

# **Psychopathy, Antisocial Personality & Sociopathy: The Basics A History Review**

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## Abstract

The concept and use of the word psychopath has a rather long history all of its own, yet, in spite of its history, a good deal of conceptual confusion remains. Many authors have honed in on a very specific type of deviant behavior that at its core is distinctly different from mental illness or psychosis-related behavior. The focus of the following article is to conceptually explore this distinctly different

behavior and the psychopathy basics, so to speak, which center on behavioral phenomena that by its very nature is best described as toxic, parasitic, predatory and potentially destructive to others. Also explored is how the related concepts of psychopathy, antisocial personality, and sociopathy have been defined, confused, and subsequently misused.

**KEYWORDS:** psychopath, psychopathy, definition of psychopathy, history of psychopathy, psychopathy basic concepts, psychopathy differential diagnosis, psychopathy conceptual history, psychopathy distinguishing features, psychopathy conceptual confusion, antisocial, antisocial personality, antisocial personality disorder, ASPD, antisocial personality definition, sociopath, sociopathy, sociopathic, sociopath definition, definition of psychopathic behavior, definition of antisocial behavior, definition of sociopathic behavior



## INTRODUCTION

The occurrence of psychopathic behavior is age old where any number of examples throughout history could be selected for discussion. For example, consider the biblical story of Cain and Abel, a classic story involving a dispute between brothers. Many have legitimately wondered what was happening with Cain when he eventually decided that a viable solution to his sibling-rivalry difficulties was to lure his brother out into a field and then murder him. Of course, as this story goes, upon his return from settling his dispute, Cain was interrogated by God. Like any other “good” psychopath, Cain tried to manipulate the situation to conceal his crime, and when that didn’t work; he resorted to flat-out denial of his role in the murder. Regardless of how one interprets this biblical story, most would agree that the story of Cain and Abel is an early example of aberrant behavior and, if nothing else, one of the earliest documented interrogations.

Attempting to understand aberrant behaviors like Cain’s that violate societal norms can be a complex task influenced by numerous factors. One significant complicating factor is that observable psychopathic behavior is typically driven by unobservable processes and dynamics. At times, these unobservable underlying processes have made understanding deviant behavior challenging and even more complex to empirically measure. Another complicating factor is that dominant personality features must be distinguished from

personality traits versus states, both of which are fluid concepts that are subject to change. Adding to the relative degree of difficulty, the terms used to describe or define aberrant behavior often change or are mistakenly used interchangeably with other terms (e.g. *psychopathy*, *antisocial personality disorder*, *sociopathy*).

In considering the research on the topic of psychopathy, it appears that the actual concept and use of the word psychopath has a rather long history all of its own. It is also abundantly clear that several theorists, psychologists, etc., have devoted a great deal of time and energy, if not entire careers, to examining psychopathy and psychopathic-related behavioral phenomena. It is further obvious that many have honed in on a very specific type of deviant behavioral phenomena that is clearly distinguished from mental illness or a psychosis and by its very nature is best described as toxic, parasitic, predatory, and destructive to others. This specific behavioral phenomenon is the focus of the following article, which seeks to explore conceptually the *psychopathy* basics, so to speak. Specifically, the following discussion identifies and describes some of the specific personality, behavioral, and affective characteristics that have been classified as psychopathic in nature and explores how the related concepts of *psychopathy*, *antisocial personality*, and *sociopathy* have been defined and applied.



## EVOLUTION OF CONCEPTS

A very large amount of materials and research exists on the topics of psychopathy, antisocial personality and sociopathy. A related publication by Gregory Zilboorg (1944), *One Hundred Years of American Psychiatry*, reviews a century of the “American psychiatric evolution . . . and the development of a medical specialty . . . [which has] endless dynamic ramifications,” (p. xi). In his forward, Zilboorg stated his intention was to review many of the far-reaching implications of the American psychiatric evolution from both a societal and historical perspective. Zilboorg does not exclusively focus on psychopathy, but he does provide a wealth of information useful in understanding the evolution of the topic. With respect to psychopathy and general societal perceptions, Zilboorg (1944) quoted John Haslem, M.D., from Haslem’s 1823 letter to the Lord Chancellor of England:

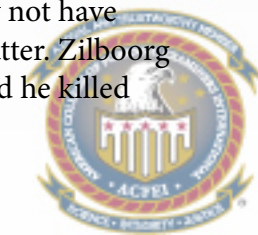
The introduction of the term unsoundness, to denote a particular state of disordered mind, which is supposed to differ from idiotcy and lunacy, has been the source of considerable perplexity to medical practitioners; and, in my opinion, opens an avenue for ignorance and injustice. The application of figurative terms, especially when imposed under a loose analogy, and where they might be supplied by words of direct meaning, always tends to error and confusion. (Zilboorg, 1944, p. 507)

Zilboorg (1944) provides a detailed discussion regarding the history of *medical jurisprudence of insanity*, a specific branch of medicine devoted to examining abnormal behavior and related legal implications. Zilboorg discussed the work of Cornelius Agrippa (1486-1535), whom he refers to as the founder of this specific branch of medicine. While Zilboorg’s work highlights the development of the insanity defense, it also provides historical information related to general societal perceptions and management of deviant behavior during this point in time. His work also highlights early societal challenges in distinguishing between types of deviant behavior, particularly aberrant behavior related to a mental illness versus behavior related to psychopathic origins. Zilboorg’s review of the

work of Agrippa and others provided early examples of the challenges faced by the courts and the field of medicine in addressing these two different realms of behavior.

