REVIEW

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Psychopathy and camouflaging: a social mask between adaptation and manipulation

Liliana Dell'Osso, Cristiana Pronestì, Benedetta Nardi, Chiara Bonelli, Barbara Carpita

Department of Clinical and Experimental Medicine, University of Pisa, Pisa, Italy

Summary

In the era of comprehensive, real-time, updated information, public opinion is deeply aware of social threats, including violent crimes eventually committed by psychopaths living next door. A very small and outdated literature focused on camouflaging as a strategy adopted to reproduce normal social behaviours, by subjects presenting antisocial/dissocial personalities. If these strategies have been investigated deeply among different clinical subgroups (i.e., patients suffering from autism spectrum disorder), the understanding of the underlying mechanisms may highlight some initial, prodromic manifestations, before a serious crime has been committed. On the other hand, similar attitudes are detected among the general population, with only a few who will become offenders. In this perspective, camouflaging might be considered as a transdiagnostic element, closely associated with the continuous distribution of the deviant personality traits among the general and clinical/criminal populations. This editorial proposes a reconceptualization of camouflaging as a diffuse phenomenon, particularly salient in psychopathy, with some historical reminder, and critically examines its potential role in facilitating social integration of high-functioning individuals with deviant traits.

Keywords: psychopathy, camouflaging, transdiagnostic

INTRODUCTION

The term psychopathy commonly refers to a personality disorder, or aberrant personality marked by alterations in interpersonal relationships, affectivity, and social behaviours[1]. While affectively superficial and uncapable of enduring bonds, psychopaths show egocentric, grandiose, manipulative, domineering, and exploitative behaviors in interpersonal field. Noteworthy, the lack of empathy, remorse, or guilt, and impulsive, thrill-seeking attitudes, significantly deviating from moral, ethical, and social norms are core features of this personality with a deep tendency to use other people for their own well-being, despite consequences, including suffering and pain[2]. As the prevalence ranges around 4.5%, implying that over one person in twenty-five may pose a societal risk[3], within incarcerated populations, psychopathy prevalence is more than three to fivefold higher[3-4]. Nonetheless, many individuals with psychopathic traits never commit crimes and remain outside the justice system, often being able to hurt others in more sneaky and underhanded ways[5-7].

In this perspective, Cleckley's pioneering work, "The Mask of Sanity" (originally published in 1941), emphasised the ability of psychopaths to mimic normal functioning by masking their personological deviance, rather than simply reporting their physical aggressions or committed crimes[8]. Particularly, the tendency to employ behavioral strategies masking inner vulnerabilities is known as "camouflaging". This term mostly appears associated with the autism spectrum disorder as an attempt to mask deficits in social contexts. However, similar strategies may be observed

Correspondence
Chiara Bonelli
E-mail: chiarabonelli.95@hotmail.it

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in other psychiatric conditions, and among neurotypical subjects[9-11]. To the best of our knowledge, camouflaging in psychopathic subjects remains partially underexplored in scientific literature. The purpose of this work is to consider camouflaging as a diffuse phenomenon and critically examine its potential role in facilitating social integration of high-functioning individuals with deviant traits.

THE CONSTRUCT OF PSYCHOPATHY: HISTORICAL ASPECTS

The clinical construct of psychopathy is the result of more than two centuries of investigations and speculations by psychiatrists and psychologists. If Pinel identified moral insanity within the scope of "*folies sans delire*", the first use of the term is due to Feuchtersleben, who differentiated psychopathy from neurosis. However, Koch, introducing the notion of *constitutional psychopathic inferiority* described organically the core features of this personality[12]. Shortly thereafter, Kraepelin coined the term *psychopathic personality*, which he placed in the extensive chapter on degeneration. For the German psychiatrist, *degenerative/moral* insanity denoted psychic deformities characterised by immutability, including the born delinquent, the unstable, the pseudo-questioners, the liars, and the morbid cheats. In the mid-twentieth century, Schneider distinguished for the first time psychosis from abnormal personalities and isolated psychopaths as individuals either suffering or causing suffering to society by their nature. Noteworthy, he specified that such conditions had nothing properly pathological[12].

Finally, the two authors widely recognised as pioneers in the field of psychopathy research are Hervey Cleckley and Robert D. Hare[8,14]. While Cleckley provided a detailed filing of the psychopathic nature, Hare utilised Cleckley's literature contributions introducing psychometric instrument that facilitated identification[8,14].

