
Psychopathy and the DSM

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Abstract

Psychopathy is one of the more well-established personality disorders. However, its relationship with the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* has been controversial. The purpose of this article is to trace and discuss the history of this relationship from the very first edition of the *DSM* to the current fifth edition. Emphasized in particular is the problematic relationship of *DSM* antisocial personality disorder with the diagnosis of psychopathy by Cleckley (1941, 1976) and the Psychopathy Checklist- Revised (Hare, 2003), as well as with the more recently developed models of psychopathy by Lilienfeld and Widows (2005), Lynam et al. (2011), and Patrick, Fowles, and Krueger (2009).

Psychopathy is perhaps the prototypic personality disorder. The term *psychopathy* within Schneider's (1923) nomenclature referred to all cases of personality disorder. The term now refers to a more specific variant: Psychopaths are

social predators who charm, manipulate, and ruthlessly plow their way through life. . . . Completely lacking in conscience and feeling for others, they selfishly take what they want and do as they please, violating social norms and expectations without the slightest sense of guilt or regret. (Hare, 1993, p. xi)

Nevertheless, the construct of psychopathy has had a troubled, and at times controversial, relationship with the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The purpose of this article is to trace and discuss this history from the very first edition of the *DSM* to the current fifth edition.

PSYCHOPATHY AND DSM-I

As suggested by Hare (1986), Patrick (2006a), and many others, the most influential description of psychopathy was provided by Cleckley (1941, 1976). Cleckley (1941) provided a diagnostic list of 21 features, eventually reduced by Cleckley (1976) to 16. Cleckley's (1941) seminal text on psychopathy preceded the first edition of the APA (1952) nomenclature by about 10 years. It is not clear, though, how much specific impact Cleckley's formulation had on *DSM-I*, as the latter was based on a number of alternative descriptions that were present at the time (Millon, 2011). However, it is evident that there was a considerable degree of overlap and congruence.

DSM-I included a "sociopathic personality disturbance" (APA, 1952, p. 38), one variation of which was the "antisocial

reaction." These persons were said to be "chronically antisocial," and to profit neither from experience nor punishment. They maintained no real loyalties to any person or group and were "frequently callous and hedonistic," with a lack of a sense of responsibility. As expressed in *DSM-I*, "the term includes cases previously classified as 'constitutional psychopathic state' and 'psychopathic personality'" (APA, 1952, p. 38).

PSYCHOPATHY AND DSM-II

The description of *DSM-II*'s (APA, 1968) "antisocial personality" was somewhat expanded and perhaps closer to Cleckley (1941), indicating that these persons were "grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment" (APA, 1968, p. 43), along with being "repeatedly into conflict with society" (p. 43), having low frustration tolerance, and having a tendency to blame others for their problems. It is perhaps noteworthy that it was further specified that "a mere history of repeated legal or social offenses is not sufficient to justify this diagnosis" (p. 43).

PSYCHOPATHY AND DSM-III

A significant shift occurred with *DSM-III* (APA, 1980). Prior to *DSM-III*, mental disorder diagnosis was notoriously unreliable, as it was based on clinicians providing an impressionistic matching of what they knew about a patient (on the basis of unstructured assessments) to a narrative paragraph description

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of a prototypic case. No specific or explicit guidelines were provided as to which features were necessary or even how many to consider (Spitzer, Williams, & Skodol, 1980). Spitzer and Fleiss (1974) reviewed nine major studies of inter-rater diagnostic reliability. Kappa values for the diagnosis of a personality disorder ranged from a low of .11 to .56, with a mean of only .29. *DSM-II* (APA, 1968) was blamed for much of this poor reliability, along with idiosyncratic clinical interviewing (Spitzer, Endicott, & E. Robins, 1975).

Feighner et al. (1972) developed specific and explicit criterion sets for 14 mental disorders. As expressed recently by Kendler, Muñoz, and Murphy (2010), “the renewed interest in diagnostic reliability in the early 1970s—substantially influenced by the Feighner criteria—proved to be a critical corrective and was instrumental in the renaissance of psychiatric research witnessed in the subsequent decades” (p. 141). Antisocial personality disorder (ASPD) was the only personality disorder to be included within the influential Feighner et al. list.

Antisocial’s inclusion in Feighner et al. (1972) was due largely to L. Robins’s (1966) systematic study of 524 persons who had been seen 30 years previously at a child guidance clinic for juvenile delinquents. Robins was studying what she described as a “sociopathic” personality disorder that she aligned closely with Cleckley’s (1941) concept of psychopathy. “It is hoped that Cleckley is correct that despite the difficulties in terminology and definition, there is broad agreement on which kinds of patients are psychopaths, or as we have designated them, ‘subjects diagnosed sociopathic personality’” (L. Robins, 1966, p. 79).

Despite her intention or hope of being closely aligned with Cleckley (1941), there are notable differences in her 19-item list. On the positive side, Robins did not include some of the unusual or questionable items of Cleckley (Hare & Neumann, 2008), such as no evidence of adverse heredity and going out of the way to make a failure of life. Robins also included a number of key Cleckley traits, such as no guilt, pathological lying, and the use of aliases. However, missing from Robins’s list were no sense of shame, not accepting blame, inability to learn from experience, egocentricity, inadequate depth of feeling, and lacking in insight. In addition, the Robins list contained quite a bit of what was perhaps nonspecific dysfunction, such as somatic complaints, suicide attempts (or actual suicide), drug usage, and alcohol use problems (albeit some of this was also in the description by Cleckley, 1941).

It is also important to note that most of Robins’s items were accompanied by quite specific requirements for their assessment. For example, poor marital history required “two or more divorces, marriage to wife with severe behavior problems, repeated separations”; repeated arrests required “three or more non-traffic arrests”; and impulsive behavior required “frequent moving from one city to another, more than one elopement, sudden army enlistments, [or] unprovoked desertion of home” (L. Robins, 1966, p. 342). The only exception was perhaps lack

of guilt, which was inferred on the basis of the “interviewer’s impression from the way in which patient reports his history” (L. Robins, 1966, p. 343), and, not coincidentally, Robins suggested that lack of guilt was among the least valid criteria due in large part to poor reliability of its assessment.

