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WASHINGTON UNIVERSITY IN ST. LOUIS
Department of Philosophy-Neuroscience-Psychology

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Moral Pathology
by
Katherine Rapier

A dissertation presented to
The Graduate School
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

May 2019
St. Louis, Missouri

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Washington University in St. Louis

May 2019

For Elliott.

ABSTRACT OF THE DISSERTATION

Moral Pathology

by

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Doctor of Philosophy in Philosophy-Neuroscience-Psychology

Washington University in St. Louis, 2019

Professor John Doris, Chair

This dissertation explores the relationship between morality and mental illness. Mental illness is often thought to impair moral functioning but careful examination reveals that mental illness offers its own insight into moral functioning. While we learn a great deal about moral responsibility and exempting conditions (psychopathy and addiction), we also discover that there are multiple ways to be moral and that many individuals act morally despite ongoing conditions (high-functioning autism spectrum disorder and recovered borderline personality disorder). I conclude that these insights ought to shape our ethical theories.

Chapter 1: Introduction – Dimensions of Moral Pathology

“But imagine this though. Imagine having a mood system that functions essentially like weather – independently of whatever’s going on in your life. So the facts of your life remain the same, just the emotional fiction that you’re responding to differs. It’s like I’m not properly insulated – so all the bad and the good ways that you and most of the people in adjacent neighborhoods and around the world feel – that pours directly into my system unchecked. It’s so fun. I call it ‘getting on my grid’ or ESP: Egregious Sensory Protection. But ultimately I feel I’m very sane about how crazy I am.”

Carrie Fisher (2008, p. 113-114)

1.1 Introduction

Carrie Fisher described her experience with bipolar disorder like being visited by a disjointed, almost whimsical intruder that disrupted her sense of narrative unity and subjected her to an onslaught on intense, impersonal emotions. Sasha Chapin (2016) experienced the same condition as central to his identity and mourned its loss when he began taking medication: “while there are lots of hard, simple words that encase identity...psychiatric diagnoses feel more fundamental...not being that [bipolar] anymore has flattened the extremities of my life. The biggest sensations of my life are over.” While individuals and clinicians alike may disagree about whether or not mental illness should define one’s identity, evidence clearly indicates that most conditions profoundly influence one’s behavior. Fisher (2008) attributed the dissolution of her first marriage and several subsequent relationships as well as multiple stays in drug rehabilitation facilities to not having a proper diagnosis or treatment plan. Chapin (2016) admits that he almost ended his life, had periods where he ate little to no food, and was an inattentive partner prior to taking medication to manage his bipolar disorder.

I am interested in how mental illness affects behavior – specifically, moral behavior. The study of mental illness and morality has been mostly neglected by the philosophical literature

with psychopathy being a notable exception. Approximately 26-33% of adults worldwide will meet criteria for one or more mental illnesses at some point in their lives (Steel et al., 2014). The frequency of mental illness alone makes the study of morality and mental illness worthwhile, but this endeavor will also produce insights about human moral functioning more broadly.

To mine these insights we must dive into the technical and empirical components of diagnosis and treatment of mental illness. Each chapter of this dissertation focuses on a different condition, analyzes its symptoms, treatment, and psychological data in order to cultivate moral insights. To understand the relevance of this process we must first understand the symptoms of mental illness as a dimension of typical functioning rather than a distinct category.

1.2 Dimensional versus Categorical

When writing the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) the American Psychiatric Association (APA) assembled a number of committees to discuss potential revisions. One of the topics under consideration was structural in the sense that it did not involve any disorder in particular but the formulation of the manual itself. Early editions of the DSM treated mental illnesses as categorical: an individual is depressed or she is not, an individual has schizophrenia or he does not. There was no room for gradations of severity or gray areas. Over time it became clear that many conditions would need additional specifications. In 1994, Asperger's syndrome was introduced in the DSM-IV to distinguish between individuals with significant language, cognitive, and social impairments and those with high-functioning autism, for example (Ozonoff, South, & Miller, 2000).

By the time the DSM-5 was in the early production stages, some disorders were already calling themselves spectrums, including autism spectrum disorder and the schizophrenic spectrum. The ideology behind a spectrum disorder was that there were not discrete conditions of

varying severities or symptoms but rather one disorder with unifying symptoms on a sliding but continuous scale of severity that could be measured by degree. There is no diagnostic precision in labeling one child autistic and another pervasively developmentally delayed based on a couple of IQ points when both clearly need similar services. While most disorders are not formally spectrum conditions, the introduction to the DSM-5 encourages clinicians to use dimensional approaches during diagnosis (APA, 2013). Under this approach, an individual who is recovering from depression may not have the required number of symptoms for diagnosis (categorical approach) but the dimensional approach allows the clinician to see that she still needs support as she works through the subclinical symptoms.

Extending the approach even further we can begin to understand the relationship between mental illness and typical functioning. Returning to the example of depression, an individual recovering from depression – let's call her Sofia – may still suffer from subclinical symptoms (e.g. has trouble sleeping once or twice a week rather than everyday, feeling down but not depressed most days, etc.) even if she does not meet full criteria for the disorder. It seems inaccurate to say Sofia still suffers from depression yet equally ill-fitting to claim that she belongs in the same category as someone who experiences no subclinical symptoms. To properly classify Sofia's experience (and others like her) it is best to understand depression as a dimensional scale ranging from common experiences of intermittent sadness and trouble sleeping, grief, etc. and severe symptoms of feeling depressed all day everyday, chronic insomnia, suicidal thoughts and actions, and other symptoms. The diagram below illustrates this idea and indicates where we might place Sofia along the dimensional continuum.

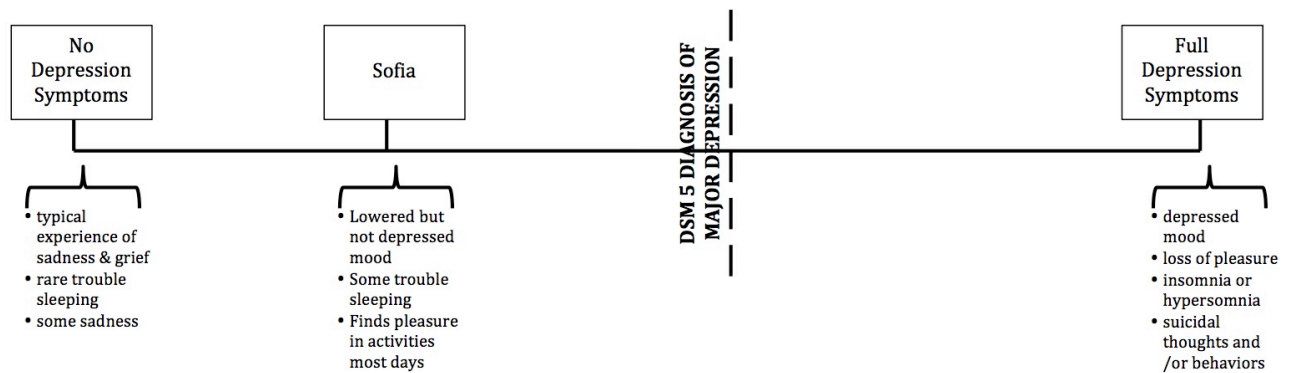


Figure 1: Dimensions of Major Depression

Note that along the continuum Sofia is much closer “No Depression Symptoms” than “Full Depression Symptoms.” She also falls to the left of “DSM-5 Diagnosis of Major Depression” which means that she does not meet criteria for the disorder. The line is dotted because the exact point at which someone meets criteria for the disorder is vague and may vary slightly depending on who is diagnosing the condition. Moreover, the dimensional model is not designed to promote an abrupt cut-off point for diagnosis, allowing clinicians to use their judgment.

This continuum demonstrates that individuals with no depression symptoms are incrementally related to individuals who meet criteria for major depression and even individuals who experience full depression symptoms.¹ While it is tempting to think of individuals with depression as wholly disparate from individuals without depression symptoms, the dimensional approach demonstrates that we are all related to individuals with major depression and many other mental illnesses. We all experience a depressed mood, difficulty sleeping, fatigue during times of stress, etc. from time to time. Similarly, we occasionally experience periods of intense worry, irritability, and restlessness but most people do not meet criteria for generalized anxiety disorder (APA, 2013). More generally, very few of us are perfect emotion regulators or

¹ Experiencing “Full Depression Symptoms” is logically possible but highly unlikely, especially since major depression includes contradictory symptoms such as “hypersomnia” and “insomnia.”

especially good at navigating interpersonal relationships. All of these qualities bring us closer to a variety of mental illnesses, particularly conditions that affect moral functioning.

1.3 Moral Functioning and Mental Illness

Again, it is important to emphasize that it is not merely meeting criteria for mental illness that affects moral functioning. Individuals with borderline personality disorder (BPD), for instance, experience an extreme fear of abandonment (APA, 2013). This fear can motivate immoral behavior, such as a partner interfering with their spouse’s promotion at work because they fear that the advancement will lead to infidelity. Individuals without BPD may also experience a fear of abandonment, either pathologically or on non-pathologically. Take Ji-hu, for example, who has been searching work for the past six months to no avail. He has been dating his partner for a year and is worried his lack of employment will cause his partner to leave. His partner reassures Ji-hu that they are still very much in love and that Ji-hu’s unemployment does not bother him. Nonetheless, Ji-hu worries his partner will leave him for someone more successful. Ji-hu’s fear of abandonment does not seem pathological but it is clear that he has some fear of abandonment. We might also think of individual symptoms dimensionally:

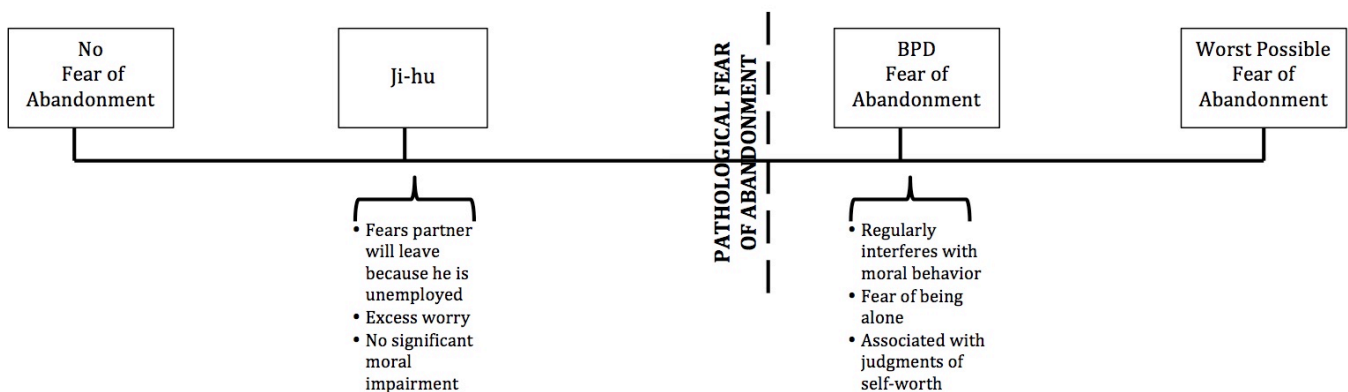


Figure 2: Dimensions of the Symptom “Fear of Abandonment”

This continuum differs slightly from the diagram used to describe the relationship between mental illness and no mental illness. The logical end points serve as mere bookends rather than anything practically useful. The BPD symptom lies just past the threshold for “pathological fear of abandonment” while Ji-hu lies well below. You can imagine someone with even less fear of abandonment than Ji-hu lying somewhere between Ji-hu and “no fear of abandonment.” While Ji-hu’s fear of abandonment causes very little interference with his moral functioning (e.g. perhaps his worry pulls away his attention from some morally relevant responsibilities), the fear of abandonment experienced by those with BPD can be very detrimental. The dimensional model demonstrates that this symptom is not all or none and that most of us, like Ji-hu, experience some fear of abandonment that can impede our moral functioning to some degree.

As I mentioned in the introduction, mental illness affects approximately one-third of the population at some point in their lives. If this is not compelling enough, then the dimensional ties to the other two-thirds of moral agents should be convincing. By carefully studying mental illness – symptoms, treatments, case studies, effects on emotional, social, and cognitive function – and morality – moral responsibility, normative theories of praise and virtue, agency – we can discover new ways in which our psychological functioning impacts moral functioning. In this dissertation I explore four conditions in depth: psychopathy, addiction, borderline personality disorder, and autism spectrum disorders. In the following section I will briefly describe the plan for each chapter.

1.4 Four Conditions

I chose to focus on these four conditions because they overtly impact moral functioning. While the symptoms of borderline personality disorder have devastating consequences for

emotional, social, and intrapersonal functioning that cause clear moral harms (more on this below), the symptoms of disorders like bipolar disorder, obsessive compulsive disorder, and post-traumatic stress disorder (while harrowing for the individual and their loved ones) influence moral functioning much more subtly. Carrie Fisher attributes the dissolution of her first marriage to her bipolar disorder but the causal relationship is unclear. Was it the days of depression where she could not get out of bed and fulfill the promises she made to her partner? Or was it the manic episodes where she was excessively irritable and treated her partner poorly? We could speculate why she blamed herself but with a condition like bipolar the moral consequences are much harder to connect back to the symptoms of the disorder.

On the other hand, we might think of someone who meets criteria for BPD and also sees his marriage come to an end. It is clear that Michael is morally responsible for the end of his marriage because of his tendency to lash out violently at his partner, often causing serious physical harm. Not all cases of BPD will be this clear-cut but as the chapter demonstrates, BPD is a disorder with symptoms that directly impact moral functioning. Again, I do think most mental illnesses impact moral functioning but it makes sense to focus on the clearest cases.

1.4.1 Psychopathy

There is perhaps no clearer case of mental illness affecting moral functioning than the case of the psychopath. Psychopathy is not an official DSM diagnosis; rather, it is a classification developed by Robert Hare and colleagues (1990) to describe a subset of individuals with antisocial personality disorder. I describe the condition in depth in the chapter but briefly: psychopaths are impulsive, callous, and often criminal. They appear to act without any regard to moral rules and are often described as “amoral”. Some philosophers have argued that psychopaths suffer from a rational deficit: Maibom (2005) claims that psychopaths struggle with

practical reasoning which includes tasks like making plans, assessing one's own abilities, and moral reasoning. Others like Caouette (2013) argue that psychopaths are motivationally deficient: they are less motivated than non-psychopaths to act morally. While some psychopaths may suffer from deficits in practical reasoning (and other cognitive functioning) as well as motivation, I argue that these deficits do not get at the heart of the *moral* deficit characteristic of the disorder: psychopaths are incapable of compassion.

The idea that psychopaths do not feel compassion is supported by empirical literature and helps explain the kind of immoral behavior we see from this population. A psychopath without significant intellectual deficits may keep up appearances, following some of society's moral rules for the sake of their own convenience. John Grambling Jr., a successful businessman to all his peers and clients, tricked his sister into signing a \$4.5 million mortgage, took the money, and left her in debt. At home he was tyrannical and his wife feared for the family's safety (Rosner, 1990). Grambling felt nothing for his sister, his wife, or his children but was motivated to behave collegially at work to promote his business career.

I conclude that psychopaths exhibit the importance of compassion in moral functioning by virtue of its absence. Compassion is not merely an emotion; it is our capacity to detect morally-relevant cues in the environment. Compassion allows us to see a financial arrangement with our sister as more than an opportunity to make money. With compassion we understand the potential suffering we can cause by ripping someone off or engaging in deceptive practices. Compassion does not guarantee that we will choose the morally right action, but it allows us to flag the situation as moral and distinct from non-moral situations.

1.4.2 Addiction

The chapter on addiction takes a different approach than psychopathy. Over the past century addiction has gone from a highly moralized disorder (i.e. something like a weakness of will for which the agent should be blamed) to being understood as a clinical disease (i.e. addiction is something that happens to you, no blame). When talking to addicts, however, I found that many want to be held responsible for their condition. Addiction can lead to any number of immoral actions, from those done in pursuit of additional substances (e.g. stealing money from family members) to those done under the influence of substances (e.g. driving while drunk). Unlike psychopaths, individuals with addiction can and often do feel genuine guilt for their actions. Moreover, they are often motivated to recover from addiction and act morally.²

The DSM-5 divides addiction into separate disorders based on substance. In my chapter I generalize across substances – from nicotine to narcotics – and focus on five general components listed in the DSM: impaired control, social impairment, risky use, tolerance, and withdrawal (American Psychiatric Association, 2013). I argue that many cases of addiction are caused by deficits in emotion regulation and that these deficits exempt individuals who suffer from addiction from moral responsibility. We use emotion regulation to deal with challenging life circumstances which may include difficult coworkers, the death of a loved one, breakups, or bad traffic. Emotion regulation allows us to respond to these situations with the appropriate amount of emotion: we grieve our loved ones rather than shutting down, we engage with the painful emotions of a breakup rather than simply getting angry, and so on. Substances provide an alternative to dealing with our emotions appropriately. Utilizing empirical data, I argue that

² Compared to psychopathy which is not curable. Psychopaths do not usually want to be cured or overcome their morally relevant deficits.

many individuals suffering from addiction cope with difficult situations and emotions through substances rather than effective emotion regulation strategies.

Individuals with addiction who learn emotion regulation strategies in treatment programs experience better outcomes than individuals who do not learn emotion regulation strategies (Hopwood et al., 2015; Tull et al., 2012; Axelrod et al., 2011). Addiction demonstrates that emotion regulation is a capacity necessary for moral functioning. I expand upon Vargas's (2013) view of moral responsibility and argue that emotion regulation is another psychological capacity needed for full moral functioning.

1.4.3 Borderline Personality Disorder

The discussion of "fear of abandonment" demonstrated one way that the symptoms of BPD can influence moral functioning. BPD is a chronic mental illness affecting social, emotional, and cognitive functioning as well as the stability of one's identity (APA, 2013). BPD can make it difficult to keep a steady job, maintain relationships, and sometimes leads to criminal behavior. While I argue that individuals who meet criteria for BPD are not morally responsible for their actions, the bulk of my discussion is devoted to the unique characteristics of individuals in recovery from BPD. I argue that these individuals are morally responsible for their actions and pose a unique challenge for virtue ethics.

Recovery from BPD is a continual, arduous journey that requires adept emotion regulation to manage mood swings and heightened anger, carefully practiced interpersonal skills to combat relational turmoil, and more. Because of the extra effort required to manage their symptoms, the individual in recovery from BPD does more than the typical moral agent to perform the same moral actions. These extra efforts, however, mean that individuals in recovery from BPD are not capable of achieving virtue according to most virtue theories. Virtuous activity

is supposed to come with little or no difficulty to the virtuous agent. Individuals in recovery from BPD, unlike virtuous agents, often find virtuous activity extremely difficult.

I argue that despite the traditional methodologies, individuals in recovery from BPD are virtuous and that our virtue theories should be revised to accommodate diverse moral psychologies. Unlike the previous chapters, the BPD chapter does not illuminate a deficiency in moral functioning to illustrate the importance of any one psychological capacity; rather, it shows how mental illness can expand our understanding of what it means to be morally excellent.

1.4.4 Autism Spectrum Disorders

Symptoms of autism spectrum disorders (ASD) affect social, sensory, and cognitive functioning. The severity of symptoms varies widely: some individuals live independently and pursue competitive careers while others require lifelong assistance. These symptoms may make moral functioning more challenging but unlike psychopathy, addiction, and BPD, ASD does not seem to impact moral functioning in any unique way. Individuals with severe cognitive deficits may be exempt from moral responsibility but this is not unique to ASD. Conditions like intellectual disability, Alzheimer's disease, traumatic brain injury, and even some presentations of psychopathy also feature severe cognitive impairments (APA, 2013) that intuitively mitigate or exempt the individual from moral responsibility.

Instead I focus on individuals without severe cognitive impairments. These individuals are considered high-functioning (HFASD). I argue that individuals with HFASD should be held morally responsible for their actions. My view focuses on the capabilities of individuals with ASD rather than any moral deficits. Unlike psychopaths, individuals with HFASD are capable of empathy though they may encounter challenges expressing it. They experience deficits in social functioning that may make it harder to come up with the right words of comfort in a difficult

situation. I argue that these challenges to implement empathic actions but do not affect moral responsibility. As I have argued elsewhere, empathy motivates moral actions when we recognize the suffering of another and feel a desire to help (see Cameron and Rapiet, 2017). Individuals with HFASD can recognize the suffering of another, feel a desire to help, and act morally. The symptoms of HFASD may make it more difficult to discern which actions to implement. I argue that these differences in moral functioning do not prevent an individual with HFASD from acting morally in most cases.

Unlike cases of emotional fatigue or compassion collapse, symptoms of HFASD do not cause the individual to ignore the suffering of another or fail to implement a moral action. The social deficits in HFASD can prevent the individual from having epistemic access to information about the morally appropriate action. I suggest that these cases are rare and that in most instances individuals with HFASD can detect suffering and implement moral action. We should treat these failures of epistemic access the same as encountering novel, difficult moral situations. For example: you perceive that a colleague is suffering from financial problems because he no longer attends office lunches or contributes to group gifts. You understand that he is in distress and are motivated to help. You do not know him well enough to ask about his troubles nor is it socially appropriate to collect money on his behalf. It is unclear what action morality requires and doing nothing does not seem necessarily blameworthy. Similarly, an individual with HFASD realizes a friend is suffering after the loss of a loved one. The individual with HFASD feels sorrow for her friend but has never lost a loved one herself. She feels for her friend, is motivated to help, but does not know what to do. Again, it seems that the individual with HFASD is not morally blameworthy for not knowing what to do.