In discussing these two different realms of behavior, Zilboorg discussed Agrippa and his student protégé Johan Weyer’s (1515-1588) work, which supported the use of the insanity defense. Zilboorg noted that these two were also among the first to argue that many criminals of this time needed treatment instead of punishment. Zilboorg noted that Agrippa and Weyer introduced the use of expert psychiatric opinions in criminal cases where issues of insanity and/or psychopathy were at hand (Zilboorg, 1944). Zilboorg stated that the opinions of Agrippa and Weyer “. . . were not met with great favor; the lawgiver sharply denied any physician the right to set his medical opinion above that of the law in matters of mental pathology in relation to crime” (Zilboorg, 1944, p. 509). In response to the pair’s work, Zilboorg presented the opposing opinion of Jean Bodin (1530-1596). Bodin “. . . was vituperative and venomous for fear that this first intrusion of psychiatry into the business of legal justice might let a host of responsible miscreants go unpunished with all the dire consequences there from made inevitable” (Zilboorg, 1944, p. 509). Zilboorg’s work offers one view on the challenges faced early on by general society in distinguishing between abnormal behavior related to insanity versus behavior related to psychopathy or *moral insanity* and ways to manage it.

Zilboorg noted that during the time of Agrippa, Weyer, and Bodin’s work, another theorist, Jerome Cardan, was also weighing in on such matters. Zilboorg (1944) stated that Cardan became particularly involved in exploring the distinction between insane behaviors versus psychopathic behaviors. Zilboorg stated that Cardan “. . . suggested the notion of the psychopathic personality, or [an] irresistible impulse . . . Cardan proceeded to argue that certain psychopathies should exempt one from legal responsibility” (p. 510). Of course it should also be noted that Zilboorg offered a related back story in his writings, which may or may not have had something to do with Cardan’s chosen opinion on the matter. Zilboorg stated, “One of Cardan’s sons didn’t get along with his wife and he killed her” (Zilboorg, 1944, p. 510).



Questionable family stories aside, the writings of Zilboorg, Cardan, and others indicated that society was struggling with how to define and manage behavior that seemed to be of two different origins; genuinely *insane* or mentally-ill-related behavior, and *morally insane* or *psychopathic personality*-related behavior. Zilboorg (1944) stated, “The concept of moral insanity is historically and psychologically of great importance in psychiatry, for under this term the first appearance of the concept of psychopathic personality or neurotic character is marked” (p. 550). Zilboorg defined *moral insanity* as a specific type of madness and offered:

... consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses without any remarkable disorder or defect in the intellect or knowing and reasoning faculties and particularly without any insane illusion or hallucination. . . . What ‘natural’ meant in the English language at that time and in this context was partly the spontaneous sense of right and good and partly the extended sociological connotation which it had begun to inquire.(Zilboorg, 1941, p. 417)

This same concept was also referred to by D.H. Tuke as *inhibitory insanity* (Zilboorg, 1944, p. 551).According to Tuke, inhibitory insanity occurs “. . . when the inhibitions in normal civilized persons are disorganized”(Zilboorg, 1944, p. 551).Expanding on this concept, Zilboorg noted, “If there be moral insanity anywhere, it is likely to manifest itself on Wall Street. The wonder is that it should never have been set up as a defense for the various iniquities committed there . . . Moral insanity bears a striking resemblance to [a] vice” (p. 552).

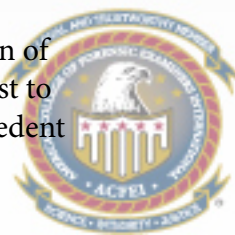
Several significant contributions in the field of law and psychiatry occurred during the late 1700s to 1800s.One the most significant contributions relevant to the discussion of psychopathy was that the disciplines of psychiatry and law began to recognize that mental conditions can indeed negatively effect behavior and that some of these behaviors are beyond an individual’s control. As a result, society began to recognize the need for specialized treatment and care for such individuals. Within this context, society began to recognize and distinguish between

socially offensive behaviors that coincided with some defect of moral character as opposed to a legitimate mental illness or some other type of psychosis-related condition.

The 1800s marked the beginning era of institutionalization and formal procedures to regulate involuntary commitments of insane persons to asylums. During this period Philippe Pinel focused on the management of *the mind and differentiating among species of mental derangement* (Whitaker, 2002, p. 22).Pinel believed there were five different types of madness, or “species derangement . . . and patients would be treated with therapies suitable for their particular kind of madness”(Whitaker, 2002, p. 22). Pinel’s five different types of mental derangements included a subtype that appeared to be designated for psychopathic individuals. The term Pinel used to describe this group was *manie sans delire*, or *insanity without delirium* (Whitaker, 2002).Pinel also used this term to refer to disorders that were “. . . characterized by aberrant affect, proneness to impulsive rage, but no deficit in reasoning ability” (Sutker& Allain, 2001, p. 445).Pinel was one of the first to explain psychopathic processes in terms of a moral deficit or deficiency that was distinguished from other types of madness (Sutker& Allain, 2001).One of Pinel’s main contributions was creating an early classification system that assisted in distinguishing between civil and criminal confinement (Swenson, 1997).

In 1835 Benjamin Rush and J.C. Prichard seemed to share Pinel’s opinion that there are individuals who act in socially deviant ways and who are not affected by an underlying psychotic or delusional process. Like Pinel, Rush and Prichard believed that those who do so possess major deficiencies in moral faculties (Zilboorg, 1944).Prichard coined the term “moral insanity. . . [where] antisocial behaviors resulted from constitutional factors with poor prognosis for change” (Sutker& Allain, 2001, p. 445).

