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SUBTYPES OF PSYCHOPATHY: PROPOSED DIFFERENCES BETWEEN NARCISSISTIC, BORDERLINE, SADISTIC, AND ANTISOCIAL PSYCHOPATHS

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Atascadero State Hospital (ASH) is a maximum-security forensic hospital that houses male patients with a wide range of psychiatric diagnoses. Psychopaths at this institution appear to be a heterogeneous group of individuals who, while sharing core personality characteristics, manifest substantial variability in their behavior. Identifying subtypes within this clinical classification can have implications for patient treatment and management, as well as for the safety of the staff who work with them and for the communities to which they will eventually return. Several means of identifying subtypes have been proposed in the literature, and potential subgroups have been identified. Clinical observations at ASH have suggested 4 possible subtypes of psychopathy: narcissistic, borderline, sadistic, and antisocial. Issues related to the conceptualization of psychopathy are addressed, recognizing that additional data are needed to understand the observed variations in cases of psychopathy.

KEY WORDS: psychopathy; narcissism; sadism; borderline.

The views expressed are those of the authors, and do not necessarily reflect the position of Atascadero State Hospital or the California Department of Mental Health.

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Atascadero State Hospital (ASH) is a maximum-security forensic hospital with a census of approximately 1000 male patients who suffer from a wide range of serious mental illness and personality pathology. One of five state hospitals in California, it is the only facility that exclusively houses maximum-security forensic patients. Given the size of the facility and the nature of the individuals housed there, a great deal of attention is paid to the identification of patients who are psychopathic and could pose significant risks to the therapeutic milieu of the hospital, the security of the institution, and the safety of the communities to which they will eventually return.

Clinically, it has been observed that psychopaths in this institution, while similar in many ways, seem to manifest substantial variability in their behavior. Some maintain a low profile and attempt to ingratiate themselves with staff but are suspected of dealing drugs or pressuring peers for material goods or sexual favors. Others are more overt in their contempt of others and are aggressive, impulsive, and difficult to manage. While variability occurs within any group of individuals, the differences observed among patients known to be psychopaths suggest potential advantages in explicitly subdividing this clinical classification into subtypes.

Specifically, psychopathy is seen to encompass several personality features which, depending on their prominence, will determine the presentation and unique clinical challenges of the disorder. The entitled, superior, self-absorbed and belittling narcissistic psychopath, the needy, labile, and impulsive borderline psychopath, the deliberately cruel sadistic psychopath who is attuned to the suffering of others, and the remorselessly criminal antisocial psychopath who is not, are all variations of psychopathy observed among forensic patients.

BACKGROUND

Holland and colleagues (1) suggested over two decades ago that psychopaths can be discriminated from other groups but also demonstrate heterogeneity within the class. Identification of meaningful, reliable subtypes among psychopaths might serve to facilitate more effective approaches to management, safety, and treatment with this difficult population.

Psychopathy, while not a formal diagnosis (2), is a personality disorder in which the individual displays a lack of conscience, seeks self-gratification at others' expense, is emotionally detached, and generally leaves a path of destruction in the wake of their interpersonal

relationships (3). The concept of psychopathy has been given attention in the psychiatric literature and the media for the better part of the past one hundred years. Similar constructs appear to have a much longer history. Kraepelin first used the term "psychopathic state" in the fifth edition of his psychiatric textbook in 1896 (4). Phillipe Pinel coined the term "insanity without delirium" almost a century earlier to describe individuals who demonstrated lack of restraint and remorselessness (3). Much earlier still, Theophrastus, a student of Aristotle, wrote of the Unscrupulous Man (5). Contemporary conceptualizations derive mostly from the work of Cleckley (6) and his concept of the "mask of sanity." The Cleckley psychopath lacks emotions, is callous, unreliable, and superficial, but may or may not become involved in criminal activities. Cleckley's definition primarily involves aspects of the personality rather than the behavioral manifestations of psychopathy.