While psychopaths are incapable of feeling for another, individuals with HFASD feel empathy but experience social and communication deficits that can make moral action more challenging. These challenges are not distinct from the difficulties we all face when navigating the moral landscape. We all, at times, fail to identify the proper moral action due to barriers in epistemic access. Imperfect knowledge does not lessen our moral responsibility.

1.5 Conclusion

This dissertation features four mental illnesses – psychopathy, addiction, borderline personality disorder, and autism spectrum disorder – and their relationship with moral functioning. The philosophical assertions are supported by empirical findings as well as the words of individuals who experience the conditions. These words are especially important in capturing the experience of living with mental illness. While I take this project to be an academic endeavor it is also a personal one for approximately 2 billion people worldwide who either have or will experience mental illness and countless others whose lives have been changed by the diagnosis of a loved one. That is why I have taken care to research each condition thoroughly, providing a fair and rigorous analysis. I have also spent clinical hours with individuals with substance use disorder and autism spectrum disorders. I have consulted at length with clinicians who treat borderline personality disorder and spent time unstructured time with individuals with this condition. Unfortunately I was not able to meet with psychopaths or clinicians in this area but I included more case studies in my background reading for this condition to compensate. This is not to say that there will not be complaints, concerns, and mistakes, only to show that I made a good faith effort.

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Chapter 2: “How did you feel the last time you squashed a bug?”³: Compassion, Moral Responsibility, and the High-Functioning Psychopath

2.1 Introduction

Robert Hare – a clinical psychologist who worked with criminal populations – once interviewed a man serving time for kidnapping, rape, and extortion. Discussing his crimes, the man said:

Do I care about other people? That’s a tough one. But, yeah, I guess I really do...but I don’t let my feelings get in the way... You’ve got to look out for yourself, park your feelings...Do I feel bad if I have to hurt someone? Yeah, sometimes. But mostly it’s like... uh... [laughs]... how did you feel the last time you squashed a bug? (Hare, 1999, p. 33).³

Hare’s clinical evaluation ultimately determined that this man was a psychopath. Psychopaths are individuals, like the man quoted above, who meet clinical criteria for psychopathy – they may act impulsively, callously, and criminally. When people think of psychopaths, one (or both) of the following profiles comes to mind: a high-ranking business professional who functions well in society but who’s successful career was built upon cutthroat tactics and cold-hearted decision-making, or an inscrutable career criminal, who’s in and out of prison for most of his adult life for offenses ranging from murder and assault to petty larceny and check fraud.

These disparate profiles demonstrate why I divide psychopathy and other mental disorders into two categories: high-functioning and low-functioning psychopaths. Individuals with high-functioning presentations of mental disorders often “pass” as typically functioning

³ Quote from Hare (1990, p. 33) from a psychopath in prison for rape, kidnapping, and extortion.

adults – they hold steady jobs, maintain long-term relationships, and demonstrate competence in basic social interactions. The high-functioning psychopath, the CEO archetype, possesses callous and unemotional traits but does not experience other cognitive deficits. The high-functioning psychopath performs well in society – he is capable of caring for himself, holding a steady job, and pursuing serious romantic relationships.

Low-functioning presentations of mental disorders are characterized by mild to severe cognitive deficits, including low IQ scores, poor impulse control, and difficulties performing daily tasks. The low-functioning psychopath, the career criminal, may or may not possess callous and unemotional traits but does experience cognitive deficits, particularly in areas of executive functioning (e.g. planning, impulse control). The low-functioning psychopath may have difficulties adapting to adult responsibilities (e.g., paying rent, treating chronic health problems, obeying laws), jump from job to job (consistent with his prison record), and often experiences tumultuous temporary romantic relationships or marriages.

On many accounts, the low-functioning psychopath and individuals with low-functioning presentations of other mental disorders escape moral responsibility in the same way an individual with moderate intellectual disability (IQ < 52) might be exempt (Shoemaker, 2010).⁴ For the purposes of this dissertation, I will ignore the arguments concerning exemption for individuals with low-functioning presentations of mental disorders. I am more interested in cases where we are not convinced that an individual with a mental disorder meets cognitive deficiency criteria for exemption from moral responsibility or legal insanity – the individual with high-functioning autism spectrum disorder, borderline personality disorder, substance abuse disorder, and, for the purposes of this essay, the high-functioning psychopath. These individuals are often highly

⁴ Shoemaker (2010) argues that individuals with mild intellectual disability (IQ 52-69) are usually considered members of the moral community (p. 202).

successful, holding prestigious positions at universities or running business featured on the Forbes Global 2000. By nearly all definitions these individuals are competent to stand trial and face the legal consequences of their actions. But are they morally competent? More specifically, are high-functioning psychopaths morally responsible for their actions?

Many philosophers argue that it is the rational deficits present only in individuals that I have designated low-functioning psychopaths that mediate moral responsibility (Kennett, 2010). Caouette (2013), for example, argues that while it might be motivationally difficult for psychopaths to act morally, there is no evidence that they cannot act morally. High-functioning psychopaths in particular should be able to overcome this rational deficit and learn to act morally.

Despite their intellectual competence, I argue that high-functioning psychopaths should not be held morally responsible for their actions. High-functioning psychopaths are emotionally deficient. Specifically, high-functioning psychopaths are unable to pick up on compassion-relevant cues in the environment through emotional pathways. This deficit, on my view, prevents the psychopath from feeling the force of moral salience.

I begin by discussing the clinical criteria for psychopathy through empirical literature, highlighting the importance of deficits in compassion. Then I distinguish between high-functioning and low-functioning psychopaths. Next I discuss how compassion and responsiveness to punishment develop in typically developing human beings versus psychopaths. I then describe moral agency and moral responsibility, using Vargas's (2013) reasons-responsiveness account. I consider several consequences of this view and answer potential objections in Section 4 and conclude with Section 5.

2.2 Delineating Psychopathy

2.2.1 Emotional Insight versus Compassion

Psychological research suggests that psychopaths are fully capable of emotional insight – understanding the emotions of another (also known as cognitive empathy, mindreading, etc.). The same studies also conclude that psychopaths suffer from severe deficits in picking up on compassion-relevant emotional cues about the needs and interests of others. I use the term “compassion” to refer to an emotion and behavior (Cameron & Rapier, 2017). Specifically: “the feeling that arises in witnessing another’s suffering that motivates a subsequent desire to help” (Goetz et al., 2010, p. 351). Though the term “compassion” has recently been obscured by folk psychological intuitions and philosophical stipulations, I use “compassion” to refer to the ability to pick up compassion-relevant emotional cues in the environment and feel concern. For example, when I see a colleague at my office (environment) expressing distress (compassion-relevant emotional cue) over research deadlines, I identify his suffering (emotional insight), but also feel a sense of emotional concern for his plight. I feel compassion.

Psychopaths also demonstrate deficits in anxiety and fear processing (see below; also Dolan & Rennie, 2007). Some psychopaths exhibit difficulties in managing anger (Blackburn, 1988). Though this is much more readily apparent in low-functioning psychopaths whose angry outbursts often result in violent criminal behavior (e.g., Kiehl, 2014), high-functioning psychopaths can struggle with anger as well, as demonstrated by individuals like John Grambling, Jr. discussed in section 2.3 whose anger took a toll on his close personal relationships.

In the following subsection I discuss the empirical data in detail. Authors like Maiese (2014) argue that the “emotional” deficits in psychopathy are interdependent with cognitive

deficits; she denies the claim that we can meaningfully distinguish between cognitive and emotional processes like emotional insight and compassion sensitivity. I present empirical evidence that contradicts this claim.

2.2.2 Clinical Criteria for Psychopathy

Psychopathy is primarily diagnosed through Robert Hare's Revised Psychopathy Checklist (1990; see Levenson, Kiehl, & Fitzpatrick 1995, Morgan & Lilienfeld, 2000, and Blair, 1995). The Checklist is a semi-structured interview completed by a trained clinical psychologist, typically in an institutional setting. It includes items measuring traits and behaviors ranging from "criminal versatility" to "shallow affect" (Hare et al., 1990, p. 339). At first glance, the checklist seems to encompass a variety of symptomatic presentations. For example, someone may score highly on items like "need for stimulation" and "impulsivity" but fail to demonstrate symptoms like "pathological lying" and "conning/manipulating." After conducting a two-factor analysis of the items, Hare and colleagues found that 10 items correlated with the factor associated with "need for stimulation" and impulsivity" (p. 339). They found that 8 other items correlated with the factor associated with "pathological lying" and "conning/manipulating."⁵ For a discussion of moral agency and salience, I am interested in individuals who score highly on the 8-item-factor. I'll call this the interpersonal-affective factor.⁶

The interpersonal-affective Factor includes 8 items assessing the following traits and behaviors: "glibness/superficial charm," "grandiose sense of self-worth," "pathological lying," "conning/manipulative," "lack of remorse or guilt," "shallow affect," "callous/lack of empathy," and "failure to accept responsibility" (p. 339). The total score for these eight items ranges from 0

⁵ Astute mathematicians may have noticed that these two factors combined only account for 18 of the 20 items on Hare's Checklist. The other two items, "promiscuous sexual behavior," and "criminal versatility," did not correlate with either factor group.

⁶ In another essay, Hare and Neumann (2010) refer to four of the items as "interpersonal" and the other four as "affective," thus the name I give the combined factor.

to 16. Using the same proportions as Hare and colleagues used to determine the cut-off score for the entire Checklist, a score of approximately 12 would be clinically significant.⁷ Hare and colleagues identify this subset of psychopaths but do not name them. I will call individuals who satisfy this criterion Callous-Unemotional Psychopaths.

Schwenck and colleagues (2012) differentiated between two factors in Hare's (1990) Psychopathy Checklist, Factor 1 (affective/interpersonal deficits) and Factor 2 (executive functioning) (p. 339), to measure psychopathic traits in children with conduct disorder. Conduct disorder is diagnosed in childhood and can be understood as the developmental prerequisite for psychopathy.⁸ Conduct disorder is characterized by aggressive, violent, and dishonest behaviors, such as breaking into a building or physical/psychological cruelty towards persons or non-human animals (American Psychiatric Association, 2013). The disorder also has a "with limited prosocial emotions" specification, including "lack of remorse or guilt," "callous-lack of empathy," and "shallow or deficient affect" (American Psychiatric Association, "Conduct Disorder", 2013). Conduct disorder is a requirement for an adult diagnosis of antisocial personality disorder, though not all children with conduct disorder will meet criteria for antisocial personality disorder as adults. Note that not all individuals with antisocial personality disorders are psychopaths, but all psychopaths meet criteria for antisocial personality disorder (Hare, 1999). To address this confusion, the authors differentiate between conduct disorder with callous-unemotional traits and conduct disorder without callous-unemotional traits. Children in

⁷ A score of 30 is 75% of the maximum score of 40 on the full Revised Psychopathy Checklist. The maximum score for the Interpersonal-Affective Factor is 16; 75% of 16 is 12.

⁸ Note that all personality disorders require that the individual be eighteen or older. In other words, psychologists cannot diagnose a child with antisocial personality disorder even if they display psychopathic traits. This is where conduct disorder comes in.

the latter category are less likely to become psychopaths as adults.⁹ The authors evaluated callous-unemotional traits using the Inventory of Callous-Unemotional Traits (Kimonis et al. 2008).

The Inventory of Callous-Unemotional Traits closely resembles Hare's Factor 1 – the interpersonal-affective factor. Recall that Hare's Psychopathy Checklist is designed for clinicians to assess primarily incarcerated or hospitalized adults. Frick developed the Inventory of Callous-Unemotional Traits using the youth version of the Psychopathy Checklist and made modifications to measure psychopathic traits in children outside of the clinic. The Inventory evaluates participants along three traits/behaviors: uncaring (“I do things to make others feel good,” reverse-scored), callousness (“The feelings of others are unimportant to me”), and unemotional (“I do not show my emotions to others”) (Kimonis et al., 2008, p. 248). These traits align with four of the eight Interpersonal-Affective items on the Psychopathy Checklist, with uncaring tapping into “lack of remorse or guilt” and “grandiose sense of self-worth,” callousness tapping into “callous/lack of empathy,” and unemotional tapping into “shallow affect.”¹⁰

Schwenck and colleagues (2012) used the parental report version of the Inventory. Parents rated the items from 0 to 3, with 0 indicating that the trait/behavior does not describe their child. Total scores range from 0 to 72. The authors used the median score of the entire conduct disorder group (p. 32) and above to differentiate between individuals with and without callous-unemotional traits, and reported that this was similar to the cutoff used in previous studies (p. 652-653). Using this distinction and a comprehensive assessment for autism spectrum disorders, the authors assessed cognitive and affective empathy in children with high-functioning

⁹ A child who presents with the full spectrum of psychopathic traits is more likely to become an irrational psychopath, based on additional cognitive deficits outside the Inventory of Callous-Unemotional Traits.

¹⁰ Hinshaw and Zupan (1997) claim that symptoms of psychopathy vary throughout the lifespan. Given this insight and the developmental research presented in other sections, it makes sense that the Inventory of Callous-Unemotional Traits would not measure all of the factors assessed in the adult Psychopathy Checklist.

autism spectrum disorder, conduct disorder with and without callous-unemotional traits, and a control group.

The authors found no significant differences in emotional insight in the control group and both conduct disorder groups. The control group and both conduct disorder groups were able to correctly identify cognitively complex behaviors in the animated-shapes-task and were able to quickly recognize the emotional expression in the morphing faces task. Consistent with previous studies, individuals with high-functioning autism spectrum disorder performed more poorly than the control group and both conduct disorder groups on the animated-shapes-task (they identified the cognitive complex tasks less accurately) and the morphing faces task (they took longer to recognize expressions of sadness) (Schwenck et al., 2012, p. 655).

In the compassion sensitivity tasks, individuals with high-functioning autism spectrum disorder and conduct disorder without callous-unemotional traits performed comparably to control groups. Participants in the conduct disorder with callous-unemotional traits, however, were significantly less emotionally affected by the video clips than the high-functioning autism and control groups. (Schwenck et al, 2012, p. 656).

In a similar study Jones, Happé, Gilbert, Burnett, and Viding (2010) found that boys (ages 9-16) with psychopathic traits demonstrated deficits in compassion sensitivity but not emotional insight, while boys with autism spectrum disorder demonstrated deficits in insight but not sensitivity. Jones and colleagues (2010) used an emotional attribution task to assess affective empathy. Boys with psychopathic traits (as measured by Frick's Inventory of Callous/Unemotional Traits) responded less emotionally to written scenarios like "You made fun of a quiet girl you know and it made her cry. How *guilty* would you feel?" than boys with autism spectrum disorder (p. 1192).

Mullins-Nelson, Salekin, and Leistico (2006) also found a deficit in compassion sensitivity in individuals with high levels of psychopathic traits (as measured by the short form of Hare's Checklist) from an undergraduate population. Individuals with high levels of psychopathic traits scored lower on the empathic concern subscale of the Interpersonal Reactivity Index (self-report measure of empathy) and the shame and guilt subscales of the Test of Self-Conscious Affect (a scenario response-based assessment, similar to Jones and colleagues' (2010) methodology). As we will discuss in section 2.3, the developmental literature is essential to our understanding of compassion sensitivity in psychopathy.

Psychopaths also demonstrate deficits in fear responsiveness (Hoppenbruwers, Van der Stigchel, Slotboom, Dalmaijer, & Theeuwes, 2015; Dolan & Rennie, 2007; Birbaumer et al., 2005). Psychopaths do not respond to fearful stimuli in the same way as typically developing individuals. One hypothesis suggests this deficit is related to higher-order cognitive processes and attention. Psychopaths are not adequately sensitive to emotion-laden stimuli in their environment (Newman, Curtin, Bertsch, & Baskin-Sommers, 2010). This deficit has been robustly demonstrated in low-functioning psychopaths but has yet to be substantially studied in high-functioning psychopaths. While this deficit will likely support arguments in favor of excusing rational psychopaths from moral responsibility, the current data is insufficient.

2.2.3 CEOs and Serial Killers

Dividing psychopaths into two groups is a thorny task subject to many debates. Maibom (2008) denies that there is any meaningful distinction between "successful" and "unsuccessful" psychopaths. I should first note that I partially agree with Maibom: psychopaths in vivo do not divide neatly into two discrete categories. Nonetheless, the distinction allows us to talk about psychopaths with or without intellectual impairments. There is a significant difference between

individuals who score highly on the Psychopathy Checklist and present with other cognitive deficits versus individuals who score highly and function normally in society. As I mentioned in the introduction, low-functioning psychopaths are typically exempt from moral responsibility due to significant cognitive deficits. The notion of a high-functioning psychopath allows us to discuss how psychopathy mediates moral responsibility independent of comorbid cognitive or intellectual deficits.

High-functioning psychopaths are characteristically cunning, manipulative, and suave. One case of a high-functioning psychopath is John Grambling, Jr. Grambling and his associate stole \$23.5 million total from several banks by appearing good-natured and trustworthy. Grambling's social finesse allowed him to manipulate high-ranking bank officials to loan him money (Hare, p. 103). Not to confuse Grambling with some kind of Robin Hood – merely stealing from large corporations who (arguably) had the cash to spare and giving to the poor – he conned his family as well as corporations for personal gain. Grambling convinced his sister to sign a \$4.5 million mortgage only to run off with the money and leave her in debt. At home, Grambling was a terrible father, unfeeling and unavailable, and his wife feared for the safety of their children. The attorney that prosecuted Grambling, Brian Rosner (1990), sums up Grambling's character and the portrait of a greed-driven, high-functioning psychopath as follows: “the relentless drive to accumulate wealth; the use of people to obtain that end; the abandonment of all emotion and human attachment other than self-love” (p. 361).

Ressler and Burgess (1985) identify other characteristics of what they call an “organized offender”: social and sexual competence, average to above-average IQ, relative relational stability (“living with partner”), stable mood while committing the offense, and may have recently experienced a stressful life event, among others (p. 19). These traits describe Grambling

and a high-functioning psychopath. High-functioning psychopaths may work their way up to positions of authority in law, business, medicine, politics, or academia (Hare, p. 107). Because of their success, high-functioning psychopaths are more difficult to identify.

Unlike high-functioning psychopaths, low-functioning psychopaths are often caught and thereby identifiable through the justice system. Low-functioning psychopaths are commonly featured in the media through high-profile murder cases or horrific fictional portrayals. Low-functioning psychopaths often end up in prison, readily available for psychological and criminological research.

Now that we have a basic understanding of my use of “psychopath” in this essay and the difference between high-functioning and low-functioning psychopaths, I should clarify what I mean by compassion sensitivity. My discussion of compassion is grounded in the developmental literature. I cite psychological research that demonstrates that, unlike most other adults, psychopaths do not develop compassion sensitivity in childhood.

2.2.4 Burgeoning Psychopathy: The Developmental Trajectory

2.2.4.1 Compassion Sensitivity

Compassion allows human beings to recognize morally-charged situations. Compassion sensitivity allows an individual to detect another’s suffering and inquire about the cause. Human beings are not born with perfectly tuned compassion sensitivity; rather, typically developing individuals refine their compassion sensitivity throughout the lifespan.

According to Hoffman (2000), researchers observe signs of empathic distress in newborns. Most people are familiar with the image of a wailing nursery room at the maternity wing of a hospital: one infant starts crying, and before long all babies within hearing range chime in. This reaction, however, is simply emotional contagion. Emotional contagion is an automatic

response in which an observer imitates the emotions displayed by another (Coplan, 2011). Emotional contagion is distinct from compassion because emotional contagion does not involve genuine concern for the other. Children begin to show signs of burgeoning compassion sensitivity as early as ages two and three (Hoffman, 2000). Children will become distressed and demonstrate concern at the sight of a crying adult or peer, rather than merely mimicking the other's display of sadness. Though a young child's expression of compassion is cognitively simplistic, it is crucial to the development of the capacity for sophisticated compassion sensitivity.

Recall from the introduction: compassion sensitivity is the ability to recognize compassion-relevant emotional cues about the needs and interests of others. According to this definition, at least two capacities must be present in order to experience compassion: (1) the ability to distinguish between one's own feelings and the feelings of another and (2) the ability to feel emotional concern for another. Infants and young children who have not moved past the emotional contagion stage of development struggle to disentangle their own feelings of distress from the feelings of the other. This affective quagmire makes it difficult to feel genuine concern for another, since the observer is often overwhelmed by her own feelings of distress.

The first capacity is clearly detailed in the developmental literature. Hoffman (2000) claims that children begin to distinguish between self and the other around age two. Very young children (ages 2-4) recognize themselves in the mirror and begin to understand that others have feelings and other mental states that may or may not match their own. The second capacity is more complicated. As I discussed above, children begin to feel distress at the sight of another's sadness around ages two and three. They feel uncomfortable when another child displays sadness and seek to escape from the situation. When does this distress evolve into emotional concern? In

other words, when does the child feel moved to remedy the cause of the other child's sadness rather than escape? Consistent with the developmental literature, I claim that emotional concern comes in degrees (Hoffman, 2000; Zahn-Waxler & Radke-Yarrow, 1990; Eisenberg, McCreath, & Ahn, 1988). The development of emotional concern for another is gradual and individualized throughout the lifespan.

