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ARE PSYCHOPATHS LEGALLY INSANE?*

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ABSTRACT

The question of whether psychopaths are criminally and morally responsible has generated significant controversy in the literature. In this paper, we discuss what relevance a psychopathy diagnosis has for criminal responsibility. It has been argued that figuring out whether psychopathy is a mental illness is of fundamental importance, because it is a precondition for psychopaths' eligibility to be excused via the legal insanity defense. But even if psychopathy counts as a mental illness, this alone is not sufficient to show the insanity defense is applicable; it must also be shown that, as a result of the illness, specific deficits in moral understanding or control are present. In this paper, we show that a diagnosis of psychopathy will generally not indicate that a defendant is eligible for an insanity defense. This is because the group of individuals subsumed under the diagnosis is so heterogeneous that while some psychopaths do show significant impairments in affect and control which may impact on their responsibility, many psychopaths are not incapacitated in a way relevant to responsibility.

Keywords: *psychopathy, mental disorder, dysfunction, criminal responsibility, insanity defense*

1. Introduction

The question of whether psychopaths are criminally and morally responsible has generated significant controversy in the literature. In this paper, we discuss what relevance a psychopathy diagnosis has for criminal responsibility. Nadelhoffer and Sinnott-Armstrong (2013) have argued that figuring out whether psychopathy is a mental illness is of fundamental importance, because it is a precondition for psychopaths' eligibility to be excused via the legal insanity defense. However, even if psychopathy counts as a mental illness, this alone is not sufficient to show the insanity defense is applicable; it must also be shown that, as a result of the illness, specific

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deficits in moral understanding or control are present.[1] In this paper, we show that a diagnosis of psychopathy will generally not indicate that a defendant is eligible for an insanity defense. This is because the group of individuals subsumed under the diagnosis is so heterogeneous that many psychopaths are not incapacitated in a way relevant to responsibility. First, in section two, we will explain how psychopathy is defined and diagnosed. We will then discuss the relationship between mental illness and legal culpability in section three. Finally, we discuss the question of whether psychopaths as a group exhibit incapacities relevant for an insanity defense in section four.

2. The psychopathy construct and how psychopathy is diagnosed

2.1. Diagnosis

Psychopathy is a personality disorder characterized by affective and behavioral anomalies. It is not currently a recognized mental disorder in the DSM-5, which instead operates with the definition of antisocial personality disorder (ASPD). However, the DSM-5 does link ASPD to psychopathy as follows: "The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as psychopathy, sociopathy, and dissocial personality disorder" (APA 2013, 659). The ICD 10 (International Classification of Diseases 10, compiled by the World Health Organization) lists psychopathy under dissocial personality disorder.

The history of psychopathy as a diagnosis goes back at least to Philippe Pinel (Pinel 1962) and Ludwig Koch, who introduced the term 'psychopathy' (Koch 1891). However, Hervey Cleckley is generally considered the father of the present-day construct. In his 1941 book 'The Mask of Sanity' Cleckley tried to give a systematic account of psychopathy and provided a number of diagnostic criteria, including the affective ones which are now thought to be central. For example, Cleckley lists egocentricity and incapacity for love as criteria for diagnosis, as well as poverty in major affective reactions.

In the last 50 years or so, psychopaths have primarily been the subject of forensic psychology, and this discipline has yielded the standard assessment tool for diagnosing psychopathy, Hare's Psychopathy checklist, the PCL-R (Psychopathy Checklist Revised) (Hare 1991). Hare and his colleagues developed the psychopathy checklist as a tool for distinguishing psychopathic from non-psychopathic subjects in the prison population for research purposes (Hare 1999, 32). The construct of psychopathy that the PCLR is meant to diagnose is the one originally developed by Cleckley.

The list of traits for which a potentially psychopathic individual is assessed is subdivided into two main factors - affective/interpersonal and antisocial behavior/lifestyle. The affective/interpersonal dimension lists the following characteristics: Glibness, superficial charm, grandiose sense of self-worth, deceitfulness; shallow affect, lack of empathy, lack of remorse or guilt, manipulativeness. The items

[1] As we discuss below, some legal tests for insanity, including the U.S. Model Penal Code test, require that a defendant should either have deficits in moral understanding or in volitional control (1985). However, the common law test of the U.K., U.S.A. and Australia, known as the M'Naghten rule, requires that a defendant lack moral understanding and does not excuse those lacking control.

found in the antisocial behavior/lifestyle factor are: Impulsivity, thrill seeking, early behavioral problems, parasitic lifestyle, poor behavioral controls, lack of realistic long-term goals, juvenile delinquency, revocation of conditional release. Items which do not fit into the two main categories are promiscuity, many short-term relationships, and criminal versatility.

