CHAPTER 1

Psychopathy as Masked Pathology

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> [I]t is a different kind of abnormality from all those now recognized as seriously impairing competency. . . . The first and most striking difference is this: . . . The observer is confronted with a convincing mask of sanity. All the outward features of this mask are intact. . . .
>
> —Cleckley (1976, p. 368)

The cited quotation, from the fifth (1976) edition of Hervey Cleckley's book *The Mask of Sanity* (originally published in 1941), captures what Cleckley considered the most salient feature of psychopathy as a major psychiatric condition: It entails a highly credible appearance of psychological normality ("sanity") that operates to conceal ("mask") a severe underlying pathology that is manifested in reckless, unrestrained behavior across multiple areas of life. The passage of the book containing this quotation contrasts the coherent thought processes of psychopathic individuals with the confused, disrupted cognitive style of patients with schizophrenia; additionally, it characterizes psychopathic individuals as showing ostensibly healthy "verbal and facial expressions, tones of voice, and all the other signs . . . implying conviction and emotion and the normal experiencing of life," along with verbal "judgments of value and emotional appraisals [that appear] sane and appropriate" (p. 369). Elsewhere in his book, Cleckley amplifies this "mask" conception by identifying the following as defining features of psychopathy: a positive social demeanor marked by affability and agreeableness ("Alert and friendly in his attitude, he is easy to talk with and seems to have a good many genuine interests"; p. 339); a salient absence of anxiety or internalizing symptoms ("[T]he psychopath is nearly always free from minor reactions popularly regarded as 'neurotic' or constituting 'nervousness' "; p. 339); and a disinclination toward suicide ("Instead of a predilection for ending their own lives, psychopaths . . . show much more evidence of a specific and characteristic immunity from such an act"; p. 359).

The mask component of psychopathy is arguably its most distinctive feature as a clinical condition, and without question a major source of its enduring fascination. The idea that there are reckless, untrustworthy individuals in our midst who present as psychologically normal (cf. Hare, 1993) is both disturbing and intriguing. This idea connects in turn with the notion of the artful trickster, a recurring image in stories and legends throughout history and across cultures of the world, which Jung (1963) recognized as a core thematic element (archetype) of the human psyche. Additionally, it relates to the concept of a primitive–instinctual "id" (Freud, 1923/1961) or "shadow" (Jung, 1963) side within each of us that operates in counterpoint to our rational–prosocial tendencies.

In this chapter, I discuss the mask component of psychopathy in relation to historic accounts of this condition, and contemporary theoretical and empirical work in this area. I consider the mask component hand in hand with the "madness" features

described by Cleckley (1941/1976) and others, and suggest alternative ways in which these two contrasting "faces" of psychopathy might relate to one another. In doing so, I foreshadow major themes addressed in other chapters of this book and highlight interesting new directions for research that emerge out of the concept of psychopathy as masked pathology.

Origins and Development of the "Mask" Concept

The idea of psychopathy as a distinct psychiatric illness marked by serious behavioral deviancy in the context of intact rational function is commonly traced to Pinel (1806/1962), who documented a condition he labeled *manie sans délire* (mania without delirium). However, in contrast with Cleckley's (1941/1976) illustrative cases (discussed below), the dominant characteristic in Pinel's clinical examples was explosively violent behavior ("abstract and sanguinary fury")—and, indeed, one of his three sample cases would likely meet criteria for intermittent explosive disorder according to current diagnostic guidelines (American Psychiatric Association [APA], 2013), rather than psychopathy or antisocial personality disorder. Cases more akin to those of Cleckley were documented by subsequent psychiatric scholars. Kraepelin (1904/1915), for example, identified a group of patients termed "swindlers," who exhibited salient charm and persuasiveness but were amoral, untrustworthy, and devoid of loyalty; they commonly specialized in con artistry and fraud, and accrued large debts they failed to pay. Along similar lines, Schneider (1934) documented a "self-seeking" type whom he characterized as pleasant and congenial in demeanor but selfish, attention-seeking, and superficial in emotional reactions and social relations; like Kraepelin's (1904/1915) swindlers, individuals of this type were pervasively deceitful and prone to acts of fraud.

At the same time, it should be noted that both Kraepelin (1904/1915) and Schneider (1934) applied the term "psychopathic" to a range of other clinical conditions beyond these—in Kraepelin's case, to chronic conditions marked by "moral defect" that he presumed to be biologically based, including hostile–impulsive ("quarrelsome"), persistent antisocial ("born criminal"), and addiction-driven ("compulsive") types, along with so-called "swindlers"; and in Schneider's case, to deviant personality or "characterological" conditions ranging from hypochondriacal ("asthenic") to submissive ("weak-willed") to deceptive–antisocial types (i.e., impulsive–aggressive ["explosive"] and callous–predatory ["affectionless"] types, along with the self-seeking variant). The use of the label "psychopathic" by these authors for conditions of such different types highlights a major problem in the literature up to the time of Cleckley (1941/1976)—namely, the tendency on the part of clinicians and scholars to apply the term so broadly as to render it meaningless. This problem was exemplified in the writings of British physician J. C. Pritchard (1835) and German psychiatrist J. L. Koch (1891), who grouped conditions as diverse as substance addictions, sexual paraphilias, mood disorders, psychosis, and intellectual disability into the category of "moral insanity" or "psychopathic inferiority."

A major goal of Cleckley's in writing the *Mask of Sanity* (1941/1976) was to counter this excessively broad use of the term:

> It is my earnest conviction that, traditionally confused with a fairly heterogeneous group under a loose and variously understood term, a type of patient exists who could, without exaggeration, still be called the forgotten man of psychiatry (p. 16). The chief aim of this book is to help . . . bring patients with this type of disorder into clearer focus so that psychiatric efforts to deal with their problems can eventually be implemented. (p. 23)

Focusing on cases encountered in his practice within a large psychiatric hospital, Cleckley (1941/1976) sought to establish more precise usage of the term by presenting detailed descriptions of the demeanor and actions of various patients he considered psychopathic (n = 15), formulating explicit criteria for diagnosing the disorder based on these case examples, and highlighting distinctions between psychopathy and other psychiatric conditions (including ones previously classed with it). In the concluding chapter of the first edition of this volume, I (Patrick, 2006) summarized salient characteristics of the cases presented by Cleckley, noting in particular that (1) lack of anxiousness was clearly evident in most of these cases; (2) hostile–aggressive behavior was a dominant feature in only a small number of them; and (3) other types of law-breaking behavior (e.g., fraud, theft, forgery, fire setting, drug offenses, drunken/disorderly conduct, vandalism, truancy, reckless driving) were evident in all cases—but marked by a peculiar aimless ("inadequately motivated") quality: "He will commit theft, forgery, adultery, fraud, and other deeds for astonishingly small stakes and under much greater risks of being discovered than will the ordinary scoundrel. He will, in fact, com-

mit such deeds in the absence of any apparent goal at all" (p. 343).

In my closing chapter of the first edition of this handbook, I also discussed Cleckley's (1941/1976) 16 diagnostic criteria for psychopathy, grouping them into three thematic categories (see Table 1.1). The first category consists of the "mask" features that set psychopathy apart from other psychiatric conditions: good intelligence and social charm; absence of nervousness; absence of delusions/irrationality; and suicide rarely carried out (Table 1.1, top part). Of note, in describing these features, Cleckley referred to not only an absence of visible symptoms of mental illness but also the presence of social poise and emotional stability: "The surface of the psychopath . . . shows up as equal to or better than normal and gives no hint at all of a disorder within. Nothing about him suggests oddness, inadequacy, or moral frailty. His mask is that of robust mental health" (p. 383).