Societal discussion regarding moral insanity simultaneously continued around the time of the 1843 criminal case of Daniel McNaughten. The McNaughten case is relevant to the discussion of psychopathy because it explores some of the questions of interest to society at the time. Specifically, McNaughten established a precedent



that explored whether defendants knowingly understood what they were doing at the time a crime was committed, and if so, whether they were able to understand that their behaviors were wrong (Bartol & Bartol, 2004). Through McNaughten, society, the courts, and various scientific fields were prompted to further consider management of socially deviant behavior chosen of one's intact and unimpaired free will. Similar discussions like those occurring around the time of McNaughten continued throughout

the 1900s and onward. Key components of such discussions included further distinctions of aberrant behavior associated with free will and choice versus aberrant behavior associated with mental illness or brain defect. Related discussions and debate contributed to the following basic definitions.

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## BASIC DEFINITIONS

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Basic definitions of personality disorder, psychopathy, antisocial personality disorder, and sociopathy include:

**Personality Disorder:** “An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.” (DSM-IV, p. 629; DSM-IV-TR, p. 685)

Merriam-Webster's Collegiate Dictionary (2004) offers:

**Psychopath:** “A mentally ill or unstable person, esp., a person affected with antisocial personality disorder.” (p. 1004)

**Psychopathy:** “Mental disorder esp. when marked by egocentric and antisocial activity.” (p. 1004)

**Antisocial:** “Averse to the society of others. Hostile or harmful to organized society, esp., being or marked by behavior deviating sharply from the social norm.” (p. 56)

**Antisocial personality disorder:** “A personality disorder that is characterized by antisocial behavior exhibiting pervasive disregard for and violation of the rights, feelings, and safety of others starting in childhood or early teenage years and continuing into adulthood—also called psychopathic personality disorder.” (p. 56)

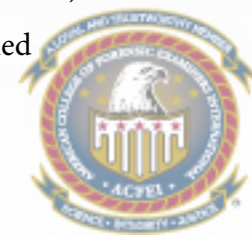
**Sociopath:** “A sociopathic individual; psychopath.” (p. 1184)

**Sociopathic:** “Relating to or characterized by asocial or antisocial behavior or exhibiting antisocial personality disorder.” (p. 1184)

Mosby's Medical, Nursing, & Allied Health Dictionary (2002) Sixth Edition offers the following:

**Psychopath:** “A person who has an antisocial personality disorder. Also called sociopath. See Antisocial Personality Disorder.” (p. 1429)

**Psychopathy:** “Any disease of the mind, congenital or acquired, not necessarily associated with subnormal intelligence. Also called psychopathia.” (p. 1429).



**Antisocial Personality Disorder:** “A condition characterized by repetitive behavioral patterns that are contrary to usual moral and ethical standards and cause a person to experience continuous conflict with society. Symptoms include aggressiveness, callousness, impulsiveness, irresponsibility, hostility, a low frustration level, a marked emotional maturity, and poor judgment. A person who has this disorder overlooks the rights of others, is incapable of loyalty to others or to social values, is unable to experience guilt or to learn from past behaviors, is imperious to punishment, and tends to rationalize his or her behavior or to blame it on others. Also called antisocial reaction.” (p. 115)

**Antisocial personality:** “A person who exhibits attitudes and overt behavior contrary to the customs, standards, and moral principles accepted by society. Also called psychopathic personality, sociopathic personality. See also antisocial personality disorder”. (p. 115).

**Sociopath:** “Popular term for antisocial personality disorder.”(p. 1599)

**Sociopathy:** “A personality disorder characterized by a lack of social responsibility and failure to adapt to ethical and social standards of the community.”(p. 1599)

## Additional Descriptions

Benning, Patrick, Hicks, Blonigen, and Krueger (2003) state, “Psychopathy is a personality disorder characterized by impulsive acting out in the context of affective and interpersonal detachment” (p. 340). According to J. L. Skeem, D. L. Polaschek, C. J. Patrick, S. O. Lilienfeld (2011), psychopathy is currently defined in psychiatry and clinical psychology as a condition characterized by a lack of empathy or conscience, and poor impulse control or manipulative behaviors. Cleckley (1988) offers another definition:

Every physician is familiar with the term psychopath, by which these people are most commonly designated. Despite the plain etymologic inference of a sick mind or of mental sickness, this term is ordinarily used to indicate those who are considered free from psychosis and even from psychoneurosis. The definitions of psychopath found in medical dictionaries are not consistent nor do they regularly accord with the ordinary psychiatric use of this word. (Cleckley, 1988, p. 10)

### *Primary & Secondary Psychopathy*

While not officially recognized, some professionals are of the opinion that the current DSM IV TR (2000) antisocial personality disorder diagnostic criteria can be further subdivided into two subtypes or classifications, primary psychopathy and secondary psychopathy (Meyer, Wolverson & Deitsch, 1994). Meyer, et al, (1994) state that these two subdivisions can be distinguished by “1) Very low levels of anxiety, avoidance, or remorse, 2) They are even more refractory to standard social control procedures, 3) They are higher in sensation and thrill seeking behaviors particularly the ‘disinhibition’ factor that refers to extroverted, hedonistic pleasure seeking” (p. 121). These authors go on to state, “Both the secondary and the primary psychopath are quite different from those individuals who are antisocial because they grew up in and adapted to a delinquent subculture” (Meyer, et al, 1994, p. 121).



