychopathie en negatief affect of affectieve stoornissen. Onze resultaten zijn dus in tegenspraak met de klassieke idee dat juveniele psychopathie gekenmerkt wordt door een fundamentele afwezigheid van emotionele ervaringen, angst en vrees (Cleckley, 1976; Karpman, 1959 ; Lykken, 1957; McCord & McCord, 1956) en bieden bovendien geen evidentie voor het bestaan van neuropsychologische deficits zoals gepostuleerd door de dual deficit theorie (Fowles, 1980 ; Fowles & Dindo, 2006). Anderzijds sluiten onze bevindingen wel aan bij een groeiend aantal studies die wijzen op een positief verband tussen psychopate trekken bij jongeren en internaliserende psychopathologie (o.a. Bauer, Whitman, & Kosson, 2011; Kosson, Cyterski, Steuerwald, Neumann, & Walker-Matthews, 2002). Gebaseerd op onze studie naar defensiemechanismen en onze kwalitatieve studies postuleren we dat een onderliggende angstige positie centraal staat binnen de emergentie van psychopaat gedrag bij adolescenten. Onze resultaten suggereren dat een groot deel van wat we juveniele psychopathie noemen gedetermineerd wordt door hoe de jongere zichzelf beschermt tegen angst en traumatische of negatief beladen ervaringen. In hoofdstuk 4 en 5 observeerden we bijvoorbeeld een verband tussen psychopate trekken en de immature defensiemechanismen ‘dissociatie’ en ‘splitting’. Op basis van ons klinisch werk achten we het weinig waarschijnlijk dat de onderliggende angstige positie merkbaar zou zijn in de

eerste ontmoetingen met de jongeren. Zelfonthulling heeft immers tijd nodig, in het bijzonder bij personen met een traumatische geschiedenis, en de angsten van een persoon zullen veelal pas verschijnen als een vertrouwensband tussen individu en hulpverlener is geïnstalleerd (Verhaeghe, 2004). In hoofdstuk 5 en 6 beschreven we dan ook dat de fundamenteel angstige positie van jongeren met psychopate trekken verborgen blijft (zelfs op een bewust niveau voor de jongere zelf) door een zelfbeschermend masker van grandiositeit en door een geprononceerde identificatie met een primitief ideaalbeeld van de viriele, onbevreesde, onkwetsbare en onaantastbare jongeman/crimineel. Dit is hun robuuste zelfbeschermende strategie om om te gaan met en te overleven in een voor hen fundamenteel onbetrouwbare sociale wereld. Niettemin suggeren deze zelfbeschermende strategieën het bestaan van een onderliggende angst in één van zijn meest rudimentaire verschijningsvormen; namelijk de hulpeloosheid van het individu in relatie tot de enigmatische intenties van significante anderen en de (letterlijke) woordenloosheid van het individu ten aanzien van traumatische gebeurtenissen uit het verleden en huidige negatief beladen situaties. Dit basiswantrouwen en de bijbehorende defensiemechanisme sluiten aan bij eerdere conceptualisaties en bevindingen van andere auteurs (Corval, 2009; Meloy, 2004; Norbech, Crittenden , & Hartmann, 2013; Vaillant, 1975).

Gevaren en valkuilen bij het diagnosticeren van juveniele psychopathie

Op basis van onze kwalitatieve studies (Hoofdstuk 5 en 6) achten we het belangrijk om enkele valkuilen te belichten die samengaan met de huidige beschrijvende conceptualisering van psychopathie. Ten eerste, Hare's conceptualisatie van psychopathie en in het bijzonder zijn Psychopathy Checklists focussen in grote mate op een afwezigheid van bepaalde fenomenen (bv. de afwezigheid van een wijd spectrum aan emoties, de afwezigheid van schuld en empathie, de afwezigheid van diepgaande interpersoonlijke relaties, enzovoort). Echter, het kan beargumenteerd worden dat het niet verschijnen van bepaalde fenomenen niet betekent dat deze fenomenen ook daadwerkelijk afwezig zijn. Dit illustreerden we duidelijk in onze casestudie waarin een divers spectrum aan affecten pas verscheen nadat een vertrouwensrelatie was geïnstalleerd tussen de jongere en de psycholoog.