The 19-item list from Robins (1966) was substantially reduced by Feighner et al. (1972) to nine items. Relatively weak items were dropped (e.g., heavy drinking, excessive drug usage, somatic symptoms, and suicide). However, notably absent as well was lack of guilt. Pathological lying and aliases were collapsed into one item. Each of the items was again accompanied by relatively specific criteria for their assessment.

The Feighner et al. (1972) criteria were subsequently revised for inclusion within the Research Diagnostic Criteria of Spitzer, Endicott, and E. Robins (1978), and then revised again for *DSM-III* (APA, 1980). Dr. Robins was a member of the *DSM-III* personality disorders work group. The nine items in *DSM-III* were conduct disorder (required), along with poor work history, irresponsible parent, unlawful behavior, relationship infidelity or instability, aggressiveness, financial irresponsibility, no regard for the truth, and recklessness (APA, 1980). It is again worth noting that each criterion had relatively specific requirements. For example, recklessness required the presence of “driving while intoxicated or recurrent speeding” (APA, 1980, p. 321), and relationship infidelity required “two or more divorces and/or separations (whether legally married or not), desertion of spouse, promiscuity (ten or more sexual partners within one year)” (APA, 1980, p. 321).

The major innovation of *DSM-III* was the inclusion of the specific and explicit criterion sets (Spitzer et al., 1980). *DSM-III* ASPD became the “poster child” within the personality disorders section for the success of this innovation. All of the personality disorders, including those with highly inferential diagnostic criteria, could be assessed reliably when aided by the presence of a semistructured interview (Widiger & Frances, 1987). However, in the absence of a structured interview, the clinical assessment of personality disorders continued to be unreliable, with one exception: ASPD (Mellsop, Varghese, Joshua, & Hicks, 1982; Spitzer, Forman, & Nee, 1979).

Concurrently with the development of *DSM-III*, however, was the development of the Psychopathy Checklist (PCL) by Hare (1980), “the conceptual framework for the ratings being typified best by Cleckley’s (1976) *The Mask of Sanity*” (p. 111). “We wished to retain the essence of psychopathy embodied in Cleckley’s work” (Hare, 1986, p. 15). Hare worked from the 16-item list of Cleckley, administering them to 143 prison inmates. Hare (1980) acknowledged, consistent with the view of L. Robins (1966), that “some of these criteria seem rather vague and require a considerable degree of subjective interpretation and difficult clinical inference” (p. 112).

Hare (1980) constructed a 22-item checklist on the basis of the 16-item Cleckley (1976) list. Hare’s (1986) 22-item PCL was aligned much more closely with Cleckley’s list than the

DSM-III. The PCL included Cleckley's superficial charm, lack of remorse, egocentricity, and lack of emotional depth, none of which were included in *DSM-III*. However, it is also worth noting that the PCL did not include a number of the Cleckley items, some of which were likely good decisions (e.g., absence of delusions, good intelligence, fantastic behavior when drunk, and suicide rarely carried out). The decision to exclude impersonal sex life and absence of nervousness, though, might have been questionable. In addition, it is important to note that the PCL included items not explicitly present in Cleckley's (1976) list, such as proneness to boredom, parasitic lifestyle, poor probation risk, and previous diagnosis as a psychopath (Hare & Neumann, 2008).

A further distinction between *DSM-III* ASPD and PCL psychopathy is that the former required the presence of a conduct disorder. The PCL included two items that were consistent with *DSM-III* conduct disorder (i.e., early behavior problems and juvenile delinquency), but they were not required. A potential advantage of *DSM-III* ASPD was that its diagnosis provided greater assurance that the behavioral pattern had some degree of temporal stability from childhood into adulthood, given this childhood conduct disorder requirement. One might alternatively consider the PCL to have an advantage in that it would be able to diagnose the presence of psychopathy that was not evident in adolescence, becoming evident for the first time (for instance) in middle age. However, the concept of adult-onset ASPD and/or psychopathy is perhaps inconsistent with a personality, dispositional model of antisocial behavior (Blonigen, 2010).

PSYCHOPATHY AND *DSM-III-R*

DSM-III ASPD (APA, 1980) quickly became a primary foil for the PCL. One common criticism was that the PCL assessed traits, whereas the *DSM-III* assessed behaviors. "The checklist differs from *DSM-III* in that it also considers personality traits whereas *DSM-III* focuses almost exclusively on a list of anti-social acts, some of them trivial" (Hare, 1986, p. 21). This distinction was perhaps at times overstated. *DSM-III* ASPD did include traits (e.g., aggressiveness, recklessness, and no regard for the truth). In addition, an assessment of the PCL traits of glibness, egocentricity, and lack of empathy (for instance) will almost always be based on an observation or reporting of current or past behaviors identified within a criminal record (Widiger, 2006). The prison record may not indicate that a person lacks empathy, but it would include past criminal behaviors that suggested a lack of empathy. The primary distinction between the *DSM-III* and PCL is that, for *DSM-III*, the behaviors that could be used to infer the presence of a particular trait were explicitly listed, and in that regard the ASPD criterion set was indeed more behaviorally specific than the PCL.

Hare (1980) suggested that the emphasis on behaviorally specific acts for *DSM-III* ASPD was not really necessary for

the obtainment of inter-rater reliability. Hare reported that the correlations of PCL assessments by independent judges were typically above .90. Hare (1980) indicated, for example, that

an undergraduate assistant who had worked for us for only a few weeks was able to use the manual to complete checklists for 71 of the 143 inmates; the correlation between his total score and those of each of the two more experienced investigators was .91 and .95, respectively. (p. 114)

These were very impressive reliability coefficients. However, they may reflect in large part that PCL assessments relied substantially on a detailed prison record. Independent raters were then being provided with precisely the same historical information (i.e., they could not elicit or obtain different information from a respective patient) that was apparently fairly easy to score for PCL items. This information was very rarely available for clinicians assessing ASPD in medical centers, hospitals, clinics, or private practice offices. Hare (1980, p. 118) acknowledged, "I'm not sure how useful the [PCL] scale will be for assessing psychopathy in noncriminal populations. . . . It would be difficult to obtain sufficient information to complete them with confidence."

