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CHAPTER 82

THE PSYCHOPATHOLOGY
OF PSYCHOPATHS

JÉRÔME ENGLEBERT

INTRODUCTION

THE objective of this article is to present a holistic conception of psychopathy inspired by phenomenological psychopathology and to compare it with the mainstream nosographic diagnosis. First, two major theoretical works dedicated to this nosographic entity are discussed. One is German: Schneider's *Psychopathic Personalities* (Schneider 1923). The other is American: Cleckley's *The Mask of Sanity* (Cleckley 1941). The well-known work of Hare (Hare 2003) is then summarized, including the so-called *Hare Psychopathy Checklist* (PCL-R), as well as the critique by Cooke et al. (Cooke and Michie 2001; Cooke et al. 2004, 2007, 2012).

Next, I illustrate how a structural-phenomenological approach enhances the psychopathological investigation of psychopathy. I first compare Binswanger's conception of mania with psychopathic functioning. Patients' behavior is similar but the difference relates to the dialectic between the ego and the alter ego. A patient with mania is affected by a fundamental crisis of the ego, which a psychopath does not have. A second dimension relates to emotions and the adaptive dimension of psychopathy. An epistemological discussion of the concept of emotions reveals that psychopaths are competent at managing emotional stimuli, which bestows a psychological advantage upon them. Finally, a reflection enlightened by the contributions of phenomenological philosophy (Stein 1989; Scheler 2008; Zahavi 2005, 2011) on empathy and sympathy clarifies the presentation of "psychopathic *being-in-the-world*." Starting with the tension between clinical practice and criticism of the dominant diagnostic scales, we consider the "essential characteristics" of the psychopathic disorder to be: reification of the alter ego without an ego-related disorder, emotional coldness as it provides adaptive benefits, and empathic skills without sympathy.

PHENOMENOLOGICAL PSYCHOPATHOLOGY OF PSYCHOPATHY?

As a discipline, the purpose of phenomenological psychopathology is to identify the logical structure of psychological functioning; it favors an approach based on understanding over interpretation or explanation (Stanghellini 2009; Cutting 2012; Englebert 2013). One of its aims is to identify the specific psychological features inherent to nosographic entities (the dimension of eidetic phenomenology which focuses on the study of essences and identification of the basic components of phenomena—in the specific field of phenomenological psychopathology, we speak about specific *being-in-the-world*). This method partly derives from Minkowski's legacy (1927, 1966), who suggested engaging in a “psychology of the pathological” rather than a “pathology of the psychological,” that is, seeking a structural understanding of psychological organization. This approach to psychopathology is intrinsically clinical; the fundamentals of its research topics—phenomena—emerge from clinical practice (Stanghellini 2009; Nordgaard et al. 2013). This theoretical essay is informed by clinical situations involving psychopaths who were interviewed in prison or in forensic centers.

If phenomenological psychopathology is interested, largely, in psychotic issues, many studies do analyze other psychopathological disorders and psychopathological manifestations (Broome et al. 2013). Work on the consideration of psychopathy in a phenomenological paradigm, as far as it is concerned, is recent. These studies are particularly interested in the subject's experiential dimension of time and show deficits in the imagination of the future and massive deficits with respect to *mental time travel* (McIlwain 2010; Levy 2014; Berninger 2017). Let's also mention the amazing approach of philosopher Glover (2014) at Broadmoor high-security psychiatric hospital, in England, which analyzes the moral and ethical dilemmas of the psychopathic subjects he went to meet (along with other diagnoses). If they observe cognitive and moral bias in their speech, Glover's hypothesis is precisely to consider that such biases are in parallel to those seen in many people considered normal (Glover 2014). Finally, let's notice that the work of phenomenological psychopathology centered on psychopathy also discusses the emotional dimension of this disorder (Beringer 2016; Englebert 2013b, 2015).

Strictly speaking, psychopathy or “psychopathic personality” is not a medical/psychiatric diagnosis. As we shall see, the psychopath is in fact absent from domineering nosography as in the DSM or ICD. However, this diagnosis is of considerable importance in many contemporary debates on psychopathology because of its many clinical and societal issues. Important links are identified between the psychopathic trait and other disorders such as antisocial personality disorder (Hare 2003; Hare et al. 1991), borderline personality (González et al. 2016), and schizophrenia (Abu-Akel et al. 2015). From a developmental point of view, many studies underline connections between certain psychological disorders of childhood and adolescence (including Callous-unemotional line) and the development of psychopathic characteristics into adulthood (Bird and Viding 2014; Frick et al. 2014; Henry et al.