Ten tweede, volgens de conceptualisering van Hare wordt het herhaaldelijk engagement in antisociaal gedrag opgevat als een duidelijke indicatie voor de afwezigheid van schuld en berouw. Onze casestudie toonde echter aan dat dit een bedenkelijke redeneerlijn is. De casestudie gaf aan dat gevoelens van schuld, schaamte en spijt niet afwezig waren, maar dat deze gevoelens niettemin onvoldoende waren om toekomstig antisociaal gedrag te voorkomen vanwege de particuliere status die deze daden vervulden in het leven van de jonge delinquent. We bediscussieerden immers in hoofdstuk 5 en 6 dat voor jongeren met psychopate trekken de wereld niet gestructureerd is op een symbolische manier, wat hen hulpeloos maakt in relatie tot de enigmatische intenties van anderen. In overeenstemming met het ideeëngoed van Lacan (1993 [1955-56]), stellen we dat deze jongeren zich in een onvoorspelbare wereld staande pogen te houden op een imaginair vlak door een sterke identificatie met het primitieve en agressieve ideaalbeeld van een koelbloedige, onkwetsbare en onbevreesde jongeman/crimineel. Naast het gebruik van andere defensiemechanismen, is het doorheen de antisociale en agressieve act dat ze zichzelf als subject pogen te positioneren in relatie tot andere mensen. Volgens deze redenering kan de afwezigheid van een verandering in het antisociaal gedrag niet gelijkgeschakeld worden met gewetenloosheid of een afwezigheid van schuld.

Het labelen van een jongere met een diagnose van juveniele psychopathie houdt bijkomend het gevaar in dat er niet verder wordt gezocht naar de contextuele inbedding, de socio-psychologische dynamieken en de subjectieve logica onderliggend aan de antisociale of asociale daad. Door de overtuiging dat een jongere ageert zoals hij ageert *omdat* hij een 'juveniele psychopaat' is, ontneemt men de jongere mogelijks de kans effectief ver*antwoord*elijkheid op te nemen voor zijn eigen gedrag. Hierbij aansluitend, worden binnen de huidige conceptualisatie van psychopathie de tekorten op affectief, interpersoonlijk en gedragsmatig vlak grotendeels gesitueerd binnen het individu met psychopate trekken, zonder referentie naar zijn socio-culturele context. Onze kwalitatieve studies (Hoofdstuk 5 & 6) illustreerden echter dat de affectieve, interpersoonlijke en gedragsmatige problemen van de jongeren duidelijk ingebed waren in een complexe familieconstellatie en een bredere sociale context die zij percipiëren als fundamenteel vijandig en onbetrouwbaar.

Onze finale bezorgdheid betreft de communicatie van de diagnose[2] aan de jongere zelf. Via het praktijkvoorbeeld van ADHD illustreerden we in hoofdstuk 7 hoe kinderen en

jongeren de neiging hebben zich te identificeren met een aanvankelijk ik-vreemd label en hoe het label na verloop van tijd fungeert als een lens doorheen dewelke het eigen gedrag wordt gekaderd en geïnterpreteerd, met weinig ruimte voor alternatieve interpretaties. In het geval van juveniele psychopathie zou het meedelen van dergelijk beladen label nog tot nefastere gevolgen kunnen leiden op het vlak van de identiteitsontwikkeling van de jongere. We observeerden in jongeren met psychopate trekken (Hoofdstuk 5 & 6) een tendens zich te identificeren met het imago van een vaak agressieve, extreem viriele en onkwetsbare jongeman/crimineel. Deze jongeren informeren dat zij psychopate trekken vertonen, kan mogelijks dit type imaginaire identificatie verder bekrachtigen en bestendigen. Het spreekt voor zich dat we in ons klinisch-forensisch werk net op zoek moeten gaan naar andere manieren voor deze jongeren om zich te identificeren en naar constructievere defensiemechanismen om om te gaan met een onbetrouwbare sociale wereld, dan via een identificatie met het label van juveniele psychopathie.