## Primary Psychopathy

According to B. Karpman (1948), the primary psychopath can be described as:

The root disorder in patients diagnosed with it whereas secondary psychopathy was defined as an aspect of another psychiatric disorder or social circumstances. Today the primary psychopathy is considered to have mostly Factor 1 traits from the PCL-R (arrogance, callousness, manipulative, lying) whereas secondary psychopaths have a majority of Factor 2 traits (impulsivity, boredom proneness, irresponsibility, lack of long term goals).”(Karpman, 1948, p. 525)

Other authors have noted that *primary psychopathy* is used “. . . to differentiate between psychopathy that is biological in origin and secondary psychopathy that results from a combination of genetic and environmental influences” (Mealey, 1995, p. 3).

## Secondary Psychopathy

According to D. DeMatteo and J. Edens (2006) Secondary Psychopathy is defined by the Factor 2 elements measured by the PCL-R which include impulsivity, weak behavioral controls, irresponsibility, lack of realistic long-term goals, need for stimulation, parasitic lifestyle, early behavioral problems, and juvenile delinquency. This resource further notes that secondary psychopathic criminal behavior is often unplanned and impulsive in nature, with little regard paid to consequences for one's behavior.

## Sociopathy

The term sociopath has often been used interchangeably with the terms psychopath and antisocial personality. Many people, including Hare, have noted the official stance of the American Psychiatric Association as presented in the DSM-IV-TR is that psychopathy and sociopathy are obsolete synonyms for antisocial personality disorder. According to the Harvard Mental Health Letter (2000):

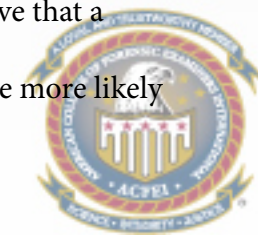
The terms “sociopath,” and “antisocial personality,” refer mainly to behavior and its consequences, “psychopath” to inner experience. But the three terms are used more or less interchangeably today. . . . at one time [they were] even used as a synonym for mental illness in general. . . . a condition close to psychosis. The present psychiatric terminology has no such connotations; antisocial personalities are sane in the everyday sense.” (p.1)

There are those who say psychopathy and sociopathy are actually two distinct types of antisocial personality disorder. According to Meyer, et al (1994), “. . . the psychopath or sociopath is typically seen as a subgroup of this category [antisocial personality disorder]”(p. 121).

According to Hare (1993), the distinguishing feature between a true psychopath and a sociopath is that psychopaths are born as psychopaths whereas sociopaths are the product of one's developmental environment. G.E. Partridge (1930) used the term sociopathic personality to stress the importance of environmental influences. Partridge used this term “. . . to emphasis failure to conform to societal demands and pointed to the role of environmental or cultural factors in the etiology of behavioral deviance”(Sutker& Allain, 2001, p. 446).Hare notes that both personality disorders (psychopathy and sociopathy) are the result of an interaction between genetic predispositions and environmental factors, but psychopathy leans towards the hereditary whereas sociopathy tends toward the environmental.

In further distinguishing the difference between the terms psychopathy and sociopathy, Hare offers:

The difference between sociopathy and psychopathy . . . often reflect the user's views on the origins and determinants of the disorder. Most sociologists, criminologists and even some psychologists believe the disorder is caused by social conflicts and thus prefer the term sociopath. . . those who believe that a combination of psychological, biological, genetic and environmental factors all contribute to the disorder are more likely to use the term psychopath.(Hare,1993, p. 23)



## Formal Diagnostic Criteria

Although imperfect and not without sociocultural criticisms, research on the topic of psychopathy, antisocial personality and sociopathy support several different diagnostic classification systems that have been proposed, adopted, revised, etc. across time. In examining conceptual psychopathy basics, two diagnostic and classification systems are explored: (a) *The World Health Organization's International Classification of Diseases and Related Health Problems (ICD-10)*, and (b) *The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

### The World Health Organization's International Classification of Disease (ICD-10)

In the early 1960s the World Health Organization, along with several other professional and scientific disciplines, became actively engaged in improving the diagnostic and classification systems of mental disorders (ICD-10, 1992). To that end, worldwide collaboration efforts took place that eventually resulted in the publication of the World Health Organization's International Classification of Diseases and Related Health Problems (ICD-10, 1992). In terms of psychopathy-related disorders and formal diagnostic classifications, the ICD-10 (1992) contains the major classification, *Disorders of Adult Personality and Behavior*. The ICD-10's general description of a personality disorder is a condition deeply engrained and that is demonstrated through one's behavior patterns. Within this classification system, personality disorders have been classified on the basis of behavioral manifestations or patterns (ICD-10, 1992). Recognizing that psychopathy can co-occur with almost any other mental disorder, the two personality disorders found within this larger classification and that are directly relevant to this discussion of psychopathy are *Dissocial Personality Disorder* and *Emotionally Unstable Personality Disorder*. The ICD-10 (1992) provides: Table 1 and Table 2 as follows

**Table 1. World Health Organization's International Classification of Diseases & Related Health Problems, ICD-10 (1992)**

**F60.2 Dissocial (Antisocial) Personality Disorder:** A personality disorder, usually coming to attention because of a gross disparity between behavior and the prevailing social norms and is characterized by at least three of the following:

1. Callous unconcern for the feelings of others.
  2. Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.
  3. Incapacity to maintain enduring relationships, though no difficulty in establishing them.
  4. Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
  5. Incapacity to experience guilt and to profit from experience, particularly punishment.
  6. Marked proneness to blame others, or to offer plausible rationalizations, for the behavior that has brought the patient into conflict with society.
- There may be a persistent irritability as an associated feature. Conduct disorder during childhood and adolescent, though not invariably present may further support the diagnosis. Includes; a moral, antisocial, asocial, psychopathic, and sociopathic personality disorder. Excludes; Conduct disorders and emotionally unstable personality disorder. (ICD-10, 1992, p.204)



**Table 2. World Health Organization's International Classification of Diseases & Related Health Problems, ICD-10 (1992)**

**F60.3 Emotionally unstable personality disorder:** A personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. Ability to plan ahead may be minimal and outbursts of intense anger may often lead to violence or behavioral explosions. These are easily precipitated especially when impulsive acts are thwarted or censored. (ICD-10, 1992, p.204)

Two variants of this personality disorder are specified and both share this general theme of impulsiveness lack of self-control.