Conversely, the current diagnostic criteria for antisocial personality disorder (APD) almost exclusively involve behavioral problems, neglecting the personality variables identified by Cleckley (2). This is potentially a weakness as it captures only the criminal portion of society. MacKay (7) points out in his review of the literature that approximately 80% of criminals meet criteria for APD in DSM-III, but that this diagnosis fails to provide much in the way of discriminatory information about the population. In contrast, the construct of psychopathy provides a more detailed description of the individual's behavioral, affective, and interpersonal functioning. The resulting distinction of personality-based pathology is potentially more useful for risk assessment, safety precautions, and treatment planning.

Other weaknesses of the current APD criteria are its shifting diagnostic criteria, innumeracy, the overlap with substance use disorders, absence of symptom weighting, and temporal instability (8,9). Innumeracy refers to the multiple combinations of symptoms that meet criteria for the diagnosis, possibly resulting in different clusters or types of antisociality within the same diagnostic category.

ASSESSING PSYCHOPATHY

The most significant contribution to the definition and measurement of psychopathy has come from the work of Robert Hare and his colleagues. Hare operationalized Cleckley's concept of psychopathy and developed the Hare Psychopathy Checklist or PCL (10), which was later revised (11). The revised version utilizes a comprehensive chart review and semistructured clinical interview. The information obtained

is used to rate the individual on 20 different items, the majority of which load onto two factors. These factors have been found to capture both Cleckley's conceptualization of the psychopathic personality (Factor 1—selfish, callous, and remorseless use of others) as well as the behavioral manifestations included in the current DSM-IV criteria for antisocial personality disorder (Factor 2—chronically unstable and antisocial lifestyle).

Several studies have concluded that the PCL-R is both a valid and reliable means of assessing psychopathy (10,11). Using item response theory, Cooke and Michie (12) concluded that not only is the PCL-R appropriate for determining the presence of psychopathy, but can also determine trait strength. They also found Factor 1 items of higher importance than those of Factor 2 in determining the presence of psychopathy, even though both factors are combined in the overall PCL-R score. Factor 1 items were described as having greater precision in defining the underlying trait of psychopathy. This appears to be consistent with the clinical view of psychopathy in which Factor 1 variables are considered more central to the identification of the disorder and to cause the most difficulty for treating clinicians within the therapeutic milieu. Although Hare postulates that psychopathy is one construct with two components, the first factor seems to outweigh the second in terms of clinical utility and diagnostic specificity.

The presence of psychopathy is determined when an individual's score is 30 or above on the PCL-R. Psychopathy as measured by the PCL-R is currently conceptualized as a taxon, or nonarbitrary class, rather than a continuum. However, there appears to be heterogeneity among psychopathic individuals, suggesting varying degrees of psychopathy or perhaps different subtypes within the construct. Many of these perceived differences may be due to variability in the behavioral manifestation of the disorder. This is consistent with Cleckley's (6) view of psychopathy, whereby the personality is stable and consistent across individuals but behaviorally manifested in different ways.

It is unclear, however, the degree to which psychopaths are similar in personality features, given the various combinations of PCL-R variables that can yield a high score. This is similar to Cunningham and Reidy's (8) issue of innumeracy within the APD diagnosis, representing a criticism potentially applicable to all personality disorders.

Despite these concerns, there is support for the existence of psychopathy as a psychological or behavioral entity. Harris, Rice, and Quinsey (13) found support for the existence of a taxon underlying psychopathy in the distribution of PCL-R scores and the convergence of data on childhood problem behaviors. Hart and Hare (14) utilized the Big 5 model of

personality to provide support for the construct of psychopathy. The Big 5 model of personality proposes five dimensions that have been found to comprehensively describe normal personality, including neuroticism, extraversion, agreeableness, conscientiousness, and openness to experience (also referred to as culture or unconventionality). This model has been described as the most validated and comprehensive model of personality (14).

Support has been found within the Big Five framework for the construct of psychopathy as it is negatively correlated with several aspects of "normal" personality. For example, Hart and Hare (14) found that psychopathy was negatively correlated with agreeableness, conscientiousness, openness, and neuroticism. They concluded that these results were consistent with previous research that had looked at correlations between psychopathy and measures of normal personality. Lilienfeld's (15), review of the literature included a study in which the Big Five model did not differentiate between Factor 1 and Factor 2 on the PCL. Agreeableness and conscientiousness, however, are two dimensions that consistently appear to have an inverse relationship with measures of psychopathy and are relevant to psychopathy as a whole.