Kritische beschouwingen over het verband tussen juveniele psychopathie en gevaarlijkheid

Het construct van (juveniele) psychopathie is nauw verbonden met de notie en/of de perceptie van gevaarlijkheid. Vergeleken met delinquenten zonder psychopate kenmerken, wordt van psychopaten verondersteld dat ze gevaarlijker (re)ageren, zich moeilijker opstellen en zich meer misdragen binnen de context van een instelling en dat ze meer gewelddadige misdrijven plegen (Cleckley, 1976; Hare, 2011). Onze resultaten (Hoofdstuk 1) bevestigden echter niet (of slechts partieel) de verwachtte relaties tussen psychopate trekken enerzijds en institutioneel wangedrag en risico op recidive anderzijds. In hoofdstuk 1 toonden we bijvoorbeeld aan dat in de klinische steekproef van delinquente jongeren psychopate trekken (PCL:YV) statistisch niet gerelateerd waren aan ernstige overtredingen van de regels van de instelling, noch aan gewelddadig gedrag binnen de instelling. Kleinere overtredingen (bv. onbeleefd gedrag) waren significant gerelateerd aan de Levensstijl en Antisociale dimensie van psychopathie en de totale psychopathiescore (PCL:YV), maar niet aan de Affectieve en Interpersoonlijke kenmerken van psychopathie. Bovendien scoorden jongeren die hervielen na vrijlating, in vergelijking met jongeren die geen nieuwe feiten pleegden, enkel significant hoger op de Antisociale dimensie van de PCL:YV maar niet op de

overige psychopathie dimensies. Anderzijds waren zelf-gerapporteerde psychopate trekken significant maar moderaat gecorreleerd met zelf-gerapporteerde gewelddadige delicten uit het verleden. Globaal beschouwd, sluiten onze bevindingen aan bij eerder onderzoek (bij zowel jongeren als volwassenen) dat aantoont dat psychopathie inderdaad significant gerelateerd is aan vroeger en toekomstig crimineel gedrag en aan toekomstig geweld ten opzichte van anderen, maar dat het verklarend en voorspellend vermogen van een verhoogde psychopathiescore eerder beperkt is (Edens, Skeem, Cruise, & Cauffman, 2001; Leistico, Salekin, DeCoster, & Rogers, 2008). In overenstemming met onze bevindingen toonden eerdere studies bovendien aan dat de Interpersoonlijke en Affectieve dimensies niet doorslaggevend zijn in de voorspelling van recidivisme en institutioneel wangedrag (Kennealy, Skeem, Walters, & Camp, 2010; Leistico et al., 2008 ; Walters, 2003). In overeenstemming met de studie van Cooke & Michie (2010) geven onze bevidingen aan dat het ethisch onverantwoord is om uitsluitend de totale psychopathiescore te hanteren binnen het kader van risicotaxatie of gerechtelijke besluitvorming. Er is dus meer wetenschappelijk onderzoek nodig naar andere mogelijke factoren, naast psychopate kenmerken, die toekomstige delicten kunnen voorspellen en aldus voorkomen. Ons inziens is er tot op heden nog een gebrek aan een uitgewerkt conceptueel kader dat ons inzicht geeft in hoe de complexe relatie tussen psychopate trekken en antisociaal gedrag te begrijpen. In onze kwalitatieve studies (Hoofdstuk 5 en 6) maakten we hiertoe enkele voorzichtige stappen, door te beargumenteren dat de antisociale daad voor de jongere mogelijks ook een separerende en identiteitsverlenende functie heeft daar het hem in staat stelt een enigmatische en onbetrouwbare ander op afstand te houden.

