Clinical Psychology Review 98 (2022) 102214

Contents lists available at ScienceDirect

Clinical Psychology Review

journal homepage: www.elsevier.com/locate/clinpsychrev

Commentary

Some critical comments on the Frick (2022) paper titled "Some critical considerations in applying the construct of psychopathy to research and classification of childhood disruptive behavior disorders"

Randall T. Salekin *

Department of Psychology, PO Box 870348, Tuscaloosa, AL 35487, USA

ARTICLE INFO

Keywords
Psychopathy
GM traits
CU traits
DI traits
DBDs

ABSTRACT

Frick (2022) presented a narrative review of some literature and made several critical comments regarding the extension of the full psychopathy construct to research and classification of childhood disruptive behavior disorders (DBDs). His arguments cautioned against the use of the multicomponent concept of psychopathy for specification of DBDs for several reasons including definitional issues, symptom sequencing, specifier versus risk factor considerations, potential overlap with other disorders and criteria (e.g., ADHD), and concerns regarding harm. While I agree with Frick (2022) that we need to be cautious when extending personality constructs to the DBDs, the remaining arguments in his paper fall short of calling for the exclusion of psychopathy components in the examination of DBDs. Rather, the counterpoints in this paper further convince that the multidimensional model of psychopathy, when applied to the DBDs, could better facilitate understanding of the etiology and mechanisms for Conduct Disorder (CD), and, it may help us to predict the prognosis and treatment outcomes of children with various forms of DBDs such as CD and Oppositional Defiant Disorder (ODD). To have the most informative designs, future research should examine the broad construct to glean a better understanding of psychopathy and the DBDs. Further, research should continue to examine sequencing and external correlates at the component level and to test the incremental value of the multicomponent model of psychopathy to help us better comprehend how *each* component may facilitate our understanding of the *types* and *severity* of conduct problems exhibited by youth with DBDs (i.e., CD, ODD).

Frick (2022) recently provided a narrative review where he makes five critical considerations in applying the construct of psychopathy to the disruptive behavior disorders (DBDs). First, Frick argues that we do not know the defining features of psychopathy so we should not use the broader set of traits to specify the DBDs. Second, he argues that we need to understand the developmental progressions and integration of existing research on temperament and personality to extend psychopathy components to the DBDs. Third, Frick claims that callous-unemotional (CU) traits work as a specifier whereas the other components operate as risk factors. Fourth, he argues that existing disorders (ADHD) and criteria (deceitfulness or theft) are already in the DSM, so there is no need to add the other psychopathy components. Finally, Frick contends that there are issues to consider such as "do no harm." In sum, the Frick (2022) article infers that the broader construct of psychopathy and its components should not be used to better understand the DBDs.

While I appreciate the effort to cover these issues and the need to be careful when extending new constructs to help understand the DBDs, I disagree with many of the critical comments outlined by Frick (2022). Frick utilizes a select set of articles to argue his points, yet, it is important to keep in mind that the framework from which one reviews and interprets existing lines of research has consequences for the conclusions drawn and potentially whether one correctly configures conduct disorder (CD).[1] For instance, there is considerable research now to suggest that the multicomponent model for psychopathy which consists of grandiose-manipulative (GM), CU, and daring-impulsive (DI) traits, in combination with CD symptoms may also add clinical value (e.g., Forth, Kosson, & Hare, 2003; Salekin, 2017). This research has suggested that each dimension may have differing psychobiological correlates, which may indicate the need for tailored interventions (Salekin et al., 2022). Thus, focusing on only one component of psychopathy could hamper not

* Corresponding author at: Department of Psychology, PO Box 870348, Tuscaloosa, AL 35487, USA.
E-mail address: rsalekin@ua.edu.

[1] I focus to a larger extent on CD in this paper.

https://doi.org/10.1016/j.cpr.2022.102214

Available online 21 October 2022

only research but also clinical practice in terms of limiting information germane to a complete clinical picture of children and adolescents with DBDs.