A related criticism of the *DSM-III* criterion set was the perception that it placed too much emphasis on a particular type of behavior: criminality. "DSM-III has difficulty in identifying individuals who fit the classic picture of psychopathy but who manage to avoid early or formal contact with the criminal justice system" (Hare, 1986, p. 21). This criticism was perhaps again somewhat overstated. Most of the *DSM-III* diagnostic criteria made no explicit reference to criminal activity (e.g., poor work history, irresponsible parent, relationship infidelity, aggressivity, and financial irresponsibility). In addition, this charge was also somewhat ironic, given the heavy reliance on a criminal record for a PCL assessment (Skeem & Cooke, 2010).

Nevertheless, members of the *DSM-III-R* personality disorders work group appreciated the criticism that the ASPD criteria might be sacrificing validity for the sake of reliability. As expressed by Frances (1980), a member of the *DSM-III* and *DSM-III-R* personality disorder work groups, "for clinicians who work in prisons, it would seem to be more useful to have criteria that distinguish those criminals who are capable of loyalty, anxiety, and guilt from those who are not" (p. 1053). In the final report from the work group, it was acknowledged that "the *DSM-III* criteria set may have selected too many criminals and excluded persons who were not criminal but who demonstrated the social irresponsibility, lack of guilt, disloyalty, lack of empathy, and exploitation central to most theories of psychopathy" (Widiger, Frances, Spitzer, & Williams, 1988, pp. 789–790). Therefore, new to the *DSM-III-R* criterion set was lacks remorse, obtained from the PCL and Cleckley (1976), along with impulsivity or failure to plan ahead (APA, 1987).

PSYCHOPATHY AND DSM-IV

By the time of *DSM-IV* (APA, 1994), the PCL (Hare, 1980) had been replaced by the PCL-R (Hare, 1991). The revision to the PCL included the deletion of two items (drug and alcohol abuse, and a prior diagnosis of psychopathy) and the broadening of the irresponsibility item to involve behaviors beyond simply parenting. In addition, it appeared that the structure for the PCL-R was largely settled on two factors (Hare et al., 1990). Factor 1 was described as a “selfish, callous, and remorseless use of others” and Factor 2 as a “chronically unstable and antisocial lifestyle” (Hare, 1991, p. 38). Preference in the psychopathy literature was given to the first factor, said to involve “traits commonly considered to be fundamental to the construct of psychopathy” (Hare, 1991, p. 38), whereas the second factor was said, perhaps derogatorily, to involve simply a “social deviance” (p. 38).

The differential attitude toward the two factors paralleled the commonly reported finding that *DSM-III* and/or *DSM-III-R* (hereafter *DSM-III(-R)*) ASPD correlated more highly with the second factor than with the first (Hare, 1991). The relatively greater alignment of *DSM-III(-R)* ASPD with the second factor was essentially bad news for the second factor. As expressed by Hare (2003), “research that uses a DSM diagnosis of [ASPD] taps the social deviance component of psychopathy but misses much of the personality component, whereas each component is measured by the PCL-R” (p. 92).

It is evident *DSM-III(-R)* ASPD was aligned relatively more closely with Factor 2 of the PCL(-R) than with Factor 1. However, in defense of Factor 2, it is worth noting that it has been shown to be more useful than Factor 1 in risk assessment, prediction of violence, and criminal recidivism (Corrado, Vincent, Hart, & Cohen, 2004; Leistico, Salekin, DeCoster, & Rogers, 2008), which has long been a major strength of the PCL(-R) (Hare, Neumann, & Widiger, 2012). In addition, the characterization of Factor 1 as involving personality traits and Factor 2 as involving behavior and/or social deviance is again potentially misleading. As noted earlier, the behavior of antisocial and psychopathic persons can be understood as reflecting underlying personality traits, including those behaviors assessed by Factor 2 and *DSM-III(-R)* ASPD. An alternative interpretation of Factor 1 is that it was confined largely to traits of antagonism (e.g., callousness, lack of empathy, arrogance, conning, manipulative, and lack of remorse), whereas Factor 2 included largely traits of low conscientiousness (e.g., irresponsibility, impulsivity, promiscuous, and poor behavior controls), as well as antagonism (Lynam & Widiger, 2007). In sum, the distinction between these two factors is largely substantive (i.e., antagonism vs. low conscientiousness), not a distinction with respect to the level of assessment (i.e., traits vs. behaviors).

Nevertheless, surveys of clinicians during this time indicated a preference for the more inferential traits of psychopathy than for the behaviorally specific diagnostic criteria (e.g., Blashfield & Breen, 1989; Livesley, Reiffer, Sheldon, & West,

1987). Studies directly comparing *DSM-III(-R)* to the PCL(-R) within prison and forensic settings consistently reported that the PCL(-R) was more discerning, identifying appreciably fewer cases (e.g., Hare, 1983; Hart & Hare, 1989). The PCL(-R) was also obtaining incremental validity over the *DSM-III(-R)* in predicting criminal recidivism (e.g., Hart, Kropp, & Hare, 1988; Serin, Peters, & Barbaree, 1990). Therefore, it was the intention of the authors of the *DSM-IV* ASPD to shift the diagnosis closer still to the PCL-R conceptualization (Widiger & Corbitt, 1993). Considered for *DSM-IV* was an abbreviated version of the PCL-R developed by Dr. Hare, consisting of 10 items (Hare, 2003; Widiger & Corbitt, 1993).

A field trial was developed to compare the reliability and validity of the *DSM-III-R* and the abbreviated psychopathy criterion sets (Widiger et al., 1996). Four sites were sampled, including a prison inmate site (Dr. Hare was its principal site investigator), drug treatment–homelessness site (Dr. L. Robins), psychiatric inpatient (Dr. Zanarini), and methadone maintenance site (Dr. Rutherford). External validators included clinicians’ diagnostic impression of the patient, using whatever construct they preferred (at the drug-homelessness, methadone maintenance, and inpatient sites); interviewers’ diagnostic impressions at all four sites; criminal history; and self-report measures of empathy, Machiavellianism, perspective taking, antisocial personality, and psychopathy. The primary finding was that there was a clear difference in the validity of items depending upon the site. For example, number of arrests and convictions correlated significantly with both ASPD and psychopathy in the drug-homelessness clinic, the methadone maintenance clinic, and the psychiatric inpatient hospital, but not with ASPD or psychopathy within the prison setting. Items that were unique to the PCL-R (e.g., lacks empathy, inflated and arrogant self-appraisal, and glib, superficial charm) correlated more highly with interviewers’ ratings of ASPD and psychopathy within the prison setting, but not within the clinical settings. The PCL-R items that were most predictive of clinicians’ impressions of psychopathy within the drug treatment and homelessness sites included adult antisocial behavior. Within the psychiatric inpatient site, the most predictive items were adult antisocial behavior and early behavior problems (along with glib, superficial charm). In contrast, the most predictive items within the prison site were inflated, arrogant self-appraisal, lack of empathy, irresponsibility, deceitfulness, and glib, superficial charm.