MEASURING PSYCHOPATHY

Psychopathy was one of the first personality disorders reaching attention among psychiatrists. Nevertheless, after hundreds of years of investigation, the debate on the definition of psychopathy as an abnormal personality or, rather, abnormal behaviour is still partially unresolved[13]. In his original description, Cleckley identified 21 key aspects, eventually reduced to 16 in 1976, mentioning antisocial behaviours, but focusing on personality traits, including superficial charm, lack of empathy, unreliability, grandiose self-worth, untruthfulness, lack of guilt or remorse, and insincerity[8]. A little further, based on Cleckley's work, Hare published his Psychopathy Checklist (PCL), with several updated/revised versions[14], which has now become the standard diagnostic tool for psychopathy. This scale includes affective/interpersonal aspects (Factor 1) and socially deviant aspects (Factor 2) assessed by a standardized and detailed manual. Several other psychometric scales, empathy tasks, and electrophysiological measures are now available to objectify specific characteristics, whilst self-reported empathy products are less useful in the clinical environment[4]. However, the cornerstone of identification in forensic populations requires combining clinical observation with standardized instruments, with the PCL-R (Psychopathy ChecklistRevised) remaining the gold standard. In the general population, self-report measures may help assess trait levels.

THE "DIAGNOSIS" OF PSYCHOPATHY

In 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM) partially embraced previous descriptions of psychopathy adopting the term "sociopathic personality disturbance" or "sociopathy", later converted to antisocial personality disorder (ASPD), defined as a pattern of disregard and violation of the rights of others that manifests as early as 15 years of age[15] (APA, 2022). Similar to the DSM, the latest version of the International Classification of Diseases[16] refers to dissocial personality disorder, with several traits associated with the ASPD[13,16]. However, several authors have questioned the validity of ASPD as a means of identifying the construction of psychopathy[17]. While most psychopaths fulfil the criteria for ASPD, not all individuals with ASPD are psychopaths. At the same time, most inmates may meet the criteria for ASPD. Conversely, a small proportion of them are psychopaths[17]. The partial overlap between ASPDs and psychopathy could be explained by the fact that the diagnostic classification systems focused on social deviance paying less attention on the affective and interpersonal components of psychopathy[18]. In this framework, formal diagnosis of psychopathy does not still appear in DSM. Nevertheless, the core features of psychopathy are distributed across all cluster B personality disorders (ASPD, borderline, histrionic, and narcissistic), all sharing a substantial lack of empathy and more or less manipulative attitudes[19-21]. Unfortunately, the overlap with other personality cluster symptoms and camouflaging behaviors (i.e., deceptive responses) makes it hard to identify psychopathy.

PATHOGENESIS OF PSYCHOPATHY: AETIOLOGICAL HYPOTHESES AND NEUROSCIENCE RESEARCH

A consistent literature identified the core manifestations of psychopathy, but the aetiology, pathways, and theoretical limits remain far from being fully clarified. Since the early works of Karpman[22], psychopathy was distinguished into *primary* or "true" psychopathy, when innate or linked to neurobiological mechanisms, and *secondary*, when associated with early trauma, abuse, neglect, or dysfunctional environments. More recently, the ongoing public opinion and most of the literature consider psychopathy as a mental disorder, although there is an alternative hypothesis basing on the role life history may have on the subject's behaviours evolution[13]. Several studies reported that genetic and neurobiological pathways represent the basis of psychopathy, while life experiences influence

its peculiar features and severity[23-24]. However, the neurobiological findings about mechanisms possibly underlying psychopathic traits is insufficient to explain their pathogenesis. A recent meta-analysis compared some authors the lesions of brain network leading to deficient activity in the antisocial population with 655 control lesions. The work focused on amygdala, orbitofrontal cortex, prefrontal cortex, fusiform face area, and supplementary motor area, previously correlated to emotional face processing, empathy, and the serotonergic system. Combining all these alterations, the authors found some antisocial behaviors by altering specific mental processes[25]. Studies based on functional MRI reached similar conclusions[26]. Life adversity - especially in early childhood - may amplify vulnerabilities. However, not all exposed individuals manifest psychopathy, emphasizing the gene–environment interaction[4]. These neuroscientific findings highlight possibilities for early detection, although ethical and practical challenges remain considerable. Noteworthy, all these issues contain important ethical and moral issues, including both pre-criminal situations and forensic individuals.

