Abstract

We are delighted that practitioners, theorists, and researchers have been following the clinical and diagnostic endeavors in psychopathology of our team at NYU. In a recent set of publications delineating specific aspects of character disorders [Juni 2009, 2009a, 2010, 2014], a comprehensive psychodynamic model of psychopathy has been emerging as clinical findings led us to reconceptualize symptom clusters. I have been asked by the editor of this journal to share a unified model of psychopathy and antisocial behavior which incorporates our findings and conceptualizations. This paper is descriptive, intended to present an abridged summary of our conceptual system as it has evolved to date. The theoretical development and clinical rationales of the elements in this model are detailed in our previous papers. Grounded in our publications to date, the model is made more robust by incorporating the Oppositional Defiant factor and fine-tuning the other categories based on more recent clinical insights. Culling the conclusions from our clinical research studies, we annotate and outline the key elements of recent diagnostic and theoretical expositions of psychopathy, while elaborating and refining constructs of personality and behavioral disorders. The model is offered as a uniform classification strategy to systematize and reconcile disparate clinical and research data in the fields of neuropsychiatry, neuropsychology, personality, forensics, and social psychology.

INTRODUCTION

Psychopathic personality vs. Behavioral disorders

Psychopathy has been described as one of the most ill-defined and controversial disorders of psychopathology [1]. The term has been further fractured by dual tracks in medicine and diagnostics which focused inconsistently on psychodynamics and on overt behaviors.

The theoretical stance of this paper is not congruent with the view of the antisocial personality disorder espoused in the current version of the Diagnostic and Statistical Manual of Mental Disorders [2]. Starting with the fourth edition in 2010, DSM decided to substitute the term “antisocial” for the term “psychopathic” in an effort to stress the behavioral, rather than the dynamic, aspects of the disorder. This category is presented as a collection of behavioral anomalies which share antisocial qualities – in a stark departure from the psychodynamic origins of psychopathy postulated by Henderson [3] and Cleckley [4] and fleshed out by Hare [5], and Meloy [6,7].

We find the DSM stance regarding behavioral and antisocial disorders diagnostically unsound. By contrast, we find the criteria of the Aggressive Psychopath elaborated in the Psychodynamic Diagnostic Manual [8] to have a more sound definitional integrity as it retains the dynamic aspect of this disorder.

While psychopathy is often accompanied by antisocial behavior, the two phenomena are not equivalent. Psychopathy is a disorder of personality. It may, or may not, be expressed in specific behavior patterns, and negative behavior – regardless of its intensity or pervasiveness – is insufficient evidence of a personality disorder (Footnote 1).

Similarly, behaviors which are antisocial may be attributable to causes other than psychopathy. This divergence has been common sense knowledge for decades in the fields of psychiatry and clinical psychology, but has been steadily eroded by the atheoretical transformation of American psychiatry into a behavioral-oriented discipline (evidenced in the gradual exorcising of psychodynamics in the progression of DSM editions) though the tide has been somewhat stemmed by the valiant efforts of a consortium of psychoanalytic associations championing PDM. Ironically, DSM still uses the nomenclature of Antisocial Personality Disorder though its elements are almost all circumscribed to habitual antisocial behavior. Psychopathy, as defined conceptually in PDM, focuses primarily on personality disorder and features traits and attributes that may – or may not – engender antisocial behavior.

Our classification model

Our model is based on three postulates which differentiate between pathological personality factors and behavioral patterns
as follows:

- Psychopathic Personality Disorder is intrapsychic, and its diagnosis is not obviated by a lack of antisocial behaviors. Its criteria are emotional rather than behavioral.
- Antisocial Behavior patterns are typically due to specific deficits in emotional modulation and cognitive anomalies. Therefore, diagnosing personality disorders in general – and psychopathy in particular – based on overt behavior is inappropriate.
- DSM diagnostic criteria for Antisocial Personality Disorder are primarily behavioral. As such, they are only marginally relevant to Psychopathy.

The foundations of our conceptual strategy are anchored in the differential seminal psychodynamic approaches of the classic psychopathy theoreticians -- Hare [5], Cleckley [4], and Meloy [6] -- as elaborated by elements championed in DSM, PDM, and our own studies. Our system, presented in Table (1), sorts the various affective, relational, and behavioral factors into distinct categories which show minimal overlap.