While the PCL-R is the best-known and most frequently used tool for diagnosing psychopathy, psychopathy was initially introduced as a clinical diagnosis by Cleckley and there are tests for the diagnosis of psychopathy which do not primarily target the prison population; for example the PPI-R (Lilienfeld and Widows 2005) or the Levenson Self-Report Psychopathy Scale (Levenson et al. 1995). The latter two are self-report tools, which involve certain limitations, given the fact that dishonesty is a core diagnostic criterion of psychopathy. There is, furthermore, ongoing uncertainty about the extent to which different self-report measures pinpoint the same construct (Lilienfeld and Fowler 2006).

The criteria a subject has to meet to qualify as psychopathic on the PCL-R and those for the DSM category of Antisocial Personality Disorder (ASPD) exhibit a large overlap. This may suggest that psychopathy is just the forensic equivalent to ASPD. This is not the case, however. Scientists working on psychopathy agree that psychopathic individuals form a subset of people with ASPD (Blair 2008; Harris et al. 2001; Skeem et al. 2011). The main difference between the two diagnoses is that criteria for the diagnosis of psychopathy explicitly include personality traits (callousness, grandiose sense of self-worth, irresponsibility), whereas the ASPD diagnosis in the DSM focuses more strongly on observable antisocial behavior (cf. DSM 5). However, the diagnostic criteria for ASPD has moved closer to those for psychopathy in the current DSM-5. As the ASPD diagnosis is less specific than the PCL-R, someone diagnosed with psychopathy will normally also be diagnosable as having ASPD, but not vice versa. Individuals diagnosed with psychopathy also frequently meet the criteria for other Axis II B disorders such as narcissistic or borderline personality disorder. In particular, it has been hypothesized that borderline personality disorder might be the female phenotype of secondary psychopathy (Sprague et al. 2012). Given the focus on socially undesirable personality characteristics in axis II cluster B personality disorders, the presence of an overlap is hardly surprising. Furthermore, some of the key characteristics, such as problems with empathy, are shared across such diagnoses as psychopathy, narcissistic personality disorder and borderline personality disorder (Baron-Cohen 2012).

2.2. Diagnostic criteria and the psychopathy construct

From the outset, antisocial behavior has figured prominently in the diagnostic criteria for psychopathy. This has led to a number of discussions regarding the question whether what we are faced with is a genuine medical condition or a pattern of disvalued behavior (cf. Blackburn 1988; Karpman 1948). The heavy reliance on antisocial behavior complicates the picture, because the relation between social deviance and personality traits needs to be established. Making antisocial behavior part of the diagnostic criteria risks including very diverse individuals with regard to the cause of the undesirable behavior; and this is indeed an objection raised against both ASPD and psychopathy as diagnostic categories (Blackburn 1988; Mullen 2007). As Blackburn points out: “The contribution of personality characteristics to antisocial behavior is an empirical question which can only be answered if the two are identified independently” (Blackburn 1988, 507).

The problem of using undesirable behavior as a diagnostic criterion is part of a more general problem regarding our understanding of a condition and the way it is diagnosed

in psychiatry. Diagnostic criteria serve the purpose of establishing when someone has condition x. In psychology and psychiatry, we do this by looking at behavior, which is generally the only way we can access differences at the psychological level. The reason why the DSM is so strongly focused on behavioral measures is because they make a diagnosis reliable across patients and clinicians (Cooper 2014). However, what we are really after is something that goes beyond a mere behavioral description, something that indicates the underlying cognitive and emotional dysfunctions which lead to this kind of behavior (namely, some causes of the behavior). In a review paper, Skeem and colleagues draw attention to this in the context of psychopathy, saying that

> The PCL-R has played an extraordinarily generative role in research and practice over the past three decades—so much so, that concerns have been raised that the measure has become equated in many minds with the psychopathy construct itself. (Skeem et al. 2011, 95)

The diagnostic criteria of the PCL-R do attempt to capture the specific underlying personality characteristics which Cleckley used to define psychopathy. The most important underlying characteristics assessed by the diagnostic are affective deficits, most notably in empathy, as well as problems with impulse control. Both are central to the construct of psychopathy. Thus, while antisocial behavior figures prominently in the diagnosis, it is supposed to be linked to the affective deficits. Emotional deficits of psychopaths thus help distinguish psychopathy from less well circumscribed conditions such as antisocial personality disorder and provide us with characteristics which help to explain the problematic behaviors exhibited by psychopaths.