The *DSM* is constructed primarily for use within clinical settings, and the result of the field trial did not suggest that the items unique to the PCL-R were really that useful for the assessment of psychopathy within traditional mental health settings. Adult criminal behavior is common to persons who are not psychopathic within prison settings, whereas, in contrast, adult antisocial behavior is more specific to persons who are psychopathic within routine clinical settings. The *DSM-IV* ASPD criteria were presented within the diagnostic manual in descending order of diagnostic value (Gunderson, 1998).

Adult criminal behavior was listed first because it was the most useful criterion within general clinical settings (Widiger & Corbitt, 1995).

Objections were also raised with respect to the proposal to include psychopathic glib charm, arrogance, and lack of empathy within ASPD. The work group members in charge of narcissistic personality disorder expressed the concern that these were features already included within the diagnostic criteria for narcissism (Gunderson, 1998; Gunderson, Ronningstam, & Smith, 1991). This might not have been a necessarily compelling argument. If these traits are considered to be central to the disorder's diagnosis, then one might argue that they should be included regardless of the problem of differential diagnosis. Social withdrawal is included within the criterion sets for both the avoidant and schizoid personality disorders. This contributes to their diagnostic co-occurrence, but the removal of social withdrawal would grossly alter the conceptualization and diagnosis of either disorder. Nevertheless, the authors of the *DSM-IV* criterion sets were attempting to reduce the problematic diagnostic co-occurrence. It appeared to them to be grossly inconsistent with this mandate to add three criteria to ASPD that were already within the criterion set for narcissistic personality disorder.

A further revision of the *DSM-IV* criterion set for ASPD was the removal of much of the behaviorally specific requirements that had been included in L. Robins (1966), Feighner et al. (1972), *DSM-III* (APA, 1980), and *DSM-III-R* (APA, 1987). *DSM-IV* simply stated, for instance, that ASPD includes "impulsivity or failure to plan ahead" (APA, 1994, p. 650) without requiring that this criterion be determined by "traveling from place to place without a prearranged job" or "lack of a fixed address" (APA, 1987, p. 345). These specific exemplars were included instead in the text discussion, along with other possible indicators. Also included in the text were the proposed psychopathy criteria considered in the field trial, noting that these features "may be particularly distinguishing of ASPD in prison or forensic settings where criminal, delinquent, or aggressive acts are likely to be nonspecific" (APA, 1994, p. 647).

PSYCHOPATHY AND DSM-5

APA ASPD has a rich empirical history; however, by the time of *DSM-5*, there was considerably more research concerning psychopathy than ASPD. Whereas in the last century there were texts devoted to ASPD (e.g., Stoff, Breiling, & Maser, 1997), by the turn of the century, the texts had become devoted to psychopathy (e.g., Patrick, 2006b). Blashfield and Intoccia (2000) conducted a computer search for research concerning the APA personality disorders. They concluded that "antisocial personality disorder has a large literature but has shown relatively stagnant growth over the last three decades (with some change in the 1990s)" (Blashfield & Intoccia, 2000, p. 473). If they had included psychopathy within their search, they would have likely concluded that the research was more truly alive

and well, as much of the research concerning this personality disorder had shifted to studies of psychopathy.

It again appeared to be the intention of the *DSM-5* work group to shift the diagnosis of ASPD toward PCL-R and/or Cleckley psychopathy. This was explicitly evident in the proposal to change the name from "antisocial" to "antisocial/psychopathic" (Skodol, 2010). However, the primary basis for diagnosing antisocial/psychopathy in the initial proposal for *DSM-5* was through a clinician's overall impression of a patient matched to a two-paragraph narrative describing a prototypic case, the source for which was not the PCL-R (Hare, 2003). It was instead the prototype narratives of Westen, Shedler, and Bradley (2006).

The prototype narrative proposal, though, was soon withdrawn due in large part to the questionable empirical support for its reliability and validity (Widiger, 2011; Zimmerman, 2011). It was replaced by a hybrid model, combining deficits in the sense of self and interpersonal relatedness (Bender, Morey, & Skodol, 2011) with maladaptive personality traits obtained from a five-domain dimensional trait model (Krueger et al., 2011). The hybrid criterion set for ASPD consisted of four deficits in self and interpersonal functioning and seven maladaptive personality traits (APA, 2011). The four deficits included impairments to identity (e.g., egocentrism), self-direction (e.g., goal setting based on personal gratification; failure to conform to the law), empathy (e.g., lack of remorse), and intimacy (e.g., incapacity for mutually intimate relationships). The seven traits were manipulateness, deceitfulness, callousness, and hostility from the domain of antagonism, and irresponsibility, impulsivity, and risk taking from the domain of disinhibition.

The deficits in self and interpersonal relatedness are to some extent suggestive of PCL-R and Cleckley psychopathy (e.g., egocentricism), but, as noted earlier, these were obtained from the prototype narratives of Westen et al. (2006). No reference was made to the PCL-R or Cleckley in the presentation of the rationale and empirical support for the hybrid model (Blashfield & Reynolds, 2012; Hare et al., 2012).

The seven maladaptive traits aligned very well with the *DSM-IV* criterion set for ASPD (Lynam & Vachon, 2012). However, there again did not appear to be an effort to go beyond the *DSM-IV* criterion set to represent additional traits of PCL-R psychopathy (Lynam & Vachon, 2012). Missing from the description were traits included within the PCL-R that were not included within *DSM-IV*, such as arrogance, glib charm, lack of empathy, and shallow affect (Hare, 2003; Widiger et al., 1996). Grandiosity is included within the dimensional trait list (APA, 2013) and aligns closely with PCL-R grandiose sense of self-worth (Hare, 2003), yet it was not included within the dimensional trait description of ASPD nor even within the eventually added psychopathy specifier (discussed below). As indicated by Blashfield and Reynolds (2012), "Cleckley and Hare are well-known authors who defined how psychopathy is currently conceptualized; neither was referenced in the *DSM-5* rationale" (p. 826).