Children develop emotional concern as they begin to understand emotional complexity. Prepubescent children (ages 8-11) understand that a child can be both happy and sad about the same situation: Jayden is happy that his mom picked him up early from school but sad to miss the birthday party held in the afternoon (Hoffman, 2000). They also understand how an individual's past experience can affect her current emotional experience: if the child knows that his friend Hae was bitten by a dog in the past, the child understands that Hae will not be happy to meet a puppy and can feel emotional concern for Hae, even as the child himself is excited to see the puppy. In adolescence, children begin to recognize emotional deception: an adolescent can feel emotional concern for his father's stress, even as the father pretends to be happy about leaving for work before sunrise (Hoffman, 2000).

Variance in the capacity for emotional concern for others modulates the degrees of one's compassion sensitivity and thus one's degree of moral responsibility. A young child, for example, has a limited capacity for emotional concern, thus a limited capacity for compassion and a low degree of moral responsibility. An emotionally mature adult, on the other hand, has full capacity for emotional concern and sufficiently developed compassion sensitivity. In typically developing individuals, moral responsibility, emotional insight, and compassion sensitivity increase with age until early adulthood. Individuals with autism spectrum disorder, borderline personality disorder (and other personality disorders), and psychopathy grow up

differently than typically developing children. In psychopaths, emotional insight develops (if at all) independently of compassion. Without compassion sensitivity, psychopaths cannot be held responsible for their actions. In the following section I analyze psychological research on psychopaths and compassion sensitivity that demonstrates the validity of this exemption.

2.2.4.2 Responsiveness to Punishment/Reward

Research in developmental predecessors of psychopathy such as conduct disorder reveal a developmental trajectory that looks markedly different than typically developing children. A key component of developing antisocial behavior involves responsiveness to punishment.

Parents and teachers scaffold a child's development of emotional concern through punishment. If Joanna's father observes her repeatedly smashing Izzy's fingers in the Barbie elevator, he will scold Joanna and might punish her by putting her in a time out. The prospect of punishment serves as a further deterrent for antisocial action while children are developing compassion. Children with psychopathic traits, however, do not respond to punishment in this way, as demonstrated by the empirical literature.¹¹

Jones and colleagues (2010) used the Outcome Values Measure (Boldizar, Perry, & Perry, 1989; Pardini et al, 2003 as cited by Jones et al., 2010) to evaluate how boys with and without psychopathic traits valued various outcomes of aggression towards a male peer. One of the possible outcomes involved punishment. Participants were asked "how much they cared about...being punished for their aggressive response" (Jones et al., 2010, p. 1191). The authors found that boys with psychopathic traits were less concerned about being punished for aggression than boys without psychopathic traits (Jones et al., 2010, p. 1193). In other words,

¹¹ There are several theories that try to explain this difference (Pardini, Lochman, & Frick, 2003). One involves self-regulation. Children with psychopathic traits might have a harder time adjusting their behavior to meet certain goals. Another explanation involves belief: children with psychopathic traits do not believe that their behavior causes punishment. A third explanation, and the explanation I find most compelling, claims that children with psychopathic traits do not value the consequences of punishment in the same way as typically developing children.

boys with psychopathic traits did not respond to the prospect of punishment in the same way as boys without psychopathic traits. Typically developing children will be concerned about the prospect of being punished for aggressive behavior, perhaps even to the point of being motivated to inhibit aggressive behavior. Boys with psychopathic traits, on the other hand, do not consider the prospect of being punished a salient factor in determining when they will behave aggressively.¹²

Such early acts of violence and aggression are symptoms of conduct disorder. Children with conduct disorder often violate rules, resulting in juvenile detention and school sanctions (i.e., suspension, expulsion). Violent and antisocial behavior also has consequences for interpersonal relationships. Children with conduct disorder often struggle to develop and maintain quality friendships (Green, Gilchrist, Burton, & Cox, 2000).

The developmental evidence suggests that psychopaths grow up differently than typically developing children. They are more likely to have encounters with law enforcement, are not deterred by punishment, make fewer friends, come up with their own strategies for understanding the emotions of others, and do not feel the interpersonal consequences of harmful behavior.

2.3 Moral Responsibility, Moral Agency, and Exempting Conditions

In this essay I briefly discuss a positive account of moral responsibility and focus primarily on the kinds of conditions that excuse or exempt an individual from moral responsibility¹³. Ignorance can excuse or exempt an individual from moral responsibility¹⁴. Some

¹² This effect is likely present in children more generally (males and females), but studies in this area rarely gather a significant number of female participants, if any at all.

¹³ This version of moral responsibility is roughly Humean (1888) but is not strictly committed to any Humean principles.

¹⁴ This idea is consistent with a wide variety of accounts of moral responsibility, see Fischer and Ravizza (1998) for one example.

standard examples of ignorance as an exempting condition include young children and individuals with severe intellectual deficits. Such individuals will not be held morally responsible for their actions because they do not recognize the kinds of stimuli that require a morally salient response. In typically developing adults, ignorance can be an excusing condition in cases where an individual did not have knowledge of a morally salient stimuli and is not culpable for this ignorance. For example, I might offer half of my sandwich to a new coworker without knowing that she's allergic to peanuts. I was not aware of her allergy and would be excused from moral responsibility for her subsequent allergic reaction.

Psychopaths experience a different kind of ignorance. Psychopaths often semantically recognize stimuli that require a morally salient response. Hare's patient, for example, recognized the expectation that he should feel remorse for the harm he caused to others. He knew that murder, rape, extortion, etc. are morally wrong actions. Psychopaths experience a kind of emotional ignorance – they cannot recognize compassion-relevant stimuli. This compassion ignorance leads to a failure to act morally in situations where compassion is a significant factor. For example, we might think of a man who is angry at his boss for unfairly terminating his employment. The boss chose to fire this man even though he was more experienced and better qualified for his job than many of his coworkers who were not fired. The man shows up in his boss's office with a gun, ready to murder her for this injustice. The boss pleads for her life. She tells him that she's a single mother with a sick son and needs to stay alive to care for him. If the man is not a psychopath, he will likely feel some degree of compassion for this woman and her son. He may change his plan, aiming to painfully injure her rather than shooting her in the head. He may also feel this compassion and suppress it, deciding to go through with his plan despite her pleading. Whatever action he chooses, her plea will be recognized as an instance where

compassion is relevant. If, on the other hand, the man is a psychopath he will most likely stick to his regular plan. He will hear her plea but fail to recognize it as an instance where compassion is relevant. He will not be tempted to feel compassion for her. If he does change his mind, the change will be caused by something other than his compassion for the woman and her son.

Conversely, we can generally agree that most of the adult population is capable of moral agency in some degree. According to Vargas (2013), individuals have moral agency in so far as they possess the “capacity to offer and exchange in reasons-giving” (p. 139). On this account, agents are held morally responsible when they are capable of generating reasons for their actions. In this sense, agents are *reasons-responsive* and able to be held morally responsible for their actions. Vargas’s notion of moral responsibility includes all of the cases we are interested in, while excluding cases of individuals who are not acting as moral agents.¹⁵

In this essay I focus on a particular kind of reasons-responsiveness: compassion sensitivity. For example, a typically developing adult woman who deliberately murders her partner while he is sleeping can demonstrate her reasons-responsiveness by engaging in a discussion about what motivated her actions – how she planned to collect his life insurance and start a new life with her long-time lover (reasons for her actions). Upon further discussion, she may also admit that she knows the action was morally wrong. Even if she does not feel compassion toward her deceased partner, she can imagine attempting the same action on her new partner but ultimately feeling the force of her compassion towards him and his suffering. On the other hand, an adult with severe cognitive deficits may not be able discuss his motivational reasons for stealing a necklace from a neighbor’s house. He cannot engage in a discussion about

¹⁵ The view I present here is generally in line with Shoemaker’s (2010) pluralistic notion of moral responsibility. On Shoemaker’s view, the psychopath can be held attributability and answersability responsible for his actions but not accountability responsible. I agree with Shoemaker but do not want to alienate any portion of my audience that may not be on board with his model of moral responsibility. The account of moral responsibility I give here is meant to be general; the more theories my view is consistent with, the better.

plans to sell the necklace or get revenge on the neighbor because reasons did not play a role in his actions. He cannot imagine feeling compassion towards the person he has wronged, even if he stole a necklace from his mother or another close relative. In yet another case, an adult with no cognitive deficits who meets criteria for psychopathy can usually engage in a discussion about her motivational reasons for poisoning her partner (e.g., life insurance money, suspicion of infidelity, etc.) but is unable to understand how compassion might have figured in to her actions. She cannot imagine feeling compassion toward a partner she loves (or anyone else, for that matter) and does not feel the force of compassion in attempting to guide her actions.¹⁶

Lack of compassion sensitivity is not the only way we can fail to be reasons-responsive. Borrowing from Fischer and Ravizza (1998), excusing conditions may include ignorance (e.g. serving peanut butter without knowing someone is allergic), force (e.g. robbing a bank under threat of death), or temporary incapacitation (e.g. under the influence of psychedelic drugs). In other words, most of us can be held morally responsible for most of our actions most of the time.

As I mentioned above, children are temporarily excused from moral responsibility due to their levels of ignorance or mental incapacitation. For example, we do not typically consider a twelve-year-old fully excused from moral responsibility when she steals from the middle school cafeteria. This is where degrees of moral agency and moral responsibility come into play. The twelve-year-old who steals from her cafeteria is far less ignorant or incapacitated than the five-year-old that performs the same action and can engage in a discussion about reasons while the five-year-old cannot. The twelve-year-old is thereby considered more morally responsible for her actions than the five-year-old. Again, typically developing children grow out of their exemptions

¹⁶ High-functioning psychopaths are rational agents despite their moral incompetence. Though she feels no compassion, the woman murdered her partner may take pains to make it look like an accident and destroy the evidence to avoid getting caught.

and progress to being held fully morally responsible for most of their actions by the time they reach adulthood.

The developmental trajectory from full exemption from moral responsibility to full moral responsibility progresses linearly in typically developing children. As I demonstrated in previous sections, psychological research suggests that children with psychopathic traits develop differently than children without psychopathic traits, particularly in the areas of emotional sensitivity and responsiveness to punishment. I have argued that the aberrant developmental trajectory prevents a child with psychopathic traits from developing into a morally mature adult. Children with psychopathic traits do not move past the exempting condition of ignorance due to severe deficits in compassion sensitivity; they never grasp the compassion component of reasons responsiveness.¹⁷ Adult psychopaths, therefore, should not be held morally responsible for their actions. In future chapters I will analyze the developmental trajectory and adult emotional functioning in individuals with other mental disorders – autism spectrum disorder, borderline personality disorder, and substance abuse disorder – to determine if such individuals should also be exempt from moral responsibility.

2.4 Objections

Schiach Borg and Sinnott-Armstrong (2013), in their essay on psychopathy and moral judgments, agree that psychopaths demonstrate deficits in compassion sensitivity but conclude: “If psychopaths have any deficits or abnormalities in their moral judgments, their deficits seem subtle – much more subtle than might be expected from their blatantly abnormal behavior.” Like the present essay, the authors cite a wealth of empirical evidence to support their view.

¹⁷ Psychopaths are incapable of compassion and are thus incapable of caring about their lack of compassion. This kind of meta-affective attitude does not affect the psychopath’s moral responsibility, but will be relevant in my discussion of other mental disorders, particularly autism spectrum disorders and substance abuse disorders.

I have two possible responses to this view. First, Schiach Borg and Sinnott-Armstrong may claim that we are discussing two distinct components of the moral decision-making process. While I focus on moral salience that allows individuals to detect moral stimuli, they discuss moral judgments. On this view we don't actually disagree: just because psychopaths do not demonstrate significant deficits in moral judgment does not mean that they should be held morally responsible for their actions. Schiach Borg and Sinnott-Armstrong might argue, however, that moral judgment is necessary and sufficient for moral responsibility. Psychopaths should be held morally responsible for their actions because they are fully capable of making moral judgments.

This leads to another possible interpretation of their view: Schiach Borg and Sinnott-Armstrong disagree with my interpretation of the empirical evidence and conclude psychopaths are full (or nearly full) moral agents who are fully (or nearly fully) responsible for their actions. Alternatively, they could claim that the evidence is insufficient to definitively support one view over the other. Either way, my view is capable of addressing their concerns.

Schiach Borg and Sinnott-Armstrong and I cite the same criteria for psychopathy: Hare's Revised Psychopathy Checklist (p. 108). We differ, however, on the kinds of psychological studies we use to support our view. Schiach Borg and Sinnott-Armstrong cite studies assessing adults' (typically in criminal populations) levels of moral reasoning. These studies did not assess or were inconclusive about the participants' emotional response to moral transgressions. The authors suggest that the future of research in psychopathy and morality lies in fMRI studies of brain activity (p. 124).

I have suggested that the developmental literature provides unique insight into the moral development of children with psychopathic traits and ultimately, high-functioning and low-

functioning adult psychopaths. The developmental research reveals that burgeoning psychopaths have not yet learned to “talk the talk” of morality. Recall that Schwenck and colleagues (2012) found that children with psychopathic traits resembling those of an adult, high-functioning psychopath could make rational judgments about moral situations but did not demonstrate compassion in response to the suffering of others in moral situations. Schiach Borg and Sinnott-Armstrong’s studies involve adults who have likely learned to provide socially appropriate responses to questions about moral behavior. Furthermore, my account of moral responsibility in high-functioning psychopathy is consistent with the development of compassion sensitivity in children (Hoffman, 2000). Perhaps Schiach Borg and Sinnott-Armstrong could provide a developmental story consistent with their arguments, but it is not obvious how their view could account for the empirical evidence I have discussed in this essay.

I do, however, support the call for additional research on psychopathy and moral functioning (as Schiach Borg and Sinnott-Armstrong do) especially in adult, non-criminal populations. Such studies require broad canvassing of community populations but are not impossible. There is at least one promising study in progress studying a variety of personality disorders in adult community populations (Gleason, Weinstein, Balsis, & Oltmanns, 2014).

2.5 Conclusion

The consequences of this view fly in the face of burning desires for justice: psychopaths are not morally responsible for their actions and should not be punished like non-psychopathic criminals. When a community reads stories of malicious crimes committed by individuals who feel no remorse for their actions, they feel moral outrage. This moral outrage seems justified. These kinds of actions disturb the moral order of the community and ought to be condemned. When it comes to moral responsibility, however, we should not condemn psychopaths.

The horrific acts of psychopaths should be viewed more like the American who fails to remove his shoes when he enters a home in India than the college student who cheats on an exam. The tourist knows the Indian custom – he frequently visits India and visited throughout his childhood – yet the act of wearing his outdoor shoes into the house does not carry an emotional force for him. He did not grow up in a culture where wearing outdoor shoes inside felt disgusting or offensive so the act does not carry the affective punch that it carries for most individuals native to India. He knows the rule and should be expected to follow it, but if he violates the custom, this behavior should be viewed as a mistake rather than a deliberate act with malicious intent; the tourist has some reduced degree of moral responsibility. If we know that the man is generally absent-minded, we might even go as far as to say he is not morally responsible for his behavior. Even if the tourist learns the rule, it will not carry the same emotional force as someone who grew up in a culture where wearing outdoor shoes inside was considered offensive.

On the other hand, consider a college student who has lived his entire life in a culture where cheating is morally wrong. The act carries an emotional force for him and he feels a pang of guilt as he copies his classmate's answers. He also knows the university rules against cheating and should be expected to follow them. The college student, unlike the bumbling tourist, is fully morally responsible for his behavior. A psychopath is like a bumbling tourist in the moral world; moral rules have never carried affective force.

The comparison between the psychopath and the bumbling tourist looks compelling in cases of low-functioning psychopathy. High-functioning psychopaths, on the other hand, seem much more like the cheating college student. As I mentioned in the introduction, high-functioning psychopaths leave relatively normal and successful lives. They usually thrive in

society. We have the impulse to say that high-functioning psychopaths *know better*, that they manipulate and exploit their peers with full knowledge of moral rules. The high-functioning psychopath arrives at the house in India, knows that he should remove his shoes and that it will cause his hosts much discomfort if he does not, and walks proudly through the door, wearing his filthiest pair of hiking boots.

Despite our contempt for characters like Grambling and Hare's interviewee, we should strive to view high-functioning psychopaths like the foreign tourist. Though they semantically know the rules of society and the harms caused by their actions, this does not constitute full knowledge of one's actions. High-functioning psychopaths lack the deeper, emotional knowledge necessary for full moral agency and responsibility. The high-functioning psychopath's compassion deficit renders her not only exempt from morally agency and responsibility, but also makes her extremely dangerous. We should expect high-functioning psychopaths to learn and abide by the rules of society (e.g., if the tourist moved to India) and impose sanctions for violations. Nonetheless, such sanctions must take into account that the psychopath is not morally responsible for her actions. Sanctions against psychopaths should be primarily protective (for the rest of society) rather than punitive.

I have shown that compassion plays a crucial role in detecting moral salience for typically developing children and adults. Psychopaths follow a radically different developmental trajectory that does not include emotional sensitivity. This deficit persists into adulthood and provides an exempting condition for moral responsibility. In the mind of a psychopath, killing another human being carries no more affective force than squashing a bug. I will employ a similar methodology to evaluate moral responsibility in high-functioning presentations of autism spectrum disorders, borderline personality disorder, and substance abuse disorders. While some

disorders may prove worthy of exempting conditions similar to psychopathy, others will be determined to possess degrees of moral responsibility close to the full moral responsibility of a typically developing adult.

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Chapter 3: “Check(ing) out” of Moral Responsibility: Understanding Addiction as an Impairment in Emotion Regulation

3.1 Introduction

When I asked a group of adolescent substance users who had faced legal sanctions for drug offenses if they were morally responsible for their actions, they all, much to my surprise, said yes. It was their own fault that they used drugs, made poor decisions, and ended up in treatment. Similarly, adult programs like Alcoholics Anonymous encourage accountability for one’s behavior. It seems counterproductive and perhaps even paternalistic to suggest that addicts are not morally responsible for at least some of their behaviors.

The solution, according to some ethicists, comes in degrees. Sinnott-Armstrong (2013), for example, argues that an addict’s moral responsibility varies in proportion to her degree of control over her addiction. The adolescents in the support group or members of AA are coming out of an addiction. These individuals are regaining a sense of control and thus a sense of moral responsibility for their actions. While I agree with Sinnott-Armstrong’s endorsement of moral responsibility in degrees, I disagree with his conclusion that degrees of moral responsibility vary with levels of control.

Rather than facing difficult emotions, individuals with emotion regulation deficits use maladaptive coping strategies (e.g. self-harm, substance abuse, suicidal thoughts/attempts, etc.) to escape. I am focusing specifically on those who use substance(s) to compensate. In this essay I offer an empirically-based moral account of substance abuse that proposes explanations for

relapse as well as why certain circumstances (e.g. financial difficulties, significant life events, war) make substances more enticing.

Substance use as a coping strategy is demonstrated by studies like Robins, Davis, and Goodwin (1974) that found that 20% of a sample of enlisted men self-reported being addicted to heroin while serving in Vietnam. Similarly, I spoke with one adolescent substance user in a treatment facility whose parents had recently divorced and who was struggling in school. The adolescent felt “angry and depressed” and “wanted to check out...I didn’t want to deal with it” so the adolescent took a daily mix of substances that allowed them to feel numb.

Deficits in emotion regulation excuse individuals with substance use disorder from moral responsibility. Emotion regulation skills develop in adolescence and are a crucial component of morality. Treating deficits in emotion regulation through substance use affects individual performance across interpersonal and mental health domains as well. Emotion regulation deficits in addiction provide general excusing conditions for moral responsibility. In other words, individuals with substance use disorder are excused from moral responsibility for addiction-related behaviors as well as moral behaviors across all domains of their lives.

The emotion regulation view is one of several potential philosophical conceptions of moral responsibility in substance use. In the next section I will define addiction using DSM-5 criteria for substance use disorder. I will then discuss the role of emotion regulation in moral development. Synthesizing the psychological data with philosophical views on moral responsibility, I will formulate the emotion regulation view. I will argue that the emotion regulation view is more plausible than alternative views for understanding morality and addiction. The emotion regulation view explains etiology, pathology, treatment, and recovery in addiction.

3.2 Diagnosing Addiction: Substance Use Disorder

3.2.1 DSM-5 Criteria

As I mentioned, I will discuss addiction as a mental illness. Clinically, addiction is classified as substance use disorders and, like major depression, autism spectrum disorders, and schizophrenia, substance use disorders are delineated in the DSM-5 by general characteristics as well as specific symptoms. Specific symptoms vary depending on the substance and/or the stage of the use (general use, intoxication, withdrawal, and other induced or unspecified related disorders)¹⁸ (American Psychiatric Association, 2013). The diagnostic criteria acknowledge that individuals often use multiple types of substances at once (e.g. opioids and alcohol) or use one substance to curb the withdraw effects of another (e.g. cigarettes at rehab facilities), resulting in regular comorbid diagnoses within the “Substance-Related and Addictive Disorders” category. Additionally, substance use disorders are comorbid with other mental illnesses but I will discuss this further in the following section.