As we will argue below, it is these underlying cognitive or emotional dysfunctions that we are interested in when we make judgments regarding a psychopath's criminal and moral responsibility. We want to know whether the psychopath has certain psychological features which make immoral or illegal behavior difficult or impossible to avoid, or lacks understanding of what constitutes morally right or wrong action.

2.3. Further distinctions between different types of psychopath

The literature often subdivides psychopaths further according to behavioral profiles, hypothesized underlying causes, etc. One such division is between primary and secondary psychopathy (Lykken 1996; Mealey 1995; Newman et al. 2005; see also Maibom's contribution to this issue), and another is the one between successful and unsuccessful psychopaths (Gao and Raine 2010; Ishikawa et al. 2001; Sifferd and Hirstein 2013). The primary/secondary distinction tracks affective differences. Primary psychopaths are characterized by low anxiety, whereas secondary psychopaths are more anxious (cf Lykken 1996; Newman et al. 2005). Primary psychopathy is also associated with fearlessness, low emotional empathy, and is inversely associated with negative emotionality, whereas secondary psychopathy is associated with negative emotionality, impulsivity, frustration, sensation-seeking, and reactive aggression (Skeem et al. 2011). In sum, it seems that when divided this way, only primary psychopaths may have flattened affect.

Some authors also take the primary/secondary psychopathy distinction to distinguish the way psychopaths acquired the condition. Primary psychopaths are 'born psychopaths', whereas secondary psychopaths are thought to have developed psychopathic traits because of other psychological deficits or in reaction to a difficult social and familial environment (Mealey 1995; Porter 1996). There is a growing body of evidence which shows that psychopathy is correlated with childhood abuse and neglect (Craparo et al. 2013; Marshall and Cooke 1999). On the primary/secondary distinction,

individuals whose condition is caused by abuse and neglect would be secondary psychopaths.

Work on primary versus secondary psychopathy indicates that psychopaths may be heterogeneous both in terms of the specific traits that they manifest and in the etiology of their condition. This should already cause us to question whether psychopaths, as a group, have a mental disorder that ought to be considered exculpatory. In addition, there is a further important distinction made in the literature between so-called successful psychopaths, who remain undetected (at least by the law) but whose behavior may well be immoral or illegal, and unsuccessful psychopaths, who tend to get caught up in the criminal justice system (Ishikawa et al. 2001). Whether there is a significant number of successful psychopaths is far from clear (Skeem et al. 2011), but that some people with psychopathic tendencies actually manage to avoid contact with the law or psychiatric institutions is assumed by authors whose positions on psychopathy differ significantly (Babiak and Hare 2007; Babiak et al. 2010; Hare 1999). Both individuals who exhibit psychopathic traits but refrain from 'traditional criminal activity,' and those who engage in criminal activity but manage to escape conviction have been categorized as successful psychopaths (Anderson and Kiehl 2012).

Conceptions and ways of classifying psychopaths as successful (i.e. the tests administered) are not uniform across the literature (cf. Gao et al. 2010). However, on the most general level possible, we can say that successful psychopaths are those individuals who have escaped imprisonment but exhibit psychopathic traits. Whether their success can be explained by the fact that they score lower on certain psychopathic traits, such as lack of impulse control, as a number of authors hypothesize (Poythress and Hall 2011) is still under investigation. Even so, the two categories of psychopaths – successful and unsuccessful – seem to exhibit differences regarding the core underlying dysfunctions or causes of psychopathy, including emotionality and impulsivity, as we shall see below.

A further factor that is important when considering the condition is that, like most mental disorders, psychopathy is increasingly viewed as dimensional. A dimensional conception of mental disorders stresses the continuity between traits found in the population overall and those found in certain disorders, conceptualizing pathological traits as varying in degree, rather than in kind. In other words, psychopathic traits lie on a continuum and can to a lesser degree also be found in individuals who do not meet the criteria for a diagnosis of psychopathy. "[A] "psychopath" as we think of him/her likely represents the extreme end of the continuum of symptom severity" (Glenn et al. 2011, 372). Hare and Neumann (2008) also suggest that it may be more useful to characterize people as exhibiting psychopathic traits to varying degrees rather than positing a psychopath/non-psychopath dichotomy.