We demarcate between behavioral disorders and psychopathy. Within behavioral disorders, we feature the following:

**Social intelligence deficit:** Many individuals are psychiatrically and legally classified with Antisocial Behavior and Psychopathy labels after inappropriate interpersonal interactions or running afoul of the law. We repeatedly find that these people have no intention of acting inappropriately and certainly no negative emotionality which motivates them. Instead, they simply lack sufficient social intelligence to understand the meaning or significance of their acts and do not anticipate the fact that those acts would be perceived as negative or hostile.

Characteristically, such “perpetrators” are genuinely puzzled at the trouble they find themselves in, and honestly believe that it was all just a big “misunderstanding” (which it indeed is, since they lack the social intelligence to understand the perceived meaning and consequences of what they did). Their understanding of social repercussions of behavior is limited, rendering their judgment dysfunctional. Behavior which deviates from accepted social mores is thus unwitting. We state emphatically that not only can such activities not be considered pathological, but they cannot even be considered antisocial, even if the behavior is offensive to others.

**Impulse control deficit:** Here, too, there is no evidence of personality pathology. There is an inability to delay gratification delay and a diminished capacity to clamp down on impulse expression. Thus, such individuals have difficulty controlling any incipient impulses which may arise for them, including (for example) sexuality, appetite, and thrill seeking. Aggression is but an instance where control is lacking. While such individuals will express their aggression when frustrated, they have no particular investment in belligerence, nor do they harbor an untoward degree of hostility or anti-social motivations.

Diagnostically, this pattern too is a behavioral style. It is certainly not a personality disturbance, and has no implications of negative attitudes toward others.

Within the psychopathy category, we include the following:

**Oppositional defiant disorder:** This is a new category we recently added to our model of psychopathy based on analyses of patient protocols.

To capture the flavor of this distinct psychopathic orientation, we adapted the term Oppositional Defiant Disorder from DSM. DSM limits this diagnosis to children who defy rules and regulations, are deliberately contrary, and show antisocial behaviors. In our use of the term, we recognize that some psychopathic adults have a characterological disposition to defy societal rules, authority figures, and their regulations. We postulate this pattern to comprise a distinct motif in the classification of psychopathy. To be sure, we accentuate the characterological aspects of the disorder (in accordance with the perspective of PDM) instead of focusing on the overt behavioral DSM markers.

Developmentally, such individuals bring with them a perceived history of mistreatment by powerful others which prompted their very personalities to coalesce around defiance, and to adopt an oppositional attitude and a combative stance toward any directives by superiors or authority figures. For these individuals, oppositionalism is an end in itself, divorced from, and unrelated to, context or situational features.

Normal healthy development is predicated on the internalization of cultural norms and mores. Reasonable prosocial external restrictions and behavioral mandates, though initially experienced as dystonic, gradually get incorporated into one’s own set of values. Oppositionally Defiant adults do not experience this transition, and continue to perceive norms and rules as infringements of their agency. Pathognomically, they “carry the torch” of defiance to a pathological degree, as they become preoccupied with defying authority figures and regulations (to the point of seeking out confrontations) even in situations where conflict is easily avoidable. (Footnote 2)

**Pervasive aggression:** Although DSM subsumes individuals with excessive aggression under the diagnostic category of Conduct Disorders, we classify them as psychopathic because their behavioral pathology derives from abnormal drive levels. We refer here to individuals who show a marked proclivity for aggressive behavior. They get into altercations even with minimal or no frustration. Fights are not means to achieve an end. Rather, they are enjoyable in themselves. Their aggressive behavior is not

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<th>Table 1: Factors of Antisocial Behavior and Psychopathy.</th>
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<td>I. Antisocial Behavioral Disorders</td>
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<td>1. Social Intelligence Deficit</td>
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<td>II. Characterological Psychopathy</td>
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<td>1. Oppositional Defiant Disorder</td>
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<td>a. Characterological Cruelty</td>
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necessarily linked to anger or hatred. Their fighting "adversaries" are often good friends, and the friendship is not disrupted by the physical altercations. Moreover, the intent of fighting is not to win the fight. Many individuals in this category enjoy fighting even when they get seriously hurt. They will feel uneasy when interactions are not problematic, and often go out of their way to seek out a brawl.