TABLE 1.1. Categorization of Cleckley's (1941/1976) 16 Diagnostic Criteria for Psychopathy

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

However, this overt appearance of robust mental health is accompanied by persistent and severe behavioral deviancy: "The psychopath, however perfectly he mimics man theoretically, that is to say, when he speaks for himself in words, fails altogether when he is put into the practice of actual living. His failure is so complete and so dramatic that it is difficult to see how such a failure could be achieved by anyone less defective than a downright madman" (Cleckley, 1941/1976, p. 370). This behavioral deviancy aspect of the disorder is captured by a second set of indicators, including impulsive antisocial acts, irresponsibility (unreliability), promiscuity, and absence of any clear life plan (Table 1.1, middle part). Along with the "mask" and behavioral deviance features, Cleckley's criteria for psychopathy also included a third set of features pertaining to affective/social shallowness and deceptiveness, including general poverty of affect, absence of remorse, inability to love, and lack of loyalty or social reciprocity, along with untruthfulness/insincerity (Table 1.1, bottom part).

In the context of specifying these central defining features, Cleckley (1941/1976) discusses in detail how psychopathy differs from other psychiatric conditions, in a section of his book titled "A Comparison with Other Disorders." He notes that psychopathic individuals are free from the salient cognitive–perceptual disturbances seen in psychotic patients ("There are no demonstrable defects in theoretical reasoning. . . . He carries out his activities [with] ordinary awareness of the consequences and without the distorting influences of any demonstrable system of delusions"; p. 247) and do not exhibit the social awkwardness/detachment or hostile suspiciousness seen in schizoid and paranoid personality conditions, respectively. In contrast with anxious–depressive (psychoneurotic) patients, psychopathic patients are energetic, socially assertive, and "very sharply characterized by the lack of anxiety (remorse, uneasy anticipation, apprehensive scrupulousness, the sense of being under stress or strain) and, *less than the average person,* show what is widely regarded as basic in the neurotic" (p. 257, emphasis added). Relative to individuals with substance problems or sexual paraphilias, psychopathic individuals are not oriented toward specific hedonistic pursuits and exhibit more wide-ranging behavioral deviancy.

Importantly, Cleckley (1941/1976) also differentiates psychopathy from other forms of crimi-

nality and antisocial deviance. In contrast with typical repeat offenders ("ordinary criminals"), psychopathic individuals lack clear motivation for much of their antisocial behavior, fail to gain systematically from such behavior, harm others inadvertently rather than on purpose, and rarely "commit murder or other offenses that promptly lead to major prison sentences" (p. 262). Cleckley likewise distinguishes psychopathic deviancy from "normal delinquency" in terms of its pervasiveness across situations, persistence over time, and extent of adverse effects on the individual's life.

Having characterized psychopathy in these diagnostic terms and distinguished it from other psychiatric disorders, Cleckley (1941/1976) highlights with particular emphasis the unusual, incongruous nature of this condition:

> The observer is confronted with a paradox within the already baffling domain of mental disorder. . . . A man who is sane by the standards of psychiatry, aware of all the facts which we ourselves recognize, and free from delusions but who conducts himself in a way quite as absurd as many of the psychotic. . . . (p. 367)

> Only very slowly and by a complex estimation or judgment based on multitudinous small impressions does the conviction come upon us that, despite these intact rational processes, these normal emotional affirmations, and their consistent application in all directions, we are dealing here not with a complete man at all but with something that suggests a subtly constructed reflex machine which can mimic the human personality perfectly. (p. 369)

Furthermore, and of importance, Cleckley (1941/1976) expresses the view that psychopathic individuals are themselves largely unaware of how discrepant their day-to-day conduct is from the social image they present to others. More specifically, Cleckley suggests that the process that underlies their convincing mask of sanity—"a consistent leveling of [emotional] response to petty ranges" (p. 383)—operates as a barrier to objective self-appraisal (i.e., insight):

> Without suffering or enjoying in significant degree the integrated emotional consequences of experience, the psychopath will not learn from it to modify and direct his activities as other men whom we call sane modify and direct theirs. He will lack the real driving impulses which sustain and impel others toward their various widely differing but at least subjectively important goals. He will naturally lack insight into how he differs from other men, for of course he does not differ from other men as he sees them. It is entirely impossible for him to see another person from the aspect of major affective experience, since he is blind to this order of things or blind in this mode of awareness. (p. 373)

Cleckley's (1941/1976) concept of psychopathy as masked pathology has been enormously influential over the decades since his classic book was first published. Of particular importance, his conceptualization (1) resulted in a rapid shift in the use of the term "psychopathic," from a generic label for diverse psychiatric conditions to one designating a distinct pathology marked by unique clinical features, and (2) fostered a general recognition that antisocial or criminal behavior is not sufficient in itself for a diagnosis of psychopathy. Echoing Cleckley's latter point, Karpman (1941, 1948) advanced the notion of "primary" versus "secondary" psychopathy: "Many of even the most recalcitrant psychopaths are nothing but neurotics, meaning that the reactions flow out from unresolved inner conflicts. . . . In my experience, the symptomatic or secondary psychopath furnishes about 85 per cent of what is diagnosed or passes for psychopathy or psychopathic personality. The remaining 15 per cent I put in a special group which I designate as primary, idiopathic, or essential psychopathy" (1948, p. 487). In a related vein, Lykken (1957) classified young antisocial offenders into primary versus secondary subgroups using Cleckley's (1941/1976) diagnostic criteria and presented experimental evidence that the two groups differed in anxiousness and capacity for fear—an idea that received extensive support from subsequent laboratory–experimental studies by Hare (e.g., 1965a, 1965b, 1978) that also used Cleckley's criteria to identify psychopathic offenders.

The "Madness" Component of Psychopathy

The most visible expression of the underlying "madness" of psychopathy according to Cleckley (1941/1976) was a pervasive unrestrained behavioral style that produces severe adverse consequences both for the psychopathic patient and others associated with him or her (Table 1.1, middle portion). Cleckley asserted that information regarding the patient's behavior in various spheres of life outside the clinic setting, gained through direct observation and reports of knowledgeable associates, as well as discussions with the patient, is necessary to appreciate the severe pathology concealed by the "mask": "The disorder can be demonstrated only

when the patient's activity meshes with the problems of ordinary living. . . . To see [psychopathic individuals] properly . . . we must follow them from the wards out into the marketplace, the saloon, and the brothel, to the fireside, to church, and to their work." (p. 22–23). Cleckley's clinical case histories were written to provide this perspective. Each case includes extensive compelling examples of the reckless, capricious, and irresponsible behavior that Cleckley described as the most salient manifestation of the "madness" of psychopathy:

> He seems to go out of his way to make a failure of life. . . . He eventually cuts short any activity in which he is succeeding, no matter whether it is crime or honest endeavor. . . . His behavior gives such an impression of gratuitous folly and nonsensical activity in such massive accumulation that it is hard to avoid the conclusion that here is the product of true madness—of madness in a sense quite as real as that conveyed to the imaginative layman by the terrible word lunatic. (p. 364)

Of note, though Cleckley (1941/1976) characterized psychopathy in its full form as a severely debilitating condition, he also presented case examples of psychopathic individuals who managed to achieve and maintain successful functioning in the community (e.g., "The psychopath as businessman"; "The psychopath as scientist"; "The psychopath as physician"; and "The psychopath as psychiatrist"). He referred to such cases as "incomplete manifestations or suggestions of the disorder" (p. 188). By "incomplete," he meant that the core underlying disturbance, while present, was not expressed in a seriously maladaptive behavioral manner: "The psychopathologic process . . . is, as with the [full clinical cases], a process affecting basic personal reactions; but here it has not altogether dominated the scene. It has not crowded ordinary successful functioning in the outer aspects of work and social relations entirely out of the picture" (p. 189). However, as discussed in the preceding section, Cleckley also made it clear that the presence of reckless, antisocial behavior does not in itself warrant the diagnosis: "There are many patients who show relatively circumscribed antisocial behavior or temporary episodes of gross, general delinquency, who have . . . much less in common with the obvious psychopath than those who make a better outward impression but who consistently show signs of inner subjective reactions typical of the clinically disabled patient" (pp. 190–191). In summary, therefore, Cleckley viewed reckless, unrestrained, and often self-defeating (as well as other-damaging) conduct as symptomatic of the underlying pathological process in psychopathy, and highly typical of psychopathic individuals residing in general inpatient and forensic settings.