3. Capacity responsibility and legal insanity as an excuse

As noted above, Nadelhoffer and Sinnott-Armstrong argue that whether psychopathy counts as a disorder or illness is important, because if this is the case, psychopaths may be eligible for the insanity defense. They note that "the crucial point here is that neither formulation [of the insanity defense] has any chance of applying to psychopaths unless psychopathy is a "disease of the mind" (M'Naghten) or a "mental disease" (ALI/MPC)" (Nadelhoffer and Sinnott-Armstrong 2013, 230). Nadelhoffer and Sinnott-Armstrong claim psychopathy is a disorder on all reasonable definitions of disorder. We are not so sure this is the case; it seems to us that whether psychopathy counts as a disorder depends upon the definition of disorder used and the subtype of psychopathy under

consideration. Thus, while Nadelhoffer and Sinnott-Armstrong argue that psychopaths should count as disordered on an adaptationist, harmful dysfunction account, too, a number of authors have recently argued that on Wakefield's harmful dysfunction approach, psychopathy should not be understood as a disorder, but as an adaptation (Harris et al. 2001; Krupp et al. 2013; Lalumière et al. 2008; Reimer 2008).

Rather than resolving the question whether psychopathy is a disorder, we recommend a different approach. We contend that what is relevant is whether psychopaths meet whatever threshold capacities are needed for criminal responsibility. We take this approach for a number of reasons. First, on a practical note, it is worth pointing out that whether a condition is counted as a disorder by the courts will be more likely to depend on whether it features as a disorder in the two main diagnostic manuals, the DSM-5 and the ICD 10, then on whether it counts as a disorder according to a specific philosophical account of mental illness. Second, possession of a mental disorder is a necessary but not sufficient condition for legal insanity. Once it is established that a defendant has a mental disorder, it must still be shown how this disorder affects his criminal responsibility (if at all). We are more interested here in determining whether psychopaths possess the deficits that indicate they are not fully responsible. Third, we take it that legal insanity is not the only means for a defendant with such deficits to claim a legal excuse. If a psychopath does not have the relevant capacities for criminal responsibility, then he may be eligible for either the legal insanity defense, if the court counts psychopathy as a disorder; or, if the court does not recognize psychopathy as a disorder, the same deficits may ground a claim of diminished mental capacity. Diminished mental capacity is a partial failure of proof defense, which means that to be eligible for the excuse a defendant must lack the mental capacity to form the specific mental intent required for his crime (Morse 1984). A defendant with diminished mental capacity may be capable of being reckless; but may not be capable of the level of understanding or control over her act to have committed it "purposely" (the mental state required for first degree murder under the U.S. Model Penal Code).[2]

In the end, we will argue that the group "psychopath" – as identified by current diagnostics, described above – is so heterogeneous with regard to the capacities necessary for responsibility that a diagnosis of psychopathy is at best an indicator to the court that further psychological testing is required to prove that the defendant ought to be excused as legally insane (or due to diminished mental capacity).

A number of authors argue that when we aim to establish responsibility, the status of a condition as a disorder is not what is at stake, rather it is the specific psychological dysfunctions that matter (Butlin and Papineau 2017; Vincent 2008,).[3] Butlin and Papineau (2017) make the following assertion in the context of the question whether addiction is a disease:

> Of course, issues of responsibility, blame and punishment are real and pressing, and particularly so with respect to addicts. But they are best addressed directly, without a detour into the issue of disease. We can

[2] The Model Penal Code was developed by the American Legal Institute to serve as a guide for state legislators, and to encourage uniformity across the US state penal codes. (1985)

[3] The Swiss criminal code reflects this view. Swiss Article 19 – 1 states that "If the person concerned was unable at the time of the act to appreciate that his act was wrong or to act in accordance with this appreciation of the act, he is not liable to prosecution."

> simply ask straight off about the responsibility, blame, and punishment of addicts, without also worrying about whether addicts are ill or not. (Butlin and Papineau 2017, 101)

However, the issues of whether a condition should count as a disorder, and whether it mitigates responsibility, are closely linked. Indeed, they normally rely on the same facts – facts about psychological deficits that impair agents' decision making and actions in such a way that we take them to be ill, and less able or unable to meet moral demands. So, a diagnosis of a disorder may be read as shorthand for the existence of cognitive deficits or dysfunctions which *may* also lead to lack of what legal scholars call "capacity responsibility" – the general mental capacities an agent must possess to be legally liable for her actions (Hart 1968). According to Hart, these include: "understanding, reasoning, and control of conduct: the ability to understand what conduct legal and moral rules require, to deliberate and reach decisions concerning these requirements; and to conform to decisions when made" (Hart 1968, 227).