The authors of the *DSM-5* hybrid model referred instead to a new model of psychopathy, developed concurrently with *DSM-5*: the triarchic model of psychopathy, assessed via the Triarchic Psychopathy Measure (TriPM), by Patrick et al. (2009). Patrick et al. (2009) described their proposal as a “novel conceptualization of psychopathy” (p. 913), one based on recurring themes that they gleaned from “historic and contemporary accounts of the disorder” (p. 913). They identified three constructs they considered to be essential to the understanding of psychopathy: boldness, meanness, and disinhibition. TriPM boldness relates closely with the fearless-dominance factor of the Psychopathic Personality Inventory-Revised (PPI-R; Lilienfeld & Widows, 2005), as well as the emotional stability factor of the Elemental Psychopathy Assessment (EPA; Lynam et al., 2011). Meanness and disinhibition align closely with PPI-R impulsive-antisociality, with EPA antagonism and disinhibition (respectively), and with *DSM-IV* ASPD (Crego & Widiger, 2014).

After the final posting on the *DSM-5* Web site, further revisions were made to the proposed criterion set for ASPD; more specifically, three additional traits were provided as potential specifiers for psychopathy: low anxiousness, low social withdrawal, and high attention-seeking (APA, 2013). These traits were said to represent TriPM boldness and PPI-R fearless-dominance. “High attention-seeking and low withdrawal capture the social potency (assertive/dominant) component of psychopathy, whereas low anxiousness captures the stress immunity (emotional stability/resilience) component” (APA, 2013, p. 765).

However, concerns have been raised regarding these new components (Marcus, Fulton, & Edens, 2012; Miller & Lynam, 2012). One concern is the extent to which they represent components of Cleckley (1976) and PCL-R psychopathy (Hare, 2003; Hare & Neumann, 2008; Hare et al., 2012); a second concern is that they are largely components of normal, adaptive functioning (Marcus et al. 2012; Miller & Lynam, 2012); and third, they are being assessed in part by two reverse-keyed scales (Crego & Widiger, in press). Each of these concerns will be discussed in turn.

Coordination of Boldness and Fearless-Dominance With Cleckley and PCL-R

Ever since the *DSM-III* (1980) was published, there has been a recurrent criticism of the APA diagnostic manual for failing to be fully commensurate with the conceptualization of psychopathy by Cleckley (1941, 1976) and the PCL(-R) (Hare, 1980, 2003). The authors of *DSM-5*, however, may have shifted the ASPD toward their own, more recently developed, conceptualization of psychopathy.

It was initially suggested that PPI-R fearless-dominance did in fact align with the first factor of the PCL-R (Benning, Patrick, Hicks, Blonigen, & Krueger, 2003; Benning, Patrick, Salekin, & Leistico, 2005), but the support for this hypothesis

was largely indirect (Miller & Lynam, 2012). It eventually became apparent that fearless-dominance is not aligned well with the first (or second) factor of the PCL-R. As indicated by Malterer, Lilienfeld, Neumann, and Newman (2010), the correlations across three independent data collections between the respective first PCL-R and PPI-R factors “ranged from .15 to .24, accounting for only 2% to 5% of shared variance” (p. 11).

Patrick et al. (2009), however, argue that Cleckley (1976) did include boldness within his criteria for psychopathy. They suggest that four of Cleckley’s (1976) 16 criteria for psychopathy are indicators of a social boldness: superficial charm and good intelligence, absence of delusions or irrationality, absence of nervousness, and low incidence of suicide. Hare and Neumann (2008), in contrast, suggest that absence of delusions, irrationality, nervousness, and suicide might be better understood as exclusionary criteria of clinical dysfunction, rather than the presence of superior psychological adjustment. It might indeed be a stretch to morph absence of delusions, absence of suicide, and good intelligence into “a phenotypic style entailing a capacity to remain calm and focused in situations involving pressure or threat, an ability to recover quickly from stressful events, high self-assurance and social efficacy, and a tolerance for unfamiliarity and danger” (Patrick et al., 2009, p. 926).

Hare and Neumann note an explicit reference to fearlessness provided by Cleckley (1988) when he was discussing Ferenc Molnar’s (1937) *Liliom*. *Liliom* was a tough, cocky, and ne’er-do-well carousel barker who was described by Cleckley (1988) as failing “all who trust him and fails himself with the prodigious consistency of a real psychopath” (p. 319). Cleckley (1988) further stated, though, that “*Liliom*’s suicide . . . his warmth, and his depicted strength and fearlessness all stand out in contrast, however, to the personality patterns discussed in this book” (p. 319). In sum, when Cleckley made an explicit reference to fearlessness, it was to suggest that it was not a trait of the typical psychopath.

Nevertheless, when describing cases of psychopathy, Cleckley did refer explicitly to traits of charm, social poise, and calmness within stressful situations.

It is highly typical for him not only to escape the abnormal anxiety and tension fundamentally characteristic of this whole diagnostic group [i.e., psychoneurosis] but also to show a relative immunity from such anxiety and worry as might be judged normal or appropriate in disturbing situations. . . . Within himself he appears almost as incapable of anxiety as of profound remorse. (Cleckley, 1976, p. 340)

Cleckley (1976) went on to say,

Regularly we find in him extraordinary poise rather than jitteriness or worry, a smooth sense of physical well-being instead of uneasy preoccupation with bodily functions. Even under concrete circumstances that would for the ordinary person cause embarrassment, confusion, acute

insecurity, or visible agitation, his relative serenity is likely to be noteworthy” (p. 340)

Still, one would think that if Cleckley considered fearlessness or boldness to be a predominant feature of psychopathy, he would have included them explicitly within his 16-item criterion set. Yet, there is no explicit reference. One instead has to infer that this was his intention when he referred to absence of delusions or irrationality, absence of nervousness, low incidence of suicide, good intelligence, and superficial charm.