Habitual aggressive behavior is arguably a diagnostic enigma. Individuals who are excessively aggressive may be classified as compulsive, because they often feel compelled to act out. Descriptively, they also fall within the criteria of Conduct Disorder. However, we believe that categorizing this pattern solely as a behavioral abnormality or conceptualizing it as a compulsion both miss the dynamic basis of the disorder. Furthermore, these individuals cannot be diagnosed as evincing Antisocial Personality Disorder, since their repertoire does not entail negative or hateful attitudes toward others or toward society. In fact, the social attitudes of these individuals are psychologically intact, and their cognition is not disturbed as a rule.

The fact that habitual excessive aggression often yields significant harm to others is not sufficient to merit a psychopathic diagnosis, since behavioral abnormality is not necessarily indicative of personality disorder. Although the judgment of such individuals is usually suspended when they act out, they do appreciate the negative repercussions of their behavior pattern when not involved in aggressive frenzies. Psychodynamically, however, it is clear that the behavioral disturbance in such individuals -- which derives from a miscalibrated innate aggressive drive -- justifies the classification of psychopathy. (Footnote 3)

**Superego deficit:** The superego of normal individuals is effective only insofar as it has recourse to inculcate guilt in the individual. Lack of remorse and absence of guilt is a diagnostic marker of Superego Deficit, hence the common depiction of such individuals as callous.

The avoidance of guilt is accomplished by massive emotional repression and reaction formation. Other affect is often also repressed as the effects of this self-protective defensive process solidify. It is this generalization from guilt negation to the blockage of other emotions which renders psychopaths with superego deficit shallow. (Footnote 4)

It is important to note that a large proportion of psychopathic personalities actually succeed – and even excel – in vocational and societal interaction. Particularly, those with high social intelligence understand others’ feelings and expectations and then play along manipulatively. In such cases, their superego deficit and lack of guilt is often an asset, enabling them to act in a self-serving manner without personal discomfort.

**Sadism:** Sadistic psychopaths engage in aggression only because they enjoy the pain they cause others. With Sadism, we have two diagnostic categories, the second being a subset of the first.

**Characterological cruelty:** The pathognomic marker of sadism is the enjoyment experienced when inflicting pain. Psychoanalytically, we believe that this enjoyment is erotically derived, and that the disorder entails the displacement of eroticism from sexuality to aggression in a process of pathological fusion. It is for this reason that the enjoyment of cruelty may be conceptualized psychoanalytically as related to fetishism. It is important to stress that Sadism without reenactment features is "reality oriented" since it does not engender deterioration in reality testing.

**Reenactment Complex:** Individuals in this sub-category share the pathological devotion to pain infliction with those who merely exhibit characterological cruelty. What is distinct about reenactment sadists is a pattern of ritualistic acting out of historic trauma and perceived injustice. Clinically, we find that the brutal acts of the reenactment sadist (often featuring sexual violence) are relational in nature. The emotional reactions of the sadist and the victim are key to understanding the intent of the attack. In the perpetrator’s mind, the attack is construed as an interaction into which he or she projects a distinct relational tone. As the planned attack script unfolds, it is a psychopathic sequel to an unresolved historic trauma suffered by the perpetrator, intended to "solve" the trauma by enacting a corrective redress.

The pathology in Reenactment Sadism shows a range of symptomatology with borderline features which sometimes usurp reality testing. Reenactment has the earmarks of compulsion – especially when it repeated serially – featuring precise rituals in which victims are forced to participate and typically combine aggressive and sexual features.

**Neurodegenerative Diseases, Psychopathy, and Antisocial Patterns**

Recent studies have shown a general linkage between neurodegenerative disorders, antisocial personality, and behavior patterns. We highlight a representative sample.

In a comprehensive review of the link between psychopathy to the cognitive and affective functions of the prefrontal cortex, Koenigs [9] outlines the projected analysis of PhineasGage’s brain by Damasio et al. [10], the personality changes in patients with brain damage involving ventral PFC [11], Damasio’s subsequent analyses zeroing in on the ventromedial prefrontal cortex, and a number of follow-up studies highlighting a variety of traits and characteristics which may be associated – centrally or peripherally – with psychopathy.

