DIFFERENTIATING EMOTIONAL DISTURBANCE FROM SOCIAL MALADJUSTMENT: ASSESSING PSYCHOPATHY IN AGGRESSIVE YOUTH

CARL B. GACONO

Austin, Texas

TAMMY L. HUGHES

Duquesne University

The Individuals with Disabilities Education Act (1997) requires identification of emotional disturbance by special education criteria. It also requires that emotional disturbance be distinguished from social maladjustment. In some cases, a thorough evaluation of the child’s character pathology can aid in this determination. While methods such as the Rorschach, BASC, and MMPI-A are useful in understanding behavior and personality, psychopathy assessment may be particularly useful for organizing opinions in this matter. In this article we discuss the relevance of psychopathy’s two-factor structure in formulating a schema for making the differentiation between emotional disturbance and social maladjustment and review methods for gathering information about this troublesome aspect of character pathology. © 2004 Wiley Periodicals, Inc.

The Individuals with Disabilities Education Act (IDEA 1997) mandates identification of emotional disturbance by specific special education criteria [§ 300.7(c)(4)(ii)], and requires that emotional disturbance and social maladjustment be differentiated [§ 300.7(c)(4)(ii)]. While this difference is essential to various decisions regarding special education eligibility and service provision, it can be a daunting task for the evaluation team. However, in some cases evaluating the character pathology of the child can aid the evaluator in making this determination. Specifically, evaluating one aspect of character pathology, psychopathy, may be useful in differentiating the child with an emotional disturbance from the child with social maladjustment.

The importance of assessing psychopathy in children and adolescents is twofold. First, elevated psychopathy levels alert clinicians to individuals who are at high risk for preying upon others (Rutter, Giller, & Hagell, 1998). This is a serious concern when both groups are placed in the same educational settings. Although common in some school systems, when groups are placed together the child with a social maladjustment (psychopathic traits) is afforded access and opportunity to exploit the child with an emotional disturbance. Second, elevated psychopathy levels are associated with disruptive patients for whom more traditional treatment approaches tend to be ineffective (Fisher & Blair, 1998; Samenow, 1998). In fact, traditional treatment approaches may make the socially maladjusted worse (Hare, 1999; Sherman, 2000). Indeed, for the more psychopathic youth, behavior management strategies within a secure setting, rather than treatment, may be the recommended mode of intervention (Gacono, Nieberding, Owen, Rubel, & Bodholdt, 2001).