2016; Muratori et al. 2016). Finally, a clarification of psychopathy is very important for the forensic field and for the psychopathological reflection on criminal matters (Kiehl and Sinnott-Armstrong 2013; Englebert 2013).

HISTORICAL AND CONTEMPORARY NOSOGRAPHIES

Historical Background

Psychopathy was described in the early nineteenth century by Pinel. He observed that some subjects presented a state of “*manie sans délire*” [insanity without delusion]¹ (Pinel 1800: 151). This early description is very important as it will enable us to explain the problem inherent to modern conceptions of psychopathy. The work of Schneider and Cleckley gradually led to a common and still current definition of psychopathy: a serious disorder or imbalance of the character or personality that does not include psychosis or significant mental deficiency (Schneider 1923; Cleckley 1941).

In contemporary nosographic work, psychopathy occupies an ambiguous position. This uncertainty is reflected in its absence from the DSM-IV and DSM-5 and from the ICD-10 and future ICD-11.

According to Schneider (1923), psychopaths present antisocial manifestations and character disorders such as instability, irritability, inability to adapt, increased tendency to commit crimes and consume drugs and alcohol, etc. In addition, psychopathy is said to be characterized by a firm opposition to social rules and norms (see Table 82.1). Cleckley (1941) identifies sixteen key signs that tend to describe a typical psychopath. This is an individual who is characterized by *superficial charm and high intelligence*, who does not suffer from *delusions or irrational thinking*, but also does not present signs of *neurosis, guilt or shame*. *Lacking in insight* and presenting *emotional reactions* described as *poor*, a psychopath is also *unable to behave appropriately in interpersonal relations*. *Hypocritical and untruthful, egocentric and incapable of love*, this is a person who cannot be counted on, is unable to learn from experience, or follow a life plan. Finally, in addition to *engaging in inadequately motivated antisocial behavior*, a psychopath *demonstrates fantastic and objectionable behavior under the influence of alcohol*, has an *impersonal and trivial sex life*, and is *unlikely to attempt suicide* (see Table 82.1).

The Hare Psychopathy Checklist—Revised

Despite the lack of a definition in the international classifications, an important movement in the literature attempted to formulate a pragmatic definition of psychopathy, based on

¹ The traditional English translation is certainly not the best since it translates the word “*manie*” [mania] with “insanity” as in French we mean by the word “*folie*.” For our purposes we will retain the notion of mania to be able to dialogue with the theses of Binswanger on the manic state and to refine our critique of the scale of Hare (see section on “Mad?: The Dialectics of Ego and Alter Ego in Psychopaths and Manic Subjects”).

the work of Hare (2003). *The Hare Psychopathy Checklist—Revised* (PCL-R) presents a set of behavioral, interpersonal, and affective characteristics, including egocentricity; manipulation; insensitivity to others; irresponsibility; unstable relationships; impulsivity; lack of empathy, remorse or guilt; and poor behavioral control. All of the PCL-R items is presented in a summary table below (see Table 82.1). These signs are most likely to manifest in antisocial behavior (Hare 2003; Cooke et al. 2004). These antisocial characteristics are part of the clinical picture, but they are not sufficient to diagnose psychopathy: a psychopathic subject necessarily has an antisocial personality, but the opposite is not necessarily true (Hare 2003; Hare et al. 1991; Cooke et al. 2004). According to this conception, one might consider psychopathic personality to be a way of adapting to the world through affective and interpersonal experiences (Cooke et al. 2004), whereas the antisocial dimension is primarily a set of behaviors involving transgressions against social laws and standards (Hare 2003; Hare et al. 1991).

This work adds a specific set of items to the diagnosis of antisocial personality disorder in order to isolate psychopathy as a specific nosographic entity. These items mainly concern the interpersonal sphere and the affective dimension.