Hierbij aansluitend, merken we op dat huidig onderzoek naar de behandeling van jonge delinquenten met psychopate trekken zich vooral richt op therapietrouw en het inperken van antisociaal gedrag en recidivegevaar (Salekin, Worley, & Grimes, 2010; Salekin, Tippey, & Allen, 2012). Andere positieve therapeutische effecten (bv. de verbetering van interpersoonlijke relaties, constructievere manieren om om te gaan met negatief beladen levensgebeurtenissen) worden hierbij nauwelijks in rekening gebracht. Bovendien, terwijl therapieonderzoek duidelijk aantoont dat de kwaliteit van de therapeutische relatie één van de sterkste voorspellers is van therapiesucces (Roth & Fonagy, 2006), worden in het huidig therapieonderzoek nauwelijks of geen richtlijnen geformuleerd met betrekking tot hoe een dergelijke therapeutische vertrouwensrelatie kan geïnstalleerd worden met jonge

delinquenten met psychopate trekken. We menen echter dat onze kwalitatieve studies (Hoofdstuk 5 en 6), waarbij we beargumenteerden dat deze jongeren vrezen ten prooi te vallen aan de kwaadwillige en enigmatische intenties van anderen, mogelijks instructief zijn voor de klinisch-forensische praktijk. Onze kwalitatieve studies suggereren ons inziens dat een particuliere ethische positie van de therapeut beslissend kan zijn voor de installatie van een therapeutische vertrouwensrelatie, namelijk de positie van een niet-veroordelende toehoorder, die zichzelf ervan behoedt al te snel te willen begrijpen en op die manier aan de jongere de mogelijkheid geeft echt verantwoordelijkheid op te nemen voor zijn daden en gedrag.

TEKORTEN VAN DE HUIDIGE STUDIE

De bevindingen van ons onderzoek moeten uiteraard in het licht van enkele beperkingen beschouwd worden. Onze kwantitatieve studies (Hoofdstuk 2, 3 en 4) maakten gebruik van een cross-sectioneel design waardoor we geen causale interpretaties kunnen maken over de relaties tussen psychopate trekken en verschillende vormen van externaliserende en internaliserende problemen. Bovendien maakten we in de niet-klinische steekproef enkel gebruik van zelfrapportagematen voor de beoordeling van psychopate trekken en verschillende types van internaliserende en externaliserende psychopathologie. Bovendien is de grootte van de klinische steekproef te klein om robuuste conclusies te trekken op basis van onze kwantitatieve studies (Hoofdstuk 1, 2 en 3). Verder dient te worden opgemerkt dat de PCL:YV en de DISC interviews werden afgenomen door dezelfde onderzoeker, waardoor de resultaten kunnen beïnvloed zijn door vertekening bij de beoordelaar. Een laatste beperking betreft de generaliseerbaarheid en repliceerbaarheid van onze bevindingen, in het bijzonder deze in relatie tot de klinische steekproef van adolescente delinquenten. Deze steekproef bestond voornamelijk uit persistente mannelijke jeugddelinquenten. Deze groep is mogelijks niet representatief voor de meerderheid van adolescente mannelijke delinquenten. Bovendien kunnen onze bevindingen niet gegeneraliseerd worden naar vrouwelijke adolescente delinquenten.

EEN FINALE SUGGESTIE VOOR ONDERZOEKERS EN HULPVERLENERS

Om te eindigen, willen we als onderzoekers binnen de *humane wetenschappen* een pleidooi houden voor een meer *humane* wetenschappelijke studie en behandeling van jonge delinquenten met (en zonder) psychopate trekken. Een pleidooi voor een ideografische wetenschappelijke en klinische benadering waarbinnen er ruimte is voor de jongere om zijn vaak diffuus levensverhaal te vertellen, waarbinnen er tijd is voor de jongere om te antwoorden volgens zijn eigen subjectieve logica en aldus verantwoordelijkheid te nemen voor zijn eigen (antisociaal) gedrag. We zijn ervan overtuigd dat het doorheen de authentieke ontmoeting is (en niet vanop een afstand) dat onderzoekers en clinici kunnen observeren dat deze 'probleemjongeren' bovenal ook mens zijn, en dat niks menselijks hen vreemd is, zelfs de angst niet. We hopen dat dit proefschrift andere onderzoekers en clinici zal inspireren om deze 'walk on the wild side' te nemen.