Understanding Psychopathy

While emotional disturbance encompasses a range of DSM Axis I mental disorders and clinical syndromes such as anxiety and depression, psychopathy is a distinct personality syndrome. As noted in Table 1, personality characteristics such as superficial charm, shallow affect, egocentricity, impulsiveness, and lack of guilt or anxiety, make it more akin to a personality disorder than an Axis I syndrome.
<table>
<thead>
<tr>
<th>DSM-IV Criteria Conduct Disorder</th>
<th>DSM-IV Criteria Antisocial Personality Disorder</th>
<th>Cleckley's Characteristics of Psychopathy</th>
<th>Psychopathy Traits &amp; Behaviors Hare (1980; 1990)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. At least 3 of the following in the past 12 months, with at least 1 present for 6 months:</td>
<td>A. At least 3 of the following since age 15:</td>
<td>1. Superficial charm and good intelligence</td>
<td>1. Glibness/Superficial charm</td>
</tr>
<tr>
<td>Aggression to people and animals</td>
<td>1. Arrestable acts</td>
<td>2. Absence of delusions and other signs of irrational thinking</td>
<td>2. Grandiose sense of self worth</td>
</tr>
<tr>
<td>1. Bullies, threatens, or intimidates others</td>
<td>2. Lies</td>
<td>3. Absence of “nervousness” or psychoneurotic manifestations</td>
<td>3. Need for stimulation, proneness to boredom</td>
</tr>
<tr>
<td>3. Weapon use that can cause serious physical harm</td>
<td>4. Fights &amp; assaults</td>
<td>5. Untruthfulness and insincerity</td>
<td>5. Conning/Manipulative</td>
</tr>
<tr>
<td>5. Physically cruel to animals</td>
<td>6. Irresponsible</td>
<td>7. Shallow affect</td>
<td>7. Shallow affect</td>
</tr>
<tr>
<td>Destruction of property</td>
<td>C. Conduct disorder, onset before 15</td>
<td>10. Poor behavioral controls</td>
<td>10. Poor behavioral controls</td>
</tr>
<tr>
<td>8. Fire setting with intention of causing serious damage</td>
<td>D. Antisocial behavior not exclusively during schizophrenia or manic episode.</td>
<td>11. Promiscuous sexual behavior</td>
<td>11. Promiscuous sexual behavior</td>
</tr>
<tr>
<td>Deceitfulness or theft</td>
<td></td>
<td>13. Lack of realistic, long-term goals</td>
<td>13. Lack of realistic, long-term goals</td>
</tr>
<tr>
<td>11. Lies to obtain goods/favors/avoid obligations</td>
<td></td>
<td>15. Irresponsibility</td>
<td>15. Irresponsibility</td>
</tr>
<tr>
<td>12. Stealing nontrivial items without confronting a victim</td>
<td></td>
<td>16. Failure to accept responsibility for own actions</td>
<td>16. Failure to accept responsibility for own actions</td>
</tr>
<tr>
<td>Serious violations of rules</td>
<td></td>
<td>17. Many short-term marital relationships</td>
<td>17. Many short-term marital relationships</td>
</tr>
<tr>
<td>B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Psychopathy also differs from the Conduct Disorder (CD) and Antisocial Personality Disorder (ASPD) designations (DSM-IV-TR; American Psychiatric Association, 2000). These disorders rely primarily on behavioral criteria (social deviancy model; Robins, 1966), while “psychopathy” (traditional psychiatric model; Cleckley, 1976) includes both traits and behaviors. As can be seen in Table 1, the psychopath (Cleckley, 1976) bears only a passing resemblance to the Conduct and Antisocial Personality Disorder (APA, 2000) diagnostic classifications.

The DSM disorders (e.g., CD and ASPD) include a heterogeneous group of individuals diverse in personality functioning and behavior (Rogers, Duncan, Lynett, & Sewell, 1994). In fact, Rogers et al. (1994) suggested that there are over a half-million criterion combinations that allow for a diagnosis of ASPD. The number of criterion combinations for CD is even more. The prevalence of these disorders is also very high among any populations with behavioral problems. For example, in forensic or correctional settings 50 to 80% of individuals may meet these criteria. Since both emotionally disturbed and socially maladjusted youth exhibit behavioral problems, the DSM criteria fail to distinguish between them (Bodholdt, Richards, & Gacono, 2000; Loving & Gacono, 2002). Psychopathy is different. As can be seen in Table 1, it is composed of both personality traits and behaviors. The construct’s two-factor structure (traits and behaviors) results in a syndrome (elevations on many of the variables) that is much more homogeneous than the DSM diagnosis.

Elevated psychopathy levels are also predictive. They are associated with a variety of problematic outcomes, including institutional misbehavior, re-offending, violent re-offending, and treatment failure (Gretton, McBride, Hare, O’Shaughnessy, & Kumka, 2001; Hare, 2003). The same prediction should not be assumed for the more heterogeneous CD and ASPD diagnoses (Gacono, 2000a). The relationship between psychopathy and the DSM-IV diagnoses can be summarized as follows:

1. Psychopathy is defined in terms of both personality traits and behaviors. Conduct Disorder and Antisocial Personality Disorder are based largely on a social deviance model defined predominantly in terms of antisocial and criminal behaviors.
2. While most psychopaths meet criteria for CD or ASPD, most individuals with CD or ASPD are not psychopaths.
3. In forensic or correctional settings, base rates for CD and ASPD are high and perhaps three times greater than base rates for psychopathy.
4. The CD and ASPD diagnoses apply to a diverse group of individuals who may have little in common other than the presence of criminal or antisocial behavior.
5. Conceptually, psychopathy is a combination of traits and behaviors from paranoid, borderline, narcissistic, histrionic, and antisocial personality disorders.
6. The presence of CD or ASPD does not have the same association with risk for offending or for violence as psychopathy does. Psychopaths comprise one extreme subset that demonstrates the highest levels of risk for problematic behaviors (also see Loving & Gacono, 2002; Gacono, 2000a).