Contemporary clinical-psychological research has established a specific diagnostic label for problematic conduct of this type: "externalizing behavior." In work dating back 50 years, Achenbach (1966) reported results from a factor analysis of childhood psychopathology symptoms that revealed the presence of two major dimensions of symptomatology, which he labeled "internalizing" and "externalizing" (see also Achenbach & Edelbrock, 1978). The internalizing factor was marked by symptoms including fears/phobias, worry, depression, shyness/social withdrawal, obsessions, compulsions, and somatic complaints (e.g., stomachaches, other pain); the externalizing factor was associated with symptoms including disobedience, truancy, running away, lying, swearing, stealing, fighting, vandalism/destructiveness, and "sexual delinquency." Subsequent work has demonstrated a highly similar two-dimensional structure for common adult forms of psychopathology, in which anxious–depressive disorders (or their symptoms) demarcate a higher-order internalizing factor, and impulsive–antisocial and substance use disorders/symptoms demarcate a broad externalizing factor (Krueger, 1999; Krueger, Caspi, Moffitt, & Silva, 1998; Krueger, McGue, & Iacono, 2001). The externalizing problem domain, which connects clearly with the behavioral tendencies exhibited by Cleckley's (1941/1976) prototypical clinical cases, has also been termed the "disinhibitory" spectrum of psychopathology (e.g., Gorenstein & Newman, 1980; Sher & Trull, 1994). Behavior-genetic research using twin participants has demonstrated that the general tendency to exhibit problems of this type reflects a continuously varying, etiologically coherent trait liability with very high (~80%) heritability (Krueger et al., 2002).

The idea of a general spectrum of psychopathology encompassing impulse control problems of various types is helpful for understanding why the term "psychopathy" has been applied to such a broad range of conditions historically. Externalizing forms of psychopathology are clinically salient, relatively common, and co-occur frequently with one another—so that unrestrained antisocial behavior of the sort described by Cleckley (1941/1976) is often seen in individuals with substance problems or other impulse-related conditions distinct from psychopathy (e.g., pathological gambling, sexual deviancy, borderline personality).

However, while externalizing behavior is highly characteristic of clinically psychopathic individu-

als, persons who exhibit behavior of this type differ as a whole from individuals described as psychopathic by Cleckley (1941/1976). In particular, externalizing symptomatology is generally associated with (1) *increased* rather than decreased levels of internalizing symptomatology (i.e., internalizing and externalizing factors of psychopathology are correlated to a moderate positive degree; Achenbach & Edelbrock, 1978; Krueger, 1999; see also Vaidyanathan, Patrick, & Iacono, 2011), (2) *higher* rather than lower scores on scale measures of anxiousness, neuroticism, and negative emotionality (e.g., Ellingson, Littlefield, Vergés, & Sher, Chapter 26, this volume; Krueger, Caspi, Moffitt, Silva, & McGee, 1996; Sher & Trull, 1994), and (3) increased risk for suicidal ideation and action (Verona & Patrick, 2000; Verona, Sachs-Ericsson, & Joiner, 2004).[1] From this perspective, the psychopathic individuals that Cleckley described are markedly anomalous: They exhibit severe impulsive–externalizing behavior without accompanying internalizing psychopathology and are notably lacking in anxiety or neuroticism, as opposed to high in these traits. Additionally, in Cleckley's words, they show a "specific and characteristic immunity" to suicidal behavior. Thus, the "mask" features identified at the beginning of this chapter as most central to Cleckley's conception are the characteristics that differentiate highly psychopathic individuals most clearly from other individuals who exhibit salient externalizing tendencies.

Below, I consider some alternative ways to think about the relationship between the "mask" features of psychopathy as Cleckley conceptualized it, and the reckless–externalizing behavior he described as the most conspicuous expression of the "madness" associated with it. First, however, I describe an alternative perspective on psychopathy that emerged out of the criminological literature of the mid-1900s—one that emphasizes callous–aggressive tendencies more than charming insouciance.

Predatory Criminality versus Masked Psychopathology

An alternative conceptualization evident in historic writings is of psychopathy as an asocial, predatory form of criminal deviancy. In contrast with Cleckley's (1941/1976) portrayal of psychopathic hospital patients as affable and socially adept but aimless and untrustworthy, writers concerned with psychopathy in criminal populations highlighted features of emotional detachment, abrasiveness, and aggressive exploitativeness toward others. Lindner (1944), for example, characterized criminal psychopaths as hostile, defiant, and combative. McCord and McCord (1964), in their book *The Psychopath: An Essay on the Criminal Mind,* emphasized tendencies toward affective coldness, social disconnectedness, and dangerousness, along with lack of behavioral control. Like Cleckley (1941/1976), these authors described psychopathic offenders as low in anxiety and emotional sensitivity, but saw these qualities as reflections of social disengagement and unconcern ("lovelessness" and "guiltlessness") rather than of a general affective deficit: Lacking in social conscience and inhibitions against aggression, offenders of this type are prone to react with rage rather than fear under circumstances of frustration or threat.

Lee Robins (1966, 1978) also emphasized early and persistent aggressive antisocial deviance in her empirical accounts of maladjusted youth who developed into adult "sociopaths." Robins's work served as the basis for the modern psychiatric diagnosis of antisocial personality disorder (ASPD) included in the third through fifth editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III, DSM-IV, DSM-5; APA, 1980, 2000, 2013), which emphasize aggression and destructiveness, along with theft, deceitfulness, and rule breaking in childhood, and assaultiveness, lack of remorse, and reckless disregard, along with impulsiveness, irresponsibility, deception, and repeated law-breaking, in adulthood.

These descriptions of psychopathic criminal offenders as cold, vicious, and predatory contrast with Cleckley's (1941/1976) characterization of psychopathic inpatients as affable, emotionally calm, and generally uninclined toward serious acts of violence. However, this alternative perspective has been similarly influential over the years, and some contemporary instruments for assessing psychopathy in youthful and adult clinical samples reflect this predatory criminal concept more than Cleckley's masked pathology concept (Drislane, Patrick, & Arsal, 2014; Sellbom & Phillips, 2013).

Conceptualizing the "Mask" of Psychopathy

Key Findings from Contemporary Empirical Research

In thinking about how to conceptualize the mask component of psychopathy described by Cleckley (1941/1976), it is important to consider what

we now know about this clinical condition from contemporary research studies using established assessment methods. Two findings in particular that must be considered are that (1) psychopathy is dimensional rather than typological in nature, and (2) psychopathy is multifaceted rather than unitary in terms of its symptomatic features.