EINDNOTEN

1. ‘Callous-Unemotional’ is een Angelsaksische term die tot op heden geen passende Nederlandse vertaling kent.
2. Voor de volledigheid vermelden we dat we bij kinderen en jongeren we nog niet kunnen spreken van een psychopate persoonlijkheidsstoornis. We kunnen slechts spreken van een groot aantal psychopate trekken of een verhoogde score op een instrument dat psychopate karakteristieken meet.

REFERENTIES

Andershed, H., Kerr, M., Stattin, H., & Levander, S. (2002). Psychopathic traits in non-referred youths: A new assessment tool. In E. Blaauw, & L. Sheridan (Eds.), *Psychopaths: Current international perspectives* (pp. 131-158). The Hague, The Netherlands: Elsevier.

Bauer, D. L., Whitman, L. A., & Kosson, D. S. (2011). Reliability and Construct Validity of the Psychopathy Checklist: Youth Version Scores among Incarcerated Adolecent Girls. *Criminal Justice and Behavior, 10*, 965-987.

Cleckley, H. (1976). *The Mask of Sanity* (Fifth Ed.). Saint Louis: The C.V. Mosby Company.

Cooke, D. J., & Michie, C. (2010). Limitations of diagnostic precision and predictive validity in the individual case: A challenge for forensic practice. *Law and Human Behavior, 34*, 259-274.

Cooke, D., & Michie, C. (2001). Refining the construct of psychopathy: Toward a hierarchical model. *Psychological Assessment, 13*, 171-188.

Corr, P. J. (2010). The psychoticism-psychopathy continuum: A neuropsychological model of core deficits. *Personality and Individual Differences, 48*, 695-703.

Corrigan, P. W., & Watson, A. C. (2002). The Paradox of Self-Stigma and Mental Illness. *Clinical Psychology - Science and Practice, 9*, 35-53.

Corval, P. (2009). *Violence, psychopathie et socioculture.* Paris: L'Harmattan.

de Botton, A. (2005). *Status Anxiety.* London: Penguin Books.

Edens, J. F., Skeem, J. L., Cruise, K. R., & Cauffman, E. (2001). Assessment of "Juvenile Psychopathy" and Its Association with Violence: A Critical Review. *Behavioral Sciences and the Law, 19*, 53-80.

Forth, A., Kosson, D., & Hare, R. (2003). *The Hare Psychopathy Checklist: Youth Version.* Toronto: Multi-Health Systems, Inc.

Fowles, D. C., & Dindo, L. (2006). A dual-deficit model of psychopathy. In C. J. Patrick (Ed.), *Handbook of psychopathy* (pp. 14-34). New York: Guildford Press.

Fowles, D. C. (1980). The three arousal model: Implications of Gray's two-factor learning theory for heart rate, electrodermal activity, and psychopathy. *Psychophysiology, 17*, 87-104.

Freud, S. (1978 [1926d]). Inhibitions, symptoms, and anxiety. In *Standard Edition* (Vol. 20, pp. 75-175). London: Hogarth.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist* (Second Ed.). Toronto, ON: Multi Health Systems.

Hare, R. (2011). *Without Conscience: The Disturbing World of the Psychopaths Among us* (EPUB format). New York: Guilford Press.

Karpman, B. (1959). *Symposia on Child and Juvenile Delinquency. Presented at the American Orthopsychiatric Association.* Washington, D.C.: Psychodynamics Monograph Series.