The Psychopathy Checklists

The Psychopathy Checklists (Hare, 2003; Forth, Kosson, & Hare, in press; Hart, Cox, & Hare, 1995; Frick & Hare, 2001) were developed, in part, due to the limitations in the DSM diagnosis. This family of instruments includes the Antisocial Process Screening Device (APSD; Frick & Hare, 2001), the Psychopathy Checklist: Youth Version (PCL:YV; Forth et al., in press), the Psychopathy Checklist-Revised (PCL-R; Hare, 1991, 2003), and the Psychopathy Checklist: Screening Version (PCL:SV; Hart et al., 1995). The APSD is a 20-item rating scale used with children between the ages of 6 and 13 years old. Both the APSD and its predecessor the PSD (Psychopathy Screening Device) are scored based on parent and teacher ratings. The PCL:YV and
PCL-R are 20-item, 40-point scales scored from record review and semi-structured interview.\textsuperscript{1} The PCL:YV is used with young offenders from 12 to 18 years of age; the PCL-R with adult offenders. The 12-item PCL:SV is a screening tool for use in both offender and nonoffender populations.

Psychopathy Checklist items reflect specific traits that are theorized to be present in psychopathy. The PCL:YV, PCL-R, and PCL:SV are scored 0, 1, or 2. When insufficient information exists for scoring, items are omitted and the score is prorated. Items are scored from record review and semistructured interview data.

The PCL:YV and PCL-R consist of two separate but related factors (Hare, 1991, 2003). In addition to including behavioral features that are highly correlated with CD and ASPD criteria, the PCL:YV and PCL-R assess certain interpersonal or affective features that theoretically underlie those behaviors. Factor 1 items (e.g., glibness and superficial charm, grandiose sense of self worth, shallow affect) collectively reflect the longstanding interpersonal and affective traits, and correlate with Narcissistic and Histrionic Personality Disorders. Factor 2 items (e.g., need for stimulation, juvenile delinquency, criminal versatility) are largely behavioral in nature and correlate mostly with CD or ASPD. Additionally, most self-report scales, such as those of the MMPI-2 and MMPI-A [e.g., Scales 4 (Psychopathic Deviant) and 9 (Hypomania)], CPI [e.g., So (Socialization Scale)] and MCMI-III (e.g., Antisocial), correlate more with Factor 2 than Factor 1. Studies that use a self-report measure scale or score as the independent measure of “psychopathy” frequently have few if any actual psychopaths in them. They often include antisocial or conduct-disordered subjects, so that what is being assessed is a behavioral dimension of criminality akin to the PCL-R Factor 2.

Psychopathy can be viewed either categorically (i.e., a discrete taxon that is either present or absent [Harris et al., 1994]) or dimensionally (i.e., existing along a continuum of severity). In research, psychopathy is usually treated categorically (psychopathic/nonpsychopathic). In applied contexts, the condition is treated dimensionally—the relevant score becomes more important than whether or not the patient is psychopathic (see Gacono, Loving, & Bodholdt, 2001). To be high in psychopathy (e.g., PCL-R total score $\geq 30$), items from both factors must be endorsed. In other words, unlike CD or ASPD, a psychopathic designation is never considered due to the presence of persistent antisocial behavior alone, but must also include personality traits (e.g., Factor 1).