One might be able to safely infer that Cleckley meant fearlessness (although he never stated this explicitly) when he referred to an absence of nervousness (although see Hare & Neumann, 2008, for a more cautionary view), but even here the trait is still only one of 16 features. In stark contrast, boldness is one-third of the personality structure of psychopathy within the TriPM of Patrick et al. (2009). Fearless-dominance constitutes half of the personality structure of psychopathy as described within the factor-analytic solution of the PPI-R (Benning et al., 2003, 2005), albeit slightly less than half of the structure if the additional Coldheartedness scale is included. Cleckley (1941, 1976) does not appear to provide the traits of boldness or even fearless-dominance with this degree of predominance within his conceptualization of psychopathy, focusing greater attention on such antagonistic traits as untruthfulness, insincerity, unreliability, lack of remorse, and egocentricity.

However, it should also be emphasized in defense of the traits of boldness, fearless-dominance, and emotional stability that even if they are not prominent or even present within Cleckley’s model (1941, 1976), this does not necessarily suggest that they do not belong in a conceptualization of psychopathy. Hare and colleagues (2012) have for many years been critical of the APA diagnosis of ASPD because it was not sufficiently close to Cleckley’s description. Ironically, the PCL-R itself eventually began to receive criticism for not being sufficiently close to Cleckley psychopathy (e.g., Patrick, 2006a; Salekin, 2002), including even the charge of having an excessive reliance on criminal acts for its assessment (e.g., Skeem & Cooke, 2010). In defense, Hare and Neumann (2008) argued compellingly that a “literal and uncritical acceptance [of Cleckley] by the research community has become problematical” (p. 217), as if “we uncritically view *The Mask of Sanity* as a bible and those who deviate from its teachings as apostates” (p. 224). L. Robins (1966) would probably have appreciated this acknowledgment.

It would be a rather dogmatic scholasticism to require that all future conceptualizations of psychopathy be consistent with one developed by a particular clinician from the 1940s. Cleckley was brilliant and insightful, but it is reasonable to suggest that his conceptualization was not without some flaws and lapses (e.g., the inclusion of fantastic behavior when drunk, suicide rarely carried out, good intelligence, and failure to follow a life plan). It is not really clear why one has to justify

the inclusion of a trait largely on the basis of its endorsement by Cleckley.

There has been long-standing support for the inclusion of low anxiousness irrespective of Cleckley (1976) within a conceptualization and assessment of psychopathy (Brinkley, Newman, Widiger, & Lynam, 2004). Miller, Lynam, Widiger, and Leukefeld (2001) surveyed 21 psychopathy researchers and asked them to describe a prototypic psychopath in terms of the Five-Factor Model (FFM). There was consensus support for the inclusion of low anxiousness and low vulnerability. Low anxiousness was even included when researchers (Lynam & Widiger, 2001) and clinicians (Samuel & Widiger, 2004) were asked to describe a prototypic case of ASPD (albeit low vulnerability was not). Miller et al. (2001) concluded that “the additional neuroticism facet of low vulnerability included by the experts . . . captures the fearlessness of psychopathy emphasized by Lykken (1995)” (p. 270). Decuyper, De Pauw, De Fruyt, De Bolle, and De Clercq (2009) conducted a meta-analysis of research relating measures of psychopathy to the FFM. They reported a significant correlation with low anxiousness across alternative measures of psychopathy, although they did also note that the magnitude of the relationship ($r = .15$) was “small” (Decuyper et al., 2009, p. 546).

Kreis, Cooke, Michie, Hoff, and Logan (2012) surveyed 132 mental health professionals with expertise in psychopathy, asking them to indicate the prototypicality of 33 potential traits of psychopathy (boldness was not included in their list of potential traits). Twenty-five traits were considered to be descriptive, including low anxiety and a sense of invulnerability. However, it should be noted that low anxiety received the 24th highest rating out of 25. Ranked higher than a sense of invulnerability were such traits of antagonism as lacks remorse, self-centered, manipulative, deceitful, insincere, self-aggrandizing, uncaring, and aggressive.

In sum, it appears reasonable to include fearless-dominance, boldness, and emotional stability as components of psychopathy, irrespective of whether they were included by Cleckley (1976). However, how best to validate their presence, beyond simply obtaining the opinions of researchers and correlations with extant measures, is not entirely clear. They do not appear to relate well to traditional validators, such as criminal history, aggression, and other indicators of dysfunction, particularly if one controls for traits of antagonism (Marcus et al., 2012; Miller & Lynam, 2012). Their primary role might be as moderating variables (Lilienfeld, Patrick, et al., 2012; Marcus et al., 2012; Lynam & Miller, 2012). One might speculate that fearlessness, boldness, and emotional stability would facilitate the successful commission of particularly dangerous or risky crimes, although one could also make the case for such traits contributing to criminal failure, disposing the person to take unnecessary chances that lead to arrest and/or injury. An important question for future research is the most compelling means for assessing the contribution of fearless-dominance, boldness, and emotional stability for the diagnosis of

psychopathy, particularly if they are understood to be adaptive personality strengths.

Boldness, Fearlessness, and Emotional Stability as Adaptive Personality Strengths

An additional concern regarding TriPM boldness, PPI-R fearless-dominance, and EPA emotional stability is that they are adaptive personality strengths (Lynam & Miller, 2012; Miller & Lynam, 2012). A personality disorder is defined in *DSM-5* as “an enduring pattern of inner experience and behavior that . . . leads to distress or impairment” (APA, 2013, p. 645, emphasis added). It is not unusual for a personality disorder to be associated with some degree of social and/or occupational success. Successful outcomes have been associated with obsessive-compulsive personality disorder (Samuels & Costa, 2012), narcissistic personality disorder (Miller & Campbell, 2011), and dependent personality disorder (Bornstein, 2012). However, these successful outcomes have also been controversial (e.g., Pincus & Lukowitsky, 2010). It should go without saying that what makes a personality disorder a disorder is the presence of maladjustment, not superior adjustment (Livesley, 2007).

Ideally, if low anxiousness is included within a definition of psychopathic personality disorder, perhaps it should be a problematically low anxiousness, contributing, for example, to a failure to be appropriately concerned about the negative consequences of risky, dangerous, or criminal behavior. If charm is included, perhaps it should be one that is superficial and slick. The charm of a psychopath can be initially instrumental and advantageous in his (or her) seductions, cons, and frauds, but perhaps it should also be ultimately exposed for its insincerity, shallowness, and superficiality. Patrick et al. (2009), however, are critical of the PCL-R representation of charm precisely because it is understood in a “deviant manner, that is, reflecting an excessively talkative, slick, and insincere demeanor” (p. 917), whereas the interpersonal charm within the TriPM is considered to be an adaptive, normal charm, without insincerity, slickness, or superficiality.