CATEGORY VS. CONTINUUM

Despite empirical support for the construct of psychopathy, there is continuing debate as to whether it is a discrete category of personality disorder or represents a continuum along a dimension of personality features. Blackburn and Coid (16) address the issue of psychopathy as a dimension of personality (albeit at the extreme end of the continuum) rather than one of several discrete categories. McHoskey, Worzel, and Szyarto (17) advocate a dimensional view of personality and personality disorders, including psychopathy, while Morey (18) and Harris, Rice, and Quinsey (13) provide support for a more categorical view. Lilienfeld (15) concluded that while evidence for a latent taxon in relation to some aspects of psychopathy has been suggested, the debate over categorical versus dimensional classification of psychopathy has yet to be decided. The argument against the current categorical approach used in the DSM-IV centers on the considerable overlap or covariance among the Cluster B personality disorders, which includes narcissistic, antisocial, borderline, and histrionic personality disorders (19,20).

Given this overlap within diagnostic criteria, these personality disorders could be conceptualized as recurring patterns of covarying traits rather than discrete categories (21). In other words, there is a great deal

of overlap between the disorders, such that it might be more accurate to conceptualize the Cluster B disorders along a continuum. For example, poor impulse control is a diagnostic criterion for both borderline personality disorder (BPD) as well as antisocial personality disorder (APD), while lack of empathy or remorse is considered for APD as well as narcissistic personality disorder (NPD). Clinically, the seductiveness of the histrionic personality (HPD), while similar in some ways to the sexual impropriety of the borderline, is qualitatively different in intensity. There are other ways in which these disorders may overlap both conceptually and in practice.

There is conceptual overlap between cluster B personality disorders and psychopathy as well. Stanlenheim and von Knorring (22) found that borderline personality disorder was more closely related to psychopathy than antisocial personality disorder. Perhaps one reason for this is that psychopathy is more extensively defined than APD, which is mostly limited to behavioral descriptors. BPD diagnostic criteria include symptoms of affective disturbance and interpersonal difficulties which can resemble the affective and interpersonal deficits of the psychopath (22).

Hart and Hare (23) point out conceptual overlap in their review of the literature on the association between psychopathy and narcissism. Most psychopaths are notably narcissistic, yet not all narcissists are necessarily psychopathic. MacKay (7) presents Antisocial Personality Disorder as a subgroup of pathological narcissism, supporting the conceptual connection between disorders. Gabbard (24) proposed that narcissism should be considered on a continuum with two subtypes, with an oblivious subtype at one end of the continuum and a hypervigilant subtype at the other. Gabbard discusses various treatment and management issues that clearly differentiate these two subtypes within the larger class. This approach toward narcissism, while not formally adopted in the DSM nomenclature, suggests the potential utility of considering psychopathy in a dimensional manner. Examination of degrees or patterns of psychopathy might identify those traits most associated with becoming a management problem or refractory to treatment.

MODERATING VARIABLES

Research looking at potential moderating variables offers another perspective on the identification of clinically useful subtypes among psychopaths. Rather than providing additional information about the individual's personality, moderating variables involve other characteristics

which interact with personality variables so as to shape their manifestation. Such moderating variables might prove relevant to successful patient management and treatment.

Considering intelligence, for example, Heilbrun and Heilbrun (25) found that psychopaths with low IQ scores who were also withdrawn and had a prior history of violence were at the highest risk for institutional violence and violence on parole. Heilbrun (26) makes a distinction between low IQ psychopaths and high IQ sadistic psychopaths. IQ was found to moderate between psychopathy and violent crime, with less intelligent psychopaths showing uniquely impaired impulse control relative to prisoners showing other combinations of intelligence and psychopathy. In Heilbrun's sample, there were eight times as many violent as nonviolent criminals among low IQ psychopaths, whereas violent and nonviolent criminals were about equally distributed among more intelligent psychopaths. There was no moderating effect of intelligence within his nonpsychopathic group.