Roughly all substance use disorder diagnostic criteria consist of five main categories: impaired control, social impairment, risky use, tolerance, and withdrawal (American Psychiatric Association, 2013). Impaired control symptoms include things like drinking more alcohol than you intended, wanting to cut back on smoking but failing to follow through, and doing whatever is necessary, even if that means compromising your values, to obtain your substance of choice. Social impairment symptoms include things like forgetting to pick your kids up from school because you were high, losing your job due to substance use, and continuing to use substances despite conflicts with family and friends. Risky use symptoms include sharing needles with

¹⁸ For hallucinogens there is also “Hallucinogen Persisting Perception Disorder.” This category is unique to hallucinogens and not relevant to the broader discussion.

potentially infected strangers in order to get high, using hallucinogens despite persistent terrifying trips, and continuing to use substances despite heightened risk of being caught by law enforcement and/or increased penalties. Tolerance symptoms involve the need for an increased amount of the substance in order to achieve the desired effect and vary according to the physiological makeup of the individual and the substance. Similarly, withdrawal symptoms vary by individual and substance and occur when the individual is no longer using the substance.

3.2.2 Comorbidity

Comorbidity complicates moral responsibility. As I discuss in other chapters, different mental disorders have distinct effects on moral responsibility. These diverse effects are not my focus in this essay. I am concerned with substance use as a stand-alone disorder despite the fact that such cases rarely occur in vivo. I argue that substance use disorder alone is often sufficient to render an individual excused from moral responsibility. Substance use disorder is often comorbid with other conditions including post-traumatic stress disorder (De Bellis, 2002; Robert, Roberts, Jones, & Bisson, 2015; Grant et al, 2016), mood disorders, anxiety disorders (Campbell-Sills & Barlow, 2007; Grant et al, 2016), and personality disorders (Grant et al, 2016). In cases where substance use disorder is not sufficient to excuse an individual from moral responsibility, it may be the case that her comorbid mental disorders combined with substance use disorder excuse her from moral responsibility. I will not speculate on such cases here.

3.3 Emotion Regulation

Before we dive into the crux of the moral argument, we must first discuss the role of emotion regulation in moral development. Primitive emotion regulation strategies emerge in early childhood and mature into adolescence (Hilt, L. M., Hanson, J. L., & Pollak, S. D., 2011; Masters, 1991). We regulate our emotions for our own benefit (personal) or for the benefit of

others (social) (Masters, 1991). A child, for example, may develop strategies to suppress his sadness when his parents argue because he has learned that his sadness causes him discomfort (personal) and/or that when his mother observes him crying she becomes more upset (social).

As children mature, they develop more cognitive complex strategies across both personal and social domains and, if all goes well, become more skilled at emotion regulation. However, not all strategies are created equal. Strategies are deemed adaptive or maladaptive depending on their effectiveness in reducing distress without creating further problems like depression or anxiety (Aldao, Nolen-Hoeksema, & Schweizer, 2010). For example, if an adolescent has a bad first date she might find it soothing to think about everything that went wrong over and over again, engaging in a practice called rumination. She may even engage some of her peers who have had similar experiences with dates and they may all discuss their negative experiences over and over in co-rumination. Though common, both practices are considered maladaptive, ineffective methods for regulating emotions. In many cases such maladaptive practices persist into adulthood.

To correct these practices, emotion regulation features prominently in major schools of therapy, including cognitive behavioral (CBT) and dialectical behavioral (DBT) (Gratz & Roemer, 2004; Aldao, Nolen-Hoeksema, & Schweizer, 2010; Linehan, 1993). Patients are taught strategies to tolerate distress and regulate impulsive responses to live healthier, more socially cohesive lifestyles. Studies have shown that individuals who practice maladaptive emotion regulation strategies like suppression or avoidance are more likely to experience more symptoms of psychopathology than individuals who employ adaptive strategies like problem solving and cognitive reappraisal (understanding the function of the emotion and its relevance to one's goals)

(Gratz & Roemer, 2004; Aldao & Nolen-Hoeksema, 2012; Aldao, Jazaieri, Golden, & Gross, 2014).

Individuals with poor emotion regulation skills often experience difficulties pursuing goals while under emotional duress, maintaining meaningful relationships, and suffer from mood and/or anxiety disorders (Gratz & Roemer, 2004; Campbell-Sills & Barlow, 2007; Linehan, 1993; Phan & Sripada, 2013). It is important to note that both CBT and DBT believe that deficits in emotion regulation can be treated. I will return to this conclusion in the next section.

On the neural level, emotion regulation is thought to help direct our attention towards relevant stimuli (Lewis, 2013). For example, if I cannot regulate my fear about an email that my boss is supposed to send me in the next week, I might find myself refreshing my inbox while driving, causing me to hit a pedestrian in the crosswalk. I could not tolerate my fear, nor could I come up with a healthy coping mechanism (another emotion regulation skill), thus I performed an immoral action. Not all instances of poor emotion regulation result in immoral action but the example demonstrates that emotion regulation affects behavior in surprising ways.

The research I've presented shows that an individual must possess some basic emotion regulation skills to be psychologically healthy. Most of us develop these skills in adolescence. Some of us need therapy to help hone our skills. This essay focuses on the large group of individuals who do not develop emotion regulation skills in childhood or therapy but turn to substances to aid in distress tolerance, impulse control, etc. I have demonstrated in this section that these individuals are operating at a significant psychological disadvantage.

3.4 Moral Implications

Individuals with substance use disorder and related conditions are excused from moral responsibility because of deficits in emotion regulation. The previous section established that

individuals with untreated deficits in emotion regulation are at a significant psychological disadvantage to individuals with typically developed emotion regulation skills. To understand this thesis, we must first understand what it means to be excused from moral responsibility. Borrowing from Fischer and Ravizza (1998), excusing conditions may include ignorance (e.g. serving peanut butter without knowing someone is allergic), force (e.g. robbing a bank under threat of death), or temporary incapacitation (e.g. fallen ill with the flu). Individuals who are excused from moral responsibility, unlike individuals who are exempt, can overcome their excusing conditions and once again be morally responsible for their actions.

On my view, an individual with substance use disorder qualifies under something like ignorance, as we can see in the discussion of emotion regulation. To be even more precise, we can think of emotion regulation as a capacity required for moral responsibility. Vargas (2013) argues that individuals have a capacity for detecting moral considerations and a capacity for self-control. He claims that these capacities can be exercised or fail to be exercised depending on the context. Only systemic failures of these capacities constitute grounds for exempting conditions. For example, if I recognize the moral salience of the situation but fail to exercise self-control and eat the piece of cake I was supposed to save for my partner but typically exercise self-control when faced with delicious desserts that do not belong to me, I would not be exempt from moral responsibility. If, on the other hand, I have a condition that impairs my ability to recognize the moral salience of this situation and/or exercise self-control (e.g. I am child, have severe intellectual impairments, suffer from Prader-Willi syndrome, etc.), I would be exempt from moral responsibility in all relevant situations. There may also be isolated instances where we think that an individual is responsible for most of her actions but is excused in a particular context at a particular time. If I come home intoxicated, for instance, and eat the cake that I know

belongs to my partner my moral responsibility would be (at the very least) mitigated on Vargas's view.

We can summarize Vargas's view as follows: moral responsibility is assessed on a case-by-case basis. Some individuals have impairments that span multiple situations but in general, a person who is exempt in one context will be responsible in others. Vargas seems to think that global views of responsibility – an individual is exempt/responsible in all cases – are implausible. While I agree that all individuals will fail to be responsible in some possible context, I do find it plausible to posit that some individuals can be exempt from moral responsibility in all possible contexts. Recall at the outset of the discussion of moral responsibility that I stated that emotion regulation is a capacity. One might argue that emotion regulation falls under Vargas's self-governance, but as I concluded in the previous section, emotion regulation involves tolerating distress and finding healthy outlets for emotional experiences. We cannot, therefore, relegate emotion regulation to a subsidiary of self-governance or as a part of detecting moral salience (Vargas's other morally relevant capacity). Emotion regulation affects both of these capacities and so much more.

Emotion regulation should be considered a capacity in its own right. Vargas may be willing to accept this addition to his view but I also argue that deficits in emotion regulation can constitute global exemption from moral responsibility. As I mentioned, Vargas does not support global exemptions and argues instead for considering cases individually. As I discussed in the previous section outlining the clinical criteria for substance use disorder, the condition affects multiple domains of the individual's life. This position is consistent with other views of addiction (such as Sinnott-Armstrong's (2013) control view which I will discuss in depth in the following section) as well as the DSM-5's description of substance use disorder as a

comprehensive disorder that affects every aspect of the individual's life (American Psychiatric Association, 2013).

Unlike psychopathy where deficits in compassion are irreparable, individuals with substance use disorder and related conditions can learn strategies for emotion regulation through therapy. Depending on the program, an individual with substance use disorder may or may not learn emotion regulation strategies in rehab. My argument does not claim that an individual with substance use disorder is excused from moral responsibility until they go to rehab; they must learn emotion regulation strategies before they can be considered fully morally responsible for their actions. For the sake of argument we will assume that an individual enters a rehabilitation facility with sufficient chemical detox and therapeutic support. We will also assume that they are receiving DBT (though CBT would be equally effective). How does this individual learn emotion regulation strategies?

Briefly, the individual will work with an individual therapist and attend group therapy. In group they will learn various skills, including specific strategies for emotion regulation. For example, rather than relaxing with a beer after a long day of work, an individual might help her son with his homework (contributing), go see a play (vacation), or practice yoga (relaxation). She will also do her best to get plenty of sleep and exercise, eat well, and go to the doctor when needed (PLEASE). Additionally, she will be more aware of her emotions. If her emotion does not fit a particular situation (e.g. if she is angry at her spouse for no apparent reason) she will act contrary to that emotion to try to change it (e.g. doing something nice for her spouse) (Linehan, 1993). Through individual and group therapy she can learn how these skills (and others) serve as more effective methods of emotion regulation than substance use.

Despite the promise of skill-based therapy, we seem to have a problem. If the individual is excused from moral responsibility, she is not morally obligated to participate in therapy or develop emotion regulation strategies. I concede this point but do not think the problem is devastating. Substance use disorder does not render an individual completely irrational. The individual may still be fighting cravings and struggle to manage her emotions, but this does not mean that most individuals, when given a fair opportunity, will not try to get better.

The relapse data on substance use disorder, however, seems to tell a different story. First, some individuals leave treatment programs early (Hopwood et al, 2015) and do not spend enough time in therapy to develop emotion regulation skills. These cases are the burden of the treatment facility to find creative solutions for engaging clients rather than the subject of moral arguments. Relapse rates for individuals who complete rehabilitation programs range from 40-60% 6-12 months after treatment (McLellan et al, 2000). These rates suggest that many (if not most) substance users continue to be excused from moral responsibility (per my standards) even after treatment.

As the authors of the meta-analysis that published these rates acknowledge, 40-60% covers individuals sent to all kinds of treatment facilities, many of whom received no follow up care such as group or individual therapy once they were discharged. These rates include individuals who were discharged prematurely (by therapeutic standards) due to overcrowding or insurance limitations. Additional research should focus on the attrition and relapse rates facilities using empirically informed therapy (e.g. CBT or DBT).

Studies have demonstrated that once individuals with substance use disorder learn adaptive emotion regulation strategies they are more likely to continue treatment (Hopwood et al, 2015), participate in fewer impulsive behaviors (Tull et al, 2012), and experience improvements

in mood (Axelrod et al, 2011). Despite this empirical data I think it is worthwhile to revisit Sinnott-Armstrong's control view a final time to make sure the emotion regulation view is more explanatory.

3.5 Alternate Views

You might think that moral responsibility in substance use only becomes problematic after an individual is hooked on a particular drug or sometime after her first use. I call this view "first use." Alternatively, we might distinguish moral responsibility based on types of substances. On the "types of substances" view one might argue that some substances affect moral responsibility in users more than others. Finally, I discuss the "cognitive impairments" view. On this view, the most interesting discussion of moral responsibility in substance use resides in cases of substance use-induced cognitive impairments. In this section I briefly discuss each of these views and explain why they do not provide the most philosophically interesting discussion of moral responsibility.

3.5.1 First Use

Some philosophers may be tempted to assign moral responsibility at first use of an addictive substance. We might think of this view as a response to the intuition that someone who is addicted to a substance has little control over her actions. When she first inserted the needle into her arm, however, she was not in the throes of a craving or the pangs of withdrawal. The substance had not sunk its hooks into her impulse control and decision-making. She seems to have made the decision to try drugs freely and thereby seems morally responsible for this decision. From this initial responsibility, the first use view can argue that substance user is responsible in general. In other words, because the substance user is responsible for her first use she does not qualify for excusing or exempting conditions due to her substance use.

Sinnott-Armstrong (2013) calls this “transference” and argues that most users would not be held morally responsible on this view due to ignorance or because their first use came from legal prescription drugs. Furthermore, the strategy of assigning blame at first use seems obviously problematic for individuals who ultimately generalize to other opiates (e.g. heroin) whose first use came as part of a legal, legitimate medical procedure. I argue that this strategy is problematic for individuals who do not fall into any of these categories – individuals whose first use came in the form of snorting cocaine or injecting heroin.

The first use response seems problematic for legal substances like alcohol, nicotine, and in many areas, marijuana. For legal substances, there is a widespread belief that universal abstinence is not necessary to prevent addiction. In cases of familial inheritance, the argument becomes more complex. I will not address cases of familial inheritance for legal or illegal substances in this essay. The same argument applies for pain medications. Pain medications are necessary for certain medical procedures and should be prescribed responsibly. Again, universal abstinence does not seem like a popular option.

Illegal substances face a much less accepting audience. When I discuss the recent spate of heroin overdoses in my small Kentucky hometown I hear the same message over and over “they never should’ve tried it in the first place.” The logic seems to follow that once an individual sticks the needle into her arm for the time, she has chosen her fate, mortally and morally.

Many individuals turn to substances to cope with mental disorders. Others start using in adolescence, when their rational and moral mind is still under construction. Some might start using while under the influence of other substances like alcohol or under pressure from a controlling partner. The reasons for putting the needle in one’s arm or snorting the line are numerous but the magnitude of the effects is beyond comprehension. The fact remains that the

vast majority of people cannot imagine what their life will be like as an addict. Owen Flanagan (2011) describes his experience with his drug of choice, alcohol, but the substance could be replaced with any drug:

...I now spent most conscious, awake, time drinking, wanting to die. But afraid to die. When you're dead you can't use. I lived to use and to die. The desire to live was not winning the battle over death. The overwhelming need – the pathological, unstoppable – need to use, was. Living was just a necessary condition of using. (277)

Even ignoring the moral consequences – no one would choose a life like this. We cannot hold someone morally responsible for all of the actions of the addict when they use a substance for the first time.

3.5.2 Types of Substances

I did not make any moral distinctions based on types of substances. As the discussion above foreshadowed, I do not think an individual who abuses nicotine is more or less morally responsible than an individual who abuses cocaine. Some substances may correlate with higher levels of moral responsibility since they are often used by psychologically healthy individuals – for example, a psychologically healthy individual who smokes cigarettes and cheats on her taxes would likely be held morally responsible for cheating on her taxes.

On the other hand, some might argue that illegal substances like heroin, methamphetamine, and cocaine come from dubious sources in addition to being dangerous. Such substances are commonly depicted in popular culture through television shows like *Breaking Bad* and *Narcos* as well as countless news reports of seized meth labs below daycares or mass graves of enemies of the Cartel. According to this argument, a reasonable adult should be concerned not only for their own well being when using substances like methamphetamine, heroin, and cocaine but also the well being of their community that clearly suffers from the proliferation of these substances.

My first response to this argument is to reiterate my reply about first use: individuals using drugs like heroin, methamphetamine, and cocaine usually have no idea the magnitude of what they are doing. Should they be thinking about the effects of their use on the broader community? Perhaps, but I do not think this is a strict moral ‘should’ that is any stronger than individuals who drink alcohol without considering sexist advertising campaigns and deaths from drunk driving, or individuals who buy chocolate without researching the supply chain. In other words, the moral obligation to consider the damage of hard drugs to one’s community is something like a weak moral duty that does not make an individual’s use of these substances morally different in any meaningful way.

On the other hand, we might be concerned about excusing nicotine users from moral responsibility. Nicotine addicts are often indistinguishable from typically functioning adults – they do not find themselves in trouble with the law, checking themselves into rehab facilities, or struggling to maintain jobs or relationships. As I will discuss in the next section detailing the specifics of substance use disorder, not everyone that uses a substance meets clinical criteria for substance use disorder. Individuals who drink a few beers on the weekends are not alcoholics and many individuals who use nicotine do not meet criteria for substance use disorder. Substance use disorder involves significant impairments in multiple aspects of functioning. The impairments in emotion regulation, I argue, affect moral responsibility. Individuals who use nicotine can suffer from substance use disorder and impairments in emotion regulations and can thereby be excused from moral responsibility.

3.5.3 Cognitive Impairments

We could also argue that individuals with substance use disorder are excused from moral responsibility due to cognitive impairments. Prolonged alcoholism, for example, can result in

memory deficits, frontal lobe impairment, and in rare cases, dementia (Theotoka, 2006; Vandrey & Mintzer, 2009). Long-term opioid users often demonstrate deficits in decision-making and other impairments commonly associated with frontal lobe functioning (Gruber, Silveri, & Yurgelun-Todd, 2007). Even prolonged cannabis use resulted in decreased performance on decision-making, attention, memory, and problem-solving tasks when compared with controls (summarized in Vandrey & Mintzer, 2009). Except for serious alcohol-induced conditions like dementia, most of the impairments caused by prolonged use can be reversed by prolonged abstinence. While using substances or during the early stages of recovery, however, an individual with substance use disorder will likely have some cognitive impairments.

Severe, permanent cognitive impairments exempt some individuals with substance use disorder from moral responsibility. Individuals who experience near fatal overdoses, for example, may have permanent, severe brain damage due to loss of oxygen. Barring major developments in neuroscience, these individuals are permanently exempt from moral responsibility. Other individuals might have temporary, substance-induced impairments in decision-making, impulse control, or even memory that are sufficient to excuse them from moral responsibility. A man with severe prolonged alcoholism, for example, may leave his young child at home alone for twenty-four hours without food or water because he forgot it was his weekend to take care of his son. If the man has severe memory deficits, we might argue that he is not morally responsible for his actions (and that he is unfit for unsupervised visits).

While such cases may be common, I do not think that all cases of moral wrongs committed by individuals with substance use disorder can be resolved by referencing cognitive impairments. I cannot give even an approximate number of cases but I do believe that there are plenty of interesting cases to discuss without referencing cognitive impairments. I endorse the

notion that many individuals with substance use disorder should be exempt from moral responsibility due to severe cognitive impairments but will demonstrate in this essay that the most philosophically interesting cases are those in which the individual does not suffer severe cognitive impairments.

In this section I have discussed three views on moral responsibility in substance use. I argued that each of these views was insufficient. The first use view is based on an inaccurate understanding of why individuals try substances and the amount of knowledge available about the consequences of substance abuse. Next, I considered distinguishing moral responsibility based on types of substances. I argued that this view fails to capture the vast individual differences observed in substance use disorder. Finally, I argued that while some individuals with substance use disorder suffer from cognitive impairments, most do not and the most interesting ethical questions surround individuals with substance use disorder who do not have cognitive impairments.

3.6 Objections – the Control View

Sinnott-Armstrong (2013) argues that whether or not an individual with substance use disorder (he uses the term addict¹⁹) is morally responsible depends on how much control she has over her actions. Her level of control comes in degrees and depends on a variety of factors including environment (e.g. resisting a drink in a bar versus at home) and risk factors (e.g. would she quit at the prospect of losing her job). Higher levels of addiction result in lower degrees of control and moral responsibility on this view.

He also distinguishes between individuals who are addicted to substances and heavy users of substances. Sinnott-Armstrong (2013) argues that heavy users differ from addicts

¹⁹ I do not believe that I have altered Sinnott-Armstrong's argument by using "individual with substance use disorder" rather than "addict." My term is consistent with the psychological literature and captures the individuals Sinnott-Armstrong discusses in his essay.

because they are in full control of their substance use; a heavy user could quit at any time. Since they are in full control of their use they are also fully morally responsible for their actions. On the emotion regulation view, however, a heavy user could be considered equal to an addict in terms of moral responsibility. As long as both met criteria for substance use disorder and both were using substances to regulate their emotions, both would be excused from moral responsibility. This seems like a problem for the emotion regulation view if you share Sinnott-Armstrong's intuitions about control and heavy users.

My response is two-fold. First, I want to agree with Sinnott-Armstrong in some cases. Take a business executive whose firm entertains potential clients at drinking events three or four times a week. She drinks more than the average person but this is explained by the demands of her career. She is not using alcohol to cope, rather, she uses alcohol as part of a social ritual that is well accepted in her field. Her drinking does not cause problems in her social life and actually advances her career. It is unlikely that she has ever been in trouble with the law or that she drinks to the point of physical illness. If she were promoted and found herself spending less time with clients and less time at drinking events, she would not feel compelled to keep drinking heavily. The business executive, on Sinnott-Armstrong's view, is a heavy user and is morally responsible for her actions. This is consistent with the emotion regulation view because she is not using alcohol to cope with her emotions and she does not meet the criteria for substance use disorder.