Psychopathy Is Dimensional

Although personality disorders including ASPD and psychopathy have traditionally been viewed as discrete conditions ("taxons"; Meehl & Golden, 1982) that are either present or absent in assessed individuals, empirical research over the past three decades has roundly challenged this view. As a reflection of this, alternative dimensional systems for personality pathology have existed for some time in the clinical assessment literature (e.g., Clark, 1993; Livesley & Jackson, 2009), and the manual for DSM-5 (American Psychiatric Association, 2013) includes a new dimensional-trait system in Section III, titled "Emerging Measures and Models," as an alternative to the traditional categorical system for personality disorders in the main "Diagnostic Criteria and Codes" section of the manual.

A number of studies have specifically addressed whether psychopathy as assessed by well-established interview- and self-report-based inventories is taxonic or dimensional. The majority of these have provided clear evidence for the dimensionality of psychopathic symptoms, with only a small number of methodologically flawed studies providing evidence for taxonicity (Walters, Marcus, Edens, Knight, & Sanford, 2011). Thus, in contrast with Cleckley's view of psychopathy as a distinct syndrome with a discrete underlying cause, and despite the long-standing practice in research of separating participants into psychopathic and nonpsychopathic groups on the basis of diagnostic cutoff scores, available evidence indicates that psychopathic tendencies vary along a continuum from low to high—with individuals diagnosable as psychopathic differing from others in degree rather than in kind.

Psychopathy Is Multifaceted

It is also well established now that psychopathy encompasses separable symptom subdimensions rather than comprising a single, coherent continuum of symptomatology (see Part II of this volume, titled "Distinct Phenotypic Facets of Psychopathy"). The best-established contemporary inventories for assessing psychopathy all contain "factors" or "facets" reflecting psychologically distinct subsets of symptoms. Even measures that were designed to index psychopathy as a unitary syndrome contain distinguishable (albeit correlated) factors. For example, the interview-based Psychopathy Checklist—Revised (PCL-R; Hare, 2003), originally developed to identify offenders in correctional settings who closely matched Cleckley's diagnostic profile (Hare, 1980), contains subsets of items that define interpersonal–affective (Factor 1) and impulsive–antisocial (Factor 2) subdimensions—each divisible into narrower facets (Hare, Neumann, & Mokros, Chapter 3, this volume).

Inventories patterned after the PCL-R, including the informant-rated Antisocial Process Screening Device (APSD; Frick & Hare, 2001) and self-report-based measures, such as Paulhus, Neumann, and Hare's (2015) Self-Report Psychopathy scale (SRP) and the Youth Psychopathic Traits Inventory (YPI; Andershed, Kerr, Stattin, & Levander, 2002), likewise contain correlated factors. Of note, symptom subscales of the self-report-based Psychopathic Personality Inventory (PPI; Lilienfeld & Andrews, 1996; Lilienfeld & Widows, 2005), developed to index psychopathy-related traits represented in differing historic accounts of the disorder, demarcate *uncorrelated* Fearless Dominance (FD) and Impulsive Antisociality (or Self-Centered Impulsivity; SCI) factors, along with a narrower coldheartedness facet. The implication is that psychopathy subdimensions may be more or less interrelated depending on the conceptual referents and measurement methods used in developing a particular inventory.

Importantly, the symptom subdimensions of psychopathy as assessed by different inventories show contrasting correlates with external criterion measures. In some instances, correlations are selective to one subdimension or another (e.g., PCL-R Factor 2, but not Factor 1, correlates with trait impulsiveness and substance-related problems; Reardon, Lang, & Patrick, 2002); in others, correlations are in opposing directions for one subdimension versus another (e.g., the PPI's FD factor correlates negatively with trait anxiety and internalizing problems, whereas its SCI factor correlates positively with these distress-related criteria; Benning, Patrick, Blonigen, Hicks, & Iacono, 2005). For correlated subdimensions such as those of the PCL-R or SRP, opposing relations with certain criterion measures (including ones related to anxiety, internalizing problems, and suicidal be-

havior; Hicks & Patrick, 2006; Verona, Patrick, & Joiner, 2001) become stronger when researchers control for the shared variance between the subdimensions. This effect, known as "statistical suppression," is critical to understanding how attributes of different types combine or blend with one another to produce a distinct clinical presentation—and I return to it in the next section.

Psychopathy as Masked Externalizing Psychopathology: Two Perspectives

In this section, I consider two alternative perspectives on the relationship between the "mask" component of psychopathy and the deviant behavioral tendencies that it operates to conceal. One of these, termed the "unitary-mechanism model," reflects Cleckley's (1941/1976) view that the various diagnostic features of psychopathy emanate from a discrete underlying "disability, disorder, defect, or deviation" (p. 367). The other, termed the "dual-disposition model," posits that the mask features of psychopathy reflect a dispositional tendency separate from that which underlies extreme externalizing tendencies.

Both models rely on a distinction between observable (phenotypic) tendencies of "boldness" and "disinhibition," as described in the triarchic model (Patrick, Fowles, & Krueger, 2009), a conceptual framework put forth to reconcile and integrate different historical descriptions of psychopathy and alternative instruments for assessing it. Boldness relates to the PPI's FD factor and to a structural model of fear/fearlessness measures (Kramer, Patrick, Krueger, & Gasperi, 2012), and encompasses attributes of social assertiveness, emotional stability, and venturesomeness (Lilienfeld, Watts, Smith, & Latzman, Chapter 8, this volume). Disinhibition relates to the PPI's SCI factor and to the concept of general externalizing proneness (Krueger et al., 2002) and involves tendencies toward nonplanfulness, weak restraint, urge-driven behavior, and undependability (Nelson & Foell, Chapter 6, this volume). Conceptualized in this manner, these two dispositional tendencies are largely independent of one another. The triarchic model also recognizes a third dispositional tendency, termed "meanness" in historic conceptions of psychopathy. This construct relates to concepts of callousness–unemotionality (Viding & Kimonis, Chapter 7, this volume) and antagonism (Lynam, Miller, & Derefinko, Chapter 11, this volume) in the child and adult psychopathy literatures, respectively, and to the affectionless, predatory view of the disorder emphasized in writings on criminal psychopathy.

As I discussed earlier, disinhibitory–externalizing behavior aptly characterizes the overt deviancy component of psychopathy as described by Cleckley (1941/1976), and empirical research confirms a close association between the externalizing psychopathology factor and the impulsive–antisocial subdimension of psychopathy, whether indexed via clinical interview or self-report (e.g., Blonigen et al., 2005, 2010; Patrick, Hicks, Krueger, & Lang, 2005). However, Cleckley's concept of psychopathy includes a distinct absence of the distress and internalizing symptoms that typically accompany externalizing psychopathology, and the triarchic model reconciles this by characterizing Cleckley's sample cases as high in boldness, as well as disinhibition—with boldness reflected in the "mask" features of the disorder, and disinhibition reflected in the overt behavioral deviancy component. Recent research by Crego and Widiger (2016) provides empirical confirmation of boldness as a salient feature of Cleckley's prototype cases. These investigators asked naive participants to rate Cleckley's case examples for various dispositional tendencies, including traits related to boldness, and found that his cases as a whole were perceived as very high in these traits.

Thus, the two models discussed below conceive of Cleckley's (1941/1976) psychopathic patients, in observable symptomatic (i.e., phenotypic) terms, as high-bold/high-disinhibited individuals. However, the models differ in the presumed etiological (genotypic) basis for this configuration of observed tendencies.