The case of J provides a clinical example of the moderating effect of IQ on the expression of psychopathy. J has a PCL-R score in the severe range and his psychological testing revealed borderline intellectual functioning. J has a longstanding history of violence against family members and strangers that dates back to early adolescence. After only a few months of hospitalization, he has been repetitively assaultive, has obtained and used drugs and patient-made alcohol openly in front of staff, and has behaved in a sexually inappropriate manner. Despite the consequences for this type of behavior, J continues his flagrant disregard for the rules and for the personal rights of others. Staff members have been forced to place him on permanent one-to-one supervision for the safety of others.

Another potential moderating variable is anxiety. Cleckley's (6) conceptualization of psychopathy (theoretically similar to Hare's Factor 1) includes the characterization that psychopaths have a basic inability to feel guilt, remorse, or anxiety. This idea is hypothesized to relate to the observation that psychopaths are not generally amenable to treatment and are less responsive to punishment or consequences.

Alterman et al. (27) found that individuals that scored high on measures of psychopathy but also had a moderate degree of antisociality (antisocial behavior and asocialization) had lower amounts of both state and trait anxiety. This is consistent with Cleckley's conceptualization of the psychopath but is inconsistent with research suggesting that psychopathic individuals vary in their experience of anxiety. Schmidt and Newman (28), for example, found that psychopathy and anxiety covary independently, rather than demonstrating an inverse relationship.

One possible explanation for the variability in research regarding anxiety and psychopathy can be found in Alterman et al. (27). They hypothesized that psychopathic individuals whose behaviors were confined to criminality and substance abuse might constitute a type of psychopath that is more consistent with the Cleckley conceptualization of the disorder. Psychopaths who do experience anxiety might have other features of antisociality in their personality, or might have aspects of yet another personality or emotional disturbance that could account for their experience of this emotion. For example, if a psychopath has elements of another disorder, such as BPD, he might experience anxiety secondary to fear of abandonment or an inability to tolerate ambiguity, which is quite common in those with BPD. Some psychopaths might also suffer from symptoms of a mental illness, such as paranoia, that can itself produce symptoms of anxiety. This distinction is potentially useful in treatment and management decisions, in that an individual who is able to experience anxiety may be more likely to respond to traditional treatment approaches and to the typical consequences of inappropriate behavior.

One way to view the relationship between psychopathy and Cluster B personality disorders is to consider the cooccurrence of other cluster B personality disorders as a moderating variable. However, the problem of conceptual overlap in diagnostic criteria, discussed previously, complicates the operationalization and measurement of such a variable.

SADISM

No longer a formal diagnosis in the current DSM-IV, sadism has a relatively small research base from which to draw conclusions about its relationship to psychopathy (29). It is essentially defined as the derivation of pleasure from the physical or emotional suffering of another, or from the control and domination of others (30). Sadists have also been described as aggressive narcissists or malignant narcissists, in that their pleasure is derived at the expense of others with no apparent concern that others are harmed in the process (30,31).

Much of the recent literature about sadism has focused on sexual sadism, or the sexual offender whose crimes involve homicide and/or the mutilation of erogenous areas of the victim's body. Holt, Meloy, and Strack (32) described sadism as deeply endogenous character pathology that is common in psychopathy. They point out that all psychopaths may have sadistic elements to their personality, but that this is only one trait of many. Stone (33), on the other hand, postulates that only a subgroup of psychopaths are sadistic.

The presence of sadism is not substantially addressed in the current assessment of psychopathy. Only one item on the PCL-R, "callousness/lack of empathy," potentially addresses the issue of sadism. It is conceivable that an individual can have a very high score on the PCL-R but not score highly on this item. This does not necessarily mean that he is not sadistic, according to the maxim that absence of evidence is not evidence of absence. Furthermore, an individual may score high on this particular item, but still not derive pleasure from the suffering of others. Other means of assessing sadism, such as scale 6B on the MCMI-III can provide information about this aspect of the psychopath's personality that he might not otherwise be willing to reveal. Holt, et al (32) found evidence using the MCMI-III that suggests that psychopaths are more sadistic than nonpsychopaths.