An impressive body of research supports the reliability and internal consistency of these instruments, and particularly with the PCL-R, its concurrent and predictive validity. In adult offender samples (Hare, 2003), high PCL-R scores have been associated with higher rates and a wider variety of offenses committed, higher frequency of violent offenses, higher rates of re-offending, poor response to traditional treatment interventions (Ogloff, Wong, & Greenwood, 1990; Rice, Harris, & Cormier, 1992), and more serious and persistent institutional misbehavior (Gacono, Meloy, Sheppard, Speth, & Roske, 1995; Gacono, Meloy, Speth, & Roske, 1997; Heilbrun et al., 1998). High psychopathy levels have been shown to be one of the most robust predictors of violence. Consequently, PCL-R scores have been incorporated into certain adult actuarial risk assessment instruments (e.g., Quinsey, Rice, Harris, & Cormier, 1998) and psychopathy assessment has been considered an essential component of forensic practice (Bodholdt et al., 2000; Gacono, 2000b, Gacono & Bodholdt, 2001, 2002; Hart, 1998).

\textsuperscript{1}The PCL-R may be scored reliably from records (Grann, Langstrom, Tengstrom, & Stalenheim, 1998; Wong, 1988) but never from interview alone (see Gacono, 2000b; see Gacono 2000c for the PCL-R Clinical and Forensic Interview Schedule). Additionally, the reliance on historical data for completing these instruments drastically reduces the effects of response style (see Bannatyne, Gacono, & Greene, 1999).
The Psychopathy Checklist for Youth (PCL:YV)

The empirical assessment of youthful psychopathy began in the late 1980s (Forth, Hart, & Hare, 1990) with the PCL-R research (see Loving & Gacono, 2002). The discovery that some of the original PCL-R items (e.g., parasitic lifestyle, many short-term marital relationships) were not appropriate for younger offenders resulted in the development of an 18-item modified version of the PCL-R for adolescents (Brandt, Kennedy, Patrick, & Curtin, 1997; Forth et al., 1990; Smith, Gacono, & Kaufman, 1997), and eventually, to the development of the 20-item PCL:YV.

While the PCL:YV is similar to the PCL-R, there are two important differences. First, several PCL:YV items have been renamed to reflect somewhat different content coverage (e.g., the PCL-R “many short-term marital relationships” was renamed to “unstable interpersonal relationships”). Second, scoring criteria have been adjusted to make them more applicable to younger examinees (i.e., fewer criminal acts are required to earn points on relevant items).

Preliminary studies have found the PCL:YV to be reliable and internally consistent (Forth, 1995; Forth & Burke, 1998; Gretton et al., 2001; Sheruda et al., 2001; Whalen, 1999). Its two-factor structure is highly similar to the PCL-R (Forth, 1995; Sheruda, Loving, & Russell, 2001). High scores on the PCL:YV or the modified PCL-R (for adolescents) are associated with earlier onset of delinquent and violent acts, higher frequency and variety of criminal and violent acts, more severe criminal behavior, and higher rates of institutional misconduct (Brandt et al., 1997; Forth & Burke, 1998; Forth, Hart, & Hare, 1990; Forth & Mailloux, 2000; Gretton, 1998; Gretton et al., 2001; Rogers, Johansen, Chang, & Salekin, 1997; Whalen, 1999). While preliminary information suggests the PCL:YV is equally applicable to African American and Caucasian examinees (Sheruda et al., 2001), further study is needed with other ethnic minority groups and females (Loving, Lipkin, Patapis, & Russell, 2001).

Two other instruments, which do not involve the extensive examiner training, collateral record review, and interviewing required for use of the PCL:YV have been developed for studying psychopathy in children and adolescents. The APSD (Frick & Hare, 1995; predecessor—the Psychopathy Screening Device, PSD; Frick, O’Brien, Wotton, & McBurnett, 1994) is a 20-item rating scale completed based on parent or teacher observations that can be applied to children as young as age six. The APSD measures three dimensions: callousness and unemotionallity, narcissism, and impulsivity. PSD limitations have included low inter-rater reliability between teacher and parent ratings and only weak evidence to support the instrument’s predictive validity (Frick, Barry, & Bodin, 2000). A second instrument, the Childhood Psychopathy Scale (CPS; Lynam, 1997), is a parent rating scale that draws 41 items from existing items of the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Common Language California Child Q-Sort (Casp et al., 1992). Some support has been reported for the construct validity of the CPS, including the presence of two highly correlated factors and the correlation of CPS scores with measures of impulsivity and externalizing disorders (Lynam, 1997).