1. Defining features (do we know what psychopathy is)?

Much of Frick's (2022) argument is based on the notion that we cannot define psychopathy. However, it is important to keep in mind that many researchers have referred to Cleckley (1941/1976), the author of the widely cited text *The Mask of Sanity*, as one of the most influential figures in the study of psychopathy. It is widely accepted that Cleckley substantially narrowed the scope and provided a thoughtful definition of psychopathy. The Cleckley (1941/1976) definition was so influential that Hare (1991/2003) later developed a checklist for his 16 criteria and eventually the Psychopathy Checklist-Revised (PCL-R; Hare, 1991/2003). The PCL-R yielded a four-factor model with interpersonal, affective, lifestyle, and antisocial components. Later, childhood and adolescent versions of the PCL-R were developed, and research on these measures similarly yielded multicomponent models (e.g., Forth et al., 2003; Frick, 2000). There now exists a large body of research to support the factor structure and psychometric properties of the PCL and its family of measures (Hare, 1991/2003).[2] Thus, when tied to the most prominent theorists in the field (Cleckley, 1941/1976; Hare, 1991/2003), the psychopathy concept is generally considered to be well-defined although researchers will continue to contest whether the antisocial component is part of the construct. Yet, all conceptualizations including the CU traits model connect in some way to an antisocial component (e.g., CU + CD).

A point to keep in mind is that the argument of a "poor definition" that occurs throughout the Frick (2022) paper could be applied to any disorder in the DSM or ICD.[3] To illustrate this point, the "not well-defined argument" that initiates the Frick paper can similarly apply to CU traits or the DSM's Limited Prosocial Emotion [LPE] specifier for CD (American Psychiatric Association, 2013). Lahey (2014) and others have already raised concerns about CU traits as defined by Frick as being heterogeneous, unreliable, and having questionable validity. An example of this heterogeneity can be seen across the content of the items representing callous behavior, others representing unemotional affective traits, and still, others representing being unconcerned about performance. Moreover, being unconcerned about performance applies to a host of psychiatric conditions (depression, anxiety, schizophrenia), raising further questions about the heterogeneity and construct validity of CU scales. Those arguing that CU traits are not well defined have asked questions such as, are young individuals callous?, are they unemotional?, or, are they both? And, as Lahey (2014) pointed out, what about those youth with "callous-unemotional traits" who express "happiness when they get their way" or even see others in distress (p. 60). Unfortunately, the Frick (2022) review never mentions previously articulated criticisms of CU traits, to balance perspective (e.g., Berg et al., 2013; Lahey, 2014).

2. Developmental sequencing/progressions

Frick (2022) contends that it is possible that the covariation among personality traits is indicative of a developmental relationship between dimensions. While it is a worthwhile endeavor to determine if there is indeed a sequence to the psychopathy symptoms (or any disorder), this section of the Frick article endeavors to suggest a potential developmental sequence to CU traits and presumably this sequence gives the component theoretical credibility over the other components. Additionally, Frick contends that the sequence may help with the definition of psychopathy for the DBDs. Frick argues that the potential developmental sequence includes i) *low level of emotional reactivity* ii) *temperamental fearlessness,* iii) *low guilt and low empathy*, and iv) *conduct problems*.

Research on causal models should be applauded, as determining the etiology of any mental illness is complex and a large undertaking. However, it should be acknowledged that we do not yet know the sequence to psychopathy. Indeed, we have only made minimal gains in understanding the cause of psychopathy. Thus, there is considerable research left to be done. A couple of points to consider in contemplating the sequencing of symptoms are that we need to be careful that we are not measuring the same construct or elements of the same construct across time under different terms. For instance, several personality theorists now believe that temperament and personality are essentially one in the same. Thus, "emotional reactivity," "fearlessness," and "callous unemotional" may simply reflect different names for the same underlying construct (or elements of the same construct). Therefore, the extent to which temperament leads to personality may not give us a particularly deep or elaborate understanding of the etiology of psychopathy. Another factor to consider is that the psychopathy components may initiate at the same time through genetics, neuronal anomalies, and aberrations in behavior. To test potential developmental linkages, I would argue that it is best to include all psychopathy components and to do so across development. Scientists could then look at the precursors and stability *of all the dimensions* with the goal being to better comprehend their associations with clinically important outcomes. Such an approach could also rely on statistical modeling to account for, or "pull out," components to determine, for example, the predictive validity with and without certain components (e.g., antisocial). Moreover, it has already been suggested that psychopathy may have more than one cause and that the psychological and biological mechanisms may differ by dimension (Miller & Lynam, 2015).[4] Thus, to understand the configuration of psychopathy and its impact on CD, the broader conception of psychopathy would require well-equipped studies to fully understand the causal mechanisms of the components and to determine how they assemble to create the broader disorder. Robins and Guze (1970) in their seminal paper delineated that the first phase of validating psychiatric diagnoses is to develop a clear clinical picture of the disorder (see Cleckley, 1941/1976; Hare, 1991/2003) rather than to use a single, potentially narrow, etiological perspective to define a wider clinical construct.