IDENTIFYING SUBTYPES

Despite differing viewpoints on how psychopathy and other disorders of personality should be classified, there appears to be a reasonable research base upon which to formulate hypotheses about heterogeneity among psychopaths. The usefulness of developing such a refined understanding of psychopathy can have implications for both safety and treatment. Currently, psychopaths who are identified using the PCL-R tend to be lumped into one category when scored in the severe range, and are often assumed to be essentially similar in their clinical presentation. Yet this is not consistent with clinical observations at ASH. This failure to differentiate variations in personality and behavior among psychopaths is potentially parallel to the problematic merging of disparate individuals that has occurred with criminals in the diagnostic category of APD.

Several means of identifying proposed psychopathic subtypes have been identified in the literature. Objective measures of personality such as the Minnesota Multiphasic Personality Inventory and Millon Clinical Multiaxial Inventory reveal information about the personality that can prove useful when identifying subtypes. Holland, et al (1), for example, attempted to identify psychopathic subtypes using MMPI codetypes. While unable to identify two-point codetypes that significantly discriminated between hospitalized and incarcerated psychopaths, five potential subgroups of psychopaths did emerge from their data. These included the primary or simple psychopath, the hostile psychopath, the paranoid schizoid psychopath, the neurotic psychopath, and the confused psychopath. The confused psychopath was one with symptoms of cooccurring mental illness that served to disorganize behavior.

Lilienfeld (34) found that the Harris-Lingoes psychopathic deviate (Pd) subscales had some utility in identifying aspects of antisociality in psychopaths as well as correlating well with the global construct of psychopathy. Murrie and Cornell (35) used the adolescent version of the MCM-IIII, the MACI, with adolescent offenders, and found that the substance abuse proneness, unruly, and submissive scales correlated most strongly with the PCL-R. Holt, et al (32), found the MCMI-III useful in identifying sadistic individuals using scale 6B. In contrast, Hart, Forth, and Hare (36) acknowledged that while the MCMI-III is good at identifying antisocial traits or the behavioral aspects of psychopathy, it is limited, as are other self-report measures, in its utility for identifying the affective and interpersonal characteristics of psychopathy.

Blackburn (37) noted that extremely violent offenders have been seen as being either undercontrolled or overcontrolled. Cluster analysis of MMPI scores identified two undercontrolled and two overcontrolled patterns. These four types were described as primary psychopaths (extraverted, self-confident, impulsive, hostile), secondary psychopaths (impulsive, hostile, socially anxious, withdrawn, and moody), controlled personalities (defensive, conforming sociable, unemotional), and inhibited personalities (introverted, withdrawn, controlled, depressed). These distinctions have been identified in both personality disordered and mentally disordered offenders and have been supported by research utilizing the MCMI in additional studies cited by Blackburn.

From an essentially psychodynamic perspective, Millon and Davis (38) proposed ten theoretical subtypes of psychopathy. While having potential heuristic utility, the proposed subtypes would be difficult to study empirically because their psychodynamic underpinnings are not easily operationalized. Also problematic is the apparent overlap of several subtypes. While these theoretical subtypes are in some instances too similar to one another to prove helpful in defining reliable subtypes within psychopathy, variables that appear consistent with Cluster B personality disorders are noted. For example, the "disengenuous psychopath" is typified by an extreme need for attention, a veneer of friendliness, an impressionistic personality style, and chronic unreliability. While these are also characteristics of psychopathy, an extreme expression of these personality attributes in a psychopath may suggest a stable subtype.

Three other subtypes that Millon and Davis (38) proposed are the unprincipled psychopath, the covetous psychopath, and the malevolent psychopath. These appear to be closely related to aspects of APD, NPD, and sadism, respectively. Blackburn and Coid (21), Hart and Hare (23), Holdwick, et al (19), Rasmussen, et al (20), and Stalenheim and von

Knorring (22) point out the similarities between these disorders, although once again it is unclear whether this is related to an overlap in the diagnostic criteria, and a resulting lack of reliability in classification, or represents true covariance.