When considering assessment of psychopathy in children and adolescents, practitioners must consider three things: (a) the development of these instruments has occurred only over the past decade; (b) there has been limited use of these instruments in an applied school context; and, (c) results describe the level of disturbance assessed; children are not labeled as “psychopaths” (Gacono, 2000b; Gacono, Loving, Evans, & Jumes, 2002). Despite these limitations the understanding of psychopathy and these instruments provides the clinician with a useful basis for organizing their thinking concerning the differences between emotional disturbance and social maladjustment.

Differentiating Among Juvenile Delinquents

Whereas the heterogeneity of the ASPD and CD diagnoses make them of limited use when a clinician is interested in understanding or distinguishing among juvenile delinquents, the
two-factor structure of psychopathy (Harpur et al., 1989) lends itself to this differentiation. Consider the following two case examples from Loving and Gacono (2002):

Andy, age fourteen, was recently arrested for armed robbery of a convenience store. He has two prior arrests (stolen vehicle and assaulting a police officer). Although he admits to committing many additional criminal acts for which he eluded arrest, his first arrest occurred at age twelve. His violence history includes frequent fighting, intentional fire setting, and harming animals. Bill, also age fourteen, was recently arrested for breaking and entering after he attempted to sleep overnight in a house he had thought was abandoned. During the past eighteen months, he has engaged in an increasingly conflicted relationship with his mother, and following numerous verbal altercations with her, he has run away from home for hours or days at a time. Often, following an argument, he has stayed out late at night, and then returned home after his mother was asleep. During this same time period, Bill’s attendance at school has begun to drop off, and his absenteeism has become another area of conflict at home.

Andy and Bill both meet the criteria for Conduct Disorder and hence would elevate on the PCL:YV behavioral items (Factor 2). Investigation of the boys’ respective histories, however, revealed that Andy was more narcissistic and detached (PCL:YV Factor 1—socially maladjusted), while Bill was inadequate and impulsive (emotionally disturbed). Bill lacked many of the PCL:YV trait-based Factor 1 items. He was not glib or grandiose, nor did he display shallow affect, a callous lack of empathy, or pathological lying. Because CD correlates with the PCL:YV Factor 2, most juvenile delinquents will receive mild to moderate scores for these items. However, when everything else is equal, it is the trait-based items (Factor 1) that will aid in differentiating between the emotionally disturbed (low Factor 1, moderate-to-high Factor 2) from the socially maladjusted (moderate-to-high Factor 1; moderate-to-high Factor 2).² Keep in mind that mental illness can coexist with psychopathy. These dual-diagnosed individuals are likely to be extremely difficult to manage and resistant to treatment even within secure settings (Gacono & Meloy, 1994; Young, Justice, Erdberg, & Gacono, 2000).

**Psychopathy Assessment in Context**

Making a CD diagnosis³ is only the starting point for an evaluation that continues with assessing psychopathy level and the use of other evaluation methods to understand the individual’s psychological functioning, treatability, and risk levels (Gacono & Bodholdt, 2001, 2002). As noted by Grisso (1998), “. . . The job [of the evaluator] is not to find ‘a diagnosis’ but to discover and describe the youth’s psychological condition” (p. 33). As previously noted by Gacono (2002a, 2002b) the work of Monahan et al. (2001) provides a useful model for the evaluation process by suggesting the need to gather assessment data from the following four domains:

1. Dispositional factors (including anger, impulsiveness, psychopathy, and personality disorders);
2. Clinical or psychopathological factors (including diagnosis of mental disorder, alcohol or substance abuse, and the presence of delusions, hallucinations, or violent fantasies);

²Psychopathy can be viewed either categorically (i.e., a discrete taxon that is either present or absent) or dimensionally (i.e., existing along a continuum of severity). In research, psychopathy is usually treated categorically (psychopathic/nonpsychopathic). In applied contexts, the condition is treated dimensionally, the relevant score becomes more important that whether or not the patient is psychopathic (cf. Gacono, Loving, & Bodholdt, 2001).