Table 82.1 Summary of criteria for psychopathy

Schneider's criteria	Cleckley's criteria	Hare's criteria
Antisocial manifestations	Superficial charm and high intelligence	Glibness and/or superficial charm
Instability		Grandiose sense of self-worth
Irritability	Does not suffer from delusions or irrational thinking	Need for stimulation and/or proneness to boredom
Inability to adapt		Pathological lying
Tendency to commit crimes	Does not present signs of neurosis, guilt, or shame	Conning and/or manipulative
Drugs and alcohol consumption	Lacking in insight	Lack of remorse or guilt
Characterized by a firm opposition to social rules and norms	Emotional reactions described as poor	Shallow affect
	Unable to behave appropriately in interpersonal relations	Callous and/or lack of empathy
	Hypocritical and untruthful	Parasitic lifestyle
	Egocentric and incapable of love	Poor behavioral controls
	This is a person who cannot be counted on	Promiscuous sexual behavior
	Unable to learn from experience or follow a life plan	Early behavior problems
	Engaging in inadequately motivated antisocial behavior	Lack of realistic, long-term goals
	Demonstrates objectionable behavior under the influence of alcohol	Impulsivity
	Has an impersonal and trivial sex life	Irresponsibility
	Is unlikely to attempt suicide	Failure to accept responsibility for own actions
		Many short-term marital relationships
		Juvenile delinquency
		Revocation of conditional release
		Criminal versatility

Other Instruments

I should make it clear that my goal is not to present a comprehensive examination of all contemporary models of psychopathy. I will only include the presentation of three other instruments: the *Psychopathic Personality Inventory* (Lilienfeld and Widows 2005; Uzieblo et al. 2010; Skeem et al. 2011), the *Triarchic Psychopathy Model* (Patrick et al. 2009) and the *Self-Report of Psychopathy–Short Form* (Paulhus et al. 2015). The former was revised in 2005 to become the PPI-R and now comprises 154 items organized into eight subscales (Lilienfeld and Widows 2005). The items are grouped into two overarching and largely separate factors (Factor 1—Fearless dominance: Social influence, Fearlessness, Stress immunity; Factor 2—Impulsive antisociality: Machiavellian egocentricity, Rebellious nonconformity, Blame externalization, Carefree nonplanfulness), plus a third factor that is mainly dependent on scores on the other two (Cold-heartedness).

Meanwhile, the *Triarchic model* (Patrick et al. 2009) suggests that different conceptions of psychopathy emphasize three observable characteristics to varying degrees: boldness (low fear including stress-tolerance, toleration of unfamiliarity and danger, and high self-confidence and social assertiveness), disinhibition (poor impulse control, including problems with planning and foresight, lacking affect and urge control, demand for immediate gratification, and poor behavioral restraints), and meanness (Lacking empathy and close attachments with others, disdain of close attachments, use of cruelty to gain empowerment, exploitative tendencies, defiance of authority, and destructive excitement seeking).

Finally, the *Self-Report of Psychopathy–Short Form* (SRP-SF) (Neumann and Pardini 2014; Paulhus et al. 2015). Derived from and shown to correlate highly with the PCL (2003), the SRP was developed for use in nonforensic populations as a practical and brief method to assess psychopathic traits. The latest version of this scale contains twenty-nine items and may provide an efficient method of measuring psychopathic traits among larger samples. The items are grouped into four dimensions of psychopathy: affective callousness, interpersonal manipulation, antisociality, and erratic lifestyle.

Despite the interest of these tools, I formulate my critical discussion on the basis of the PCL-R alone, as it remains the reference tool in criminological and psychopathological assessments in the field of forensics. I also specify that none of these tools falls within the scope of psychopathological phenomenology. Let's now discuss Cooke et al.'s criticism of the PCL-R's factor structure, and particularly the presence of antisocial characteristics in the diagnosis of psychopathy (this critique is also not made from a phenomenological point of view).

Critique of the Presence of an Antisocial Dimension

Cooke et al.'s work (Cooke and Michie 2001; Cooke et al. 2004, 2007, 2012) stimulated a lively debate on whether antisocial behaviors are or are not necessary in characterizing a subject as a psychopath (Patrick 2006; Vitacco 2007). This ambiguity already existed in the work of Schneider (1923) and Cleckley (1941). However, Cleckley was the researcher who most clearly considered the possibility of a diagnosis of psychopathy without the presence of antisocial or illegal behavior (Cleckley 1941; Patrick 2006).

of manic *being-in-the-world* (Binswanger 1960).² His thesis is that, in manic subjects, a disorder affecting the constitution of the alter ego coexists with a disorder of the constitution of the ego, or I:

If in mania the alter ego is not completely constituted, and thus remains largely a stranger, or even a strange thing—a mere object taken, pushed aside and rejected, used and consumed by something—then the causes are naturally not in the alter ego but in the ego.