Medical diagnoses serve different purposes than categories of excuse. Legal excuses aim to identify those whose ability to understand and obey the law is severely underdeveloped or diminished; whereas categories of disease are shaped by the medical professions' aims of diagnosing and treating illness. Thus, there are significant differences between categorization of disordered or diminished mental processes by the law versus the medical profession. Many mental disorders identified for treatment have little or no significance regarding the diagnosed person's capacity to commit a crime; and many persons excused from criminal culpability do not suffer from a mental disorder (e.g., young children).

Tests used by courts to determine if a defendant is legally insane attempt to identify capacities necessary for a person to be law-abiding, and then ask whether they are missing or diminished in a mentally ill defendant. The test for insanity adopted by most U.S. states, the M'Naghten rule, excuses a defendant who, due to a severe mental disease or defect, is unable to appreciate the nature and quality of the wrongfulness of his act. The other legal standard used in the U.S., found in the Model Penal Code (1985), requires that at the time of the criminal act a defendant diagnosed with a relevant mental defect lacked "substantial capacity to either appreciate the criminality of his conduct or to conform his conduct to the requirements of the law." Thus, the M'Naghten rule employs a purely cognitive conception of insanity, whereas the MPC rule requires that responsible defendants possess both cognitive and volitional competence.

Which test is best? David Brink and Dana Nelkin (2013) have argued that the capacities required for criminal blame and punishment are those necessary to provide an offender with "fair opportunity to avoid wrongdoing" (Brink and Nelkin 2013, 284). Certain cognitive and volitional capacities provide this fair opportunity because they allow an offender to understand moral and legal rules, and to exert control over his behavior to avoid breaking such rules (Brink and Nelkin 2013). Recognition of wrongdoing involves understanding the nature of one's act in relation to the law, as well as in relation to the circumstances surrounding the act (Brink and Nelkin 2013). Volitional capacities include a person's ability to plan and act according to that plan, to avoid impulsive reactive behavior, and in general, to inhibit behavior based on an understanding of its nature and consequences. Brink and Nelkin argue that legal excuses require substantial impairment of *either* cognitive or volitional capacities. They thus embrace the MPC test, which has both a cognitive and a volitional prong. This test is fairer to defendants because it recognizes the two main ways in which they may lack fair opportunity to be law-abiding due to their mental disorder.

As noted above, both the M'Naghten and the MPC test require that a mental disorder should cause the mental deficiencies that serve to excuse a defendant. Legal scholar Michael Moore has argued that both the M'Naghten and MPC tests assume a relation of weak relevance between an underlying mental illness and legal insanity (Moore 2015). This means that by these standards a mental disease or defect is not sufficient to excuse someone from legal responsibility: the disease or defect must cause substantial cognitive or volitional incapacity. However, Moore argues, if substantial mental incapacity is doing the exculpatory work, why does the cause of that incapacity matter to determining legal responsibility? If being unable to understand the nature and quality of one's act, or unable to control one's behavior is sufficient for excusing one from legal responsibility, then it is unclear why it matters whether such inability is caused by mental illness rather than something else.

Moore therefore claims that weak-relevance collapses into a position asserting no relevance between mental illness and responsibility, and advocates for a strong-relevance position instead. A medical concept is strongly relevant if it, by itself, captures conditions of moral and legal excuse (Moore 2015). Moore claims that in cases where mental illness provides a legal excuse, it does so by denying moral agency: like very young children, certain persons with mental illness lack the capacity to understand and follow legal rules. Moore thus seems to claim that certain mental illnesses identify persons who lack the capacity to commit a crime, or those who lack "capacity responsibility" (again, using legal scholar H.L.A. Hart's terminology). Hart argued that capacity responsibility is a foundational requirement for the efficacy of law: if a person or class of persons cannot perceive the law as a reason to act and conform their behavior to it, the law fails as applied to that person or class; because the law cannot influence their behavior (for instance, if they are seriously mentally ill), they fall outside of its reach (Hart 1968). A person with capacity responsibility can be found to have legal liability responsibility, which consists of the specific mental state attributions the criminal law must assign to a defendant if he or she is to be found guilty of a criminal act (e.g. acting "purposely" - with the purpose of causing criminal harm). In the case of the diminished mental capacity defense, degraded mental capacities may mean the defendant could not have performed an act "purposely" or "knowingly," but might still have been reckless and thus still partially responsible.