**2 Subtypes**

**1.F60.3 Impulsive type:** The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behavior are common, particularly in response to criticism by others. Includes explosive and aggressive personality disorder. Excludes dissocial personality disorder.

**2.F60.31 Borderline Type:** Characterized in addition by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants). (ICD-10, 1992, p.204)

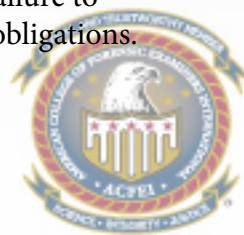
## DSM-IV (1994) & DSM-IV-TR (2000)

Throughout its revisions, many of the categories and specific diagnostic criteria found in the DSM-IV and the DSM-IV-TR were left largely unchanged (First, Frances, & Pincus, H.A., 2004). The diagnostic category for antisocial personality disorder and its specific criteria remained intact throughout both editions. Both editions note that APD is a pervasive pattern of personality traits where this pattern "... has also been referred to as Psychopathy, Sociopathy, or Dyssocial personality disorder," (DSM-IV, 1994, p.645; DSM-IV-TR, 2000, p. 702). With respect to formal diagnostic criteria for APD, the DSM-IV (1994), and DSM-IV-TR (2000) offer the following:

### 307.7 Antisocial Personality Disorder

**A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 years, as indicated by three or more of the following:**

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.



7. Lack of remorse as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another.

**B. The individual is at least 18 years of age.**

**C. There is evidence of conduct disorder with onset before age 15 years.**

**D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.** (DSM-IV, 1994, p. 649; DSM-IV-TR, 2000, p. 706)

Between DSM-III-R and the DSM-IV, Reid, W.H., and Wise, M.G. (1995) noted that significantly fewer criteria were required to meet inclusion criteria for APD. In addition, they note that the criterion regarding relationships “typically these people are promiscuous (defined as never having sustained a monogamous relationship for more than one year)” remained in the DSM-IV and DSM-IV-TR but the “for more than one year” piece was dropped. Other changes from DSM-III-R to the DSM-IV include that the separate requirement for lack of remorse has been removed and is now being one of the seven inclusion criteria choices (Reid&Wise, 1995). Reid and Wise have also noted that disregard for family obligations is no longer a separate choice or criterion. Lastly, they note that the changes that occurred between the two editions mainly involved condensing and simplifying diagnostic criteria. (Reid& Wise, 1995)

## Trends & Criticisms of the DSM

Reviewing the Diagnostic and Statistical Manual (DSM)’s origins and development is relevant to understanding the evolution of concepts like psychopathy and its related sister diagnoses, e.g., the former sociopathic personality, and the recent *antisocial personality disorder*. A main goal in the adoption and development of the DSM was to provide a consistent nomenclature that all mental health/health care professionals could use when assessing mental disorders and by doing so could better facilitate communication among professionals and institutions (American Psychiatric Association, DSM, 1952). For most disorders noted in the DSM, great strides and improvements have occurred on both accounts.

Unfortunately, not every diagnostic category has been as fortunate or self-actualizing.

Across the DSM’s development, psychopathic phenomena and the unrelated disorders have been identified and described in a number of different ways. In examining development across editions, one can see that the phenomenon of interest does not relate to psychotic or delusional influences. An observable trend evident in the more contemporary DSM-IV and DSM-IV-TR is a movement toward evidence-based assessment and testing approaches. One facet of this trend is to move away from more subjective realms and toward more objectively based testing and assessment methods. Specifically the DSM-IV and the DSM-IV-TR place an emphasis on classifying observable behaviors.

A related criticism of the DSM-III-R was that the diagnostic criterion “. . . was too long and cumbersome” (Hare, Hart& Harpur, 1991, p.391). Subsequent criteria for antisocial personality disorder in later editions did in fact become condensed. Hare, et al (1991) noted that a consequence of this condensation and simplification of the diagnostic criteria has resulted in an increased emphasis placed on examining antisocial behavior and minimization of attention placed on underlying psychopathic processes. Hare discussed the ramifications of this further:

Among the reasons given for this dramatic shift away from the use of clinical inferences were that personality traits are difficult to measure reliably, and that it is easier to agree on the behaviors that typify a disorder than on the reasons why they occur. The result was a diagnostic category with good reliability but dubious validity, a category that lacked congruence with other, well-established conceptions of psychopathy. This “construct drift” was not intentional but rather the unforeseen result of reliance on a fixed set of behavioral indicators that simply did not provide adequate coverage of the construct they were designed to measure. (Hare, 2006, p.1)

The current DSM-IV-TR and earlier editions have been criticized on the basis of not being able to capture the full essence of underlying psychopathic processes typically associated with antisocial behavior (Hare,



et al, 1991). Consider that any two people can engage in identical behavior, yet only one's behavior may be driven by underlying psychopathic processes. Exploring these underlying processes becomes critical when examining observable antisocial behavior and psychopathic personality traits; thus antisocial, socially deviant, or undesirable behavior is not synonymous with psychopathy or a psychopathic personality. According to Hare, et al (1991), the more recent editions of the DSM have been developed "... on the assumption that personality traits are difficult to measure reliably and that it is easier to agree on the behaviors that typify a disorder than on the reasons why they occur" (p. 391).