In contrast to creating purely theoretical subdivisions within the construct of psychopathy, it is hoped that identifying distinct subtypes which can be empirically validated within the diverse psychopath population will provide better answers about how to safely manage and effectively treat this difficult group. The approach taken here is that when personality characteristics not typical of psychopathy are present in the psychopath, or when particular characteristics prototypical of psychopathy are especially pronounced, a recognizable subtype of psychopathy may be present. If such subtypes can be reliably identified, the implications for treatment and management could be considerable.

Formulated within this framework, clinical observations made at ASH have suggested four possible subtypes of psychopathy: a narcissistic variant, a borderline variant, a sadistic variant, and an antisocial psychopath. The first three are consistent with three of Millon and Davis' aforementioned subtypes (4). A fourth variant, the antisocial psychopath, is consistent with research by Alterman et al (27) suggesting that a more pure form of the Cleckley psychopath is one who is low or lacking in anxiety and whose psychopathic behavior is confined to crime and substance use. The current subtypes are based upon observed differences in the interpersonal relationships, patterns of crime, and institutional behavior of psychopathic patients.

The narcissistic variant can be described as the individual who embodies the characteristics of psychopathy but whose clinical presentation includes primarily narcissistic features of a pathological degree. Grandiosity, entitlement, and callous disregard for the feelings of others are likely to be the most evident features in the personality. This subtype appears similar to the covetous psychopath described by Millon and Davis (38) and the oblivious end of the narcissistic continuum proposed by Gabbard (24). The current subtype is distinctive, however, in that it's definition is based on a specific set of diagnostic characteristics associated with an existing personality disorder (NPD) in the context of severe psychopathy.

With the borderline variant, features such as affective instability and self-destruction are most evident. This subtype shares features of the two undercontrolled patterns of psychopathy noted by Blackburn (37). However, the borderline subtype suggested here incorporates the features typical of borderline personality disorder, thereby providing a more specific and reliable diagnostic category.

The sadistic variant displays prominent evidence of deriving pleasure from the suffering of others. It is therefore similar to Millon and Davis' (38) malevolent psychopath. The distinguishing characteristic, however, is the apparent capacity to recognize the suffering of others, and the corresponding pleasure or arousal derived by the sadistic psychopath subtype.

The antisocial variant is the most purely criminal of the four. It is an extreme example of the unprincipled psychopath described by Millon and Davis (38), or the pure form of Cleckley psychopath suggested by Alterman (27). The most prominent features in this variant are the behavioral manifestations of psychopathy that reflect criminality or conformity problems such as impulsivity, poor behavioral controls, need for stimulation, and a parasitic lifestyle.

The following case examples are composite patient types frequently encountered at the state hospital. While an individual may demonstrate a psychopathic subtype and suffer from a severe Axis I mental disorder, the current cases were selected so as to most clearly represent the proposed subtypes, uncomplicated by features of psychosis. The case of M provides an example of the narcissistic variant. M demonstrates characteristics of entitlement by vigorously demanding every patient right and privilege available to him, often distorting the true intent of those rights. He frequently engages staff in arguments about the semantics surrounding hospital rules and regulations, about which he is an expert. M is also a master at catching nursing staff in minor errors or breaches in protocol, and has made numerous complaints to state ethics and licensing boards about the conduct of clinical staff. On one occasion, he stopped a clinician in the hallway and engaged him in conversation with a question about his treatment plan. As this conversation intentionally took place within reasonable earshot of other patients, M subsequently filed a complaint alleging breach of confidentiality. In treatment, when the impact of his crimes upon his victims is addressed, M is quick to divert the conversation back to himself and his needs.

A clinical example of the borderline variant is the case of S. S has made multiple suicide gestures, is emotionally labile, and alternately idealizes and devalues others. The emptiness inside S is almost palpable, as he spends his days manipulating the lives and emotions of those around him. He appears to do this as much for his own entertainment as to avoid experiencing his lack of emotions. S behaves in a seductive manner during most of his interpersonal interactions, and consistently attempts to draw female staff into emotionally inappropriate involvement.