Moore argues that mental illnesses that are strongly relevant to legal insanity are special in their exculpatory power because they usually cannot be attributed to any actions or decisions by the person who is ill. In this way mental illnesses are unlike voluntary intoxication, which may also lead to a lack of capacity but can be traced back to a decision made by the defendant. In his discussion of the Anders Breivik case, Moore claims that the medical diagnosis "psychosis" is strongly relevant to legal insanity. A person suffering from psychosis at the time he commits a crime lacks capacity responsibility, and thus ought to be excused from criminal culpability. This means that if Breivik was properly diagnosed as psychotic at the time of his crimes, he is excused.

However, in an article reflecting on the Breivik case, Bortolotti, Broome, and Mameli disagree, both that certain medical diagnoses are strongly relevant to criminal culpability, and that Breivik in particular ought to be excused due to his diagnosis of psychosis (Bortolotti, Broome, and Mameli 2014). Bortolotti et al. agree with Moore that proof of an underlying mental illness is a way of identifying a group of persons for whom certain mental incapacities are generally exculpatory. However, they note that not every person found to have a significant mental disorder at the time of their crime will be found to have incapacities significant enough for them to be excused. Bortolotti and colleagues thus embrace a weak-relevance position, and claim that even if Breivik did have delusions, and was properly diagnosed as psychotic at the time of his crime,

this fact may still be irrelevant to whether he is criminally responsible. Because the level of cognitive and social functioning can vary widely amongst those with psychosis, even a diagnosis or the symptom of hallucinations or delusions themselves do not necessarily indicate the quality of a persons' legal and moral agency. They make a similar case in another paper which discusses a case study of a patient suffering from delusions, who attacks his neighbor. They argue that delusions per se do not excuse, but that it would have to be the case that what the individual did was either no action at all, or an action which would be justified if the delusion were in fact a true belief (Broome et al. 2010). They conclude, contra Moore, that no particular set of psychiatric symptoms or diagnoses is strongly relevant to a determination of legal insanity.[4]

We agree with Bortolotti and colleagues and feel that no mental illnesses are strongly relevant to legal insanity. Even a diagnosis of schizophrenia, the illness most likely to underpin a successful plea of legal insanity in the US, may be irrelevant to a person's capacity responsibility if it is controlled by medication, or if the person had sufficient mental capacity to understand the specific moral and or legal rule broken by her crime, and the ability to have acted in accordance with those rules at the time the crime was committed. To put it more strongly, many mental disorders are probably largely irrelevant to a person's capacity responsibility. Mental illnesses such as obsessive-compulsive disorder, depression, and phobias typically will not impact a person's capacity to understand moral and legal rules, or to obey those rules. An exception might be the ability of a clinically depressed person to prepare and file a very complex set of tax returns on time – the inertia that some persons with clinical depression experience might inhibit their ability to spend hours preparing their taxes. Parents with depression or bipolar disorder may also fail in their responsibility to care for their children partly because of their condition but be less than fully legally responsible for doing so. But in general, even severe mood and personality disorders are unlikely to impact a person's ability to understand the relationship between her act and the law, or the volitional capacity to inhibit illegal behavior.

On the other hand, there may be cases where a defendant not diagnosed with a mental disorder is seriously incapacitated with regard to his ability to understand moral and legal rules, or to obey those rules. Such incapacities are not exculpatory if they are self-inflicted – for example, if a person had voluntarily taken a dose of LSD. However, if a court determined that a defendant had serious mental deficits that were not due to a mental disorder, but also were not due to the defendant's own actions, then the court may find the defendant partially excused due to diminished mental capacity. One example might be persons with severe intellectual disabilities.