Other cases, by Sinnott-Armstrong's own admission, are less clear-cut. He discusses several variations of cases involving doctors who self-prescribe narcotics (Sinnott-Armstrong, 2013). When caught and threatened with their job, most enter treatment and successfully stop using. In one case the doctor does not stop using when his wife leaves him but only after he faces losing his job. Sinnott-Armstrong argues that the prospect of losing one's job is a kind of

coercion and struggles with whether or not to call the decision to quit at this point an exercise of control. Recall that on his view degree of control mediates degree of moral responsibility. If we cannot determine the degree to which someone is in control of their actions, we cannot determine their degree of moral responsibility.

Sinnott-Armstrong does not offer a solution to this problem so we are left to sort out the heavy users from the addicts on our own. The emotion regulation view, on the other hand, allows us to avoid making the distinction between heavy users and addicts. The emotion regulation view relies on clinical criteria to determine when substance use is problematic and calls on the cause to explain why users are excused from moral responsibility. Additionally, the emotion regulation view, unlike the control view, can explain how individuals recover from substance use disorder and regain full moral responsibility.

On the control view it is unclear how an individual who has very little control begins to regain control. Perhaps it starts with an act of coercion such as court-ordered treatment or the prospect of losing one's job. Once an individual begins to regain control through treatment, the path of recovery should be linear with the individual regaining more and more control until she is cured. As I mentioned in the previous section, however, this is rarely the case as many individuals relapse despite treatment. How do we explain relapse on the control view? It seems unlikely that the individuals are leaving treatment and walking into truly coercive situations (e.g. someone forcing a needle into your arm). It is more likely, as I discussed earlier, that individuals leave treatment and walk into stressful situations that they are not used to handling without the help of substances.

You could take a hardline with the control view and argue that individuals who relapse are fully morally responsible for their actions.²⁰ Completing rehab voids any excusing conditions they previously possessed. This position fails to capture the nuances of substance use disorder. Furthermore, the emotion regulation view not only excuses the individuals who relapse from moral responsibility but it predicts and explains why some individuals do not quit successfully after their first round of treatment.

While many aspects of Sinnott-Armstrong's control view may appear compelling, I have argued that the emotion regulation view provides a more robust explanation of substance use disorder across individualized presentations and better fits the known relapse data in recovery. Though it may be useful to discuss degrees of control, we should not rely on control as a measure of moral responsibility in substance use disorder.

3.7 Conclusion

Thorny clinical and moral issues surround substance use disorder. I attempted to extract and explicate the ones most relevant to my thesis, namely: many individuals with substance use disorder are excused from moral responsibility due to deficits in emotion regulation. I established the fundamental role of emotion regulation in moral functioning and argued that the deficits in substance use disorder are not insurmountable. In the beginning I discussed several alternate approaches to substance use and morality and summarily found each to be unsatisfactory. My approach accounts for the functioning impairments caused by deficits in emotion regulation while maintaining a sense of autonomy for the recovering addict. An individual with substance use disorder is not permanently "checked out" of moral responsibility; by participating in treatment he gains freedom from addiction and reentry into the moral community.

²⁰ Unless they become addicted again at which point they will no longer be morally responsible.

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Chapter 4: Borderline Personality Disorder: The Moral Superheroes Virtue Ethics Needs

4.1 Introduction

“My whole experience of these episodes was that someone else was doing it; it was like ‘I know this is coming, I’m out of control, somebody help me; where are you, God?’ I felt totally empty, like the Tin Man; I had no way to communicate what was going on, no way to understand it.”

Dr. Marsha Linehan (quoted in Carey, 2011)

Marsha was a bright but challenging adolescent. After an agonizing stay at a residential mental health facility where she felt “out of control” and “totally empty,” and tried on several occasions to end her own life, she returned home with no hope for treatment. As young adult, however, she was determined to improve mental healthcare for individuals with difficult conditions. Marsha Linehan received a PhD in clinical psychology and went on to develop dialectical behavioral therapy – an approach designed to treat individuals with persistent suicidality. Linehan’s approach has been empirically validated and successful in treating a number of disorders, especially borderline personality disorder (Lieb et al., 2004).

Borderline personality disorder (BPD) is a chronic mental illness affecting social, emotional, and cognitive functioning as well as the stability of one’s identity (APA, 2013). Linehan herself suffered from BPD but managed to recover using the techniques in her own therapy (Carey, 2011). She knows she will never be fully free of BPD but finds that her symptoms are much more manageable than when she was a teenager, desperately banging her head against the wall in the inpatient facility in a despondent attempt to end her life.

Many individuals with BPD have stories that start like Linehan’s without the happy ending. Approximately 3-9% of individuals with BPD die by suicide, compared to 2-4% of

individuals with affective disorders like bipolar or major depression (Stanley and New, 2018; Bostwick and Pankratz, 2000). Given the global and persistent impairments, BPD is considered one of the most challenging disorders to treat. With this challenge comes stigma: mental health care providers often view individuals with BPD as “manipulative,” “demanding,” and “attention-seeking” (Aviram, Brodsky, and Stanley, 2006). Therapists often express hesitancy about working with this population and are reluctant to engage emotionally with BPD clients, which can lead to difficulties in finding adequate treatment (Bourke and Grenyer, 2010).

Given that many individuals experience symptoms like those described by Dr. Linehan, it seems likely that individuals who suffer from BPD experience morally-relevant impairments that could impair their capacity for moral agency. Even though many patients who receive treatment achieve remission without relapse or suicide (approximately 65%), many continue to experience severe symptoms (Lieb et al., 2004; Paris and Zweig-Frank, 2001) that could impair moral responsibility. I will not discuss the moral responsibility of individuals experiencing severe BPD symptoms though reflection these individuals can contribute much to the broader philosophical discussion. I have chosen to focus on individuals like Marsha Linehan who recover from BPD and successfully manage their symptoms because they pose a specific problem for virtue ethics. Individuals who recover from BPD still experience some residual, sub-clinical symptoms that interfere with moral behavior. Despite this interference, it is reasonable to suppose that these some of these individuals behave morally at the same rate as any other moral agents (cf. Zanarini et al., 2012). Additionally, I suggest that individuals that recover from BPD (and others like them) are distinct from other moral agents and warrant a different designation: moral superheroes.

I also argue in order to give moral superheroes the praise they deserve we must rethink the relationship between continence, temperance, and virtue. Many versions of virtue theory claim that temperance is more virtuous than continence. Aristotelian virtue theory takes it a step further – temperance is virtuous while continence is merely praiseworthy (commendable moral effort that aims at virtue) and not virtuous. The temperate person is not tempted by other considerations when acting morally while the continent person falls short of virtue because she is tempted by other considerations when acting in line with virtue. Moral superheroes act morally but do so while plagued by thoughts and impulses that can distract from moral behavior). It is the nature of a chronic and pervasive condition like borderline personality disorder to impose constant pressure to immoral behavior. We praise the efforts of moral superheroes because their continence is moral and aims at virtue while falling short achieving virtue itself.

I dispute this account of virtue and suggest that continence can be virtuous and more praiseworthy than temperance under a specific set of circumstances, namely, the kinds of circumstances that produce moral superheroes. I argue that a virtue theory that properly praises moral superheroes will be more inclusive than a theory that insists that silencing-like temperance is required for virtue.

4.2 Clinical Profile

Personality disorders in general should be understood as pervasive and enduring – starting at early adulthood (and likely childhood), affecting multiple areas of functioning (cognition, emotional, social, etc.), and often persisting throughout the lifespan (APA, 2013). Individuals with antisocial personality disorder, for example, must show evidence of conduct disorder (characterized by aberrant and often violent behavior) in childhood and present with deficits in interpersonal emotional functioning (they fail to form caring attachments with others)

in adulthood (APA, 2013). In BPD, studies suggest a more complex developmental profile that nonetheless shows patterns of dysfunction starting in early childhood and residual symptoms that persist despite treatment (Carlson, Egeland, and Sroufe, 2009; Zanarini et al., 2005; Dutton & Golant, 1995).

To meet diagnostic criteria for borderline personality disorder, an individual must meet five or more of the following symptoms:

1. Demonstrates strong fear of abandonment (e.g. not wanting their partner to get a promotion at work because it could eventually lead to a transfer)
2. Provokes volatile relationships; oscillates between love and loathing the other (“idealization and devaluation” (APA, 2013))
3. Maintains no secure sense of self (e.g. someone who changes careers frequently, despite being happy at his job and performing well, no clear sense of goals or values)
4. Exhibits poor impulse control in areas that are harmful to themselves, e.g. reckless spending, drug use, high-risk sex;
5. Demonstrates “recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior,” (APA, 2013)
6. Displays mood instability (e.g. individual is often irritable or anxious for brief periods of time)
7. Perceives “chronic feelings of emptiness” (APA, 2013)
8. Presents difficulties regulating anger (e.g. individual might have frequent outbursts or regularly get into physical fights)

9. Experiences “transient, stress-related paranoid ideation or severe dissociative symptoms,” (often in response to real or perceived abandonment) (APA, 2013)²¹

It is important to note that while not all the individuals with BPD may experience the suicidal/self-injury symptom at any given point in time, 87% of individuals with BPD report attempting suicide at some point in lives with an average of 3.4 attempts (Andover, Schatten, & Morris, 2018). For instructive comparison – 15% of individuals with major depression and 29% of individuals with bipolar disorder report attempting suicide at some point in their lives (Oquendo, Currier, & Mann, 2006). On a broader scale, two studies found that 40-60% of adolescents and young adults who died by suicide meet criteria for a personality disorder and borderline was diagnosed in 17-50% of that subset (Linehan et al., 2002). In other words, one of the key features of BPD is suicidality.

BPD occurs in 1-2% of the population (Stanley & Singh, 2018), with women making up 75% of those diagnosed (APA, 2013).²² Studies have also found that individuals with BPD are more likely to have chronic health problems like obesity (and related syndromes like diabetes), fibromyalgia, and back pain that require medical treatment and hospitalization than individuals who have recovered from BPD (Zanarini and Conkey, 2018). These medical conditions impose an additional burden on the individual with borderline and often shorten their lifespan.

²¹ In addition to these symptoms, individuals with BPD are also diagnosed with mood disorders (e.g. depression, bipolar, etc.), substance use disorders, post-traumatic stress disorder, eating disorders, ADHD, and other personality disorders (APA, 2013). Comorbid diagnosis with bipolar disorder occurs in 10-25% of individuals with BPD or bipolar (Gunderson et al., 2006). Though BPD and bipolar are not causally related, clinicians must be mindful of the symptomatic similarities when making diagnoses. For example, an impulsive spending spree characteristic of BPD could be mistaken for a manic or hypomanic episode.

²² This gender difference is not without controversy – Grant and colleagues (2008) found equal rates in the general population using a nationwide (United States) epidemiological survey. Becker and Lamb (1994) assigned male and female designations to identical cases distributed to mental health professionals and found that the female cases were given more diagnoses of BPD than the male cases ($F(1, 283) = 5.22, p < .05$). Nearly all individuals diagnosed with BPD report abuse and/or neglect in childhood (90% and 90%, respectively), with the severity of the abuse correlating with the severity of the symptoms (Zanarini and Conkey, 2018).

Though the myriad symptoms and comorbid conditions paints a heterogeneous disorder, every individual with BPD suffers severe, pervasive impairments. Most experienced childhood abuse and/or neglect and will, at some point over the course of their battle with the disorder, attempt to take their own life. Unlike individuals with antisocial personality disorder, who fail to form caring attachments due to emotional disinterest, those with BPD long for emotional intimacy while simultaneously behaving in ways that discourage such attachments.

This dichotomy results from the medley of symptoms best depicted by clinical case studies. Katz and Cox (2002) give a rich account of 16-year-old “Diane” (name changed for privacy) who was admitted to an inpatient facility for BPD. She was admitted after her third attempted overdose and had a history of frequent self-harm. In this instance she tried to end her life after a fight with her sister. When she arrived she met with a new doctor on a different ward and did not want to work with this psychiatrist. Her conversation with the physician, “f--- you, I want to see Dr. Smith...If that’s the case, then I won’t talk to anybody, I’m fine now...” (quoted in Katz and Cox, 2002, p. 87), demonstrated dysregulated anger, poor impulse control, and a fear of abandonment. The following day she did not attend the scheduled discharge meeting but stayed in bed crying (fluctuations in mood). Eventually she was convinced to work with the new psychiatrist and stay for treatment. She did try to strangle herself once when her psychiatrist was gone for two days (fear of abandonment, emotion dysregulation) but overall had an effective treatment experience.

We can infer that Diane’s emotional dysregulation, mood fluctuations, and fear of abandonment cause relational difficulties outside of the clinic. This is further supported by the cause of her admission: a fight with her sister that led to a suicide attempt. While she faced circumstances that left her feeling emotionally vulnerable inside the facility, she also interacted

with individuals who were skilled at interpersonal interactions. In other words: Diane's symptom presentation likely mirrors how she behaves at home. Suicidal and self-harming behaviors also tend to interfere with moral functioning.

Case studies give us an idea of moral functioning in BPD but do not paint the full picture. While some disorders like psychopathy (a subset of antisocial personality disorder) seem downright amoral with symptoms like "callous/lack of empathy" and "lack of remorse or guilt" (Hare et al, 1990, p. 339), the moral implications of BPD are not obvious. The moral consequences of BPD often extend beyond interpersonal impotence and the downstream effects of suicidality and self-harm.

Individuals with BPD are more likely to violate interpersonal and community moral standards. Interpersonally, mothers with BPD are more likely to display unhealthy to emotionally abusive parenting styles, shifting from being over-involved and demanding one day to distant and disinterested the next (Stepp et al., 2011). Dutton (2006) found that men who abuse their wives often have BPD traits or met criteria for BPD.²³ These men oscillate between "the love of my life" and "I hate that b----" and demonstrate an intense fear of abandonment. One man was at office party with his wife and could not find her for a few minutes. When he found her, he insisted that they leave the party. Later that night he pulled out of the bed and beat her unconscious, breaking her nose, two teeth and bruising her ribs. When asked why he attacked her, he said that he thought she disappeared at the party to have sex with another man (she was socializing outside with female coworkers) (Dutton, 1995).

In the community, individuals with BPD are more likely to engage in reckless driving behaviors, receiving more moving and nonmoving violations than individuals without BPD

²³ This result is surprising given that we might be inclined to think abusers would be more likely to have antisocial or narcissistic personality disorder but Dutton's thorough research consistently finds that BPD is the most common among this group.

(Sansone, Lam, and Wiederman, 2010). Many of these offenses result in time behind bars.

Sansone and Sansone (2009) argue that BPD is overrepresented in prison populations. One study found that nearly 30% of a random sampling of individuals in one facility met clinical criteria for the disorder, compared to 1-2% of the general adult population (Black et al., 2007²⁴; Stanley & Singh, 2018). These individuals were serving time for offenses such as “drug manufacturing/delivery,” “assault/abuse,” “burglary,” and “DUI/driving while barred” (Black et al., 2007, p. 401).²⁵

4.3 Recovery and Moral Functioning

Recall from the introduction that Dr. Marsha Linehan, a leading scholar and clinician in BPD research, was hospitalized with borderline personality disorder as an adolescent and young adult. After failed treatments and suicide attempts, Dr. Linehan was able to manage her symptoms, earn a PhD, and create an empirically supported treatment program. Of course not every BPD success story need be as monumental as Linehan’s – individuals who survive the disorder might enter healthy relationships, pursue meaningful careers, or simply feel their lives are worth living – and this is more than enough. Recall that these individuals do experience substantial symptom recurrence but are able to manage via medication, therapy, and coping strategies. They are still predisposed to heightened emotional responses, for example, but are able to catch these feelings before they translate into impulsive actions. Despite the effort it takes to manage the residual symptoms, individuals like Linehan act morally: they stand up to injustice, they donate to charity, they fulfill their duties to their communities, etc.

²⁴ It is also worth noting that the most common disorder in Black and colleague’s (2007) prison sample was substance use disorder, affecting approximately 95% of individuals with BPD and 91% of individuals who did not meet criteria for BPD.

²⁵ Of the individuals diagnosed with BPD, 38.5% were imprisoned for “drug manufacturing/delivery,” 24% for “assault/abuse,” 12.3% for “burglary,” and 7.7% for “DUI/driving while barred” (Black et al., 2007, p. 401).

Let's examine a fictional example: an individual who has recovered from BPD, "Omar," and a typical moral agent, "Juan," both feel the temptation to rear-end the car in front of them when they are cut off in traffic but the temptation is intensified for Omar by his predisposition towards anger (residual BPD symptom). Both Omar and Juan keep their calm and drive a safe distance, resisting the immoral action. The resulting action is the same but it seems that Omar did more to act morally. Juan felt a moderate degree of anger at the driver for cutting him off. Juan easily overcame this moderate degree of anger in order to drive safely and act morally. Omar, on the other hand, is predisposed to feel disproportionate anger due to borderline personality disorder. When he is cut off in traffic he feels a strong sense of anger boiling in his chest. Fortunately he has learned to manage his symptoms and through deep breathing, calm self-talk, and other strategies he manages to overcome his anger and drive safely.

Omar spent years developing these coping and emotion regulation strategies. He expended tremendous effort *before* this moment in order to manage his anger *in this moment*. Furthermore, Omar expended more effort in the moment due to his predisposition towards anger. His extra effort in the moment and long-term mean that Omar does much more than the typical moral agent to produce the same moral behavior. It seems both inadequate and inaccurate to say that Omar and Juan should receive the same amount of praise.

We might compare this to climbing Mount Everest. Approximately 150 people have reached the top of Everest but only one man, Erik Weihenmayer, has summited the mountain while completely visually impaired (Angle, 2016). There is something admirable about anyone climbing to the top of Everest – navigating the multi-day journey, scaling the compacted ice near the top, and surviving the thin air at the infamous 26,000+ feet "death zone" – but there is

something *especially* admirable about doing it all without sight.²⁶ Similarly, it is praiseworthy for an agent to act morally but it is especially praiseworthy for someone who has recovered from BPD to act morally. Just as it requires more effort for someone without sight to climb a mountain, it requires more effort for someone who has recovered from BPD to act morally. Individuals recovering from BPD face obstacles at each turn when attempting to act morally. Their residual symptoms make it more difficult to get out of bed (the base of the mountain), manage complicated interpersonal interactions (working with teammates), regulate emotions (navigate ice climbing), etc.

While it took more effort for Omar to regulate his anger while driving and more effort for Weihenmayer while climbing Everest, these men also worked harder to prepare for these events. When discussing effort we find praiseworthy it is helpful to distinguish between two types of effort: developmental and momentary. In the moral realm, developmental effort involves cultivating virtue or shaping one's psychology in such a way that you will be more disposed to act morally in a given moment. Someone in recovery from BPD (like Omar) can spend years learning how to regulate their emotions and manage difficult interpersonal situations. They may attend weekly groups, participate in ongoing individual therapy, have had experiences with inpatient treatment and/or medications. This effort helps them enter recovery. Once in recovery they must continue to practice these skills in order to behave morally. All of this effort amounts to the developmental effort required for someone in recovery from BPD to behave morally. As I mentioned in the driving example, it is more effortful for someone with borderline to behave morally in the moment. I call this momentary effort. When Omar acts morally on the interstate he is expending more momentary effort that is a result of more developmental effort than Juan in

²⁶ Nepal has recently banned the severely visually impaired, double amputees, and solo climbers from Everest (Pasha-Robinson, 2017).

order to produce the same moral action. Omar is more praiseworthy than Juan on both fronts, but is this enough?

4.4 Moral Superheroes

Individuals who recover from BPD face sufficient challenges and are praiseworthy enough to warrant a new category: moral superheroes. Moral superheroes possess morally-relevant dispositions that set them apart from other moral agents. Unlike moral exemplars that provide examples to inspire the efforts of typical moral agents (Zagzebski, 2017; Blum, 1994), moral superheroes experience morally-relevant challenges that other moral agents do not face. These differences make it more difficult for the moral superhero to cultivate virtue.

Moral superheroes must first learn to live with significant differences in moral faculties then work towards moral excellence (developmental effort) while keeping whatever impulses or misdirection those faculties might generate at bay (momentary effort).²⁷ In order to be a moral superhero an agent must: (1) possess marked, unchangeable morally-relevant difference(s) in moral faculties; (2) act morally at approximately the same rate or better than other moral agents; and (3) act morally for the right reasons (whatever the right reasons happen to be, given your normative theory). I include the third criteria to ensure that we do not end up with accidental moral superheroes (e.g. a woman who has morally-relevant differences in her moral faculties who acts morally at the same rate as other agents simply by chance – her behavior is completely random but just so happens to be moral enough to qualify) or supervillains masquerading as

²⁷ I envision that these qualities (morally-relevant differences in moral faculties) come from mental illnesses like BPD but there is nothing to stop these qualities coming from elsewhere, assuming that the individual meets the other criteria for being a moral superhero.

moral superheroes (e.g. a man who meets (1) and (2) but only acts morally in order gain support for his presidential campaign and ultimately start a nuclear war).²⁸

It is also important to note that morally relevant differences experienced by a moral superhero are unchangeable. I do not mean that we will never improve our treatment of BPD to the point where the morally relevant differences disappear, only that the current science of treatment supports the idea that residual symptoms remain in even the most vigilant patients. These criteria is meant to exclude individuals who possess morally relevant differences that be eradicated without concerted effort such as therapy, exposures to additional viewpoints, maturity, etc. I do not consider children (even ones who act morally) moral superheroes. Someone who acts morally while nursing a cold would also not count as a moral superhero because such conditions are cured after a few weeks of rest and rehydration.²⁹ Moral superheroes, on the contrary, face lifelong challenges. Their symptoms may be better or worse at times but their condition is ongoing – no amount of time or treatment will cure the underlying cause of the morally relevant differences.