Unitary Mechanism Model

One perspective on the relationship between the boldness ("mask") and disinhibition (behavioral deviancy) features of psychopathy as described by Cleckley (1941/1976) is that both are observable manifestations of a common underlying pathology. Cleckley's view was that these symptomatic features, along with the shallow–deceptive symptoms, were products of a constitutionally based deficit in emotional responsiveness—"a consistent leveling of [emotional] response to petty ranges and an incapacity to react with sufficient seriousness to achieve much more than pseudoexperience or quasi-experience" (p. 383). He likened the effects of this core deficit to the impact of being born with complete color blindness: Just as color blindness precludes direct experience of variations

in chromatic hue and normal appreciation of the aesthetics of such experience, the affective deficit in psychopathy results in an absence of true understanding of the emotional reactions of other people and an interpersonal style based around mimicked reactions and feigned appreciation of others' feelings: "He is . . . lacking in the ability to see that others are moved. . . . It cannot be explained to him because there is nothing in his orbit of awareness that can bridge the gap with comparison. He can repeat the words and say glibly that he understands, and there is no way for him to realize that he does not understand" (p. 40).

Lykken (1957) posited that this deficit involves a specific impairment in the capacity to develop anxiety responses to aversive cues, which he reframed later (Lykken, 1995; Chapter 2, this volume) as a temperament-based weakness in fear reactivity. Like Cleckley (1941/1976), Lykken held the view that all major diagnostic symptoms of psychopathy are traceable to this core deficit in fear response. He suggested that this weakness is necessary for the emergence of true ("primary") psychopathy, but that not all individuals who possess a "low fear temperament" are destined to develop the full clinical condition. He theorized that early socialization influences, in particular parenting style, are critical for determining whether this basic disposition is expressed in prosocial directions (e.g., leadership or heroism) or in antisocial ways (e.g., law breaking or aimless self-indulgence). Writers subsequent to Lykken have proposed dysfunction in particular systems of the brain to account for empirical findings of reduced physiological reactivity to aversive cues of different types in clinically psychopathic individuals (Blair, 2003; Fowles, 1980; Patrick, 1994).

If it is true that all aspects of psychopathy arise from a common core deficit in emotional sensitivity as suggested by Cleckley (1941/1976), or fear reactivity more specifically, as postulated by Lykken, then one might expect that different symptom subdimensions of psychopathy would relate equally to impairments in affective–fear response as indexed by laboratory–task procedures. However, this does not appear to be the case: Lab-assessed deficits in fear and emotional reactivity more broadly are reliably observed in relation to interpersonal–affective (Factor 1) symptoms of psychopathy, but not in relation to impulsive–antisocial (Factor 2) features (for reviews, see, Fowles, Chapter 5, this volume; Patrick, Chapter 18, this volume; Patrick & Bernat, 2009). For example, "aversive startle potentiation"—defined as enhancement of the reflexive blink response to abrupt noise probes presented during viewing of aversive as compared to neutral visual stimuli—is reduced as a function of higher scores on the FD factor of the PPI, but it shows no association with scores on the PPI's orthogonal SCI factor (Benning, Patrick, & Iacono, 2005; Dvorak-Bertsch, Curtin, Rubinstein, & Newman, 2009; see also Vaidyanathan, Patrick, & Bernat, 2009). Parallel results have been reported for the PCL-R's two correlated symptom factors, and in this case contrasting relations (i.e., negative for Factor 1, null for Factor 2) become more evident when researchers control for the shared variance between the two factors (Patrick, 1994; Vaidyanathan et al., 2011). The implication is that reduced affective–fear reactivity plays a role in some symptoms of psychopathy—including those associated with the "mask" component of psychopathy described by Cleckley (1941/1976)—but not in others (i.e., the overt behavior deviancy features).

Reciprocal to this, it would be expected from a unitary mechanism perspective that individuals identified as low in emotional responsiveness, or in fearfulness specifically, should generally be more prone to impulsive–antisocial behavior. Cleckley's (1941/1976) notion of a general affective deficit is challenging to quantify in trait-dispositional terms; thus, research to date has focused on the narrower construct of fearfulness, along with the construct of callousness–unemotionality. There is considerable evidence for a contribution of callousness to antisocial behavior (Frick & Marsee, Chapter 19, this volume; Frick, Ray, Thornton, & Kahn, 2014; Viding & Kimonis, Chapter 7, this volume), in line with the forensic concept of psychopathy as a severe, predatory–aggressive criminal type; however, as I discuss more below, callous–unemotional tendencies do not correspond well to the "mask" features emphasized by Cleckley.

As regards fearlessness, the evidence for a direct contribution of this attribute to impulsive–antisocial behavior is mixed. Prominent models of child temperament characterize dispositional fear as independent from the impulsivity-related dimension of inhibitory (or effortful) control, and describe the two traits as differing in their etiological bases, behavioral correlates, and contributions to the development of clinical problems (Kochanska, 1997; Kochanska, Murray, & Coy, 1997; Rothbart, 2007). Counterpart trait dimensions in adults are likewise independent from one another, whether assessed using scale measures alone (Nelson, Strickland, Krueger, Arbisi, & Patrick, 2016) or trait scales

combined with neurophysiological measures (Venables et al., 2017). Some evidence exists to indicate that low fearfulness in early childhood affects conscience development (Kochanska, 1997) and predicts the occurrence of later antisocial behavior (e.g., Gao, Raine, Venables, Dawson, & Mednick, 2010; Klingzell et al., 2016). However, measures of fearfulness have varied across such studies and in some cases have overlapped with concurrently assessed psychopathic tendencies, complicating interpretation of relations with later antisocial behavior. Findings from studies with adults have varied depending on how dispositional fear is operationalized. Associations with impulsive–antisocial behavior tend to be positive when fearfulness is assessed in terms of reported reactivity to stressors, negative when fearfulness is defined in terms of sensation-seeking tendencies, and weakly negative or negligible when fearfulness is quantified as (low) boldness (Benning, Patrick, Blonigen, et al., 2005; Blonigen et al., 2005; Drislane et al., 2014; Venables et al., 2014; see also Sylvers, Lilienfeld, & LaPrairie, 2011).

Additional perspective on whether the "mask" features and impulsive–externalizing symptoms of psychopathy arise from a common source comes from a twin study in which Blonigen and colleagues (2005) evaluated causal influences contributing to scores on the FD and SCI factors of the PPI, and tested for etiological overlap between scores on each and interview-assessed symptoms of internalizing and externalizing disorders as defined by DSM criteria. An appreciable contribution of genetic influences was evident for scores on both PPI factors (46 and 51%, respectively) and each showed some degree of genetic overlap with psychopathology symptoms of the two types. PPI SCI scores showed an expectable moderate-level genetic correlation with externalizing disorder symptoms (r_g = .49), and a more modest positive genetic association with internalizing disorder symptoms (r_g = .20).[2] By contrast, PPI FD scores showed a weak, albeit significant, positive genetic correlation with externalizing symptomatology (r_g = .16), and a moderate-level *negative* genetic association with internalizing symptomatology (r_g = –.40). These results suggest some contribution of genotypic fearlessness to impulse-related problems associated with psychopathy, but relatively minor in comparison with the contribution of heritable disinhibitory tendencies.

To summarize, the possibility that an underlying deficit in emotional reactivity generally, or in fear response specifically, might give rise to both the mask symptoms and behavioral deviance features of psychopathy cannot be ruled out on the basis of existing data. However, what we know so far from empirical research about the relationship between affective deficits and psychopathy argues against this possibility. Weak fear reactivity does appear relevant to the affective–interpersonal features of psychopathy, in particular those reflecting fearless–dominant (bold) tendencies most clearly related to Cleckley's (1941/1976) "mask" concept (Patrick et al., 2009; Patrick & Bernat, 2009; see also Crego & Widiger, 2016), but in itself seems unlikely to account—fully, or even mostly—for the dramatic behavioral deviancy exhibited by his psychopathic patients. An alternative possibility, considered next, is that the masked pathology that Cleckley described reflects the confluence of two distinct but compatible biobehavioral tendencies—one involving diminished sensitivity to aversive events and their consequences, and the other involving reduced capacity for inhibitory control.