## Specific Theories

### Cleckley's Psychopath (1941)

Hervey Cleckley, author of *The Mask of Sanity* (1941), can be considered a founding father who significantly advanced the study of psychopathy. In his work, Cleckley recalled how he began observing a specific type of patient that was neither schizophrenic nor psychotic but yet had very serious pathology and who seemed to absorb most of the mental health services and resources available at the time (Cleckley, 1941). Cleckley came to recognize that this specific subset of patients could not be understood by applying traditional theoretical models of brain disease or mental illness and noted that this subset of patients was virtually neglected within research. Cleckley stated, "With psychopaths making up so large a proportion of the patients who must be dealt with and their problems being so serious, it was indeed difficult to understand why they were almost ignored [in terms of available research and practical treatment methods]" (Cleckley, 1988, p.225). Due to the theoretical deficits and lack of practical suggestions, Cleckley set out to collect and record his observations of the specific subset of patients he was encountering.

In doing so, Cleckley (1988) described his research by stating, "The material to follow is offered not primarily for the purpose of making a diagnosis of psychopathic personality but in illustration of features which specifically to characterize the psychopath" (p. 192). Cleckley also stated

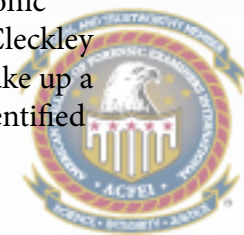
that his works were not intended to provide a theoretical opinion about psychopathy but instead to provide documentation of his observations of the significant number of his patients he believed possessed varied degrees of psychopathy (Cleckley, 1988).

In his first edition of *The Mask of Sanity*, Cleckley (1941) describes psychopathic phenomena as a specific condition distinguishable from other chronic mental conditions or illness. Cleckley (1941) stated the term psychopath personality is "a somewhat cumbersome and altogether vague diagnostic category generally used to cover a wide variety of maladjusted people who cannot by the criteria of psychiatry be classed either with the psychoses or in the psychoneuroses" (p. 19). He went on to state, "There remains a large body of people who everyone will admit are by no means normal and yet who have no standing in the ranks of the insane" (p. 17).

Benning, et al, offered their interpretations of Cleckley (1976) work stating, "In Cleckley's view, criminals with psychopathy were a distinct breed of antisocial individual characterized by relatively weak emotions and breaking through even weaker restraints" (p. 2). With respect to the definition of psychopathy and personality disorders in general, Cleckley (1988) himself states:

The diagnostic category, personality disorder, officially includes a wide variety of maladjusted people who cannot by the criteria of psychiatry be classified with the psychotic, the psychoneurotic, or the mentally defective. Until fairly recent years, it was not uncommon for the report of a detailed psychiatric examination made on a patient in a state or federal institution to end with this diagnostic conclusion: (a) no nervous or mental disease, and (b) psychopathic personality. (p. 11)

Cleckley's (1941/1988) writings revealed a considerable effort to distinguish psychopathy from other mental disorders such as schizophrenia. In terms of disease components and processes, Cleckley compared psychopathic patients to schizophrenic or other chronic mentally ill patient populations on a number of factors. First, Cleckley stated that psychopathic individuals such as schizophrenics make up a distinct population especially in that this population can be identified



by specific features or characteristics in common (Cleckley, 1941/1988). Second, Cleckley noted that like the chronic mentally ill, psychopathic patients often display a range of impairment, and this range of impairment varies in intensity. Cleckley noted that just as some schizophrenics function at a minimal level, just enough to avoid calling attention to themselves or the authorities, psychopathic individuals function in a similar manner. Like the chronic mentally ill, varying degrees of impairment can be seen across the psychopathic patient population, from mild degrees of impairment to severe degrees and fully disabled levels of impairment (Cleckley, 1941/1988).

### ***Specific Psychopathic Personality Traits***

Cleckley (1941) identified 16 specific personality traits that could be used to distinguish the psychopath from other types of individuals. A summary of the 16 psychopathic personality traits recognized by Cleckley are noted in the table 3.

**Table 3. Cleckley (1941)'s Psychopath & 16 Personality Traits**

1. Superficial charm and average intelligence.
2. Absence of delusions and other signs of irrational thinking.
3. Absence of nervousness or neurotic manifestations.
4. Unreliability.
5. Untruthfulness and insincerity.
6. Lack of remorse or shame.
7. Antisocial behavior without apparent compunction.
8. Poor judgment and failure to learn from experience.
9. Pathological egocentricity and incapacity to love.
10. General poverty in major affective reactions.
11. Specific loss of insight.
12. Unresponsiveness in general interpersonal relations.
13. Fantastic and uninviting behavior with drink, and sometimes without.
14. Suicide threats rarely carried out.
15. Sex life impersonal, trivial, and poorly integrated.
16. Failure to follow any life plan.

