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REVIEW

Psychopathy in women: theoretical and clinical perspectives

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Abstract: Prior research on psychopathy has primarily focused on the problem in men. Only a few studies have examined whether psychopathy even exists in women, and if so, how the disorder manifests itself in them. This paper presents a narrative review of the literature on gender and psychopathy. We briefly discuss why this is an important topic for women and we discuss its causes. The concept of psychopathy is defined and related to the diagnostic systems. The discussion includes a presentation of diagnostic tools, including the Hare Psychology Checklist – Revised, which are examined in relationship to the importance of biological gender. While emphasizing the similarities as well as the differences between the sexes, we discuss the matters of prevalence, behavioral expressions, comorbidity, progression, and treatment of the disorder.

Keywords: psychopathy, antisocial, dissocial, personality disorder, sex, women, review

Introduction

Psychopathy has primarily been studied in men. Relatively little research has examined whether psychopathy even exists in women, and if so, how the disorder manifests itself in them. This article provides a narrative review of the topic, which includes a synthesis of the literature on the sexes and psychopathy. We briefly discuss why this is also an important topic for women and we discuss its causes. We define the concept, place it in the diagnostic systems, and provide an overview of diagnostic procedures. In addition, while emphasizing the similarities and differences between the sexes, we discuss the matters of prevalence, behavioral expressions, comorbidity, progression, and treatment of the disorder.

Why focus on psychopathy in women?

Most studies on psychopathy have examined men with the disorder. They have assumed that the core characteristics and behavioral expressions of the disorder are transferable to women.[1–3] While this is an important topic, for clinical and theoretical reasons,[4] until recently, potential differences between the sexes have not received much scientific attention. The importance of the concept of "psychopathy" relates to its potential usefulness with regard to issues such as the choice of treatment strategies, treatment evaluation, risk assessment, and the prediction of future violence.[5] If one assumes that the same research results achieved in studying men are automatically transferable to women, one does risk misjudgments of enormous consequence. For instance, within the field of forensic psychiatry, the diagnosis of psychopathy is often

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used to justify the length of prison terms; in some countries, indefinite prison terms can be given to criminals with this diagnosis.[6] The diagnosis of psychopathy may also be used to justify patients' exclusion from treatment programs as well as other punitive measures.

Causes of psychopathy

Psychopathy cannot be understood solely as a result of social and environmental forces and influences. To a substantial degree, the condition is likely caused by genetic factors, which influence the formation of the brain and thus personality and temperament traits, which are believed to be the core characteristics of the disorder.[7–11] However, it is likely that the development of psychopathy in an individual is the result of complex interactions between biological and temperamental predispositions as well as social and environmental influences.[12] It has also been suggested that the underlying causes of psychopathy could be different in men and women.[8,13–15]

Defining and placing the psychopathy construct in diagnostic systems

As a clinical construct, a distinct pattern of emotional, interpersonal, and behavioral characteristics defines psychopathy. The literature often refers to psychopathy as a narrower diagnostic category than either antisocial personality disorder (Diagnostic and Statistical Manual of Mental Disorders IV [DSM-IV][16]) or dissocial personality disorder (International Statistical Classification of Disease and Related Health Problems, 10th revision [ICD-10][17]). Furthermore, it is often considered to be one of the most serious personality disorders.[18,19] In addition to the low recovery rate, this consideration is also due to the extensive social and personal consequences that follow in the wake of the criminal behavior of psychopaths. The emotional characteristics of psychopathy include egocentricity, blunted affect, lack of empathy, lack of remorse, and lack of guilt. The interpersonal characteristics include impulsiveness, irresponsibility, arrogance, grandiosity, and manipulation. The behavioral characteristics include a lack of respect for social norms and rules and a display of irresponsible, frightening, and violent behavior.[5,6,18] Psychopathy seems to exist in all cultures and ethnic groups.[20]

In modern psychopathy research, there are two distinct traditions: a behaviorist tradition and a personality-based approach. The American Psychiatric Association (APA) uses the behavioral approach in the diagnostic system DSM-IV;[16] psychopathy falls under the diagnostic category 301.7: antisocial personality disorder. The diagnosis mainly includes behavioral concepts; although emotional traits are mentioned as associated characteristics, they are not included as required diagnostic criteria.[16]

The category, DSM-IV 301.7, includes a far larger group than the obvious psychopaths; furthermore, with its emphasis on antisocial characteristics, this diagnostic category will include most criminals.[16,21] In contrast, there is an approach to psychopathy focusing on personality traits, and this personality-based theory is more firmly represented in the diagnostic system of the World Health Organization (WHO), the ICD–10.[17] Dissocial personality disorder (ICD-10: F 60.2) is characterized by indifference toward social obligations and an expressed lack of empathy. There is a large discrepancy between behavior and social norms, and rules and obligations. The patient lacks the capacity to experience guilt. Negative experiences, such as punishment, do not particularly affect their behavior. In addition, the patient has a low tolerance for frustration and may easily become aggressive and violent. Moreover, "there is a tendency to blame others, or to provide plausible rationalizations for the behavior, bringing the patient into conflict with society."[17] The patient also typically lacks the ability to maintain lasting relationships. Behavioral problems in childhood and adolescence may support the diagnosis, but this is not an obligatory criterion.[17]