3. Risk factor or specifier?

Arguments about whether one component of psychopathy (CU traits) is a specifier and other components (GM, DI) are risk factors cannot be conveyed with any certainty at this point. It is not known whether the components of psychopathy are risk factors, specifiers, or otherwise related to CD. It could be argued that, so far, all components of psychopathy and CD have been shown to be parts of a three- or four-factor model (Frick, 2000; Salekin et al., 2022). The statements regarding specifiers and risk factors made by Frick (2022) are premature and without systematic evidence. Much more research is required on this topic to determine these specific relations. For instance, it depends on the literature cited as to whether one draws conclusions regarding whether components of psychopathy and CD are risk factors or

[2] The Antisocial Process Screening Device, where CU traits initiated, had the PCL-R as its theoretical starting point. Much of the CU specifier research was based on the broader model or components rather than CU traits alone.

[3] Researchers and clinicians alike will continue to debate about the defining features of even well-established mental disorders. However, this does not mean that we do not generally know, for example, the defining criteria for depression.

[4] Prominent theories are not mentioned by Frick (2022); for example, response modulation (Newman et al., 2010), a dominant theory in the adult literature, is not considered in the Frick model and it may account for components other than the CU traits.

specifiers. For instance, Frick cites a paper that shows a high correlation between CD and the II factor of psychopathy, but a more modest correlation with CU traits. However, in our studies with the Proposed Specifiers for Conduct Disorder (PSCD; Salekin & Hare, 2016), we find that the correlations between the PSCD components of psychopathy (GM, CU, DI) and CD are roughly equal in magnitude. According to Frick's argument, this would indicate that *each* psychopathy component (GM, CU, DI) would influence CD, either in the type of conduct problems or severity.

While Frick (2022) argues that CU traits are a *severity specifier,* marking the most severe cases of CD, it should be acknowledged that there is already research to suggest that the LPE specifier may not always designate the most stable subgroup of individuals with CD. A number of findings indicate that children high and low in CU traits may *not* have significantly different behavioral outcomes (Déry, Bégin, Toupin, & Temcheff, 2019; Lahey, 2014; Sakai et al., 2016). For instance, Sakai et al. (2016) demonstrated that the specifier was highly unreliable and did not designate the worst CD cases in their sample of adolescents. In another study, Déry et al. (2019) found that children with CD and LPE (CU traits) did not differ from those with CD without LPE with respect to endorsing the most severe CD symptoms nor on the total number of CD symptoms. Moreover, they did not show a more stable pattern of conduct problems across a four-year time span. Déry et al. (2019) concluded that "the specifier [LPE or CU traits] appears to offer limited value in identifying those youth with a particularly severe and stable CD symptomatology" (p. 838). Preliminary research has shown the entire set of psychopathic personality traits is a stronger predictor of negative outcomes than CU traits alone (e.g., Colins, Andershed, Salekin, & Fanti, 2018; Frogner, Andershed and Andershed, 2018; López-Romero et al., 2022). Thus, there is reason to believe that assessing CU traits alone may not always designate the most severe CD cases. Instead, it may be the case that each component offers unique information (see Barry et al., 2007).

4. Existing constructs (ADHD and CD deceitful criteria)

Frick (2022) argues that ADHD captures the lifestyle (DI) component of psychopathy. While it is important to consider overlap in syndromes, I agree with Frick's (2000) earlier argument that it is also essential to examine constructs within their own theoretical framework and to consider their potential relations within a broader construct. Thus, even though there is some overlap across constructs there can be some value in considering the concepts as initially conceptualized. I similarly agree with Frick (2000), who argued that simply because the psychopathy impulsivity overlaps with ADHD, does not on its own signify that it is not a component of psychopathy but rather that a "theoretical context" is needed (p. 451). While this is a complex issue, I would argue that, rather than equate ADHD with the impulsivity component of psychopathy, that instead, additional work is needed to determine how the clinical presentation of impulsivity among those youth with psychopathic features differs from the impulsivity observed in those youth with ADHD. We have argued for the consideration of daring impulsive (DI) traits, which are focused on daring propensities as opposed to impulsivity, could partially address this issue (Salekin, 2017). We see this shift as a method to help move the concept further away from ADHD, to harmonize with the remaining psychopathy dimensions, and to more accurately represent the intended construct (Cleckley, 1941/1976).[5]