The inclusion of adaptive traits within a conceptualization and assessment of psychopathy might be problematic to the extent that they predominate the assessment or are considered in isolation from the other traits. A strength of dimensional models of personality disorder is the ability to disambiguate a complex syndrome into its component parts (Lynam & Widiger, 2007). However, when these components are adaptive personality strengths, it might be misleading to refer to them, when considered independently of the other components, as reflecting a personality disorder, psychopathy in particular. For example, Lynam et al. (2011) suggest that psychopathy includes the traits of unconcern, self-contentment, self-assurance, and invulnerability, which Few, Miller, and Lynam (2013) identify as components of emotional stability. However, many normal, well-functioning persons, who would not appear

to anyone to be the least bit psychopathic, will be emotionally stable. It would seem problematic to suggest that these persons are, to some degree, psychopathic because they are emotionally stable.

Lilienfeld, Waldman, et al. (2012) may appear to some to have suggested that Theodore Roosevelt, John F. Kennedy, and Ronald Reagan were psychopathic presidents, not because they were manipulative, duplicitous, exploitative, or deceptive, but because they were bold. Lilienfeld, Waldman, et al. made it clear that they were not suggesting that these presidents were actual psychopaths.

We should be clear about what our results do not mean. . . . [They do not] mean that presidents who are high in only one facet of psychopathy, such as fearless-dominance, should be regarded as “psychopathic.” To the contrary, the dual-process model implies that because psychopathy is a configuration or constellation of two largely independent traits, only individuals who are high on both traits will be perceived as psychopathic. (Lilienfeld, Waldman, et al., 2012, p. 500)

Theodore Roosevelt would not be regarded “as a prototypical psychopath” (Lilienfeld, Waldman, et al., 2012, p. 500), but it would not be surprising if some persons misinterpreted Lilienfeld, Waldman, et al. (2012) as suggesting that Roosevelt did have a psychopathic trait that contributed to his success as president and therefore was, at least to some meaningful extent, psychopathic. This is a potential risk of including adaptive traits within a model of psychopathy, for when these traits are considered separately from the maladaptive traits, persons who have no personality disorder whatsoever might be mistakenly said to have some degree of a respective personality disorder on the basis of having adaptive personality strengths.

Additional studies might be understood (or misunderstood) as suggesting that psychopathic persons are altruistic toward strangers (Smith, Lilienfeld, Coffey, & Dabbs, 2013), as indicated, for example, by assisting stranded motorists (Patrick, Edens, Poythress, Lilienfeld, & Benning, 2006). Clearly, something would seem to be amiss if “psychopathic” traits suggest altruistic behavior. Psychopathic persons are opposite to being altruistic (Miller et al., 2001). Their disposition is toward a self-centered, self-serving, even malevolent exploitation of others, not toward providing a helping hand to the needy and downtrodden. A person who is in fact characteristically altruistic will be high in agreeableness, and any person high in agreeableness will not be considered to be psychopathic (Miller et al., 2001). However, if one studies an adaptive component of psychopathy, such as fearlessness, independent of all of the antagonistic components, one might find that the fearlessness contributes to, for instance, certain forms of heroic, altruistic, and other pro-social behaviors.

It is perhaps, then, more accurate to say that Lilienfeld, Waldman, et al. (2012), Patrick et al. (2006), and Smith et al. (2013) were studying normal personality traits, rather than

psychopathy. More specifically, they were studying the correlates of the normal, adaptive traits of boldness, fearlessness, and assertiveness. Their findings do not provide information concerning the syndrome of psychopathy, only the correlates of a particular set of normal, adaptive personality traits independent of and separate from the presence of psychopathy. Few et al. (2013) suggest that emotional stability is a component of psychopathy, and it might be similarly odd to suggest that this psychopathic trait contributed to the mental health of a particular group of persons (e.g., nuns). Emotional stability might indeed contribute to the mental health of nuns, but psychopathy would obviously have nothing to do with such a finding.

It is intriguing to suggest “that the hero and the psychopath may be twigs on the same genetic branch” (Lykken, 1996, p. 29), but the hero and the psychopath will have substantially different personality profiles. They may share one particular trait, but heroes are unlikely to be high in antagonism and low in conscientiousness. It is perhaps comparable to equating, or at least confusing, a dolphin with a shark because they both have dorsal fins. If the only thing one notices is the fin sliding across the water, one can very likely misinterpret the agreeable dolphin with the very antagonistic shark. Adopting Lykken’s metaphor, heroes and psychopaths are perhaps best understood as occupying very different genetic branches, as the psychopathic traits of high antagonism (e.g., manipulative, duplicitous, exploitative, aggressive, and deceptive) and low conscientiousness (e.g., irresponsible, hedonistic, lax, and rash), clearly integral to the conceptualization of psychopathy (Cleckley, 1976; Hare, 2003; Lilienfeld & Widows, 2005; Miller et al., 2001; Patrick et al., 2009), will not be evident in many, if not most, heroes.

Lilienfeld, Waldman, et al. (2012) were clear in stating that the presence of psychopathy should not be based simply on the basis of fearlessness. However, how much impact an adaptive trait—such as fearlessness, boldness, or emotional stability—should have when providing a diagnosis of a personality disorder is unclear. *DSM-III* (APA, 1980) included monothetic criterion sets for some of the personality disorders, requiring all of the features to be present before a diagnosis could be made. However, it became evident that few actual cases are truly prototypic cases (i.e., having all of the features and perhaps no features of any other personality disorder). *DSM-III-R* (APA, 1987) shifted all of the personality disorders to polythetic criterion sets, requiring only a subset of features (Widiger et al., 1988).

The typical threshold for a PCL-R diagnosis of psychopathy is a score of 30 out of 40 (Hare, 2003). In other words, consistent with the *DSM*, one does not need to have all of the PCL-R features to be considered psychopathic, nor is any one of them required (albeit most are present when the person obtains a score of 30). The TriPM, PPI-R, and EPA do not have a scoring algorithm. It is an interesting question for future research to determine how many scales would need to be elevated, and whether some traits would be considered more (or less) important or necessary than others.