Using DSM-IV criteria for Anti-Social Personality Disorder, Gregory et al. [12], report significantly reduced GM volumes bilaterally in the anterior rostral prefrontal cortex and temporal poles. Based on a content review of a large number of medical records looking for indications of criminality, Lijergen et al. [13], concluded that neurodegenerative diseases can disrupt neural structures responsible for executive function, emotional processing, judgment, and self-awareness, and that resulting dysfunction can translate into antisocial acts and criminality.

Blair [14] reviewed a number of studies linking antisocial behaviors to the amygdala as the neural nexus of instrumental learning and aversive conditioning, including Blair et al. [15], Kiehl et al. [16], LeDoux, [17], Tillhonen et al. [18], and others who highlight the medial orbitofrontal cortex, since it is involved in...
response reversal – in addition to instrumental learning [19,20].

Aggressiveness is a diagnostic behavioral marker of certain neurodegenerative and trauma based disorders [21,22]. Besides characterological psychopathy, our model also offers a more specific classification differential which is applicable to the construct of aggression per se.

Differentiating between antisocial behavior and psychopathic aggression can be a crucial aspect in guiding diagnostics and treatment as well as the proper elucidation of dementia and other neurological disorders – let alone sociological and epidemiological analysis of violence.

A major stumbling block to the elaboration and charting of structural, neurological, and trauma-based effects on psychopathy is the inconsistency of definition of the latter between studies. Different scales and measures are used by various researchers, and the very measures which are used are conceptually flawed and methodologically unsound as they combine or confuse aggressive tendencies, criminal behavior, moral shortcomings, sadism, and poor social intelligence.

The negative diagnostic, clinical, and research repercussions of the misdefinition of a host of marginally related factors in psychopathy and antisocial behavior have been egregious. But the problem is much larger than this. We have argued for years that the qualitative divergence among theoreticians reflected in the literature has spawned a host of inconsistent definitions of psychopathy, which has been a hindrance to clinical and research endeavors in much of personality and social psychology as well. Some researchers and classification systems stress behavioral descriptions in [2,23]. While others stress emotionality [24] or personality dynamics [25,26]. Examples of the latter include thrill seeking [27], fearlessness and impulsivity [28], deceptiveness [29], charisma [25], absence of guilt [30], and callousness [31]. This definitional hodge-podge has virtually stymied unified research in this domain, yielding unrelated, misdefined, and irreconcilable findings.

The most widely used contemporary measure of anti-social behavior is Hare’s [32]. Psychopathy Checklist-Revised (PCL-R), a scale including lack of remorse or guilt, callousness, emotional shallowness, and lack of empathy. Analyzed initially into two factors, the "core factor" incorporates extraversion and positive affect, which can be adaptive in behaviors which are decidedly non-criminal [5], while the other factor is associated with an antisocial personality disorder, featuring reactive anger, anxiety, suicidality, impulsiveness, and criminality.

The other popular index in the field is the Lilienfeld & Widows [33] revision of the Psychopathic Personality Inventory (PPI-R). This scale includes traits such as egocentricity, social potency, poor planning, fearlessness, lack of stress, impulsivity, and cold-heartedness.

Our analysis of psychopathy finds both the PCL and the PPI clustering of symptoms conceptually unsound, and no more veridical than many of the unscaled "professional judgments" used by dinicians and researchers. We find some central to psychopathy types, some peripheral, and some incidental. Most egregious, however, is the clinically-inappropriate psychometric technique of summing all items (across the factors) into a single psychopathy index which blurs crucial inconsistencies among the varieties of the disorder.

The clinical and classic analytic literature is replete with inconsistent features of psychopathy. We argue that much of inconsistency is a reflection of the clinically faulty over-lapping of diagnostically distinct psychopathic categories. We see the dearth of consistent operational definitions of psychopathy most detrimental to studies of characterological pathology which are personality based, while they also hamper - to a serious degree -- studies of neurodegenerative diseases and aggressive patterns which hinge on psychopathic and antisocial behaviors.