Dual-Disposition Model

The idea that the unusual masked disinhibitory condition described by Cleckley (1941/1976) is undergirded by a single pathological process is appealing both from a classic medical model perspective and from the standpoint of scientific parsimony. However, the classic medical model has not fared well in general as a framework for understanding psychopathological conditions, which appear complex in neurodevelopmental (Cicchetti & Curtis, 2006; Nigg & Casey, 2005) and neurogenetic terms (Iacono, Vaidyanathan, Vrieze, & Malone, 2016; Need & Goldstein, 2016), and explanatory power needs to be considered along with parsimony in scientific theorizing. For these reasons, it is worthwhile to consider and systematically evaluate the possibility that separate dispositional tendencies with differing causal bases might underlie the seemingly paradoxical constellation of symptoms that Cleckley described. In what follows, I discuss this possibility by posing a set of questions and addressing each with reference to pertinent findings from the empirical literature.

1. *What attribute might operate as an effective mask for disinhibitory psychopathology?* Problems involving reckless, impulsive, externalizing behavior appear to derive in substantial part from an underlying trait disposition that has been termed "externalizing proneness" or "disinhibitory liabil-

ity." On average, individuals who exhibit problems of this kind show elevated levels of negative emotionality (neuroticism) and an increased incidence of anxious–depressive psychopathology (Krueger, 1999; Krueger et al., 1996; Vaidyanathan et al., 2011). They tend to be stress reactive, irritable and anger prone, mistrustful of others, pessimistic rather than optimistic, resentful about problems, and abrasive in their interactions with others (Benning, Patrick, Blonigen, et al., 2005; Benning, Patrick, Hicks, Blonigen, & Krueger, 2003, Drislane et al., 2014; Verona et al., 2001). The personality traits associated with externalizing behavior—low constraint (impulsiveness) and negative emotionality—are major trait predictors of suicidality (Joiner, Brown, & Wingate, 2005), and externalizing psychopathology shows a robust positive association with suicidal ideation and action (Venables et al., 2015; Verona, Hicks, & Patrick, 2005; Verona & Patrick, 2002; Verona et al., 2001). These characteristics are directly at odds with Cleckley's (1941/1976) portrayal of psychopathic individuals as personable, socially facile, nonanxious, free from internalizing problems, and disinclined toward suicide.

Is there a coherent dispositional attribute that can co-occur with strong disinhibitory tendencies to block the occurrence of neurotic–internalizing characteristics? To operate in this manner, the attribute in question would have to (1) systematically oppose neurotic–internalizing tendencies, but (2) not attenuate impulsive–externalizing tendencies. In statistical terms, the attribute would be one that selectively *suppresses* neurotic–internalizing characteristics but not impulsive–disinhibitory proclivities.

Statistically, "suppression" refers to a situation in which one variable or attribute operates to attenuate the association of a different attribute with a criterion measure of interest. As an example of this, Paulhus, Robins, Trzeniewski, and Tracy (2004) reported that a Shame scale measure was unrelated to self-reported aggressive behavior at the bivariate (zero-order) level, but showed a significant *positive* association with aggression when included together with a Guilt scale as predictors in a regression model. At the zero-order level, the Guilt scale showed a moderate positive correlation with the shame measure, and a weak *negative* correlation with aggression—with the latter association becoming more negative when guilt and shame were included together as regression model predictors. The authors' interpretation was that the Shame scale contained variance in common with the Guilt scale, reflecting negative self-consciousness, an attribute not related to aggression, along with variance reflecting hostile–alienated tendencies, related to aggression. In this case, the guilt-related variance within the shame measure operated to suppress its relationship with aggression; when this variance was removed (through regression modeling), a positive association became evident for shame with aggression.[3]

Relating this concept to psychopathy, it can be hypothesized that a coherent dispositional attribute separate from but compatible with impulsive–disinhibitory tendencies, and recognizable as a part of the condition that Cleckley (1941/1976) described, operates as a suppressor of neurotic–internalizing tendencies typically associated with externalizing psychopathology. An attribute that fits this description is the construct of boldness as described in the triarchic model—encompassing tendencies toward social assertiveness, stress immunity, and venturesomeness, and theorized to reflect the expression of an underlying fearless temperament across different functional contexts (Lilienfeld et al., Chapter 8, this volume; Patrick et al., 2009; see also Kramer et al., 2012). As noted earlier, recent work by Crego and Widiger (2016) confirms that boldness is a salient characteristic in Cleckley's case descriptions of psychopathic individuals. Dovetailing with this, traits related to boldness are strongly represented in the expert-generated, five-factor model (FFM) personality profile considered prototypical of psychopathy (Lynam, Miller, & Derefinko, Chapter 11, this volume; Miller, Lynam, Widiger, & Leukefeld, 2001): In a mixed-gender sample of college students and incarcerated offenders, Ross, Benning, Patrick, Thompson, and Thurston (2009) reported a correlation of .50 between boldness as assessed by the PPI's FD factor and an index of resemblance to the FFM psychopathy prototype computed from scores on the NEO Personality Inventory—Revised (NEO-PI-R); consistent with this, Poy, Segarra, Esteller, López, and Moltó (2014) reported corresponding *r*'s of .62 and .56 in college women and men, respectively, for boldness as assessed by the Triarchic Psychopathy Measure. Other work has shown that the construct of boldness is represented to varying degrees in many contemporary instruments for the assessment of psychopathy, including the PCL-R, the PPI, the SRP, and the YPI (Drislane et al., 2014; Venables, Hall, & Patrick, 2014).

Importantly, boldness as conceptualized in the triarchic model, and as assessed in alternative ways

(cf. Patrick & Drislane, 2015), is uncorrelated with impulsive–disinhibitory tendencies (disinhibition). As a demonstration of this, Drislane and Patrick (2017) modeled the constructs of the triarchic model as latent variables using multiple scale indicators from different assessment inventories, and found a near-zero correlation between latent factors of boldness and disinhibition. From this standpoint, boldness and disinhibition are fully compatible, as the presence of boldness is in no way oppositional to disinhibitory tendencies; thus, the two attributes can readily co-occur. As a corollary of this, positive predictive relations that are evident for boldness in some cases with antisocial behavior (e.g., Blonigen et al., 2005; Hall et al., 2014; Venables et al., 2014) occur independently of, and exert no suppressive effect, on relations for disinhibition.

However, the presence of high boldness *does* systematically oppose the occurrence of neurotic–internalizing tendencies: Across different scale operationalizations, boldness shows robust negative associations with measures of trait anxiety, fearfulness, neuroticism, and anxious–depressive symptomatology (Benning et al., 2003; Benning, Patrick, Blonigen, et al., 2005; Brislin et al., 2015; Drislane et al., 2014; Sellbom et al., 2016; for a review, see Patrick & Drislane, 2015). As such, the representation of boldness in assessment inventories operates to suppress associations between psychopathy scores and criterion measures of negative emotional traits, internalizing symptomatology, and suicide; that is, psychopathy measures that contain limited representation of boldness show greater positive relations with neurotic–internalizing criteria than those containing stronger representation, and for the latter, relations with neurotic–internalizing outcomes increase when boldness-related variance is removed statistically.

In the case of psychopathy measures such as the PCL-R that include correlated symptom subdimensions, mutual ("cooperative") suppressor effects are commonly observed for differing subdimensions (i.e., the contrast in their relations with neurotic–internalizing variables increases when controlling for covariance between them). For example, associations for PCL-R Factors 1 and 2 with measures of anxiety, depressive symptomatology, and suicidality become more negative and positive, respectively, when overlap between the two factors is removed (Hicks & Patrick, 2006; Verona et al., 2001, 2005). Mutual suppressive effects of this type are especially evident between the PCL-R's Interpersonal and Impulsive facets (Hall, Benning, & Patrick, 2004), which correspond most closely to boldness and disinhibition, respectively (Hall et al., 2014; Venables et al., 2014).