³Some modifiers have been recommended for CD. DSM-III (APA, 1980) allowed for assessing socialized versus under-socialized subtypes and/or presence or absence of aggressive behavior. DSM-IV (APA, 1994) included age of onset (i.e., childhood onset vs. adolescent onset) and severity (i.e., mild, moderate, or severe). These modifiers are potentially useful in discriminating among CD subjects because each have empirically demonstrated links to the severity of psychopathy (Forth & Mailloux, 2000; Frick et al., 2000).
3. Historical or case history variables (including previous violence, arrest history, treatment history, history of self-harm, as well as social, work, and family history);
4. Contextual factors (including perceived stress, social support, and means for violence).

Depending on the referral context, referral question, and setting, assessment necessitates gathering data from each of these domains. The use of multiple assessment methods, such as review of collateral materials and records, clinical and semistructured interviewing, standardized psychological testing and so forth, aids the clinician in assessing specific domains of functioning. The clinician must identify reliable and valid methods for assessing specific components of each domain. While the PCL:YV and other psychopathy assessment instruments may prove useful for collecting and quantifying certain relevant dispositional and historical variables, other methods are needed (Gacono, Evans, & Viglione, 2002).

Psychopathy has been identified as an essential component for making determinations as to the risk of future violence and/or re-offending (Gacono & Bodholdt, 2001, 2002; Hart, 1998). High levels of psychopathy predict elevated risk of re-offending and/or violence, although low levels do not immediately imply low risk. Violence, however, expresses itself in many ways, and even nonpsychopaths can pose a threat of violence or recidivism due to other features such as impulsivity, separate personality disorder diagnosis, sexually deviant arousal pattern, and so on. Aggression that stems solely from an emotional disturbance typically occurs due to emotional dysregulation (e.g., deficits or distortions in identification, expression, and/or regulation of emotion). This type of aggression is linked to real or perceived threats. Aggression that results from character pathology, such as psychopathy, may exhibit some of the same patterns as the emotionally disturbed, but typically also includes purposeful, unprompted, predatory behavior (indicative of social maladjustment).

High psychopathy levels have consistently shown a moderate association with subsequent criminal violence in adolescents (Edens, Skeem, Cruise, & Cauffman, 2001; Gretton et al., 2001). Although additional research is needed before youthful psychopathy may be considered predictive of long-term or adult violence or criminality, there is support for the use of PCL:YV as a predictor of short-term violence risk with adolescents. As such, when clinicians are required to make determinations of risk regarding violence or recidivism, PCL:YV assessment can contribute meaningfully to the data collection process. The following two cases illustrate this point (from Loving & Gacono, 2002):

Craig and Donald, both age 15, were co-defendants implicated in the brutal beating of two males. For Craig and Donald, this arrest was their first formal contact with authorities. They both faced identical charges, including Aggravated Assault. Despite highly similar and mostly unremarkable behavioral backgrounds, clinical interviews with the boys and collateral contacts with their respective parents resulted in strikingly different data with respect to interpersonal and affective features. Both claimed to experience remorse, but in response to in-depth questioning, it became clear that Donald’s negative feelings were tied more closely with having been caught than inflicting pain or suffering on the complainants. By contrast, Craig presented as genuinely embarrassed and remorseful about the incident and showed considerable sympathy toward the complainants. Donald appeared aloof and indifferent about harm he had inflicted; at one point, he blamed the complainants for instigating the dispute and commented that they “shouldn’t have started something they weren’t able to finish.” When asked about possible outcomes for their ongoing legal involvement, Craig appeared at a loss and expressed a willingness to “take whatever I got coming to me,” but Donald showed a cavalier attitude as he confidently explained how he expected to “beat” his case.