THE ZERO OF THE EMPATHY CONTINUUM

The core features of the psychopathic personality are an almost total, or complete, lack of empathy, and the inability to feel remorse or guilt, which frequently result in antisocial acts[6]. In detail, individuals with psychopathic traits reported a reduced ability in sharing emotions, defined as affective *empathy*, while *cognitive empathy*, described as the ability to recognize emotions could be partially preserved[27-29]. According to Baron-Cohen's interesting studies, empathy is distributed along a continuum among the population, from the "zero degrees of empathy" to the "hyper-empathy" [6]. The lower end of the empathic spectrum is characterised by a complete absence of understanding and participation in the emotions and thoughts of others, resulting in marked social difficulties. Nevertheless, Baron-Cohen distinguishes the zero degrees of empathy in two categories: positive zero, unlinked to antisocial behaviour (i.e., autistic patients), and negative zero, frequently related to wickedness. This last includes psychopaths, borderlines, and narcissists, all of them at higher risk to hurt other people with more or less self-consciousness[6]. Other authors identified subclinical wicked traits in a triad, named by them "The dark triad" which includes psychopathy, narcissism, and Machiavellianism. Within this triad, psychopathy represents the most behaviorally aggressive dimension, narcissism the self-aggrandizing element, and Machiavellianism the strategic manipulation[30]. Crucially, Dark Triad traits are not confined to criminal populations but could be found among persons with high functioning social abilities, short-term success, and pronounced leadership[31] . However, according to an intriguing and long-standing perspective, there is a sort of continuum starting from the so-called Vulnerable Dark Triad (borderline symptomatology, vulnerable narcissism, and secondary psychopathy) to the Dark Tetrad (psychopathy, narcissism, machiavellianism, and sadism), displacing the simplest concept of "dark personality traits"[29].

THE HIDDEN PSYCHOPATHY

Traditionally, psychopathy is strongly associated with violent and recurrent criminality, and it is prevalent among prison populations. In mass culture, the figure of the psychopath is associated with the most heinous crimes, such as serial and gory murders. However, it is also known that psychopathy can manifest itself through more hidden and subtle ways. As emerged from Cleckley's early descriptions of the psychopath's profile, individuals with psychopathic traits can also be highly intelligent, showing a cold emotional detachment, and indifference or disregard for the consequences of their actions (Cleckley 1982). All these features make them exceptional manipulators, who to hide or camouflage their psychopathic traits[6-7]. In this perspective, many psychopaths, to win the trust of their victims, assume socially acceptable and successful roles such as the professions of manager, doctor or lawyer[31]. Psychopathy does not necessarily involve bloody or violent acts, but may manifest itself more subtly, through mechanisms of psychological violence such as devaluing the pattern in a toxic relationship or bullying in the workplace. Recognising a psychopathic subject in these guises is an extremely arduous task because it requires the ability to recognise and unmask the camouflaging techniques employed by these subjects. The mask, as Cleckley originally proposed, must be removed or, at least, displaced.

CAMOUFLAGING IN GENERAL AND CLINICAL POPULATIONS

Social camouflaging is defined as a set of behavioural and cognitive strategies employed to mask perceived undesirable aspects of the personality, particularly within social contexts[9,11]. This attitude, which can range from imitating gestures to sophisticated manipulation of identity, is common among humans as well as in the animal world and is considered a form of adaptive mechanism. In clinical contexts, camouflaging manifestations may eventually be identified across a range of disorders, including dysmorphic disorders, social anxiety disorders, and mannerism symptoms observed in schizophrenia. Nevertheless, the primary focus remains on autism spectrum disorders (ASD), in which camouflaging is particularly prevalent, especially among women[33]. Individuals with autistic sub-threshold traits frequently employ learned strategies to mask their social difficulties, including maintaining eye contact, using prepackaged sentences, or imitating others' interests and behaviour. While these strategies may enhance social adaptation, they demand substantial emotional and cognitive exertion, frequently accompanied by stress, anxiety, and a sense of alienation[33-34]. Furthermore, recurring to camouflaging behaviours may also contribute to delayed or missed diagnoses[9].