4. Do psychopaths lack capacity responsibility (are psychopaths legally insane)?

The question addressed in this section is whether psychopathy is either strongly or weakly relevant to legal insanity such that a diagnosis of psychopathy should be considered exculpatory by criminal courts. We maintain that a diagnosis of psychopathy is only very weakly relevant to legal responsibility, because the diagnosis does not reliably pick out persons who lack the cognitive and volitional capacities necessary for capacity responsibility. To put it another way, psychopathy does not reliably map onto incapacities necessary for a person to have a fair opportunity to be law-abiding. The

[4] Similar points have recently been made about the relationship between mental illness and moral responsibility (King and May 2018).

best current science indicates that the heterogeneity of the group "psychopath" with regard to both cognitive and volitional competence means the diagnosis is, at best, a signal to a criminal court that further psychological testing may be warranted.

The two symptoms most likely to impact psychopaths' capacity responsibility (and thus their fair opportunity to be law-abiding) are (1) psychopaths' affective deficits, and (2) deficits psychopaths may have in their cognitive control network, or executive functions. The former may impact a defendant's ability to understand legal and moral rules, and the latter are thought to be related to impulsivity and an inability to inhibit anti-social and illegal behavior. Below we review the most current evidence regarding these two types of deficits in psychopaths.

4.1. Affective deficits

As discussed above, the PCL-R, the diagnostic most commonly used to identify psychopathy, describes psychopaths as callous, unempathetic, emotionally shallow, and unlikely to feel guilt. A number of authors (Fine and Kennett 2004; Levy 2007, 2014; Morse 2008) have argued that the affective deficits may be related to an inability to distinguish between moral and conventional rules, leading to psychopaths' inability to understand moral requirements, and therefore supporting the conclusion that psychopaths are not fully responsible. There is some evidence that psychopaths are not as good at detecting emotions in voices of other people, especially fear (Blair et al. 2002). One study also indicates that psychopaths exhibit poorer recognition of fear and sadness in faces (Blair 2008). Birbaumer et al. (2005) found reduced activity in brain regions associated with emotionality, reporting reduced vmPFC and amygdala activity in individuals with psychopathy during aversive conditioning (Birbaumer et al. 2005). Blair, Mitchell and Blair (2005) have also argued that amygdala function is impaired in psychopaths, leading to dysfunctional creation and processing of affect-laden representations, particularly of others the psychopath may harm (Blair et al. 2005). These findings might be taken to show that psychopaths do not have the necessary affective reactions that allow other people to develop moral understanding and pro-social behavior. Glenn and colleagues found reduced activity in the amygdalae of psychopaths during emotional decision making, and found that a subgroup of these subjects who were skilled at conning and manipulation showed reduced activity within this "moral circuit" (Glenn et al. 2009). They suggest failure in these circuits results in deficits in considering how one's actions affect others, failure to consider the emotional perspective of the harmed other, or a failure to integrate emotion into decision making processes (Glenn et al. 2009).

However, other studies showed that psychopaths do not show a differential brain response to emotional terms when compared to non-psychopathic controls (Williamson et al. 1991). Further, it seems that affective deficits differ across subcategories of psychopath. Cleckley argued that primary psychopaths commit antisocial acts due to a lack of empathy and fear, but secondary psychopaths, although they share many of the antisocial behaviors of primary psychopaths, are remorseful and fearful (Cleckley 1976). As noted above, primary psychopathy may be inversely associated with negative emotionality; whereas secondary psychopathy is correlated with negative emotionality, impulsivity, and reactive aggression (Skeem et al. 2007). Thus it seems only primary psychopaths may have affective deficits. Another way of categorizing psychopaths also indicates differences in affect: "unsuccessful psychopaths" tend to have reduced prefrontal and amygdala volume (Yang et al. 2005), reduced autonomic levels (Hare 1982), and impaired fear conditioning (Birbaumer et al. 2012). However, psychopaths termed "successful" - due to their ability to avoid the criminal justice system - show no reductions in prefrontal or amygdala volume (Yang et al. 2005), and intact or even

enhanced autonomic levels (Ishikawa et al. 2001). Ishikawa et al. (2001) found that successful psychopaths actually had greater autonomic responses than both unsuccessful psychopaths and non-psychopathic controls (as measured by their heart rate reactivity) during a task designed to produce embarrassment: preparing and then delivering a two-minute speech detailing their personal faults and weaknesses. A qualifying score on the PCL-R would not indicate which subcategory a psychopath falls into, because they might have reached their score by scoring particularly high on factor one (affective/interpersonal traits), or on factor two (antisocial behavior/lifestyle), or comparably high on either.