Frick (2022) makes several arguments that elements of GM traits are to some extent already in the CD criteria. Certainly, some elements of psychopathy are located in the deceitful criteria of CD. However, it is not that elements of each component of psychopathy could not be located in various pages within the DSM and ICD (World Health Organization, 2019), and even within the CD diagnostic criteria, but rather it is crucial to ensure that the personality components are *relevant*, *adequately represented*, and *properly configured*. That is, each personality component would better serve as specifier to help researchers and clinicians more accurately describe youth with CD as well as help clinicians in the future with the personality perturbations that accompany CD and potentially other DBDs.[6] Thus, it is to some extent *how* the symptoms of CD are assembled to provide a *good representation* of *relevant* traits to better describe young people with CD. With revisions of the DSM and ICD, the idea is to further refine the composition of disorders so that clinicians can more effectively and accurately diagnose the condition and we can learn more accurately about their etiology and treatment of the DBDs (Salekin, 2016). To interpret youth's displays of ADHD symptoms, rather than something more specific to psychopathy, or to use CD subtypes that may have some GM traits, but not all of them, would not advance the field forward in understanding etiology and treatment of youth with DBDs.

5. Avoiding harmful labels

The comment in the Frick (2022) article stating "do no harm" is an important point for mental health disorders in general but also for the DBDs. Specifically, for any mental health disorder delineated in the DSM or ICD, we are compelled to develop accurate diagnoses that are designed to help with the treatment of those diagnoses. I agree with Frick that, unfortunately, there is evidence that receiving any mental health diagnosis can be stigmatizing and, as a result, the benefit of labeling, such as documenting the need for treatment and preventing future distress and impairment, must be weighed against the potential harm of labeling the person with a "disorder." I agree that such concerns are magnified with terms like psychopathy. However, one must also weigh the benefit of using the broader construct versus one component. With only one component of the wider construct, the risk for false positives is quite high. To use only one component of the broader psychopathy construct signifies that young people with CU will likely be mischaracterized as having psychopathy ("disorder") when they only have a few of the symptoms. Wakefield (2022) has referred to this as the high false positive problem in the DSM, and the CU traits model could potentially contribute further to this problem. The use of the broader construct would reduce the false positive rate and capture only youth with more severe personality perturbations. Moreover, the broader model would also help clinicians understand the personality configuration for each youth, which would then help with crucial clinical decision-making tasks (e.g., estimating prognosis, planning treatment, evaluating treatment effectiveness). Harmful effects must also be considered in the context of what might be learned in future years regarding CD and how that knowledge may inform clinical practice. By excluding important components (i.e., GM and DI traits), it could be argued that the harmful effects would then apply to limits in learning the full etiology of CD and not properly innovating or tailoring interventions.

6. Conclusion

Although the Frick (2022) paper attempts to provide some thoughtful comments on potential concerns regarding the extension of psychopathy components to the DSM and ICD, the points made and conclusions drawn very much depend on the framework from which one reviews the literature and consequently the extent to which CD is properly configured. The definitional argument raised by Frick does not

[5] Equating ADHD with psychopathy could pose an unintended harmful effect. Some may equate ADHD as being a component of psychopathy.

[6] I have previously argued that it is unclear whether the LPE specifier (CU traits) will be redundant with existing CD criteria. Some believe CU is already tapped via behavioral items such as "bullying," "threatening," "armed robbery," "forcing sexual activity," "physical cruelty to animals/people."

consider the very good anchors for psychopathy that we already have with the work of prominent theorists such as Cleckley (1941/1976) and Hare (1991/2003). The points regarding precursors and sequencing of symptoms are not derived from solid empirical evidence that attempts to tease apart differences in temperament and personality and therefore are premature at this point. Overlap in categories does not mean that we should not consider how to properly configure CD and to better understand the psychobiological mechanisms for each component of personality. There is a great deal of research to show support for a three or four-factor model for psychopathy and CD (Frick, 2000; Salekin et al., 2022). Using just one component of psychopathy increases false positives, mischaracterizes youth, and limits our understanding of the etiology and treatment of CD and the DBDs. To encourage additional research that encompasses a broad set of psychopathic traits would ultimately result in meaningful refinements to the DSM and ICD criteria sets for the DBDs. This would then lead to the most effective treatment for those youth with DBDs.

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