The case of T could be considered the prototypical sadistic psychopath. His crimes have included setting a family pet on fire, threatening to cut the nipples off of one of his rape victims in order to terrorize her into keeping silent about the offense, and systematically raping and torturing several female acquaintances over periods of several days. When he talks about his crimes, he provides explicit details of what he did to his victims, but gives no consideration to what his victims might have experienced in a way that indicates empathy. While he is aware that his victims suffered, this awareness seems to cause him more stimulation than remorse.

The antisocial psychopath is characterized by B. While a lack of empathy and dearth of affect is evident in his presentation, he is not excessively grandiose or entitled like the narcissistic psychopath, does not have a history of sadistic, brutal crimes as does the sadist, and is not as emotionally labile and self-destructive as the borderline. Nor is he as charming or seductive as the other three variants can be. What stands out in his presentation is the myriad of crimes committed, the irresponsibility of his lifestyle, and his pathological lying. For him, crime is a way of life, and other people simply provide a means to his ends or an obstacle in his way.

CLINICAL IMPLICATIONS

Not only do the aforementioned individuals present differently from one another in a clinical setting, but treatment interventions, safety precautions, and treatment effects should also vary. For example, T, a sadistic psychopath, appears to become stimulated when he talks about the impact of his crimes on is victims. Traditional relapse prevention training, which involves the dissection of one's crimes in order to identify risk factors and warning signs of relapse, may for T serve to reinforce the pleasure derived from committing these crimes. In this case, such treatment may not only be ineffective, but could increase T's risk of reoffense.

The sadistic psychopath may also be at increased risk of acting out violently within a hospital setting. If he is provided treatment that serves to promote sadistic fantasy but is not provided with an appropriate means of channeling or reducing his level of arousal, he may seek to act upon this arousal by verbally or physically inflicting pain on those in his environment.

Relapse prevention training is likely to be a very different experience for M, the narcissistic psychopath. M is likely to be argumentative

and fail to recognize the need for such treatment, given his extreme grandiosity. Unless treatment is presented in a way that circumvents his entitlement and contempt for others, he is likely to be a disruptive and destructive force within the therapy group. Safety considerations would also be different for M. Violent acting out within the hospital setting is more likely to be in response to direct challenges to his inflated sense of self-worth, or a callous, predatory means of getting what he wants. He is more likely to attempt to use the force of his personality to verbally challenge and intimidate.

Issues regarding treatment center around the debate as to whether or not psychopathy is immutable. Hare (3) writes that since psychopaths do not believe that they have any problems, they are not likely to recognize a need for change. He postulates that not only is this a well-entrenched personality trait, but that many psychopaths simply enjoy who they are and what they do. Psychopaths may even use therapy to their advantage in order to better understand and thereby manipulate others.

Rice, Harris and Cormier (39) found that treatment was associated with lower recidivism rates, especially violent recidivism, for nonpsychopathic offenders. Conversely, psychopathic offenders had higher rates of violent recidivism after participating in treatment. Ogloff, Wong, and Greenwood (40) studied the effects of a therapeutic community, an environment in which peers govern and participants learn to take responsibility for their own behavior. They found that psychopathic participants were less motivated for change, had higher rates of attrition, and made less clinical improvement than other patients.

It is impossible to demonstrate conclusively that psychopaths cannot benefit from treatment, for to do so one would need to identify and empirically test all possible forms of treatment. What has been demonstrated, however, is that existing treatment programs have thus far failed to modify the socially unacceptable behavior of psychopathic offenders. However, it should be noted that these unsuccessful attempts at rehabilitation have not demonstrated that psychopathy is immutable. Psychopaths can in fact change if they decide that it is in their best interest to do so. In fact, it has been demonstrated that personality does change over time (41). It is unfortunate, but not unexpected, that psychopaths consistently select to attend to and learn that which is most useful to their own self-serving ends. Perhaps a more useful approach would be to help psychopathic clients see how their behavior, while egosyntonic, can result in consequences that do not satisfy their needs. Treatment goals that are consistent with their own self-gratification but do not involve harm to others could then be selected.