A key question that arises in relation to the hypothesis that Cleckley's concept of psychopathy reflects boldness along with disinhibition is whether individuals with these traits also exhibit shallow–deceptive symptoms (Table 1.1, bottom). From a triarchic model perspective, some of these symptoms—lack of remorse or shame, poverty in affective reactions, inability to love, and lack of social reciprocity—appear most related to the meanness (callous–unemotional) facet of psychopathy. However, meanness in the triarchic model is conceptualized as correlated with boldness and disinhibition, and in their latent-variable representation of the triarchic model, Drislane and Patrick (2017) reported correlations of .30 and .45, respectively, for latent boldness and disinhibition with latent meanness. What aspects of meanness are elevated in high bold/disinhibited individuals? One source of information about this is Krueger, Markon, Patrick, Benning, and Kramer's (2007) Externalizing Spectrum Inventory (ESI), which served as a referent for the triarchic model. The ESI includes scales indexing empathy versus callousness, honesty versus fraudulence, and dependability versus irresponsibility, and these scales cross-load on higher-order factors corresponding to disinhibition and meanness. The implication is that individuals high on disinhibition (along with boldness) are likely to be deficient in empathic concern, deceptive, and socially untrustworthy. Another source of information is Poy and colleagues' (2014) study of FFM correlates of the triarchic model traits. In this study, disinhibition showed moderate negative correlations with four of six facets of FFM Agreeableness (straightforwardness, trust, compliance, altruism), and boldness showed moderate negative associations with two (straightforwardness, modesty). As discussed below, tendencies toward meanness appear even more strongly characteristic of criminally psychopathic individuals, but the foregoing lines of evidence indicate that shallow–deceptive tendencies are likely to be evident in high-bold/high-disinihibited individuals. In addition, because such individuals tend not to be troubled by their behavioral deviancy, they can be expected to have difficulty seeing themselves as others see them (i.e., to be lacking in insight).

In summary, boldness encompasses tendencies related to Cleckley's (1941/1976) "mask" concept and is clearly represented in Cleckley's clinical case descriptions and in various psychopathy

inventories including the PCL-R and the PPI. It reflects a dispositional attribute distinct from impulsive–disinhibitory tendencies, so that high-disinhibited individuals can be high in boldness, as well as low or intermediate. Those high in boldness can be expected to present as atypical externalizers, showing strong proclivities toward impulsive–antisocial behavior and substance abuse, but lacking in anxious–depressive tendencies. Direct evidence for this comes from a study by Guarraci, Fishalow, Strickland, Drislane, and Patrick (2013), in which adult participants were recruited from the community based on questionnaire prescreening to represent differing combinations of low versus high boldness and disinhibition—that is, low on both traits, high on one or the other, or high on both—and then tested in a laboratory protocol that included interview-based assessments of DSM disorder symptoms. Participants scoring high in both boldness and disinhibition showed greatly elevated levels of antisocial and substance-related problems relative to those low on both traits, or those high on only one, while also showing the lowest rates of internalizing psychopathology.

2. *Is masked disinhibitory psychopathology the "one, true" psychopathy—or are there other variants?* As noted at the outset of this major section, the weight of accumulated evidence to date indicates that psychopathy is not a unitary taxonic entity but rather a dimensional construct with multiple facets. In light of this evidence, it has become increasingly clear that continued progress in our understanding of psychopathy demands that we move away from the idea of psychopathy as "one thing"—and from the affiliated notion that there is one "true" (constitutional, or "primary") variant of psychopathy, with other variants to be regarded as "pseudo" (psychogenic, or "secondary"). From this standpoint, the idea that psychopathy as Cleckley (1941/1976) described it reflects the conjunction of high boldness and high disinhibition does not rule out alternative variants involving different configurations of these and other dispositional attributes.

Cleckley's concept of psychopathy was based on psychiatric inpatient cases, and it is plausible that high-bold/disinhibited individuals exhibiting behavior problems of a generally nonviolent nature would be referred often to mental health facilities rather than prisons, at least in Cleckley's time. As noted earlier, an alternative conception of psychopathy, emerging out of research with criminal offenders, placed strong emphasis on predatory aggressive deviancy, often involving coldhearted acts of violence. From a triarchic model standpoint, this predatory criminal variant entails high meanness (callousness–unemotionality) along with high disinhibition. Given that these two dispositions are moderately correlated with one another rather than uncorrelated, but criminogenic in distinctive ways (Frick et al., 2014; Patrick et al., 2009), they are apt to co-occur, and to be associated with especially severe criminal deviancy when they do. However, individuals of this type are expected to appear brash, uncaring, and antagonistic rather than "positive," "agreeable," "alert and friendly," and "easy to talk with," as Cleckley's patients were.

In addition to "masked" and predatory-criminal variants of psychopathy, conceptualized here as high bold/disinhibited and high mean (callous)/disinhibited variants, another variant described in the historic literature is the so-called "secondary psychopath" (Karpman, 1941, 1948). This term has generally been used for impulsive–antisocial individuals who are notably high in anxious–neurotic tendencies, with the assumption that the behavioral deviancy is an expression of inner conflict engendered by adverse life experiences. However, an alternative view is that individuals of this sort are primarily high in disinhibition, without being high in boldness or in callous–unemotional tendencies distinct to meanness. As discussed in prior sections, disinhibition (general externalizing proneness) is substantially heritable and positively correlated with anxious–neurotic tendencies. As such, high disinhibition in itself appears sufficient to account for what has been called "secondary psychopathy," without the assumption of a unique environmentally based etiology.

It should be noted that because disinhibition and meanness are moderately correlated, violent criminal offenders with elevated scores on both these dimensions can be expected to include a mix of individuals, some who exhibit aggressive tendencies mainly due to anger and weak restraint associated with disinhibition, and others who exhibit aggressive behavior more as a function of emotional insensitivity, low social concern, and predatory goal seeking. Consistent with this, there is a wealth of evidence from the child psychopathy literature indicating that youth with conduct problems who display distinct callous–unemotional traits, compared with those who do not, show a more severe pattern of antisocial behavior involving proactive as well as reactive aggression (Frick et al., 2014; Frick & Marsee, Chapter 19, this volume). This body of evidence served as the impetus

for inclusion of a new specifier in DSM-5 to distinguish variants of conduct disorder with and without callous–unemotional traits. In the adult literature, it has been shown that offenders who score as psychopathic on the PCL-R comprise subgroups with contrasting personality profiles—one marked by very low anxiety and an active (agentic) social style, and the other involving very high hostility/aggressiveness along with high anxiety and impulsiveness, and low social affiliation (Hicks, Markon, Patrick, Krueger, & Newman, 2004; Hicks & Drislane, Chapter 13, this volume). It seems likely that offenders high in boldness as well as callous–disinhibitory tendencies fall mainly into the first of these subgroups, whereas the latter subgroup likely includes offenders high in disinhibition and meanness but not boldness, along with some primarily high in disinhibition.