CAMOUFLAGING IN PSYCHOPATHY: FROM MASKING TO MANIPULATION

Psychopaths' ability to dissimulate their deviant personality traits has a primary aim: manipulating others. It should be noted that the kind of camouflaging which could be adopted by psychopaths is different at its core from the social camouflaging used by autistic people, and thus, probably, the questionnaires used for measuring autistic-like social camouflaging would not be useful to measure this dimension. While ASD patients utilize it to mask their social inadequacy and to avoid the stigma, in a sort of "genuine" behaviour, psychopathic subjects employee camouflaging as a conscious social infiltration. They try to control, manoeuvre, and take advantage of or dissimulate guilty behaviour. This attitude may be considered in the shape of "conscious camouflaging" involving social integration, and achieving power, gaining more and more power within a group. In modern society appearances and impressions increasingly mediate social interactions. In this framework, the ability to "act normal" represents a significant competitive advantage. However, not all psychopaths are highly skilled, especially incarcerated populations or peculiar subgroups. We may hypothesize that, in this framework, intellectual abilities could mediate the effect of social camouflage[35-36].

THE PSYCHOPATHIC CAMOUFLAGING: CLINICAL AND FORENSIC IMPLICATIONS

The camouflaging strategies adopted by psychopaths represent a major challenge for both early diagnosis and monitoring clinical courses. Even the use of well-standardized tools, such as the PCL-R, could not be sufficient to properly assess the presence of psychopathic traits because all of which can be manipulated by "high functional" individuals[37]. Moreover, when dealing with forensic science, the issue of camouflaging hardens the processes of risk assessment and judicial management. This ability not only limits the identification of criminal behavior but also contrasts the prediction of recidivism, ultimately affecting the social security measures and rehabilitation interventions [7,38]. Most psychopaths do not manifest internal distress, lack of insight, but are capable of subtly influencing familial dynamics, work environment, and legislative issues, leading to many potential adverse consequences for the community[31] . Theoretically, prevention efforts should be maximized before the psychopaths become criminals. Two main reasons are the basis of this assumption: first, the main moral, practical, and economic principle of avoiding social crimes, and second, the highly challenging medical therapy of rehabilitative strategies to reduce relapses of crimes in those who are stopped by the justice system. The practical strategies include early awareness, social education, and vigilance, all of them opposed by the camouflaging strategies achieved by psychopaths. Psychotherapeutic interventions have limited efficacy without a therapeutic alliance between operators and patients, a deficit in genuine motivation, and their manipulative tendencies. Neuromodulation and pharmacotherapy remain confined to experimental settings, while early interventions in youth with altered subthreshold traits may be more effective in family/community-based environments[39-40]. Ethical concerns include stigmatization and misuse of early diagnostic labels. A long-term, individualized, multiprofessional approach should be preferred.

CONCLUSIONS

Psychopathy is a complex, multifaceted construct, beyond the classic association of deviance and violence[2,8]. On the empathy continuum, psychopaths usually occupy the lowest end, showing a total inability to recognise and share the emotions of others, including pain. However, in some cases, the lack of empathy is not complete, with cognitive empathy being preserved and affective empathy abolished[6]. Furthermore, empathy deficits do not automatically translate into sadism, and psychopathic traits can also be observed in the general population, not just in criminals. In this context, psychopaths can hide their social difficulties and assume, for example, the role of a violent partner or a cruel supervisor. One of the possible mediators of this "social mask" are camouflaging strategies. In the absence of formal criteria for diagnosing psychopathy, a normal distribution within a spectrum of manifestations ranging from subtle personality traits, hidden through camouflaging strategies, to overt antisocial behaviour, is conceivable[35-36]. In this framework, the ability to camouflage, marked in highly-adjusted subjects without severe criminal acts in their natural history, pose interesting (but challenging) questions regarding differential diagnosis, forensic assessment and prevention[39-40]. Conversely to most psychiatric conditions (i.e., autism spectrum disorder), where camouflaging has a genuine and adaptive value[9], in psychopathy, it represents a conscious strategy to obtain manipulation, social trust, or to dissimulate antisocial conduct. A comprehensive assessment, integrating clinical observation and psychometric tools, is the cornerstone of clinical interventions among those who reach the justice system. Further multiprofessional actions should be designed and promoted, together with an educational awareness, to intercept personality traits and to develop intervention strategies in those at risk. These issues should also be continuously balanced with respect for individual rights, to avoid social stigma and unethical consequences.

Conflict of interest statement

The Authors declare no conflict of interest.

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