Neither dissocial personality disorder nor antisocial personality disorder fully cover the term "psychopathy," and even if the diagnoses have much in common, they are clearly not identical. About a third of the individuals who meet the criteria for antisocial personality disorder, will also meet the criteria for psychopathy.[18,22] Because the ICD-10 diagnosis of dissocial personality disorder includes more criteria that involve emotions and interpersonal characteristics, it is probably closer to the concept of psychopathy than the DSM-IV diagnosis of antisocial personality disorder.

Diagnosing psychopathy

The most frequently used and validated diagnostic tool for assessing psychopathy is the Hare Psychopathy Checklist – Revised (PCL-R).[5] The PCL-R consists of 20 items, which are scored from 0 to 2 depending on how well each item fits an individual. Items include superficiality, lack of guilt and behavioral control, grandiosity, shallow affects, and a parasitic lifestyle. Other items are early behavioral problems and adolescent crime, lying, lack of empathy, lack of planning for the future, manipulation of others, impulsiveness and irresponsible behavior, and criminal diversity.[5] The maximum score is 40, which is extremely rare. Within research, 30 is the accepted threshold for psychopathy,[22] but a lower number (25) has been deemed more appropriate for clinical use

in some cultures/countries, for instance in Scandinavia.[6] In 1995, a revised form of the PCL-R was developed, a 12-item screening version, the Psychopathy Checklist: Screening Version (PCL: SV),[23,24] to satisfy a clinical demand for a shorter screening tool. This screening version was developed in connection with the MacArthur Violence Risk Assessment Study[24] and like the PCL-R, it is scored on a scale from 0 to 2, where a sum of 18 or more qualifies for the diagnosis "psychopath." The PCL-R is a proven solid measurement tool, and a good predictor of the probability for future violence and antisocial behavior, as well as the recidivism of criminal behavior. Metastudies, which have shown moderate to large effect sizes, have demonstrated this tendency.[25–28] Similarly promising results have been demonstrated for the PCL: SV.[29]

Research on differences between the sexes has suggested that psychopathy is less frequent in women than in men. However, it is debated whether the observed differences in the occurrence of male and female psychopaths reflect actual physical differences in the frequency of psychopathy, or whether those differences reflect factors related to aspects of the diagnostic tools and the terminology used, which surface when these criteria for evaluating psychopathy are applied to women.[2–4,13] Notwithstanding, the most frequently used diagnostic tools were developed and used primarily in male populations. In order to understand the possible importance of the diagnostic tools in relationship to what extent men and women are diagnosed as psychopaths, we must examine what the instruments measure and consider their factor structure.

The psychopathy checklists (the PCL-R and the PCL: SV) show a clear factor structure in which factor one reflects interpersonal and affective items, while factor two reflects an antisocial and criminal lifestyle.[5,30] Although the two-factor structure has been replicated in several studies,[23,31] some have suggested that a three-factor or even a four-factor model could be more appropriate.[32,33] In the three-factor model, the original factor one was split into two new factors and the new factor three consisted of noncriminal items from the original factor two.[32,33] The rationale for removing criminal items from the three-factor model was that criminal activity was not considered a core feature of psychopathy but rather a consequence of the disorder.[32,33] However, other researchers believe that criminal activity is a central element of the psychopathy construct and have maintained the necessity of including criminal activity.[34] Subsequently, a four-factor model has been proposed, involving splitting the original factor one (interpersonal, affective) and the original factor two (antisocial lifestyle) into four factors: interpersonal, affect, lifestyle, and antisocial.[34–36] The original factor one is considered stable and static, and the interpersonal facet includes characteristics such as superficiality, grandiosity, lying, and manipulation. The affective facet includes lack of guilt, shallow affects, lack of empathy, and lack of responsibility for one's actions. The original factor two seems to be more dynamic and potentially mutable, and it has been suggested that this factor is influenced by childhood experiences.[9,12,15] The lifestyle facet involves a craving for stimulation, a parasitic lifestyle, lack of plans for the future, impulsiveness, and irresponsibility. The antisocial facet involves lack of behavioral control, early behavioral problems, adolescent crime, term violations, and criminal diversity.[5,35,37–39] Two other items, promiscuous sexual behavior and multiple short-term relationships, do not load for any of the factors, but they do contribute to the total score in the PCL-R.[35]

Since research on factor structure, validity, and the reliability of the diagnostic psychopathy instruments (PCL-R and PCL: SV) has primarily involved men,[40] there is less literature on women. Nonetheless, recent research has supported the claim that a three-factor model has a better fit than the original two-factor model for women.[41–43] Studies have indeed suggested that the PCL-R and the PCL: SV are reliable instruments for measuring psychopathy in women,[36,43] but it has also been suggested that the validity seems to be higher when the checklists are applied to men.[40,44] The explanation for this finding may be that women have a lower prevalence of antisocial behavior and thus have a lower relapse rate.