In this section I suggested that individuals like Dr. Linehan – individuals who have recovered from borderline personality disorder and lead morally functional lives – are substantial enough to warrant a new category: moral superheroes. Moral superheroes are distinct from moral exemplars in that they have morally-relevant differences that can impair their moral functioning.

²⁸ Some readers may find (3) repetitive. If an individual's action has been deemed moral presumably the reason behind this action was already investigated. This is not the case for every normative theory and (3) imposes a "right reasons" check on normative theories that do not have a "right reasons" account built in.

²⁹ In BPD, many individuals find that emotional symptoms can make social interactions more volatile (impede moral functioning) but often make an individual with BPD more sensitive to the needs of others (enhance moral functioning) (for a review see Dinsdale and Crespi, 2013). In the case of individuals who have recovered from BPD, they are able to manage their symptoms that cause impediments to moral functioning (as well as those that do not) and are thought to maintain the benefits like heightened sensitivity to the needs of others.

Unlike moral exemplars tend to act morally more often than the typical moral agent (Zagzebski, 2017), moral superheroes (particularly in the case of BPD) act morally at approximately the same rate as other moral agents but fight an internal battle to overcome morally-relevant impairments. The efforts of moral superheroes may be less visible than most agents but that does not make them any less praiseworthy.

4.5 Implications for Virtue Ethics

Individuals who recover from BPD work much harder than typical moral agents to produce the same behavioral outcomes. They expend more effort in the moment but also spend years in treatment learning how to manage their symptoms. I have argued that this extra effort warrants the designation of moral superheroes. What are the consequences of identifying this new class of moral agents? As I mentioned in the introduction, the existence of moral superheroes has consequences for discussions of temperance and continence in virtue ethics. Aristotle discusses continence, incontinence, and temperance at length in Book VII of the *Ethics*, and argues that while it is admirable that the continent person is tempted by immoral pursuits but overcomes the temptation, the temperate person is not tempted by immoral actions (1151b35-1152a2). In the contemporary tradition, McDowell (1978) argues that the virtuous person is not tempted by immoral action; these options are “silenced” and the virtuous person acts morally without any second thoughts (p. 28).³⁰

4.5.1 Aristotelian Temperance and Silencing

Aristotle argues that while continence is “good and praiseworthy” (1145b8), only temperance counts as virtuous. He states that while the continent person is tempted by (but does not act upon) “base” desires, the temperate person is completely free from such desires

³⁰ Some may note that Kantian ethics could weigh in on this issue as well. In this essay I have chosen to focus on Aristotle and will take up discussions of Kant elsewhere.

(1146a12; 1152a1-2; cf. Roberts, 1989). We become temperate through habituation and by cultivating our desires such that they align with what is moral and rational.

John McDowell (1978) provides an account of temperance in which all non-virtuous considerations are “silenced” in the mind of a virtuous person (p. 26). The virtuous person perceives the situation differently than the continent person and does not consider “reasons for acting otherwise” (McDowell, 1979, p. 26). While the continent person may see danger and be unsettled by fear or the deceived hope that someone else will save the drowning child, the virtuous person will be clear-headed in her decision to jump in the water. The continent person may ultimately decide to do the virtuous action (she may even do it as quickly as the virtuous person) but she is nonetheless affected by non-virtuous considerations and cannot be considered temperate. The mind of the virtuous person, on other hand, is set solely on the virtuous task in front of her. She perceives the relevant dangers differently: she takes appropriate precautions before diving into the water (e.g. brings a spare flotation device, knows she is a good swimmer) because proper preparation is key to bravery as well (McDowell, 1979; *Nicomachean Ethics* 1117a9-25).³¹ She does not experience feelings of fear or temptations to act otherwise.

The silencing account of temperance is a tall order.³² Not only must we act as morality demands without being truly tempted by non-virtuous considerations, we cannot even *think* about these considerations when virtue calls. We must perceive, think, and act morally in order to be virtuous. Let’s say that I am excited about attending my best friend’s wedding. Just as I am

³¹ To jump into the waters too quickly and without proper considerations would be brash rather than brave, the opposite extreme of cowardice on Aristotle’s view of courage as a virtue of the mean. The well-prepared person who does not act is not courageous either.

³² McDowell grants that the virtuous individual will be tempted by non-virtuous considerations outside of morally-demanding situations: “In the absence of a requirement, the prospective enjoyment would constitute a reason for going ahead” (1978, p. 27). In a non-moral context the virtuous person could relax on the beach instead of diving into treacherous waters, enjoy a fancy dinner rather than rush into a burning building, or accelerate 0-100 on a controlled racing experience track with proper safety gear.

about to leave my partner cries out in pain, clutching their side. My partner is experiencing a sharp, agonizing pain in their right side. It is clear that they need immediate medical attention. I do not hesitate – I drive my partner to the nearest medical facility and accompany them throughout their care. Most of my mind is consumed by worry and fear for my partner’s well-being as well as practical concerns such as choosing the right facility and managing insurance. There was, however, a flicker of sadness the moment I realized we would not be attending the wedding. I might even have moments once my partner is under stable care where I think longingly of the ceremony and the speech I had planned for the reception. This is not to say that I regret taking care of my partner, only that the wedding is not completely removed from my mind. I recognize that morality (in conjunction with the demands of my relationship and love for my partner³³) demands that I forgo the wedding to take care of my ailing partner and I act accordingly. On the silencing view, my action was not virtuous because I still had thoughts of the wedding: my sacrifice was not complete. My continence (I took care of my partner despite thoughts of the wedding) is praiseworthy but falls short of virtue. If I managed to remove all thoughts of the wedding from my mind as soon as I realized my partner was seriously ill I would be more praiseworthy and likely considered virtuous on the silencing view. Although the silencing view sets a high bar for virtue we can see the intuitive appeal in this example: imagine my partner found out that I was having fleeting thoughts of the wedding while they were in agonizing pain. They would still be grateful that I came to their aid but my longing (however brief) to be elsewhere does seem to detract from the moral worth of my actions.

The silencing view also implies that the temperate person must have their mental faculties in order: they (unconsciously) regulate their emotions in stressful situations, they

³³ See Railton (1984), “Alienation, Consequentialism, and the Demands of Morality.”

overcame their fears, and they are interpersonally effective. The virtuous person cannot have ongoing symptoms of mental illness. Connecting the silencing view with BPD and the discussion in the previous section, moral superheroes are continent but not virtuous. Moral superheroes override temptations to act morally and this is the best they can do. They cannot fully extinguish their impulses; rather, they expend additional effort daily to overcome temptation and act morally. The moral agent who has never experienced BPD and acts without inclination to do otherwise expends less effort but is considered more praiseworthy than the moral superhero on the silencing view. Moreover, the moral agent whose inclinations to act contrary to the demands of morality are silenced can be considered virtuous on the silencing view while the moral superhero (who, again, expends more effort for the same moral behavior) cannot.

Perhaps my interpretations of Aristotle and the requirements of silencing have been too limited. We might adopt a more generous understanding of what is required to act with Aristotelian virtue: virtuous actors do not need to fully silence competing inclinations, they just cannot take them seriously. I can have brief, wistful moments where I think about my best friend's wedding while attending to the needs of my ailing partner as long as I do not seriously entertain the option of leaving the hospital. I am sad about the wedding but the decision does not weigh on me or cause me intrapersonal turmoil and this is what separates me from the merely continent agent. This interpretation of Aristotle allows agents to encounter non-moral considerations while also maintaining a sense of internal harmony while acting virtuously.

Unfortunately moral superheroes are still not virtuous on this interpretation of Aristotelian virtue. The non-moral considerations encountered by moral superheroes are stronger than fleeting thoughts that can be dismissed with minimal effort by most virtuous agents. Moral superheroes, particularly, individuals in recovery from BPD, experience certain non-moral

considerations as compelling alternatives to moral action. In the wedding case, the thought of leaving my partner alone at the hospital does not actually cross my mind – I am merely momentarily saddened at missing this important event. In the driving case, the thought of rear-ending the car that cut him off does cross Omar’s mind and presents as an actionable alternative to regulating his anger and driving calmly (acting morally). Omar consistently rejects the former in favor of the latter but we can see how in the case of moral superheroes, competing inclinations offer a genuine challenge to moral action. It is not accurate to say that moral superheroes experience internal conflict when acting morally – Omar does not waffle between aggression and safe driving – but it is also inaccurate to suggest that the discordant impulses that arise from conditions like BPD can constitute Aristotelian intrapersonal harmony. Even with a more generous understanding of silencing and Aristotelian virtue theory it seems that moral superheroes still fail to be virtuous.

Proponents of Aristotelian virtue might respond by saying that moral superheroes are particularly praiseworthy continent individuals since they are tempted by especially strong desires. Support for this claim can be found in the *Ethics*: “If...the appetites are weak and not base, continence is nothing impressive” (1146a15-16). If Omar resists a fleeting desire to change the channel from one baseball game to another when watching television with Juan, no one would find his continence praiseworthy. If, on the other hand, Omar resists the strong impulse to physically attack Juan for accidentally totaling his car a second time, then his continence is very praiseworthy. Proponents of the silencing view would maintain, however, that a temperate person is nevertheless more praiseworthy than any continent person, no matter how difficult the temptation the continent person overcomes.

We might see the variations in praiseworthiness amongst continence as supporting the moral superhero theory. On this view, moral superheroes experience more intense temptations than continent individuals without BPD (or other qualifying conditions). The actions of moral superheroes would likely be the most praiseworthy of all continent individuals.

But is this good enough? As I mentioned, many approaches that classify temperance as virtuous typically classify anything below temperance as non-virtuous, no matter how praiseworthy. Moral superheroes may be the most praiseworthy of all continent individuals but they are not virtuous, according to the silencing view. However, many moral superheroes seem *more virtuous* than the average virtuous person. Take Marsha Linehan: in the moment, she overcomes her fear of crowded spaces each day to drive to work and do research that helps a marginalized population (Carey, 2011). Over time she cultivated the emotional stability to be vulnerable with clients and in group settings, risking her own mood fluctuations. She raised a well-adjusted daughter while continuing her career and developing the first empirically validated treatment for BPD. She acted morally while constantly regulating her emotions, actively using mindfulness and other support skills, forcing herself to get out of bed, and so on. On the silencing view (and other views that endorse a similar definition of temperance), however, the extraordinary effort she goes through each day to act morally makes her simultaneously *more* praiseworthy than the average continent agent *and* unable to achieve virtue. It looks like the same factors that make her more praiseworthy also make her unable to achieve virtue. This appearance is puzzling.

Recall that according to the silencing account the virtuous, temperate person does not overcome mental obstacles in the moment in order to act virtuously. She does not consciously regulate her emotions because she did enough regulation in her past that now she feels the right

things in the right amount automatically. The virtuous agent became virtuous through practice – she repeatedly acted courageously in daunting situations, she chose over and over again to give generously to those in need, etc. She habituated her emotions, overcame her fears and vulnerabilities, and treated any underlying conditions so that when morality called she could answer without a second thought. Linehan might appear to be working harder but the virtuous person put in the hard work earlier in the process. If Linehan keeps working, one day she can be virtuous.

Unfortunately this is not the case. BPD is a chronic and pervasive condition. Those who recover to become moral superheroes deal with residual, sub-clinical symptoms that affect their daily functioning. Individuals like Linehan go through years of treatment and deliberate effort in order to recover from BPD. This background effort is at least as difficult if not greater than the background effort put forth by a temperate agent. When the temperate person goes to act morally the action requires no mental strain, according to the silencing view. When the moral superhero goes to act morally they must put forth effort in the moment in addition to their past effort in recovering from their condition. Individuals in recovery manage their symptoms but their battle to manage BPD can never be fully silenced. Barring some revolution in psychopharmacology, managing symptoms is the best possible outcome for BPD (and many other psychiatric conditions). Moral superheroes cannot be temperate if we understand temperance through the silencing view. On this account the virtue of temperance is also inaccessible to many people with mental illness who manage similarly intrusive conditions.

Furthermore, some virtue theorists ascribe to Aristotle's theory of the unity of the virtues. This idea claims that in order to be truly virtuous one must cultivate *all* of virtues – one cannot be truly courageous without being temperate, truly charitable without being courageous, etc.

(MacIntyre, 1981). Many authors find the unity of the virtues counterintuitive (e.g. Flanagan, 1991), others are nonetheless committed to the view. Moral superheroes introduce another criticism of the unity of the virtues: if moral superheroes cannot be temperate then they can never be courageous, charitable, just, etc. I have argued that it seems implausible to praise virtuous agents more than continent agents in the case of superheroes but it seems even more implausible to suggest that moral superheroes are barred from courage when acting bravely and charity when acting generous as well. I chose to focus on temperance and continence in this essay but the consequences of this debate spread to all other virtues according to the unity of the virtues thesis.

4.5.2 Fork in the Road

Moral superheroes bring up two related problems for virtue theory: (1) moral superheroes seem at least as praiseworthy and likely more praiseworthy than your average virtuous person, they are continent are thereby viewed as less praiseworthy than temperate agents on most views; (2) despite their intuitive moral agency and good deeds, moral superheroes can never be virtuous on many accounts of virtue theory. One solution is simple but will require some explanation: accept both (1) and (2) and acknowledge that while this outcome is not ideal, it does not affect the majority of moral agents. On this view we ought to treat moral superheroes as outliers in a data set – better to acknowledge that they are different but exclude them from our overall explanation to avoid skewing the rest of the data. The other solution (the solution I favor) involves rejecting the silencing account in favor of a pluralist view on what it means to act virtuously.³⁴

The simplest solution is to accept the consequences of (1) and (2) and maintain that moral superheroes are not virtuous. As I mentioned in the introduction, borderline personality disorder

³⁴ There is also a third solution: we could reject the unity of the virtues. If we reject the unity of the virtues we throw out a major tenant of Aristotelian virtue theory. Moreover, we do not resolve all problems for the silencing view since moral superheroes cannot be temperate.

affects 1-2% of the adult population.³⁵ I suspect that other mental illnesses or conditions will meet criteria for moral superheroes but I have not explored that idea in this essay. That being said, it is highly likely that we are talking about close to 5% of the adult population for a low estimate. It is one thing to say many people do not make the effort towards virtue but another to say they cannot work towards it. If we stick to our guns with the silencing we are effectively saying that at least 1/20 of the moral community cannot be temperate and (according to the unity of the virtues) can never be virtuous. The criticism of the silencing view has gone from making temperance difficult for everyone (recall the discussion of the silencing view) to impossible for certain groups. If we accept the unity of the virtues, not achieving temperance means that moral superheroes cannot be virtuous.³⁶

I reject the simple solution, and offer a more compelling alternative: a pluralistic account of virtue. The pluralistic account accommodates moral superheroes as well as agents who are able to pursue Aristotelian virtue via silencing or similar accounts. My view solves problems (1) and (2) while preserving the value traditional virtue ethics: individuals can pursue virtue through traditional silencing and silencing-like routes and moral superheroes can also pursue virtue through continence (as described earlier in this essay). The existence of moral superheroes suggests that virtue is not one size fits all. The silencing view implies that a virtuous agent cannot experience dispositions to act otherwise when acting morally. I accept that this is one path to virtue but unlike proponents of the silencing view, I do not believe this is the only way to be virtuous. Moral superheroes demonstrate that some individuals who experience dispositions to act otherwise when acting morally can be virtuous, despite failing to meet the requirements of

³⁵ I acknowledge that not all individuals with BPD will recover but I take an optimistic stance that all individuals have the potential to recover and qualify for moral superhero status.

³⁶ According to the unity of the virtues you must cultivate all of the virtues to be virtuous. You cannot be truly virtuous if you are temperate but not brave, for example.

the silencing view. My view is supported by other accounts of virtue, including Foot's (2002) corrective view.

Foot (2002) offers a corrective understanding of virtue that may be compatible with the moral superhero account by removing some of the cognitive component of temperance. By placing less emphasis on every thought in an agent's head we maintain many of the important demands of virtue while avoiding unnecessary demands. She also acknowledges that not all behavioral hesitation is made equal.

Foot (2002) thinks that the amount of virtue expressed in instances of hesitation (apparent incontinence) depends on the particular virtue and if the circumstances truly challenge the virtue. If a witness feels some fear when testifying against someone who tried to take her life, this seems appropriate. The virtue in this scenario is courage and the circumstances seem to truly challenge courage. If the witness feels fear she is not being incontinent – she genuinely has something to fear in this scenario. Her fear is appropriate for the situation and by testifying despite her fear she acts morally. If, on the other hand, a man is tempted to stay home and play video games rather than visit his terminally ill friend in the hospital, this seems inappropriate. In the second scenario the virtue is charity and the circumstance do not seem truly challenging. The man is incontinent rather than genuinely challenged by some competing circumstances.

On one interpretation moral superheroes struggle to act morally because they are continent (and thereby less praiseworthy) the way Foot describes: they are tempted by non-moral considerations. Returning to BPD, we might think of another case with Omar and Juan. The two friends have had plans for weeks to attend a baseball game. Juan calls at the last minute and asks to reschedule, apologizing and claiming that he is accidentally hungover. Charity demands that Omar reschedule when he is available but Omar is tempted to tell him that he is unavailable. His

impulse is driven by fear of abandonment and poor emotion regulation (symptoms of BPD).

Despite the temptation to lie to his friend, Omar acts morally: he asks if Juan wants company while he recovers and says he is willing to reschedule.

We can understand the moral superhero's incontinence to increase the virtue of the action because the moral superhero has not cultivated her mere continence, rather, her continence (and accompanying inclinations to act otherwise) is something that has happened to her by way of her disorder.³⁷ Moreover, the moral superhero has worked to cultivate virtue as evidenced by her ability to behave morally at the same rate as any other moral agent (stipulated in the second requirement for being a moral superhero).^{38, 39}

The temptation to act otherwise in the case of individuals in recovery from BPD (and other moral superheroes) is intense but it is not the product of vice or mere incontinence. Foot's (2002) supports the idea that overcoming this interference to act morally is praiseworthy and virtuous. By adopting pluralism we reject the interpretation that silencing is the only route to virtue.⁴⁰ I maintain that many instances and agents will find silencing an appropriate path to

³⁷ Again, I am open to instances where someone meets the qualifications for being a moral superhero without having mental illness.

³⁸ Foot's (2002) arguments are further supported by Carr (2009).

³⁹ If we follow the implications of Foot's view we might have concerns about individuals who are not quite moral superheroes but are working toward this designation. Behaviorally, the young aspiring moral superhero suffering from borderline personality disorder and the incontinent young adult may look remarkably similar. Someone early in treatment for BPD may not know that avoiding social interactions and moral responsibilities that make them feel uncomfortable will only make it more difficult to rise up to the occasion (and act virtuously) in the future. Similarly, the incontinent young adult avoids situations that call for virtue and then struggles to act when the call to be virtuous arrives on her doorstep. Despite the behavioral similarities there are two key differences: (1) the aspiring moral superhero's incontinence comes from her illness while incontinent young adult chooses incontinence under the influence of her own desires and preferences rather than external forces; (2) the aspiring moral superhero is in treatment for BPD and is, through this process, removing some of the barriers that prevent her from acting morally. Recall that not everyone (or even most people) with BPD becomes a moral superhero; only those who successfully manage their condition and act morally are eligible for the designation.

⁴⁰ Similarly, Foot's approach can be applied to Kantian virtue theory. We can interpret Kant to favor a similar position about the cause of hesitation and find hesitation admirable if and only if the hesitation is caused by something that does not detract from the virtue of the action. While this is not the dominant interpretation of Kant, it is not inconsistent with all readings (see Baron, 2006).

virtue. Moral superheroes suggest that the path to virtue is pluralistic: some agents with certain dispositions act without silencing inclinations to do otherwise and this should be considered virtuous.

4.6 Conclusion

Borderline personality disorder is a chronic and pervasive condition that affects social, emotional, and moral functioning. I argued that individuals who have recovered from BPD and act morally should be considered moral superheroes. Moral superheroes, act morally at the same rate (or better) than typical moral agents despite morally-relevant impairments. I argued that moral superheroes do not fit standard interpretations of virtue theories – specifically, predominant the silencing interpretation of Aristotle’s virtue of temperance. These theories cannot properly acknowledge the mental effort moral superheroes expend daily in order to function as a productive member of the moral community. I offered Foot’s account as a way to preserve virtue theories without excluding a significant portion of the population from virtue. The silencing account is not compatible with this solution but I argued that it is worth adopting a pluralistic view of virtue to properly praise individuals like Dr. Marsha Linehan:

“During those first years in Seattle she felt suicidal while driving to work; even today, she can feel rushes of panic, most recently while driving through tunnels. She relied on therapists herself... ‘I’m a very happy person now,’ she said in an interview at her house near campus... ‘I still have ups and downs, of course, but I think no more than anyone else.’” (Carey, 2011 with quotes from Dr. Marsha Linehan).