Cleckley (1941/1988) provided the following about his title, *The Mask of Sanity*:

The most striking difference is in all the orthodox psychoses . . . there is a more or less obvious alteration of reasoning processes or of some other demonstrable personality feature. In the psychopath, this is not seen. . . . The Observer is confronted with a convincing mask of sanity. All of the outward features of the mask are intact. It cannot be displaced or penetrated by questions directed toward deeper personality levels. (Cleckley, 1941/1988, p. 2)

### ***Strengths & Criticisms***

Cleckley's work was one of the earliest to provide an in-depth look at the phenomena of psychopathy and to identify specific personality and behavioral characteristics that define it. In doing so, Cleckley's work has contributed a great deal to the field by laying a sound foundation from which generations of related research could continue.

As one may expect, Cleckley's work was not without its critics. R.G. Meyer, D. Wolverton, and S.E. Deitsch (1994) state,

Cleckley asserted that psychopaths are often intellectually superior and this concept has unduly influenced attitudes towards AP [Antisocial Personality]. Cleckley was clearly in error here. Such a characterization best fits the unique subsample that he encountered within his practice. It is not surprising that those rare psychopaths who were willing to participate and stay in therapy and especially those who could pay a private therapist's fee would be brighter than the average psychopath. As a whole all subgroups of antisocial personalities actually show lower than average scores on intelligence tests. (p.122)

Unfortunately, these authors did not cite any research that would either support or refute such statements.



## HARE'S PSYCHOPATH

Hare (1991) identifies a number of behavioral characteristics and core personality traits he has incorporated into his theoretical model of psychopathy, a model that has been frequently cited and supported within the research. In terms of presenting his broader theoretical framework, Hare makes the distinction between psychopathy and antisocial personality disorder. Hare (2006) states:

The failure to differentiate between psychopathy and ASPD can have serious consequences for clinicians and for society. For example, most jurisdictions consider psychopathy to be an aggravating rather than a mitigating factor in determining criminal responsibility. In some states an offender convicted of first-degree murder and diagnosed as a psychopath is likely to receive the death penalty on the grounds that psychopaths are cold-blooded, remorseless, untreatable and almost certain to reoffend. But many of the killers on death row were, and continue to be, mistakenly referred to as psychopaths on the basis of *DSM-III*, *DSM-III-R* or *DSM-IV* criteria for ASPD (Meloy). We don't know how many of these inhabitants of death row actually exhibit the personality structure of the psychopath, or how many merely meet the criteria for ASPD, a disorder that applies to the majority of criminals and that has only tenuous implications for treatability and the likelihood of violent re-offending. If a diagnosis of psychopathy has consequences for the death penalty—or for any other severe disposition, such as an indeterminate sentence or a civil commitment—clinicians making the diagnosis should make certain they do not confuse ASPD with psychopathy. (p. 3)

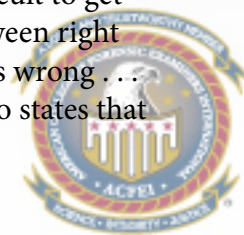
Hare offers that conceptual confusion frequently occurs when terms like psychopathy, antisocial personality and sociopathy are mistakenly used interchangeably. This conceptual confusion has occurred, at least in part, when multiple terms are used to describe similar personality traits and behaviors, e.g. *moral insanity*, *psychopathic personality*, *sociopathy*, *antisocial personality* (Hare, 1991). Hare states this confusion “. . . is compounded when these terms are used in ways that are not consistent

with the underlying clinical constructs,” (i.e., using the term psychopathy as a synonym to describe general criminality (Hare, 1991, p. 2). Hare (1991) acknowledges his theoretical model “to a large extent” is based on Cleckley's psychopath (p.2). Hare defines psychopathy as:

. . . A personality disorder defined by a distinctive cluster of behaviors and inferred personality traits, most of which society views as pejorative. . . . Psychopaths are not disoriented or out of touch with reality, nor do they experience the delusions, hallucinations, or intense subjective distress that characterizes most other mental disorders . . . they are rational and aware of what they are doing and why. Their behavior is the result of choice, freely exercised. (Hare, 1993, p. 22)

In Hare's (1993) *Without Conscience: The Disturbing World of Psychopaths Among Us*, he states, “Psychopathy is a syndrome-cluster of related symptoms” (p. 34). Hare also mentions that psychopathy is distinguished from other personality disorders on the basis of specific syndrome characteristics and patterns related to one's personality and behavior (Hare, 1991). In the preface to his book, Hare states, “Psychopaths are social predators who charm, manipulate, and ruthlessly plow their way through life, leaving a broad trail of broken hearts, shattered expectations, and empty wallets” (Hare, 1993, p. xi).

In terms of the onset of symptoms and course of this “syndrome,” Hare indicates that psychopathy is often present by middle to late childhood and typically persists well into adulthood (Hare, 1991). Hare states that psychopathic traits do not just emerge in adulthood without warning or without some indication that a disturbance has been present. Hare states, “Clinical and anecdotal evidence indicates that most parents of children later diagnosed as psychopaths were painfully aware that something was seriously wrong even before the child started school” (Hare, 1993, p. 156). Hare offered a specific example contained in a letter he received from a parent, “My son was always willful and difficult to get close to. At five years old he had figured out the difference between right and wrong: if he gets away with it, it's right, if he gets caught, it's wrong . . . his mode of operation ever since” (Hare, 1993, p. 157). Hare also states that



generally speaking, the earlier the onset, the more severe the course over one's lifespan. Lastly, in relation to childhood onset, Hare offers:

Most children who become psychopaths as adults come to the attention of teachers and counselors at a very early age and it is essential that these professionals understand the nature of the problem they are faced with. If intervention is to have any chance of succeeding, it will have to occur early in childhood. By adolescence, the chances of changing the behavioral patterns of a budding psychopath are slim . . . especially with a disorder that is widely believed to be untreatable. (Hare, 1993, p. 160)

Hare (1993) discussed the course of this syndrome and said while most people do change over time, most psychopathic personality traits and behavioral patterns tend to remain fairly stable, although there is some evidence that symptom patterns may change later in life. Hare indicated that this pattern may decrease in association with possible burnout, burnout on being incarcerated, increased maturity, increased skill level or tactics in "beating the system," etc. (Hare, 1993). Hare cautions, though, that before concluding an aging psychopath doesn't pose a threat, one should consider "(a) Not all psychopaths give up crime in middle age and may likely commit offenses well into their senior years, and (b) A decrease in criminality does not mean a significant change in underlying personality traits have occurred" (Hare, 1993, p. 98).