Wong and Hare (42) point out that much of the literature on the treatment of psychopaths provides direction on what not to do when treating psychopaths rather than information on what constitutes effective treatment. Their proposed treatment program would focus on modifying violent behavior rather than attempting to modify personality characteristics. They point out that while many of the personality characteristics of the psychopath are unpleasant, it is their criminal behavior that brings them into contact with the criminal justice and mental health systems. This approach is also likely to be less threatening to the psychopath's grandiose sense of self, and may therefore elicit less resistance.

The issue of safety for the community and safety for those who treat psychopaths also warrants mention. Risk assessment is at best a complicated and imprecise means of determining the likelihood of reoffense for a given individual. It is not difficult to say with certainty that most psychopaths, if left to their own devices in an unstructured, unsupervised setting, will involve themselves in activities that have the potential for physical, emotional, or financial harm to others. However, more precise predictions of behavior are difficult. The development of subtypes within psychopathy might serve to focus the definition of psychopathy and provide empirical data that can be used for more precise predictions of behavior. For example, some psychopathic subtypes might be associated with manipulative but nonviolent crimes, whereas others might be identified as being an imminent risk of physical harm to others (25).

Within the institutions that house psychopathic offenders, the issue becomes one of how to manage their behavior so they do not bring harm to the staff and patients who interact with them on a daily basis. Hare (3) recommends firm ground rules be set and that those who work with psychopaths be aware of the power struggles that are inherent when dealing with psychopaths. Staff must be adequately oriented to the concept of psychopathy and the associated interpersonal dynamics. For example, it is postulated that there is increased risk of staff involvement with the borderline psychopath, more challenging intimidation when dealing with the narcissistic psychopath, and physical assault by the sadistic psychopath.

In particular, staff must be vigilant about the amount of personal information they reveal about themselves and others in the environment. Psychopaths are typically very effective at manipulating information from others in conversation. They can also enhance their own manipulative skills by observing the socially appropriate behavior that is modeled for them. This highlights the question of whether treatment,

or even exposure to a therapeutic milieu, might enable a psychopath to develop more effective skills for victimizing others.

FUTURE DIRECTIONS

The approach taken here has been to identify potential subtypes among psychopaths based on the clinical observation of the most pronounced personality and behavioral characteristics with management or treatment implications. Another potential method to identify subtypes would be to analyze the various combinations of PCL-R item scores that can produce a significant overall score. For example, it is possible for one individual to be scored a "2" on several items while another is scored a "0" on those same items, and yet both might obtain the same overall score. If they are fundamentally different in aspects of their psychopathy, they can be expected to present with different behaviors, interpersonal skills, and risk factors for reoffense.

A different means of identifying subtypes is to identify behavioral manifestations of psychopathy. Variables such as staff involvement, verbal and physical aggression, chronic rule violations, suicide gestures, and cruelty in interactions with others can be operationally defined. Data on these variables can then be examined in relationship to psychopathy in an effort to identify useful subtypes.

This article has suggested four discrete subtypes within psychopathy. However, additional evidence is needed to support this contention. It will be important to consider whether subtypes represent discrete subcategories within the larger class of psychopathy, or if psychopathy is better conceptualized on a dimensional level. As with the cluster B personality disorders, there may be a considerable degree of overlap amongst the criteria for proposed subtypes. It may ultimately prove more useful to consider these subtypes dimensionally, with the emotionally unstable, self destructive borderline variant at one end, and the aggressive, assaultive sadistic variant at the other. Additional objective data are needed to determine the most effective explanation of heterogeneity among psychopaths.

Future research should therefore focus on determining whether there is sufficient evidence of the aforementioned subtypes within psychopathy. Objective personality measures may provide useful data on this issue. The patterns of MMPI-2 and MCMI-3 profiles which depict the various personality disorders (e.g. APD, BPD, NPD) or traits (e.g. sadism) should be examined in relationship to psychopathy. Additional information may be gained through the examination of the patterns or clusters

of scores on the individual items of the PCL-R. Empirical evidence supporting the detection of clinically meaningful subtypes might significantly advance the efforts to improve institutional management, risk prediction, and treatment of psychopaths.

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