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Chapter 5: Empathy, Epistemic Impairment, and Moral Responsibility in Autism Spectrum Disorder

5.1 Introduction

I am pathologically over-sensitive to criticism, I fear that people are not going to be pleased with me. I am afraid that if I do the wrong thing or say the wrong thing I will undo all the progress I have made so far. It could happen as a result of doing something by accident. (Jack Dewey, quoted in Dewey, 1991, p. 202)

I met Daniel when I was working as a research assistant in a lab studying diagnostic measures of autism spectrum disorders.⁴¹ His mother was completing the Autism Diagnostic Interview (ADI-R) with the lead psychologist and I was assigned to keep him company for a few hours. When I greeted him he said “hello” back without looking and continued to play on the computer. He appeared to be around fourteen years old, thinly built but not athletic, and uncertain of what to do with a college-aged woman in the room. His mother probably felt comfortable leaving him alone but our protocol was to leave none of the participants alone, especially since we were evaluating their level of functioning without consulting previous diagnoses for the sanctity of the study. He shot me nervous glances for the first fifteen minutes before asking:

“Do you like LEGOs?”

“Absolutely!”

He proceeded to show me YouTube videos of stop-motion LEGO reenactments of World War I battles. I happen to have a penchant for World War history and the level of detail in the videos themselves was captivating: my engagement in this shared activity was genuine. Nonetheless, Daniel stole glances from the screen to puzzle at my face, furrowing his brows each

⁴¹ Name changed for privacy.

time. We talked at length about the perils of trench warfare, the foolhardy flamethrower, and the abyss of “No Man’s Land” – all illustrated in a sea of plastic yellow faces and bend-less joints. After the second half-hour video Daniel turned to me, crestfallen: “I know these are boring. We don’t have to watch anymore if you don’t want.” It was clear others had told him this before, but what seemed especially evident was that others had watched these videos with him and feigned interest. The impetus pulling him away from the screen to glance at my face was to try and discern if I was *truly* enjoying myself.

I assured him that my interest was genuine and that I was happy to keep watching these videos until his mom returned. His face relaxed as he selected another reenactment. He continued to glance at me, even when we were not discussing tanks that could drive over barbed wire, as if he wanted to make sure I was not losing interest. His concern did not feel selfish – like that of a young man who wanted to keep watching his favorite videos⁴². Instead, I felt like I was spending time with someone who cared about my interests and happiness.

After Daniel completed the full battery of psychological tests, I followed up with the research team to see if he met criteria for autism spectrum disorder (ASD). Daniel was diagnosed high-functioning autism spectrum disorder (HFASD, formerly Asperger’s Syndrome). ASD is chronic condition developed in early childhood that affects social, sensory, and (in some cases) cognitive functioning (APA, 2013). The severity of ASD varies according to the individual’s level of functioning across each domain. ASD is treatable through skill- and accommodation-based interventions but is not curable. As a young adult, Daniel had received some psychological services through his school and his community to hone his social and communication skills.

⁴² He told me he could easily watch the videos at home as part of his attempt to discern whether or not I was truly enjoying them.

If Daniel continues to practice social and communication skills he may be able to discern needs, wants, or interests as well as individuals who do not have ASD. Daniel may need to be more explicit – asking if someone is enjoying themselves (like he did with the videos) – and he may need to work harder – attending social skills groups with peers who also experience social impairments to learn strategies for interacting with others – but Daniel is capable of navigating the social terrain. More importantly, Daniel is capable of empathy. Despite persistent social impairments, individuals with HFASD are capable of empathy and should be held morally responsible for their actions.

First I will discuss the diagnostic criteria for ASD and clarify what distinguishes someone with HFASD from the rest of the heterogeneous spectrum. I then establish criteria for research on ASD and empathy and evaluate three studies that approximate these criteria. From these results I analyze how social impairments affect moral functioning. I argue that while social competency makes morality epistemically easier, keen social functioning is not necessary for moral functioning.

5.2 Diagnostic Criteria

To be diagnosed with autism an individual must exhibit three social deficits and two or more restrictive/repetitive symptoms. The three social symptoms are:

- (1) “deficits in social-emotional reciprocity” (e.g. difficulty carrying on conversation, reciprocating emotional gestures)
- (2) impairments in nonverbal communication (e.g. poor eye contact, trouble reading body language)
- (3) “deficits in developing, maintaining, and understanding relationships” (APA, 2013)

Individuals must also demonstrate two or more restrictive repetitive symptoms:

- (1) “stereotyped or repetitive motor movements, use of objects, or speech”
(e.g. hand flapping, lining up toy cars, repeating meaningless phrases)
- (2) rigid adherence to schedules or routines
- (3) restricted interests (e.g. fascinated by wheels rather than cars)
- (4) “hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment” (e.g. strong negative reaction to certain sounds, insensitivity to pain) (APA, 2013)

The DSM describes three different severity levels of autism spectrum disorders ranging from Level 3 “Requiring very substantial support” to Level 1 “Requiring support” (APA, 2013). Functioning at each level will look a different at each age. The levels are broad enough to cover a variety of functioning but we can still get a general idea. Individuals in Level 3 may require full time care. They may be completely nonverbal and/or learn to use a symbol chart to communicate with a treatment provider. They will likely exhibit several repetitive motor behaviors (e.g. hand flapping, making sounds) and exhibit extreme distress when asked to change the present course of action. It is often more helpful to refer to individuals with Level 3 ASD as having severe ASD. Individuals at Level 1, on the other hand, do not require full time care to perform age-appropriate basic functions but may need more guidance than their peers. They speak clearly but will struggle with social interactions. Fortunately, these individual can learn skills to integrate themselves more fully into their social environment. They are inflexible in multiple areas and have a hard time changing tasks. This essay focuses primarily on individuals in Level 1, “Requiring support.” Members of this population are considered to have high-functioning autism spectrum disorder (HFASD) and I will use this designation through the essay.

From the symptom descriptions and examples, it is clear that ASD is typically diagnosed in childhood. Unlike some conditions diagnosed in childhood, ASD is a lifelong disorder that persists into adulthood (APA, 2013). While individuals often learn strategies to manage their symptoms, there is no cure for ASD. For the purpose of discussing morality and ASD I will focus on adults, though some of the research I will cite involves children and young adults.

As the long and complex list of symptoms suggests, ASD presents disparately in different individuals. Historically ASD was divided into three different conditions: autism, Asperger's syndrome, and pervasive developmental disorder not otherwise specified (PDD-NOS) (Ozonoff, South, & Miller, 2000). Autism and Asperger's syndrome were differentiated by differences in cognitive functioning and levels of support. Individuals with Asperger's syndrome required less support and performed better on cognitive tasks than individuals with autism. The variability within the autism group, however, was still significant with individuals requiring some support (e.g. communicating verbally, attending school with assistance, feeding themselves) to individuals who require significant support (e.g. no verbal communication, one-on-one specialized instruction in an autism-specific school, needs feeding assistance). Individuals with PDD-NOS did not meet previous DSM criteria for autism or Asperger's syndrome but demonstrated difficulties in cognitive, social, emotional, and/or behavioral functioning. Some individuals presented all symptoms but were excluded for historical reasons. If the parent does not remember the child experiencing difficulties before age three or the child is adopted, spent time in foster care, was diagnosed as an adult without access to this information, or simply developed symptoms later in childhood they may not have been able to satisfy the requirement that the child must have presented with "difficulties in at least one domain...prior to age 3" (Ozonoff, South, & Miller, 2000, p. 32). Most often, however, individuals with PDD-NOS were

just shy of meeting the required number of symptoms needed for diagnosis and were typically high-functioning, though not always specifically in the cognitive domain like those with Asperger's syndrome. Unlike Asperger's syndrome, PDD-NOS was not meant to be a coherent diagnosis with similar presentations but rather a catchall category for those who did not meet criteria for autism or Asperger's syndrome but would still benefit from social and educational services.

By collapsing all three conditions we may have sacrificed the coherence of Asperger's syndrome in order to rid ourselves of the arbitrary distinction between PDD-NOS and autism.⁴³ The justification behind uniting these conditions into a spectrum has been debated and discussed elsewhere so I will not debate this decision here (see Moran, 2013 for discussion). If autism covered a broad range of presentations before the merger, then adding two conditions will only increase how the symptoms manifest.

To make this condition more concrete (and more human), we can look at case studies at multiple stages of ASD. Starting with Level 3, "requiring very substantial support," we can look at Ashley as described by Cathy Lord (2014), one of the leading researchers in the field. Ashley was an adolescent with ASD, intellectual disability, and Kleefstra syndrome, a genetic disorder that contributed to her intellectual impairment. She attended a special school where she could read at roughly a second grade level with little or no understanding. She communicated verbally through curt, short sentences and could recognize words but often ignored others and did not spontaneously engage in joint attention. She loved license plates – she would draw detailed

⁴³ I do not mourn the lost of Asperger's syndrome but we cannot deny its construct validity. See Frith (1991) for a discussion and historical analysis. Lord (2014), on the other hand, argues that we should take instances of familial autism and ASD as evidence that the conditions are related and should share the same diagnoses. Individuals diagnosed with ASD may have siblings diagnosed with autism or PDD-NOS.

images of license plates of various states from memory. She was also attached to her family but did not express much interest in other adolescents.

As Lord (2014) rightfully notes, Ashley's intellectual impairments and genetic condition raise questions about the validity of her diagnosis. If Ashley suffered from intellectual disability without ASD we would expect her to have a wide range of interests – coloring, stuffed animals, toy cars, etc. – rather than an intense interest in license plates and little else. Furthermore, we would not see the same kinds of social impairments. Ashley may have difficulties communicating or engaging in the same kinds of activities as her peers but she would be interested in her peers and be capable of joint attention.

It is also instructive to discuss a case at the other end of the spectrum. Individuals like Daniel with HFASD live very different lives than individuals like Ashley, despite being diagnosed with the same condition. Margaret Dewey (1991) describes a conversation with Anne who is an example of someone with Level 1 ASD: “requiring support.” Anne lives on her own in an apartment, holds a master's degree, and enjoys reading and writing in her spare time. Despite what she has accomplished, Anne worries that society will reject her:

I think I am capable of doing good work and of being a loving wife. But I may never be able to participate fully in society. I may never be able to find somebody or be able to have a full-time job and support myself. There may be just this barrier and society will not *let* me. (quoted in Dewey, 1991, p. 202, emphasis original)

Anne recognizes that she becomes fixated on certain subjects, talking about a particular topic after her audience has lost interest (recall Daniel's LEGO reenactments). She has also developed obsessive anxious thoughts (did I leave the stove on?) and compulsive checking behaviors (getting out of bed to check the stove). She is very involved in her church and volunteers in politics but wishes she had more friends.

While Ashley and other individuals with Level 3 ASD experience deficits in cognitive, emotional, behavioral, and social functioning, individuals with Level 1 ASD like Anne and Daniel experience primarily social deficits. Anne experiences some behavioral deficits (e.g. checking the stove) but these are not the kinds of things that interfere with moral functioning. In the next section I will evaluate whether or not the social deficits experienced by individuals with HFASD are enough to excuse or exempt them from moral functioning.

5.3 Evaluating Empathy in ASD

Few authors are willing to take a definitive stance on the moral status of individuals with ASD. De Vignemont and Frith (2008) and Roskies (2011) conclude that the research on ASD (even high-functioning) is too tenuous to draw any conclusions about moral functioning. Kahn and Fenton (2009) and Jaarsma (2013) conclude that individuals with HFASD should not be held morally responsible for their behaviors due to emotional deficits – specifically, deficits in empathy.⁴⁴ None of the authors cite social deficits as a driving force for moral exemption but all acknowledge that impairments in social functioning can interfere in morality.

As I mentioned in the previous section, I will focus primarily on adults with high-functioning ASD (HFA). I do want to take a moment to discuss the moral status of individuals with severe ASD (Level 3). Recall from the description above, individuals with severe ASD have deficits in the most basic areas of functioning. Many of these individuals also suffer from intellectual deficits (APA, 2013). On most accounts of moral responsibility individuals with severe autism are exempt due to global deficits in basic functioning.⁴⁵ I take this claim to be non-controversial and will not discuss it further.

⁴⁴ I disagree with their understanding of empathy but their contribution is still relevant to our discussion.

⁴⁵ See Stout (2016) for a discussion.

Individuals with HFASD present a more complicated ethical case. On the one hand, they do not suffer the profound functional deficits that plague those with severe autism. On the other hand, the social deficits exhibited by these individuals may mitigate some of their moral responsibility. Additionally, authors like Kahn and Fenton (2009) and Jaarsma (2013) argue that individuals with HFASD experience deficits in empathy and conclude that these emotional deficits thus exempt them from moral responsibility. By carefully analyzing the empirical literature I intend to distinguish between social deficits and empathic functioning. The apparent deficits in emotional functioning in individuals with HFASD are better explained by deficits in social functioning that can limit epistemic access to morally relevant information.

5.3.1 Criteria for Obtaining Good ASD and Empathy Data

Before we dive into research on ASD and empathy we must first establish some constraints on the kinds of studies we are examining. The psychology and neuroscience literature is full of contradicting studies on ASD and empathy and we must use a reasonable heuristic to identify the most reliable sources. Rueda, Fernández-Berrocal, and Schonert-Reichl (2014) argue for two criteria in particular: a homogenous ASD sample and the use of performance-based measures to assess empathy deficits. I will discuss each of these constraints in turn.

As I discussed in the previous section, ASD has many heterogeneous presentations. Recall that previous versions of the DSM distinguished individuals with Asperger's syndrome from autism more broadly for many reasons, but for the purposes of psychological testing it is important to note that language was a major divide between Asperger's and autism more generally. Many studies of empathy in ASD still use this terminology to specify which portion of the population they are studying. Asperger syndrome may allow for a convenient distinction between HFASD and the rest of the spectrum but it is not a precise instrument.

To be more precise, research on empathy in ASD should involve participants who qualify for the Autism Diagnostic Observation Schedule (ADOS) Module 4. The ADOS assesses the patient or participant directly through structured interactions with the experimenter and comes in four different modules, numbered 1 through 4 (Lord et al., 2000). ADOS Module 1 is designed to test nonverbal young children and Modules 2-4 increase in complexity, evaluating ASD in higher mental ages and levels of verbal ability. Module 4 is designed to evaluate ASD in high-functioning older children and adults (Level 1). Similar to Modules 2 and 3, participants may be asked to construct a scene using figurines (optional) or retell a story using a picture book (required). While the earlier modules (1 and 2) involve the experimenter observing while the participant completes a task, the later modules (3 and 4) involve more conversations between the experimenter and the participant.

According to the authors, Module 4 is designed to evaluate “verbally fluent adults and adolescents who are not interested in playing with toys such as action figures (usually over 12-16 years)” (Lord et al., 2000, p. 207). This excludes younger children who might be evaluated for ASD using Modules 1-3 and non-verbal adolescents and adults. Module 4 involves conversations about daily living as well as social interactions (Bastiaansen et al., 2011). For example, the interviewer asks the participant about her experience with bullying in school and if other students were bullied. This gives participants an opportunity to discuss their understanding of the feelings of others (Lord et al., 2012). In another section, the participant is asked to describe her feelings of happiness, fear, anxiety/concern, anger, sadness, and relaxation/contentment. Module 4 also includes a scoring coding section “Comments on Others’ Emotions/Empathy” to be evaluated during conversational and narrative tasks (Lord et al., 2012, p. 17).

Unfortunately, none of the studies on ASD and empathy use the criteria outlined above.⁴⁶ Most of the studies I discuss below use DSM-IV-TR criteria for Asperger syndrome which helps narrow down the sample. While this distinction is not as modern or precise as the ADOS Module 4, it does include most of the individuals we are interested in studying. Future studies of empathy in ASD should use Module 4 eligibility.

The second criterion proposes that researchers use performance-based measures of empathy rather than self-report. Self-report measures are often biased in favor of the participant. Items such as “When I’m upset at someone, I usually try to put myself in his shoes for a while,” ask the participant to evaluate her own empathic abilities and have a clear, socially desirable response (Davis, 1980). Self-assessment runs the risk of being inaccurate; after all, an individual might think of herself as someone who can readily put herself in a character’s shoes when she actually struggles with perspective-taking tasks.

It may turn out that neither a homogenous sample or performance-based tasks are stringent enough. Perhaps a new measure of empathy in HFASD will prove more accurate than our current performance-based measures. It may be the case that only certain performance measures give us an accurate approximation of empathy in ASD.⁴⁷

5.3.2 Data on HFASD and Empathy

Using these criteria I identified several studies that measure empathic capacities in individuals with HFASD. Rueda, Fernández-Berrocal, and Baron-Cohen (2015) measured empathy using Interpersonal Reactivity Index (IRI, Davis, 1983) and the performance-based Eyes Test (Baron-Cohen et al., 2001). The IRI is a self-report, Likert-scale consisting of two subscales, perspective taking (PT) and empathic concern (EC). The Eyes Test is a performance-

⁴⁶ Studies available at time of publication and using relevant search criteria.

⁴⁷ I am grateful for personal correspondence with Susan Fitzpatrick who pointed out this issue.

based measure that evaluates the participant's ability to recognize the mental states of another agent from a photo of the agent's eyes and eyebrows (Baron-Cohen et al., 2001). In both the self-report perspective-taking subscale of the IRI and the Eyes Test, the authors found statistically significant deficits in participants with Asperger syndrome compared to age-, sex-, and IQ-matched controls (Rueda, Fernández-Berrocal, & Baron-Cohen, 2015). At first glance it appears that individuals with HFASD demonstrated deficits in empathic functioning in this study. If we look more carefully we see that both the perspective-taking subscale and the Eyes Test measure social rather than emotional capacities. The authors describe their results in terms of social consequences: "during adolescence youth with AS usually become 'target' of bullies...and do not distinguish between 'friendly jokes' and aggression or offenses" (p. 92). This suggests that the difference in descriptions is best explained by social factors.

Furthermore, individuals with Asperger syndrome did not perform significantly different on the empathic concern subscale of the IRI. The empathic concern subscale contains items like "I often have tender, concerned feelings for people less fortunate than me" (Davis, 1983, p. 117). Though it is a self-report measure (like the perspective-taking subscale), the empathic concern seems to track the emotional capacities involved in moral functioning.

Using similar methodology, Senland and Higgins-D'Alessandro (2013) compared empathy, social competency, and moral reasoning in adolescents with HFASD (the DSM-5 definition, spanning the older notions of autism, PDD-NOS, and Asperger syndrome) and age-matched controls. The authors also used the IRI as a self-report measure of empathy but employed the qualitative "difficult real life situations interview" (Wainryb, Brehl, and Matwin, 2005) as a performance-based measure. In this paradigm experimenters ask participants to do the following:

- (1) discuss an instance where they encountered a difficult situation but did not know how to handle it,
- (2) describe their response and why they made this choice
- (3) discuss their strengths in these kinds of situations
- (4) assess their ability to perform “prosocial moral behaviors including helping others, following rules, keeping promises, and being nice”
- (5) describe how they came to be self-aware of their own abilities.

To assess moral reasoning the authors used the sociomoral reflection measure (Gibbs, Basinger, & Fuller, 1992). This measure evaluates a participant’s moral values and reasons for endorsing these values. Questions include: “...how important is it for people to tell the truth?” (Gibbs, Basinger, & Fuller, 1992, p. 151) and “...how important is it for people to keep promises, if they can, to friends?” (p. 150).

The authors found that adolescents with HFASD performed more poorly on the moral reasoning tasks than controls. Consistent with Rueda, Fernández-Berrocal, and Baron-Cohen (2015), they found no significant differences in the empathic concern subscale of the IRI. The qualitative analysis is more convoluted. While both HFASD adolescents and the control group emphasized the importance of empathic concerns in difficult situations, individuals in the control group gave more examples of helping others in response to (1) above. One explanation for this discrepancy is that teens with HFASD tend to be bullied more often than other adolescents. We can see this see evidence for this in the examples provided by the participants: “We won the game...[A girl who lost comes over with a stake and hit me with it. The counselor broke it up...” (Senland & Higgins-D’Alessandro, 2013, p. 217). This study suggests that individuals with

HFASD experience social deficits that are related to, but not indicative of, their empathic abilities.

Schwenck and colleagues (2012) conducted a different performance-based task with boys with ASD, boys with conduct disorder (a condition associated with severe behavioral dysfunction), and age and IQ matched control group of boys with no diagnosed mental illnesses (IQ average of 105.7 for control group compared to 102.6 for ASD group and 101.8 for conduct disorder group, p. 653). The experimenters showed participants nine short film clips (14-48 seconds) of emotional situations and are asked to identify the emotions experienced by one or two protagonists. Participants were asked “to take the perspective of the protagonist and to explain why he had felt as he did” (Schwenck et al., 2012, p. 654). Participants were also asked how they felt after each clip.