The major point I wish to convey is that, from the modern perspective of psychopathy as dimensional and multifaceted, different configurations of psychopathy-related tendencies can occur that are clinically interesting. Two distinct configurations, one involving high boldness combined with high disinhibition, and the other high meanness coupled with high disinhibition, appear characteristic (respectively) of psychopathic hospital patients as described by Cleckley (1941/1976) and psychopathic criminal offenders, as described by McCord and McCord (1964). Since the time of Cleckley and his contemporary Karpman, high disinhibition in itself, even when expressed in terms of aggressive criminal behavior, has not been regarded as "truly psychopathic." This is understandable from the standpoint of differential diagnosis because high disinhibition is associated with multiple overlapping conditions including attention-deficit/hyperactivity disorder, substance-related problems, other addictions (e.g., gambling, sex), and borderline personality disorder. Requiring the presence of features related to boldness and/or meanness helps to distinguish psychopathy from these other disinhibitory conditions.[4]

An important priority in future research will be to systematically investigate the clinical presentation and biobehavioral correlates of differing configurations of psychopathy facets as specified in the triarchic model. In addition to comparing high-bold/disinhibited, high-mean/disinhibited, and high-disinhibited-only individuals, participants representing other configurations of triarchic traits will be interesting to recruit and study. For example, low-disinhibited individuals who score high on boldness, or on boldness and meanness together, may constitute alternative variants of so-called "successful" psychopathy (Benning, Venables, & Hall, Chapter 24, this volume). Individuals low in disinhibition and boldness but high in meanness will also be interesting to investigate, particularly in light of preliminary work suggesting that meanness in itself may dispose to circumscribed behavioral deviance of certain types (Hickey, Walters, Drislane, Palumbo, & Patrick, Chapter 23, this volume).

3. *What causal (genotypic) mechanisms underlie distinctive symptom facets and clinical manifestations of psychopathy?* The triarchic model focuses on symptomatic features of psychopathy represented in different historical conceptions and alternative measurement instruments—identifying boldness, meanness, and disinhibition as major thematic elements in differing accounts of this clinical condition. As such, the triarchic model is descriptive in nature: It organizes manifest–observed symptoms of psychopathy around hypothesized trait dimensions that connect up with constructs in other literatures—including the developmental literature on temperament, findings pertaining to normal and abnormal personality, and child and adult studies of general psychopathology (Patrick & Drislane, 2015). As a trait-oriented model with links to the personality literature, the triarchic model is compatible with descriptive schemes for psychopathy based around the FFM (Lynam et al., Chapter 11, this volume) and other general models of personality (e.g., Benning, Partrick, Blonigen, et al., 2005; Brislin, Drislane, Smith, Edens, & Patrick, 2015). This is illustrated, for example, by (1) research by Poy and colleagues (2014) showing that scores on the three constructs of the triarchic model (assessed using the Triarchic Psychopathy Measure [TriPM]) predicted scores on the FFM-based psychopathy prototype (quantified using the NEO-PI-R) at levels exceeding $R = .7$ in both male and female participants, and (2) work by Drislane, Jones, Brislin, and Patrick (2017) showing that effective scale measures of the triarchic model constructs could be constructed using items from the NEO-PI-R.

However, a major difference between the triarchic model and other descriptive systems for psychopathy is that it characterizes psychopathic symptomatology in terms of dispositional constructs that are explicitly *biobehavioral*—that is, trait constructs that relate clearly to the literature on biological systems for behavior, as well as to literatures on temperament/personality and general psychopathology. Boldness, as conceptualized in

the triarchic model, connects to the biobehavioral concept of acute threat reactivity, meanness connects to the concept of affiliation/attachment, and disinhibition to the concept of inhibitory control—concepts that relate in turn to distinct neurobiological systems (Kozak & Cuthbert, 2016). By reconceptualizing psychopathy in these terms, the triarchic model provides a framework for investigating how symptomatic features of psychopathy relate to variations in the functioning of core neurobiological systems.

Two key points regarding this biobehavioral trait approach warrant mention. First, the psychological concepts of boldness, meanness, and disinhibition are not assumed to correspond directly to neurobiological systems for threat reactivity, affiliative capacity, and inhibitory control. Instead, it is only assumed that certain physiological and behavioral indicators of these systems will relate preferentially to one or another of these constructs—for example, aversive startle potentiation to boldness (Vaidyanathan et al., 2009), recognition and processing of facial distress cues to meanness (Brislin et al., 2017; Marsh et al., 2008), and reduced cognitive brain response to disinhibition (Nelson, Patrick, & Bernat, 2011). Operating from this premise, the triarchic model provides a starting point for establishing cross-domain operationalizations of constructs corresponding to threat reactivity, affiliation, and inhibitory control, that is, assessments of these constructs that incorporate neurophysiological and behavioral indicators along with psychological scale indicators (Patrick et al., 2013; Yancey, Venables, & Patrick, 2016) as a basis for understanding psychopathy in biobehavioral terms.

The other major point regarding this biobehavioral trait approach is that it recognizes the importance of development to an etiological analysis of psychopathy and other clinical conditions. More specifically, it views psychopathological symptoms as expressions of core biobehavioral tendencies shaped by developmental processes and life experiences across time (Patrick & Hajcak, 2016), and manifested in psychologically salient, trait-relevant contexts (Eysenck, 1967; Tellegen, 1991). That is, to understand the etiology of psychopathy, it will be necessary to clarify how variations among people in the functioning of basic biobehavioral systems relate across phases of development to distinct psychological tendencies that relate in turn to observable symptoms of psychopathy (Buchman-Schmitt, Brislin, Venables, Joiner, & Patrick, 2017; Patrick & Hajcak, 2016). This point is discussed further in "Cognitive and Emotional Processing" (Patrick, Chapter 18, this volume).

As a final point, given evidence indicating highly polygenic patterns of inheritance for clinical disorders, psychological traits, and neurophysiological indicators (Iacono et al., 2016; Need & Goldstein, 2016), it seems likely that the interface between variations in the functioning of basic biobehavioral systems and proclivities toward problems of particular types will prove to be complex. For example, genes for weak threat sensitivity might combine in one case with genes for weak affiliation to produce maladaptive callous–unemotional tendencies, and in another case with experiences promoting strong affect regulation to produce adaptive bold tendencies (cf. Fowles, Chapter 5, this volume). A detailed multilevel and developmentally informed analysis will be required to achieve understanding of pathways to alternative variants of psychopathy marked by distinct configurations of observable symptoms.

Conclusion

Cleckley (1941/1976) characterized psychopathy as a paradoxical condition involving severe behavioral deviancy masked by an outward appearance of robust mental health. Although Cleckley posited a unitary causal mechanism underlying this constellation of symptoms, an alternative possibility—supported by various lines of evidence—is that the masked pathology he described reflects the co-occurrence of two separate dispositional tendencies: boldness and disinhibition. A third dispositional tendency, callousness–unemotionality or meanness, is postulated to play a greater role in criminal expressions of psychopathy involving predatory exploitativeness and violence. The triarchic model of psychopathy conceives of these three dispositional tendencies as related to variations in the functioning of different biobehavioral systems. As such, the model provides an integrative framework for characterizing alternative variants of psychopathy and clarifying causal mechanisms that give rise to them.

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NOTES

1. Examples of public figures who displayed severe externalizing problems along with salient anxious–depressive tendencies include late musicians Amy Winehouse and Simon John Ritchie (better known as "Sid Vicious").
2. The genetic correlation (r_g) reflects the magnitude of relationship between the variance in one measure that is attributable to genetic influences and the corresponding genetic variance in another measure.
3. Variance partitioning techniques, such as multiple regression and partial correlational analysis, are considered essential for detecting and clarifying suppressor effects (Tzelgov & Henik, 1991; Watson, Clark, Chmielweski, & Kotov, 2013).
4. The new trait-dimensional system for personality pathology in Section III of DSM-5 characterizes ASPD in terms of traits from domains of Disinhibition and Antagonism (corresponding to meanness), and includes a psychopathy specifier for designating a high-bold variant of ASPD.

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