The prevalence of psychopathy in women and men

It is assumed that psychopaths constitute approximately 0.5%–1% of the population, while as many as 20%–25% of prison populations qualify for the diagnosis.[35,37] Psychopaths are thought to be responsible for over half of all serious crime. This is in addition to the considerable devastation they cause in the form of physical, psychological, and financial damage for people who have been exposed to them.[6,45]

Some studies have examined the prevalence of psychopathy in women.[23,41,42,46,47] With few exceptions,[23] studies have shown that there are more male psychopaths than female. That women score lower on the PCL-R than men has been a consistent finding in prison populations[41,46] as well as the wider field of forensic psychiatry.[47] Persistent findings in surveys of violent subjects,[41] forensic psychiatric wards,[47] and other patient groups,[48] indicate that women typically do have a lower score than men both on the PCL-R and on the

PCL: SV. The results from one population study showed that women had lower sum scores and subscale scores than men on the PCL: SV and that none of the women in the study met the criteria for psychopathy.[49] However, a different study of prison inmates showed a minor significant difference in sum scores.[50] In the manual of the PCL-R,[5] the threshold for psychopathy is set at 30 points, and few women in the general population seem to achieve this score. Since women typically show less criminal and antisocial behavior, ie, the behavioral characteristics, which represent an important part of the criteria of the PCL-R and the PCL: SV, women will generally achieve lower scores on the diagnostic tools and therefore show lower occurrence rates.[51–53] Furthermore, in select populations with a higher occurrence of behavioral problems and higher rates of criminal behavior, men more often qualify for the diagnosis than women. Grann[47] found that only 11% of female violent subjects, as opposed to 31% of male violent subjects, met the criteria for psychopathy. Other studies found female occurrence rates of 16%[46] and 17.4%[42] in prison populations, ie, substantially lower rates than those found among men in prison.

Behavioral expressions in women and men

Forouzan and Cooke[2] claim that there are differences between the sexes with respect to psychopathy. They suggest four key points in the way these differences manifest: (1) behavior, (2) interpersonal characteristics, (3) underlying psychological mechanisms, and (4) different social norms for men and women. Moreover, they claim that the behavior observed in the sexes differs both with regard to the manifestation of the psychopathic behavior and in the expression of interpersonal characteristics. As for the behavioral expression of the disorder, Forouzan and Cooke[2] suggest that women who are manipulative more often tend to flirt, while manipulative men are more likely to run scams and commit fraud. In women, the tendency to run away, exhibit self-injurious behavior, and manipulation, all characterize impulsiveness and behavioral problems. Moreover, their criminal behavior consists primarily of theft and fraud. In men, however, the criminal behavior often includes violence.[11,24] Indeed, the form of aggression that is displayed appears to differ between the sexes. Although the results are divergent and inconclusive,[54] some studies have suggested that while men more often show physical aggression,[45,55] women more often display a more relational and verbal form of aggression.[51,52,56] This may, for instance, occur through manipulation of social networks in attempting to exclude the victim from a community. Alternatively, it may take the form of threats of self injury, with consequences for family and friends. Furthermore, the interpersonal symptoms in female psychopaths are not particularly characterized by superficial charm and a grandiose self-image, as is the case with men.[3] This could possibly be related to cultural conditions and childhood circumstances. As for underlying psychological conditions, it has been suggested that typical markers for psychopathy, such as promiscuous behavior, may have different underlying motivational factors in men and women.[2] For instance, promiscuity in female psychopaths may reflect a wish to gain financial or social benefits.[19] Finally, it is suggested that social norms may influence the evaluation of certain psychopathic characteristics differently in men and women.[1–3] For instance, in the West, it is accepted socially and culturally that a woman depends financially on her husband, while a man doing the same thing more easily could be seen as indulging in "parasitic behavior."[2]

Diagnostic comorbidity of women and men with psychopathy

Female inmates frequently show more Axis 1 symptoms than females in the general population or male inmates. They are clearly diagnosed more often with an emotionally unstable personality disorder and less often with an antisocial personality disorder.[22] Despite this, few studies have examined the connection between psychopathy in women and comorbidity; nonetheless, the studies that have been performed seem to indicate that there is a similar pattern in men and women.[42] The most prevalent disorder in both sexes is antisocial personality disorder, while in women there is also a strong comorbidity with all cluster B personality disorders. In both sexes, there is a clear connection between psychopathy and alcohol and drug abuse.