(Binswanger 1960: 93; my translation)

This observation is critical since it presents mania as a subclass of psychosis, which Binswanger considers, based on Husserl's work, as a failure of "appresentation" [Appräsentation]. When two people meet, "what is present to us is different but is accompanied by the same appresentation" (Binswanger 1960: 75). These two people share a set of common representations that allow them to consider each other as an *alter ego* and to share a common world. Thus, in Binswanger's understanding of the term, appresentation is an intersubjective, intuitive, and precognitive phenomenon that enables one to form relationships and that must necessarily be shared by the various partners. This a priori is crucial for the sharing of common meaning and natural self-evidence in social exchanges. It is precisely this faculty that is said to be deficient in psychotic pathologies (including mania).

Binswanger cites the example of one of his manic patients, Elsa Strauss, who entered a church and interrupted the ceremony to compliment the pianist and ask him for private lessons, offending the whole congregation. Words and actions, taken out of context, are not fundamentally incoherent or delirious, but they show a "failure of appresentation in mania and . . . the impossibility of constituting a common world" (Binswanger 1960: 78). The essence of psychosis in Binswanger's view is to escape this implicit common appresentation. This thesis can be superimposed on modern concepts of psychosis according to phenomenological psychopathology (Parnas et al. 2002; Stanghellini 2004; Sass 2014). For Binswanger, the manic reification of the other and the problem affecting the alter ego can be situated in a disorder affecting a psychotic ego. The determining factor in discriminating between manic and psychopathic subjects is at this level: the former have a disorder of the constitution of the alter ego explained by a disorder of the ego, while the latter have the same disorder but with an intact ego.

The Core Characteristic of Psychopathy: Reification of Others Without an Ego-related Disorder

The major difference between manic and psychopathic reification of the other is clearly identifiable by clinicians. For manic patients, other people are just a casual means of implementing their own projects, of enjoying themselves or their grandiosity. Their instrumentalization of others is direct, clearly pre-reflexive, even "naïve."

They do not even try to imagine what goes on in other people's minds, because this does not play a role in their projects. Their empathetic awareness of other people is non-existent

² For an overview of the concept of *being-in-the-world*, refer to selected papers of Ludwig Binswanger (1963) and for a presentation of the manic mode of *being-in-the-world*, see Broome et al. (2013: 197–203).

(however, they can also be exquisitely sensitive to the emotions of others and can feel responsible—in a grandiose way—for all of their suffering). In contrast, for psychopaths, other people are a means of gaining power and pursuing their goals in a cold, insidious way. Their instrumentalization of others has a reflective, well-thought-out component, which is somewhat “Machiavellian.” They may well use imagination and “theory of mind” in order to deceive, lie, and misuse others to achieve their own ends.

Thanks to Binswanger’s analysis of the crisis of the ego and the alter ego, we can refine this description. The radical and fundamental difference between manic and psychopathic subjects is that the latter do not present problems with the ego or I; to put it more simply, they do not have psychotic symptoms. A psychopath presents a disorder affecting the alter ego, via the reification of others (a symptom shared with manic subjects) but without presenting an ego-related disorder (a symptom not shared with manic subjects). Unlike a manic subject, a psychopath is able to maintain a stable ego and a coherent identity while still reifying others. For the psychopath, the alter ego problem is not secondary to a problem with the ego in its function as an appresentative structure.

Now let us reconsider the twenty items of the PCL-R. Based on the recommendations of the CAPP (Cooke and Michie 2001; Cooke et al. 2004, 2007, 2012), I eliminate the so-called secondary items, which are less relevant to a psychopathological approach. The remaining thirteen items are as follows: 1. *Glibness and/or superficial charm*; 2. *Grandiose sense of self-worth*; 3. *Need for stimulation and/or proneness to boredom*; 4. *Pathological lying*; 5. *Conning and/or manipulative*; 6. *Lack of remorse or guilt*; 7. *Shallow affect*; 8. *Callous and/or lack of empathy*; 9. *Parasitic lifestyle*; 13. *Lack of realistic, long-term goals*; 14. *Impulsivity*; 15. *Irresponsibility*; 16. *Failure to accept responsibility for own actions*.

The semiological picture presented above describes manic subjects just as well as psychopaths. Needless to say, I don’t think these two diagnostic entities are the same. Because it limits its analyses to a survey of interpersonal and affective dimensions considered as isolable signs, and does not provide a structural and psychopathological synthesis, this model is unable to explain the difference between mania and psychopathy.