The authors found that ASD group performed more poorly than the conduct disorder and control groups on the first task. They found it more difficult to identify the emotions demonstrated in the video clip. When asked how they felt after viewing the clip, however, the ASD group performed comparably with the control group, while the boys with conduct disorder did not feel as emotionally moved by the clips. You might think of this result as similar to watching an emotionally gripping movie with a large group of people. As long as the movie is done well, nearly everyone in the theater will feel moved by the protagonist’s plight. Afterwards you may even discuss how the protagonist felt joy at meeting the love of his life or sorrow when his mother passed away. This study suggests that individuals with ASD (high functioning, based

on the IQ scores and type of testing) may struggle to put words to the types of emotions experienced by another person but that they nevertheless feel *with* another.⁴⁸

The three studies I described above are not the only evidence on the subject of HFASD and empathy but, as I mentioned in my analysis of the kinds of research in this field, they are some of the best. Moreover, current treatment practices operate on the assumption that individuals with HFASD are capable of empathy. Children diagnosed with HFASD can be enrolled in social skills groups to improve their peer interactions. Children with severe conduct disorder, for instance, are not enrolled in these groups. Children like Daniel want to learn how to interact with others and translate empathic concern into successful social action, whereas children with severe conduct disorder (specifically, conduct disorder with empathy deficits) lack genuine empathic concern and would desire social prowess only for manipulating others.

The research above clearly indicates that individuals with HFASD experience difficulties in social functioning. The extent of these challenges can vary by age, experience with therapy program, and other factors but social impairment is a key feature in the diagnosis of HFASD. As we saw above, social impairment often interferes with an individual's empathic capacities. Even if individuals with HFASD are fully capable of empathy the social challenges may excuse or exempt them from moral responsibility.

5.4 Empathy, Epistemic Impairment, and Moral Functioning

Before we evaluate how social impairments can affect moral functioning, I think it helps to take a step back and briefly discuss what makes empathy moral. Empathy motivates moral actions when we recognize the suffering of another and feel a desire to help (c.f Cameron and Ravier, 2017). Individuals with HFASD can recognize the suffering of another, feel a desire to

⁴⁸ I acknowledge that this study was conducted with only males and with adolescents. These limitations constrain the results but also suggest that empathy is a capacity present even in children with HFASD.

help, and act morally. Like any of us, an individual with HFASD may recognize the suffering of another, feel a desire to help, but feel uncertain about the appropriate moral action. For example: I recognize that my friend is struggling to find employment. I want to help her but I have no connections in her field or her city. I can provide emotional support but her intense anxiety suggests she needs more. It is unclear what morality demands of me in this situation. My epistemic resources are limited (I am not knowledgeable about her field or location) and moreover, it does not seem like morality would require that I research jobs on her behalf. It seems that I am doing the best I can; I am acting morally.

Similarly, we can think of someone with HFASD who lacks certain epistemic resources that prevent them from discerning the morally appropriate action. Amari is a young adult with HFASD. Amari sees that his friend Malik is crying at his father's funeral (recognizes suffering) and wants to help ease his suffering (desire to help) but he does not know the conventions for comforting people who experience these kinds of losses. Amari has comforted Malik friend after several bad break ups and failed exams. During those times the young men would order a pizza, play video games, and talk about how Malik was better off single or how he would ace the next exam. The loss of Malik's father feels qualitatively different. Amari does not know how people comfort others after such a loss and none of his past experiences gives him any guidance on how to proceed. Amari decides that he ought to do something rather than nothing so he sticks with the social script he knows best. At the wake, Amari asks Malik if he wants to come over for pizza and video games later that night. Malik declines, saying he needs to be with his family for the time being.

Just as we would not hold me morally blameworthy for failing to know how to help my friend, we should not hold Amari morally blameworthy for not knowing how to comfort Malik.

(This is not a comment on mine or Amari’s agency or our level of moral responsibility at the time: if either of us were to run a red light or steal from our elderly neighbor that same day we would be blameworthy for either of those actions.) It also does not speak to our typical responsibility as friends. If my friend asked me to read a cover letter and I have plenty of time on my hands, I would be blameworthy for blowing her off. Similarly, if Malik asks Amari to feed his dog while he’s busy with funeral activities, Amari would be blameworthy for neglecting this task. Moreover, Amari is not temporarily deficient in any of his moral capacities nor does he escape responsibility due to the circumstances. Under these conditions the individual with deficient capacities typically fails to recognize the moral salience of the situation. Nor is he like the individual who recognizes the moral salience but is not motivated to act through malice, laziness, or motivational incapacitation. Finally, Amari is not like the individual who recognizes the moral salience, is motivated to act, and does not perform the moral action due to incapacitation. He is fully capable of performing the moral action but may not *know* what the action is.

This vignette is consistent with the research discussed in Section 3. Recall that across all studies HFASD participants performed just as well as the control groups in measures of empathic concern. We can understand this as Amari’s ability to recognize Malik’s suffering and feel compelled to help. Group differentiation occurred in the evaluative tasks when participants were asked to “take the perspective of the protagonist and to explain why he had felt as he did” (Schwenck et al., 2012, p. 654), approximating the kind of social guesswork involved in figuring out how to comfort someone in a novel situation.

5.4.1 Epistemic Exemption?

Up to this point I have argued individuals with HFASD are morally responsible for their actions because they are capable of experiencing empathy. Even if you are on board with the discussion thus far you may still have concerns about the epistemic impairments. If we understand the social difficulties experienced by individuals with ASD as epistemic impairments that can interfere with moral functioning, it seems that we have just pushed the problem into a new category and that epistemic impairments may still excuse or exempt individuals with HFASD from moral responsibility. Recall from the example of me and my friend, any moral agent can encounter epistemic difficulties in a moral situation. Furthermore, it seems that agents who have not cultivated their moral abilities will be more likely to encounter epistemic difficulties in moral situations.

In a study of nurses discussing workplace challenges, many participants described instances where they felt distress at the plight of their patients, were motivated to help, but felt unsure of what actions to take (Varcoe et al., 2012). One nurse described an instance where failures in hospital hierarchy left them caring for a critically ill patient (without guidance from a doctor): "...it was terrible caring for someone, feeling I was way out of my scope of practice...we felt helpless" (Varcoe et al., 2012, p. 492). Similarly, O'Donnell and colleagues (2008) found that social workers who encountered ethical stress (including situations where the morally right action was controversial or unclear) performed fewer moral actions.

Some cases of epistemic difficulties seem unavoidable. No matter how much training and preparation nurses undertake, they can still experience the consequences of incompetent superiors. A social worker with years of experience can still encounter a novel moral dilemma. We can, on the other hand, prepare for many moral situations by cultivating our moral faculties.

If we ascribe to an Aristotelian virtue theory of morality, for instance, we can do generous actions in order to become more charitable, brave actions to become more courageous, kind actions to become compassionate, and so on. If an individual without HFASD who has not cultivated her moral faculties encounters a novel moral situation she will likely have difficulty determining what to do. This does not, however, excuse or exempt her from moral responsibility; it merely makes her less virtuous or praiseworthy than the individual who has cultivated her moral faculties, knows what behavior is morally required, and behaves morally.

For an individual with HFASD, cultivating one's moral faculties involves the same moral cultivation as any other agent plus development of social faculties. As I alluded to in earlier sections, individuals with HFASD can participate in social skills groups and individual therapy to learn strategies for navigating social interactions. Jaarsma (2013) emphasizes the importance of learning moral rules, especially for children with HFASD. Social skills groups focus on interacting with peers, adults (in the case of children) and authority figures (as needed). In a meta-analysis of studies on the effectiveness of social skills groups, Reichow and Volkmar (2010) found that most participants did see a measurable improvement in social skills after attending a group. Methodology can vary from group to group and the authors acknowledged the need for additional evaluation of how different methodologies may be more effective for different individuals. For our purposes it is clear that social skills, like moral skills, can be improved.

5.4.2 Unequal Footing

The social difficulties experienced by individuals with HFASD may not be insurmountable but we might worry that starting with this kind of deficit puts the individual with HFASD at a disadvantage in discerning morally appropriate responses. Even if you are willing to

grant that individuals with HFASD are fully capable of empathy and that the social impairments do not excuse or exempt them from moral responsibility, you might still think that they are less responsible (in terms of degree) than an agent without compromised social faculties. On this view, the individual with HFASD would increase their degree of moral responsibility as they continue to develop social skills.⁴⁹

In reply I return to the example of my friend who is searching for a job. It is possible that if I had better employment connections that I would know how to help my friend in this situation. My lack of connections, however, does not diminish my moral responsibility. I am at best praiseworthy for doing everything in my power to help and comfort her and at worst morally neutral. Moral neutrality in this situation, however, does not change my capacity for moral responsibility in general. Similarly, we ought to understand individuals with HFASD as morally neutral or praiseworthy in situations where they do not have epistemic access to the morally appropriate action. These situations do not have bearing on their capacity for moral behavior or moral responsibility in general.

We might also consider Vargas's (2013) situational view of moral responsibility. Vargas argues that individuals have a capacity for detecting moral considerations and a capacity for self-control. He claims that these capacities can be exercised or fail to be exercised depending on the context. Even if we apply this situational approach, individuals with HFASD are morally responsible because they consistently exercise their capacity for detecting moral considerations.

5.5 Conclusion

It has always been one of the worst traumas for me to feel I have displeased somebody. I tend to remember it years afterwards. It hurts more than I can bear, practically. One

⁴⁹ Even if social difficulties do not affect an individual with HFASD's moral functioning, we might think that these challenges affect the pursuit of virtue. See my discussion of moral superheroes in the previous chapter.

thing I do is daydream about how I can be reconciled with people I have displeased and change their opinion of me (Jack Dewey quoted in Dewey, 1991).

The empirical evidence is clear and the people who work with individuals with HFASD will also attest: individuals with HFASD feel empathy deeply and are motivated to help others.⁵⁰ It is important not to understate the social challenges experienced by this population but it is equally important to acknowledge that these challenges are treatable through therapy and social skills groups. Individuals with HFASD experience an epistemic deficit: they recognize the moral salience of a situation, are motivated to act morally, but may not always know how to implement the proper moral action. Epistemic deficits can interfere with any agent's pursuit of moral action – from nurses to social workers. We all struggle to discern what morality requires of us yet we are still morally responsible for our actions.

⁵⁰ I acknowledge that there can be morally bad people who have HFASD.

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Chapter 6: Conclusion – Lessons in Moral Pathology

6.1 Introduction

The title “Moral Pathology” is slightly misleading. On the one hand, I discussed several instances where mental illness caused moral dysfunction. At least one presentation of all four conditions resulted in moral dysfunction. On the other hand, I also discussed how the study of morality and mental illness expands what it means to be moral and virtuous. I identified additional capacities required for functioning and argued that we should be pluralists about the pursuit of virtue. Mental illness revealed that our understandings of morality and virtue are dysfunctional. In other words, moral pathology represents two sides of the same coin: pathological moral behavior and pathological misunderstandings of moral behavioral.

In this dissertation I discussed four conditions: psychopathy, addiction, borderline personality disorder (BPD), and autism spectrum disorders (ASD). Along the way I garnered insights about moral responsibility, virtue, and methods for studying morality and mental illness. In this chapter I will summarize these insights by topic rather than condition, beginning with the capacities required for moral responsibility. I will then discuss insights into virtue followed by lessons in methodology.

6.2 Capacities Required for Moral Responsibility

I never intended to establish a unique account of moral responsibility. Throughout this dissertation I built upon Vargas’s (2013) notion of moral responsibility. His account claims that an individual is morally responsible if she has the capacity for detecting moral considerations, the capacity to provide reasons for her actions, and a capacity for self-control. I also discussed Fischer and Ravizza’s (1998) theory of excusing and exempting conditions. While Fischer and

Ravizza's account offers examples like ignorance and incapacitation (excusing conditions), they do not set out an exhaustive list of things that excuse or exempt individuals from moral responsibility. I combined these approaches and identified two new capacities required for moral responsibility: compassion and emotion regulation. Impairment in either of these capacities can result in excusing or exempting conditions, depending on the extent and nature of the dysfunction.

6.2.1 Compassion

Compassion can be understood as a particular kind of reasons-responsiveness. To be capable of compassion in the morally-relevant sense is to be properly responsive to compassion-relevant cues in the environment. An individual recognizes another person is suffering (compassion-relevant cue), feels a desire to help (often accompanied by emotional distress), and performs a moral action. Psychopaths are compassion deficient because they do not experience distress and are not motivated to help when exposed to compassion-relevant cues (i.e. another person suffering). Socially adept psychopaths often perform a seemingly moral action when confronted with compassion-relevant cues. This should not be mistaken for the capacity to experience compassion; such individuals have merely learned these socially desirable behaviors in order to advance their own ends.

Individuals with high-functioning autism spectrum disorder (HFASD), on the other hand, are capable of compassion but experience difficulties implementing moral action. Individuals with HFASD recognize compassion-relevant cues, feel compelled to act, but may not know what action to take. Individuals with HFASD experience deficits in social functioning that make it more difficult to implement compassionate in interpersonal scenarios. The contrast of these two populations demonstrates the importance of this capacity.

Schwenck and colleagues (2012) studied compassion in boys with developmental disorders. They compared boys with conduct disorder with callous and unemotional traits (boys with the prerequisites for psychopathy) and boys with ASD. Their results prove relevant to our discussion. They found that boys with callous and unemotional traits felt significantly less compassion than boys with ASD when watching emotional videos. As I demonstrated in Chapters 2 and 4, robust research in psychopathy and ASD supports the assertion that compassion is a capacity required for moral responsibility.

6.2.2 Emotion Regulation

Unlike compassion, there is nothing specifically moral about emotion regulation. Emotion dysregulation impacts our relationships, cognition, physical and mental health as well as other areas of our lives. The importance of emotion regulation may span many capacities but it no less essential to moral functioning. Similarly, Vargas's capacity for self-control spans multiple non-moral domains of our lives, including our relationships, health, and goal-directedness, but is nonetheless essential for moral responsibility. I discussed emotion regulation in Chapters 3 and 4 in the context of addiction and borderline personality disorder (BPD), respectively. Specific discussion of emotion regulation and moral responsibility took place in Chapter 3 but support for this argument was implicit in the BPD symptoms discussion in Chapter 4.

In Chapter 3 I proposed a theory of addiction and emotion regulation. I argued that individuals with substance use disorders were exempt from moral responsibility due to deficits in emotion regulation. Individuals with addiction use substances to help regulate their emotions; they compensate for deficiencies in emotion regulation through their drug(s) of choice. This theory is supported by data on successful rehabilitation strategies and studies like Robins, Davis,

and Goodwin's (1974) work on heroin use in Vietnam. The authors found that 20% of men who had not used heroin prior to enlisting reported becoming addicted to heroin while in Vietnam. The emotion regulation theory explains this rise by citing highly stressful circumstances.⁵¹ While these men were able to regulate their emotions while living in the United States and encountering fairly unremarkable obstacles, they suddenly found themselves surrounded by a treacherous hell-escape when dropped in Vietnam. The sights and sounds of death and destruction outstripped their capacities for emotion regulation and one-fifth turned to narcotics.⁵² If this explanation is correct then we would expect that nearly all of the men became sober soon after returning home. Robins, Davis, and Goodwin (1974) found that less than 1% of men reported being addicted to heroin within a year of leaving Vietnam.

We also see emotion regulation as a capacity required for moral functioning in individuals with BPD. Chapter 4 focuses mostly on individuals who are in recovery from BPD. Individuals who meet clinical criteria for BPD, though they struggle with emotion regulation, do regulate their emotions and are morally responsible for their behavior. Symptoms of BPD include difficulties regulating anger, strong fear of abandonment, mood instability, and a tendency to provoke volatile relationships (APA, 2013). These symptoms all relate to difficulties in regulating one's emotions and can interfere with moral behavior.

6.2.3 Other Observations

Throughout the dissertation I made note of several other capacities related to mental illness that are also required for moral functioning but have been discussed at length by other authors. Psychopathy, addiction, BPD, and ASD all can all cause some degree of cognitive impairment. Some psychopaths are exempt from moral responsibility based on cognitive

⁵¹ I do not deny the role of access. If cocaine had been readily available instead then the men would have become addicted to cocaine instead.

⁵² This does not include the men that started smoking cigarettes or the rates of alcoholism.

impairment alone. The autism spectrum is characterized by all levels of cognitive functioning. I focused on individuals with average or above average cognitive functioning but acknowledged that many individuals with ASD would be exempt from moral responsibility due to cognitive impairments.⁵³ In rare cases addiction can cause severe cognitive impairments which can then mitigate moral responsibility. I acknowledged that symptoms of BPD can interfere with cognitive functioning and this is but one piece of the moral puzzle in this population.

6.3 Lessons in Virtue Ethics

In Chapter 5 I concluded that certain notions of virtue ethics make the pursuit of virtue impossible for individuals who have recovered from BPD. On these views of virtue, individuals who have recovered from BPD are considered merely continent and continence is incompatible with virtue. I suggested that virtue ethics ought to be more inclusive and proposed a pluralist account. On this view, individuals who have recovered from BPD are moral superheroes who are capable of pursuing virtue.

Individuals who recover from BPD are moral superheroes because they overcome residual symptoms of BPD to act morally. The designation of “moral superhero” is not reserved only for individuals who recover from BPD. The individual with HFASD who attends social skills groups so they can better understand the nuances of others’ needs and the addict in remission who chooses to attend therapy and emotion regulation classes can both be moral superheroes. Despite their ongoing battles, I expect many individuals with mental illness are moral superheroes who are capable of pursuing virtue.

The pluralist account has implications beyond mental illness and moral superheroes. I argued that continence can be virtuous if an individual is struggling to do a virtuous action for

⁵³ It is important to note that sorting out responsibility based on cognitive functioning in the case of ASD is more complex than with psychopathy.

non-vicious reasons. This applies to individuals who have recovered from BPD because residual symptoms are non-vicious. This could also apply to someone who feels the pull of other, non-vicious inclinations that are not related to mental illness. We can think of a parent who is preparing to attend their child's graduation when suddenly their other child becomes violently ill. The parent rushes the sick child to the hospital and is forced to miss the graduation ceremony. The parent acts morally by tending to the sick child but we would be surprised if they did not feel any sorrow about missing their other child's graduation. The parent does not regret their decision but feels the weight of having missed an important occasion in their child's life.

The pluralist account makes sense of this inner turmoil: the parent's non-virtuous inclinations are non-vicious (born out of their concern for their other child) and therefore do not detract from the virtuous nature of their moral actions. Other accounts of virtue (e.g. McDowell's (1978) silencing view) would argue that the parent's actions are merely continent since she experiences inclinations to do otherwise. The pluralist account, born out of a careful analysis of borderline personality disorder, allows us to side with our intuitions in cases of non-vicious internal conflict and allow more diversity in the pursuit of virtue.

6.4 Fruitful Methodology

Perhaps the most valuable lesson to draw from this research is that studying ethics through mental illness is a fruitful endeavor. As I expected, we can learn a great deal about what it means to be a moral agent and how we should understand the pursuit of virtue by looking to the margins. Clinicians and philosophers alike shy away from BPD. By breaking down the symptoms and severity and discussing real-life cases in the literature and with practitioners, I was able to break through the stigma to reveal moral superheroes. While I was not the first philosopher to explore psychopathy, addiction, and ASD, I argued that the study of mental

illness requires critical analysis of the empirical literature and qualitative engagement with the population when available.

This approach is founded on the belief that not all studies are created equal and that some measures will be more relevant to morality than others. At times this leads to disappointment. In Chapter 5 I discussed the ADOS at length only to reveal in the following section that no current studies of ASD and morality used this measure. Nonetheless, knowledge of the philosophical (and psychological) gold standard helped me identify the kind of performance-based tasks to look for ASD research.

I believe this approach can and should be replicated when studying morality and any mental illness; careful analysis and qualitative engagement (when possible) does not merely apply to the four conditions discussed in this dissertation. Someone interested in morality and eating disorders, for instance, develop an understanding of how the symptoms manifest at different levels of severity, attend support groups (if possible) and/or meet with treatment providers, analyze data on successful treatment methodology and relapse rates, and so on. The philosopher diving into the literature on mental illness has a responsibility, not only to the discipline but also to the population she is discussing, to develop a comprehensive understanding of the condition and a critical approach to the empirical literature.

6.5 Conclusion

*...I find that I frequently feel better about myself when I discover that we're not alone, but that there are, in fact, a number of other people who ail as we do – that there are actually a number of “accomplished” individuals who find it necessary to seek treatment for some otherwise insurmountable inner unpleasantness. I not only feel better about myself because these people are also f**ked up (and I guess this gives us a sense of extended community), but I feel better because look how much these fellow f**kups managed to accomplish! Carrie Fisher (2008, p. 11)*

Fisher accurately describes a stereotype of individuals with mental illness with her choice of colorful language. She also acknowledges that many people suffer, seek treatment, and go on to do great things. What she doesn't seem to understand is that the story is often more complex. People suffer, seek treatment, and go on to do great things while having bad days and remaining in therapy. They are often capable of being morally responsible for their actions. Not only that, people with mental illness can be virtuous even if they experience some degree of near "insurmountable inner unpleasantness" that they keep at bay after (often years of) therapy, support groups, learning to manage their emotions, medication, and so on. Fisher was right. She, and others like her are "not alone"; they're members of the moral community.

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