It is suggested that utilizing the model proposed in this paper will go a long way to providing a template for neuroscientists, clinicians, researchers, and social psychologists alike. This will enable consistent cataloging of the personality, characterological, and behavioral effects of a number of developmental neurological diseases and traumas (as well as developmental and personality disorders) so that the respective fields can enjoy scientific progress in the context of descriptive clarity and common definitional language.

**SUMMARY**

The comprehensive model presented reflects the clinical and research data we have accumulated in our work with individuals diagnosed with aggressive character disorders. Our appreciation of the psychodynamics of the disorders has led to a departure from its DSM diagnostics. Differentiating between behavioral and personality disorders, this model specifies diagnostic categories within each of these by highlighting their respective pathognomonic features.

**FOOTNOTES**

**Footnote 1**

It is noteworthy that PDM does not classify most psychopaths as antisocial. Instead, it presents them as preoccupied by pronounced needs for interpersonal power, which prompts them to act manipulatively and to avoid the emotional repercussions of interpersonal interactions.

**Footnote 2**

Conceptually, there is a pathological developmental continuum from Oppositional Defiant Psychopathy to Superego Deficit. The superego represents the internalized structure of one’s entire moral, ethical, and prosocial values – which includes compliance with social mores and obedience to well-intentioned authority figures. While those with oppositional defiance evince a tendency to resist rules and authority, they still do have some internalization of morality and values; they merely see the gatekeepers as problematic. Those with superego deficit, by contrast, do not have internalized values and also do not experience guilt as a rule.

**Footnote 3**

A pathological level of aggressive behavior – regardless of how disturbing it may be -- is not sufficient to merit a diagnosis of a personality disorder. We argue, moreover, that excessive
aggressive behavior in these individuals is not a result of impulse control deficit, evidenced by the fact that they do not necessarily exhibit diminished capacity for controlling their behavior in other domains. Instead it is symptomatic of the presence of an intense aggressive drive which is beyond normal impulse control capacity. This spells an intrinsic pathology, though it is not attributable to defensive personality organization; nor is there is any affective disturbance present.

It is important to realize that there has been a significant conceptual shift in the field during the past decades, as the nomenclature gradually abandoned the traditional term of “character disorder” in favor of the DSM championed “personality disorder.” Psychodynamically, personality is construed as a stable style of functioning resulting from the balance between internal drives and a set of ego controls which modulate these drives: reality demands, superego injunctions, and defense mechanism portfolios. The term of character disorder traditionally captioned personality instability as an excess or deficit in either the drive levels or any of the ego control factors. As the term of personality disorder became preferred, the descriptions became limited to disturbance in only the level of the ego control factors. Tellingly, excessive drive levels are not mentioned as possible causes of personality imbalance. (This is based on the arguable implicit stance that drive level do not fluctuate from one person to another, or – perhaps – that such fluctuations are irrelevant to personality disorders.) While this orientation is consistent with a general pattern in modern psychoanalysis to stress ego dynamics at the expense of drive theory, we find that drive levels vary significantly – especially in psychopathy – and that pathology is often due to disturbances in drive levels.

Though a point of contention, we believe it most appropriate to categorize individuals with pathological aggressive levels as psychopathic because the excess aggression is part of their very psychological makeup, regardless of whether contemporary theorists would relegate the disorder to character or personality nomenclature.

Footnote 4

It is interesting that Hare subsumes the psychopathic lack of empathy within the context of the cardinal psychopathic trait of callousness. We stress that lack of empathy is only a specific aspect of callousness. Callousness goes beyond mere insensitivity to others’ emotionality, featuring – more significantly – the lack of concern with the harmful repercussions of one’s own behavior. As we see it, it is the latter feature which is central to the pathognomic absence of guilt which is often assumed to define the essence of psychopathy. Lack of empathy, by contrast, is marked by a lack of concern about the suffering of others which is not necessarily due to one’s own doings. In that case, it reflects a more generalized inability to experience emotions, rather than the narrower absence of guilt. Moreover, lack of empathy entails the inability to understand others’ feelings. Callous psychopaths, by contrast, often have a keen understanding of the emotionality of others (and often use this understanding to manipulate victims). What makes their pathological cruelty so pronounced, instead, is their not merely their being unfazed and unconcerned with other’s pain, but their lack of concern when they actually the perpetrators of others’ suffering.

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