Still, in the light of Pinel’s proposal to consider psychopathy as “insanity without delusion” [*manie sans délire*], we should not be surprised by this finding. The overview of Binswanger’s work highlighted that the difference between mania and psychopathy is located not really at the level of strictly behavioral signs but at the psychopathological level, based on the essential dialectic between the alter ego and the ego. Hence the decisive affiliation of mania with psychosis and not that of psychopathy. The latter should be considered a personality disorder. This allows us to remember that, of course, these two disorders are fundamentally and essentially different from a psychopathological point of view and with regard to their respective mode of *being-in-the-world*.

Adapted?: Is Psychopathy a Generalized Maladaptation?

One of the problems in understanding psychopathy may be to immediately consider it as a disorder (Cutting 2012; Englebert 2013), without further thought, and thus viewing it a priori as a maladaptation. For evolutionary psychopathology (De Block and Adriaens 2011; Brüne 2008; McGuire and Troisi 1998; Stevens and Price 2000; Demaret 2014), many behaviors considered to be pathological must have an adaptive value in the original environment in

which the morphology and psychology of our species were shaped. A change in time (a behavior in another era) or space (a behavior in another context, or social, cultural, or economic situation) may make a symptom appear adaptive (e.g. anorexia nervosa in times of famine). Regarding psychopathy, one might suggest that:

The social function of psychopaths depends on conditions in the environment. In times of peace, we lock them up; in times of war, we count on them and cover them with medals.

(Demaret 2014: 29; my translation)

Classically (Schneider 1923; Cleckley 1941; Hare 2003), psychopathy is associated with a general or specific emotional deficit, affecting the processing and production of emotion. Basic research tends to partially disconfirm this hypothesis (Poythress and Hall 2011; Brook et al. 2013; Casey et al. 2013; Maes and Brazil 2013; Bird and Viding 2014). Although the emotional dimension is considered to be the basis for the process of adaptation and social interaction and is assumed to have a regulating function (Sartre 1939; Fuchs 2013; Englebert 2013), the hypothesis that psychopaths have an emotional deficit is contradictory. I suggest instead that psychopaths are able to understand and manage emotional phenomena. This conception is in opposition to the “poor,” “narrow,” and “immature” emotional life attributed to psychopaths (Schneider 1923; Cleckley 1941; Hare 2003). It corresponds to the adaptive conception considered by Demaret (2014). In times of war, the psychopath does not suddenly regain the emotional competence he had lost in times of peace.

Emotional Coldness

“Emotional coldness” must be distinguished from “emotional deficit.” Emotional coldness, if we can agree on a definition, is clearly one of the fundamental clinical signs of psychopathy. Hare (2003) defines emotional coldness as one of the four facets of psychopathy (and thus an essential trait). I agree with this claim. He then defines it with four items: *Lack of remorse or guilt* (item 6), *Shallow affect* (item 7), *Callous and/or lack of empathy* (item 8) and *Failure to accept responsibility for own actions* (item 16). This second point is not satisfactory because Hare’s definition does not perfectly delimit the concept. Emotional coldness should instead be considered a way of managing emotional manifestations calmly and coolly, without precipitation. (This is difficult to relate to item 14 of the PCL-R, “impulsivity,” which describes antisocial subjects but not true psychopaths, strictly speaking.) Emotional coldness is a preferred method of managing emotion calmly and keeping some distance, as well as a tendency to take the time to analyze emotional experiences triggered in oneself or in others. This tendency should not be considered as being more or less adaptive, effective, or pathological than a “warm” emotion management style (tendency to react faster, by trial and error, “naturally,” or “romantically”). It is probably more profitable to have a preferred method (a style) of emotion management than to manage emotion in a more random, less coherent way. Depending on an individual’s social, relational, or professional situation, it may be more adaptive to manage emotions either “coldly” (political leader, emergency physician, etc.) or “warmly” (group facilitator, performing artist, etc.). This means that the emotional coldness generally attributed to psychopaths may be considered partly as an adaptive

advantage, which can also be found in numerous people who have no personality disorders or social or emotional deficits.

Bad?: Empathy or Sympathy Disorder?

Psychopaths are generally said to have an empathy deficit (Hare 1999; Decety et al. 2013). Once again, it is necessary to define this concept. If we examine the definition more closely, we can see that a psychopath does not actually have an empathy disorder but a sympathy disorder. This difference is crucial as it enables us to distinguish between psychopathy (sympathy disorder) and schizophrenia (empathy disorder).