Hare notes that psychopathy can be distinguished from other officially recognized personality disorders, "... on the basis of its characteristic pattern of interpersonal, affective and behavioral symptoms" (Hare, 1991). The specific psychopathic personality and behavioral traits identified by Hare (1991) are noted in table 4.

**Table 4. Hare's Psychopathy Personality and Behavioral Characteristics**

1. Glibness/superficial charm
2. Grandiose senses of self worth
3. Need for stimulation/proneness to boredom
4. Pathological lying
5. Conning and manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous and lack of empathy
9. Parasitic lifestyle
10. Poor behavioral controls
11. Promiscuous behavior
12. Early behavioral problems
13. Lack of realistic short-term goals
14. Impulsivity
15. Irresponsible
16. Fails to take responsibility for one's actions
17. Many short-term marital/interpersonal relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility. (Hare, R.D., 1993, p. 69)

Hare also stated that the specific personality characteristics he has identified encompass two primary and correlated factors, which "... together provide a useful description of this syndrome" (Hare, 1991, p. 37). Factor 1 includes the core personality traits characteristic of this syndrome such as superficiality, habitual lying, manipulation and callousness, lack of affect, guilt, remorse and empathy (Harpur, T.J., Hakstian, and Hare, R.D., 1988; Hare, 1991, p. 37). Factor 2 captures the extent of socially deviant behaviors evidenced in patterns of unstable and antisocial lifestyles (Harpur, et al, 1988; Hare, 1991, p. 37). Exploring both of these factors provide the conceptual basis for Hare's Psychopathy Checklist-Revised (PCL-R), which, according to the *Mental Measurements Yearbook* (MMY) (2007), was developed on the premise that psychopathy and antisocial personality are similar but not equivalent constructs (MMY, 2007).



## Summary

The concept and actual term *psychopathy* is no longer in and of itself an actual clinical diagnosis but rather refers to a specific cluster of traits and behaviors used to describe an individual in terms of pervasive dominating personality traits and behaviors (Gunn & Wells, 1999; Hare, 1993). The terms *psychopathy*, *antisocial personality*, and *sociopathy* have periodically been used interchangeably, which has resulted in a degree of conceptual difficulty. This review reveals that psychopathy is a specific type of personality and behavioral phenomena that by its nature has been classified as toxic, parasitic, predatory, destructive, etc., to others. This review also reveals that psychopathy, even while in the midst of conceptual difficulty, has been largely distinguished from personality traits and/or behaviors that have been associated with mental illness or some other type of psychosis related conditions.

Identifying and examining the core personality and behavioral components of psychopathy at first glance appears to be a rather straightforward task. By identifying and describing some of the *psychopathy basics*, specifically the personality, behavioral, and affective characteristics classified psychopathic, one can better appreciate the complexities of such topics. One also gains a better appreciation for the historical struggles that have occurred in labeling, assessing, and managing the behaviors of individuals engaging in psychopathic behaviors.

The future of terms and concepts like antisocial personality disorder, psychopathy, and sociopathy used to describe aberrant behavior remains unclear. Most would agree that various types of aberrant behavior can be difficult to understand, especially if that behavior appears to be chosen of one's freewill or is not related to some type of brain disease. History provides that difficulties of definition and distinction like these have dated back to primitive times. Certainly one could argue that the psychopath seen in primitive times is not the same as a more modern-day psychopath of 2013. This seems especially true considering advancements in technology and mass media that have afforded the modern-day psychopath with a wider range of tools to use. These same tools have facilitated the more sophisticated degrees of psychopathy seen in 2013. While the means and methods employed by contemporary psychopaths have become more complex, it seems that the underlying psychopathic processes and questions surrounding them have essentially remained the same. It is difficult to know whether similar discussions about the similarities and differences related to antisocial personality disorder, psychopathy, and sociopathy will still be occurring 10, 20, or even 100 years from now. One thing is certain though; regardless of labels, the behavior will continue.



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## About the Author



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Dr. Paula M. MacKenzie earned her Bachelor's of Science (B.S.) degree from Bradley University, where she majored in Psychology and Social Services. In 1999; she earned a Master's of Science Degree in Education (M.S.Ed.) from Northern Illinois University, where she majored in Counseling Psychology. Dr. MacKenzie went on to complete her doctorate degree (Psy.D.) in Clinical Psychology with a specialization in Forensic Psychology. Dr. Mackenzie's areas of expertise include using a behavioral science model to conduct threat assessments and assessments of psycho-legal competencies such as competency to stand trial, sanity, and other specialized types of forensic examinations. Dr. Mackenzie's additional areas of expertise include the assessment of psychopathy, emergency services, analysis of extremist and cult group behavior, as well as general psychological testing and assessment. Dr. MacKenzie can be reached at; [PAULA\\_MACKENZIE\\_126@comcast.net](mailto:PAULA_MACKENZIE_126@comcast.net)

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