Lilienfeld and colleagues (Lilienfeld, Patrick, et al., 2012; Lilienfeld, Waldman, et al., 2012) indicate that the traits of both PPI-R fearless-dominance and impulsive-antisociality would be required. Fearless-dominance is clearly not required for a PCL-R diagnosis, as these traits are not heavily assessed by its items. The EPA includes emotional stability, along with traits of antagonism, disinhibition, and narcissism. Lynam and Miller (2012), however, suggest that the traits of emotional stability are perhaps best understood as ancillary features of psychopathy.

The *DSM-5* Section 3 (APA, 2013) diagnosis of psychopathy requires two or more of the four self and interpersonal deficits, along with six of the seven ASPD traits from the domains of antagonism and disinhibition. Fearlessness and boldness constitute just one to three additional features after at least eight others have been confirmed to be present. The approach taken in *DSM-5* is advantageous in that it would require a considerable presence of maladaptive personality traits from both antagonism and disinhibition (i.e., the presence of ASPD), with the adaptive traits of fearless-dominance serving as a psychopathy subtype. One would then be unlikely to characterize a well-functioning person as having this personality disorder.

Negatively Keyed Scales for the Assessment of Psychopathic Traits

A third concern is with respect to the *DSM-5* representation of the psychopathy specifiers using reverse-keyed scales (Crego & Widiger, 2014). The *DSM-5* dimensional trait model was derived originally through nominations of traits suggestive of the *DSM-IV* personality disorders (Krueger et al., 2011). The judges were not instructed to nominate traits of psychopathy, let alone traits suggestive of PPI-R or TriPM psychopathy. As a result, the original list of 37 did not include such traits as fearlessness or boldness.

In the end, it was difficult for the dimensional trait model to recognize these traits because it is confined to traits from low extraversion (i.e., detachment) and high neuroticism (i.e., negative affectivity), whereas fearless-dominance and boldness are traits from high extraversion and low neuroticism (Lynam et al., 2011; Lynam & Widiger, 2007; Patrick et al., 2009). The authors of the *DSM-5* trait model, however, attempted to address this limitation by (in part) keying negatively scales of anxiousness and social withdrawal for fearlessness and boldness, respectively (APA, 2013).

Persons who are maladaptively anxious will not be fearless. Maladaptive anxiousness will correlate negatively with fearlessness (Strickland, Drislane, Lucy, Krueger, & Patrick, 2013). But persons who are not maladaptively anxious may simply be calm or relaxed without necessarily being fearless (Crego & Widiger, 2014). Consider, for example, the Clinician Rating Form developed by the *DSM-5* Personality Disorders Work Group for the assessment of the dimensional trait

model (APA, 2010). It is questionable whether clinicians could use the items provided for the assessment of anxiousness to meaningfully assess for the presence of psychopathic fearlessness. The clinician is instructed to rate the extent to which the person is maladaptively anxious on a scale ranging from 0 to 3 (0 = *very little or not at all descriptive*, 3 = *extremely descriptive*). The trait of anxiousness is described as “intense feelings of nervousness, tenseness, or panic in reaction to diverse situations; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart, losing control, or embarrassment” (APA, 2010, p. 3). If a clinician assigns scores of 0, it would mean that the persons are experiencing very little to none of the clinical symptoms of anxiousness, not that the persons have high levels of fearlessness. A clinician, administering this instrument, would not be inquiring as to the presence of fearlessness and could not use the assessment to indicate the level of fearlessness that is present (Crego & Widiger, 2014).

CONCLUSIONS

In their commentary on Miller and Lynam (2012), Lilienfeld, Patrick, et al. (2012) defended the inclusion of adaptive traits within the PPI-R conceptualization of psychopathy in part by citing the presence of adaptive hypomania within cyclothymia. Hypomania is clearly a fundamental component of the well-established syndrome of cyclothymia. However, there is perhaps an important difference between cyclothymia and psychopathy. Cyclothymia is probably a true syndrome in nature, wherein the dysthymic and hypomanic symptoms are due to a common etiology. Psychopathy, in contrast, is more likely a constellation of traits, with each having its own separate, independent etiology.

As expressed by Marcus et al. (2012), the fact that the two factors of the PPI-R, fearless-dominance and impulsive-antisociality, are largely uncorrelated is itself a testament that PPI-R psychopathy is not a true syndrome in nature. “A prison inmate who is bold and dominant is no more or less likely to also be impulsive” (Marcus et al., 2012, p. 148). One will rarely, if ever, observe the occurrence of a manic episode without eventually also observing an episode of major depression because bipolar mood disorder is a true syndrome in nature, probably the result of a common etiology or pathology. In contrast, for psychopathy, one will very often observe the occurrence of fearlessness independent of any antagonism or low conscientiousness.

This is not to suggest or imply that the concept of a psychopathic syndrome lacks clinical or social utility. The psychopathic syndrome is probably the most dangerous and virulent constellation of personality traits that one can imagine—hence, the long-standing interest in identifying its presence (Widiger & Lynam, 1998). It would certainly appear to be more dangerous to have an antagonistic person be fearless than to have an antagonistic person be fearful. However,

the syndrome probably lacks validity as a true syndrome in nature with a single common etiology. It is instead a construction by clinicians and researchers of a constellation of traits that has strong clinical and social importance.

The syndrome of psychopathy has been described differently by the APA (1952, 1968, 1980, 1987, 1994, 2013), Cleckley (1941, 1976), Hare (1983, 2003), Lilienfeld and Widows (2005), Lykken (1995), Lynam et al. (2011), L. Robins (1966), Skeem and Cooke (2010), and Patrick et al. (2009). The suggestion of Lilienfeld and Andrews (1996) that there is “a lack of consensus regarding its conceptualization” (p. 489) still holds true today. However, rather than suggest that these authors are perceiving the same person differently, we would suggest that these are alternative constructions of the same hypothetical construct (Lilienfeld, Patrick, et al. 2012; Meehl, 1986; Widiger & Lynam, 1998). There is unlikely to be a gold standard for determining which description is valid and which is incorrect. The choice of which particular constellation to use in research or clinical practice is perhaps best made on the basis of which proves to be most useful for social or clinical purposes, or at best which represents the consensus view within the field. It is not a matter of determining which author has the most accurate perception of a true syndrome in nature.

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