The concept of empathy is evoked so often that researchers often forget to define and analyze it. Some researchers with philosophical background point out that empathy is actually a phenomenon that is very difficult to delimit, and when closely examined, complicated to define (Stein 1989; Scheler 2008; Zahavi 2005, 2011). The most widely accepted definition can be summarized in this way: it is the psychological mechanism whereby an individual manages to intuitively represent another person's emotional experience or suffering. In this definition, the concept of empathy does not consider the subject's response to this representation. It is therefore a "representational ability" that allows for "understanding of others." It can be differentiated from sympathy, the object of which is other people's well-being (Scheler 2008; De Waal 2008; van der Weele 2011). Empathy is related to intuitive, implicit understanding and knowledge. Sympathy involves compassion and attention to others' well-being.

Empathetic knowledge is not "intellectual." Rather, it is a kind of intuitive, implicit knowledge that arises immediately when we meet another person. This is a primary form of intersubjectivity based on bodily expression and intercorporeality. This "implicit empathy" underlies social exchanges (Stanghellini 2004; Englebert 2013). In addition to this *pre-reflexive* tendency, psychopathologists develop a method of understanding other people's experiences. This "conative empathy" is a *reflexive* and *explicit* practice used to promote the development of intersubjectivity between the clinician and the patient. We can distinguish between two "kinds" of empathy: the clinician's (conative and explicit) and the patient's (implicit).

The investigation of implicit empathy needs to go into more depth in the case of psychopathy. A disorder affecting empathy (considered as the faculty of representing other people's experiences at the emotional, sentimental, or cognitive level) leads to a diagnosis of schizophrenia, rather than psychopathy. From this point of view, we must formally reconsider the hypothesis that psychopaths are affected by an empathy deficiency. On the other hand, it seems very possible that they have a "sympathy disorder." A psychopath has no difficulty identifying other people's feelings and experiences (unlike a person with schizophrenia), but he finds them completely irrelevant, as is other people's well-being. The analysis of other people and their experiences is strictly utilitarian and is unrelated to concern for or attention to their well-being. For example, a psychopath can describe his victims' suffering (showing evidence of empathy) but can coldly explain that they are of no importance to him (he feels no sympathy). Generally, psychopaths know that other people are bundles of emotions but they never "lose themselves" in this affective experience. A psychopathic rapist said about his victims: "What do you want me to say? That won't change anything for them. Maybe it did hurt them, but how do you expect that to change things for me? . . . What I think now

won't change anything about their situations or mine"; "I can well understand when other people want to express their feelings but it's got nothing to do with me. What other people feel isn't important to me" [Source: own clinical experience]. This sympathy disorder, which takes the form of being able to imagine other people's emotional experiences without being affected by them, may obviously overlap with the emotional coldness discussed above.

This new way of considering psychopathic affectivity has an impact on clinical practice but also on the field of research (Englebert 2015). The relationship the psychopath has with emotions should not be considered a mere deficit but, from a certain point of view, an individualistic adaptive advantage. Discrimination between empathy (psychopathic competence) and sympathy (not a psychopathic skill) points out some weaknesses in diagnostic tools such as scale Hare (Hare 2003), but also, for example, allows to reconsider an expanding field of study such as the dimensions of Callous-unemotional traits in individuals at risk of developing a psychopathic personality, especially among adolescents (Bird and Viding 2014; Frick et al. 2014; Henry et al. 2016; Muratori et al. 2016). The proposals developed in this article may suggest that the unemotional intrinsic dimension should be discussed again through a complex consideration and take into account the discrimination between emotional understanding of others (empathy) and emotional response to them (sympathy).

CONCLUSION

The purpose of this article was to examine psychopathy and the classical approaches to evaluating it through the lens of phenomenological psychopathology. Despite some behavioral similarities, the psychopathological analysis allowed us to distinguish between mania and psychopathy, to restore to psychopathy the emotional competence it had been considered not to have, and to differentiate between empathy and sympathy. The adaptive qualities that have been preserved, consistently with the mastery of empathy, do not preclude a moral disorder via the loss of sympathy for other people. Finally, this phenomenological study enabled us to identify a fundamental structural characteristic of psychopathy, namely the ability to reify other people and to keep one's own ego intact.

The tools of phenomenological psychopathology gave us the means to identify the structuring and characteristic elements of psychopathic functioning and to point out the shortcomings of contemporary nosographies and theories related to this specific entity. Resorting to structural-phenomenological methods proved essential for not reducing this condition to a mere maladaptation or to an (emotional) deficit, and to try to understand the *being-in-the-world* of these particular patients.

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