Although the above description provides only a small sampling of each adolescent’s attitudes and behaviors, their family relationships, sexual experiences, and school histories also varied. Based solely on their instant offense, Craig and Donald might have been seen as posing similar
levels of risk for re-offending despite their character differences. PCL:YV scores for Craig and Donald, would reveal similar scores on the behaviorally oriented Factor 2, but differences on Factor 1 (interpersonal/affective). However, Donald’s mild grandiosity, callous disregard for others, and failure to take responsibility for his negative actions (higher Factor 1 scores) speak to a failure to learn from or be impacted by this incident and, consequently, represent a higher risk of repeating similar behaviors in the future.

Conclusions

The majority of CD youth do not develop lifelong patterns of antisocial behavior (Moffitt, 1993). Discriminating among them has important prevention, management, and treatment considerations. There have been numerous efforts to subtype among children with conduct disorder and to identify those at high risk (Frick et al., 2000). One group of children who display a combination of hyperactive, impulsive, and inattentive symptoms (HIA) and conduct problems (CP) represent a particularly high-risk group (Farrington et al., 1990; Lynam, 1996, 1997, 1998). This combination of HIA and CP has been associated with more noncompliance, aggression, egocentricity, and frequency of conduct problems (August, Stewart, & Holmes, 1983), more police contacts, more offenses, self-reported delinquency, aggression, and/or theft, parent-reported doctor visits, temper tantrums (Loeber, Brinthaupt, & Green, 1990), earlier onset of and higher frequency of ASPD symptoms (Walker, Lahey, Hynd, & Frame, 1987), lower measures of physiological arousal (Delamater & Lahey, 1983; Pelham et al., 1991), and higher rates of antisocial behaviors among family members (Faraone, Biederman, Keenan, & Tsuang, 1991; Lahey et al., 1987). “Fledgling psychopaths” who exhibit this unique combination, have repeatedly shown a significantly higher risk for various negative outcomes than children with only one of the symptoms (Lynam, 1996).

Other children with conduct disorder who pose the highest risk for later antisocial or criminal conduct include undersocialized youths (Quay, 1987), those with low anxiety (McBurnett et al., 1991; Quay & Love, 1977; Walker et al., 1991), and those whose disruptive behavior includes not only covert but also overt acting out (Fergusson, Horwood, & Lynskey, 1994; Frick et al., 1993). Quite likely, these groups represent overlapping yet different types of youthful offenders who share some, but not all, features associated with psychopathy.

Despite the reluctance to discuss childhood and adolescent psychopathy, it does exist (Forth & Mailloux, 2000; Frick et al., 2000). The development of psychopathy begins early and follows a predictable, persistent course across the lifespan (Hare, Forth, & Strachan, 1992; Harpur & Hare, 1994; Loeber & Hay, 1997). The specific etiology of psychopathy stems from multiple factors, including biochemical, temperamental, familial, and other psychosocial elements.

Extending the psychopathy construct to youth aids in differentiating among the diverse range of individuals diagnosed with CD. All things being equal, those who are behaviorally disturbed, but low in the more trait-based features (low on Factor 1, moderate-to-high on Factor 2) are more likely to fit into the category of emotional disturbance. For them, treatment prognosis is most likely underestimated. Juveniles who are high in psychopathy (high on both Factor 1 and 2; socially maladjusted) are likely to be more problematic in traditional treatment settings, with less positive outcome related to traditional treatment methods.

For many reasons (Gacono, 1998; Gacono, Loving, Evans, & James, 2002) applied usage dictates that the Psychopathy Checklists are used as a method for organizing the historical and clinical data (dimensional usage) rather than labeling someone as a psychopath (categorical usage). When applying the construct of psychopathy to children and youth, clinical issues do not center on labeling the student as a psychopath, but rather, how these traits relate to prevention, management, and treatment. It is our hope that the psychopathy construct will be useful to school psychologists in differentiating the socially maladjusted from the emotionally disturbed, and ultimately, facilitating
IDEA compliance and the goal of matching treatment services to the child’s treatment and educational needs.

**REFERENCES**