Kennealy, P. J., Skeem, J. L., Walters, G. D., & Camp, J. (2010). Do core interpersonal and affective traits of PCL-R psychopathy interact with antisocial behavior and desinhibition to predict violence. *Psychological Assessment, 22*, 569-580.

Kosson, D. S., Cyterski, T. D., Steuerwald, B. L., Neumann, C., & Walker-Matthews, S. (2002). The reliability and validity of the Psychopathy Checklist: Youth Version in non-incarcerated adolescent males. *Psychological Assessment, 14*, 97-109.

Lacan, J. (1993 [1955-56]). *The Seminar 1955-1956, Book III, The Psychosis.* New York & London: W.W.Norton.

Leistico, A. M., Salekin, R. T., DeCoster, J., & Rogers, R. (2008). A Large-Scale Meta-Analysis Relating the Hare Mesaures of Psychopathy to Antisocial Construct. *Law and Human Behaviour, 32*, 28-45.

Lykken, D. T. (1957). A study of anxiety in the sociopathic personality. *Journal of Abnormal and Social Psychology, 55*, 6-10.

McCord, W., & McCord, J. (1956). *Psychopathy and Delinqency.* New York: Grune & Stratton.

Meloy, J. R. (2004). *The psychopathic mind: Origins, dynamics, and treatment.* Lanham, MD: Rowman & Liilefield.

Norbech, P., Crittenden , P. M., & Hartmann, E. (2013). Self-Protective Strategies, Violence and Psychopathy: Theory and a Case Study. *Journal of Personality Assessment, 95*, 571-584.

Patrick, C. J., Bradley, M. M., & Lang, A. R. (1993). Emotions in the criminal psychopath: startle reflex modulation. *Journal of Abnormal Psychology , 102*, 82-92.

Patrick, C. J. (1994). Emotion and psychopathy: startling new insights. *Psychophysiology, 31*, 319-330.

Patrick, C. J. (2007). Getting to the heart of psychopathy. In H. Hervé, & J. C. Yuille (Eds.), *The psychopath: Theory, research, and practice* (pp. 207-252). New York: Lawrence Erlbaum Associates.

Roth, A., & Fonagy, P. (2006). *What works for whom? A critical review of psychotherapy research.* New York: The Guilford Press.

Salekin , R. T., Tippey, J. G., & Allen, A. D. (2012). Treatment of conduct problem youth with interpersonal callous traits using mental models: measurement of risk and change. *Behavioral Sciences and the Law, 30*, 470-486.

Salekin, R. T., & Lynam, D. R. (2010). Child and Adolescent Psychopathy: The Road Ahead. In R. T. Salekin, & D. R. Lynam (Eds.), *Handbook of Child and Adolescent Psychopathy* (pp. 399-420). New York: The Guilford Press.

Salekin, R. T., Worley, C., & Grimes, R. D. (2010). Treatment of psychopathy: A review and brief introduction to the mental model approach for psychopathy. *Behavioural Sciences and the Law, 28*, 235-266.

Sevecke, K., & Kosson, D. S. (2010). Relationships of child and adolescent psychopathy to other forms of psychopathology. In R. T. Salekin , & D. R. Lynam (Eds.), *Handbook of child & adolescent psychopathy* (pp. 284-314). New York: The Guilford Press.

Vaillant, G. E. (1975). Sociopathy as a human process: A viewpoint. *Archives of General Psychiatry, 32*, 178-183.

van Baardewijk, Y., Andershed, H., Stegge, H., Nilsson, K. W., Scholte, E., & Vermeiren, R. (2010). Development and tests of short versions of the youth psychopathic traits inventory and the youth psychopathic traits inventory-child version. *European Journal of Psychological Assessment, 26*, 122-128.

Verhaeghe, P. (2004). *On being normal and other disorders. A manual for clinical psychodiagnostics.* New York: Other Press.

Walters, G. D. (2003). Predicting insitutional adjustment and recidivism with the Psychopathy Checklist factor scores: A meta-analysis. *Law and Human Behavior, 27*, 541-558.