Progression of the disorder in women and men

It has been suggested that the disorder has a different progression in men and women with regard to both onset and expression. The familiar understanding of the progression, in which early behavioral problems and antisocial behavior during childhood are associated with psychopathy,[12,57] seems to be most relevant for men. For women, the picture appears to be somewhat different since the behavioral problems of many in this group seem to arise first in adolescence.[14] The antisocial behavior of the young women may also have a different expression than in the young men.[14] It has been suggested that early criminal tendencies, rule violations,

physical aggression, and violence are good predictors of psychopathic development in young men.[9,12,19] At this same stage, young women, who later develop the disorder, show a more relational form of aggression characterized by jealousy, self-harm, manipulation, and verbal aggression. The exception is a small subcategory of young women who share the same tendencies as young men with behavioral problems, but with a later onset than what is typical in young men.[14]

Treatment of the disorder in women and men

Studies on the treatment of psychopathy have primarily focused on men.[1,13,43] Drawing on these studies, it is clear that psychopaths of both sexes are often regarded as a considerable violent risk and they generally respond poorly to treatment. The fact that psychopathy is a solid predictor of both harmful behavior and violence seems to be beyond question. However, responsiveness to treatment is a more controversial matter.[11,19] Research seems to indicate that those with a high PCL-R score get little benefit from the treatment and interventions, which may be suited for others, and that such treatment, in some cases, may even have a negative effect.[58] Evaluation of the treatment response in this subgroup reveals little effect of the measures taken to increase empathy, conscience, and interpersonal skills, or those targeting feelings of low self-esteem, anxiety, and depression.[19] In spite of this, there is no evidence to suggest that all types of treatment are useless. Considering the components of the disorder, factor one seems static and rigid, and factor two seems more dynamic and potentially impressionable. Accordingly, research indicates that treatment should focus on preventing violence and other more specific negative behaviors.[6,19] It is important to consider that criminals with psychopathic tendencies are not a homogenous group. The prototype of a psychopath will score high on all four facets (interpersonal, affect, lifestyle, and antisocial), while patients with more limited symptomatology, such as many women diagnosed with this disorder,[41,47–50] typically score high on fewer of the facets. For instance, a psychopathic patient with primarily manipulative tendencies may score high on the facets lifestyle and antisocial.[19,35] As a result of these varying facet scores, it may seem appropriate to target the different types of psychopathic patients with different and more individually adjusted treatment programs. Some of these patients will, in all probability, profit from a number of different treatment programs, while others may prove particularly resistant to treatment.[19] Consequently, it does not seem appropriate to offer treatment targeted at developing empathy to psychopaths with high scores in the affective facet unless there is the belief that the underlying personality can be altered. Neither does treatment directed at anger management seem appropriate for the majority of psychopaths, since the violence they perform usually is not a result of overwhelming emotions, but more often an instrumental type of violence, which is planned, nonemotional, and motivated by external objectives.[19,35] Follow-up has proved important to reduce the risk of violence, and the MacArthur study revealed that those with close and frequent supervision while on parole had a significantly lower chance of recidivism.[36] A central element in the treatment should be to reduce substance abuse, remove the association with negative (ie, criminal) networks, and alter behavior. In addition to performing a good analysis of what motivates a particular individual to change, this may, for instance, be achieved by making social behavior pay and antisocial behavior not pay.[19]

Conclusion

In this narrative review, we presented a synthesis of the literature on the sexes and psychopathy. We demonstrated that the topic is also of importance with respect to women and that a lack of focus on this disorder may have negative implications. We pointed out that the development of psychopathy in women and men is the result of complex interactions between biological and temperamental predispositions, and social and environmental influences.[12] We defined psychopathy and placed it in relation to the DSM-IV diagnosis of antisocial personality disorder and the ICD-10 diagnosis of dissocial personality disorder. In presenting the commonly used diagnostic instruments PCL-R and PCL-SV, we discussed how sex may be a factor of importance to the results achieved using these and comparable tools. Although psychopathy occurs more frequently and typically more severely in men, we additionally discussed literature that showed that the problem also exists in women. Clinicians should be aware that the behavioral expression of the disorder might differ between women and men. Female sufferers more often seem to show emotional instability, verbal violence, and manipulation of social networks, and, to a lesser degree than male psychopaths, criminal behavior and instrumental violence.[43] Finally, we discussed the aspects of comorbidity, progression, and treatment, pointing out that while there are many similarities, important sex-related differences do exist and should be considered.

Disclosure

The authors report no conflicts of interest in this work.

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