Even more interesting is new evidence that psychopaths may be able to correct for affective deficits. A recent review indicates psychopaths do not show abnormal subjective experience of fear, but instead insensitivity to fear-related cues (Hoppenbrouwers, Bulten, and Brazil 2016). Further, there is evidence that psychopaths may be able to appropriately adjust their top-down attention to better recognize and respond to affective cues (Koenigs and Newman 2013). In a recent article, Jurjako and Malatesti argue that although psychopaths seem to have trouble with cognitive tasks involving emotions, such as passive avoidance, response-reversal, and gambling tasks, the deficits are highly context dependent (Jurjako and Malatesti 2018a). When psychopaths are attentive to their goals on a passive-avoidance task, they score similarly to controls (Koenigs and Newman 2013). Further, psychopaths' performance on gambling tasks is predicted by their attention scores such that those who pay more attention score better (Lösel and Schmucker 2004). We agree with Malatesti and Jurjako that this new evidence indicates at least some psychopaths with affective deficits may be able to correct for such deficits via attentional control.[5]

There is further evidence that even if psychopaths suffer from affective deficits, this may not result in a lack of moral knowledge impacting a psychopath's ability to be law-abiding. As mentioned earlier in this section, some studies seemed to indicate that psychopaths fail to grasp the difference between moral and conventional rules (Blair 1995, 1997). This was thought to have implications for psychopaths' responsibility: because psychopaths couldn't "feel" the difference between a moral violation (such as hitting someone) and a conventional rule violation (such as a rule against parking in a certain place), they had a harder time obeying and understanding the force of moral rules. More recent studies, however, showed that when psychopaths were explicitly forced to decide which norm violations were moral vs. conventional, they performed in a manner equal to controls (Aharoni, Sinnott-Armstrong, and Kiehl 2012, 2014).[6] Again, attentional control seemed to ameliorate any deficits psychopaths experience in moral knowledge.

[5] What abilities of correction and compensation these findings would support depends on how the specific differences observed in experimental settings translate into capacities relevant for moral action and judgment. As the findings don't directly test capacities we are interested in when assessing responsibility, a certain amount of interpretation regarding the likely implications for the relevant capacities is required. If the thought is that affective deficits make acting morally more difficult in certain situations, then the ability to compensate seems highly relevant. If the underlying model is one by which affective deficits stunt the development of moral understanding generally, the ability to compensate locally may be less relevant.

[6] For a discussion of the current evidence on psychopaths understanding of the moral conventional distinction, see Godman and Jefferson (2017).

This conclusion is in keeping with a study by Glenn et al. (2009) that showed psychopaths solve moral decision tasks by utilizing different brain areas than controls, including the dorsolateral prefrontal cortex. This may mean they are able to access moral knowledge from faculties other than the affective system. If this is the case, then any affective deficits they suffer may not be exculpatory.

4.2. Cognitive control

The studies above indicate that psychopaths' ability to correct for affective deficits is dependent on their capacity for top-down attentional control, which is thought to be a part of the larger cognitive control system. Cognitive scientists often call the components of this system "executive functions," which are thought to be accomplished by the fronto-parietal cognitive control network (working together with adjunctive areas). Executive functions include planning and goal-setting; monitoring of perceptions, emotions, and behavior; utilization of working memory; inhibition; and task-switching, as well as top-down attention. Recent research indicates that persons diagnosed as psychopaths may have very different executive profiles (Jurjako and Malatesti 2018b). Some studies indicated that unsuccessful psychopaths had reduced prefrontal and amygdala volumes as well as hippocampal abnormalities, possibly resulting in reduced executive functioning, including impaired decision-making (Gao and Raine 2010). In contrast, a community-recruited sample of psychopaths did not show similar structural and functional impairments of the prefrontal cortex, amygdala and hippocampus (Gao and Raine 2010).[7] One Ishikawa et al. study found that, compared with unsuccessful psychopaths who had at least one criminal conviction and controls, successful psychopaths had better executive functioning as measured by the Wisconsin Card Sorting Task (WCST) (Ishikawa et al. 2001).[8] Ishikawa and colleagues suggested that better executive function might play a protective role for successful psychopaths, decreasing their tendency to be caught up in the criminal justice system (Ishikawa et al. 2001). A recent review of existing studies by Maes and Brazil (2013) examined the relationship between executive function and the two psychopathy factors measured by the PCL-R. Specifically, Maes and Brazil tried to determine if there was a positive correlation between the affective-interpersonal (factor 1) aspects of psychopathy and executive function; and also whether the anti-social/behavioral (factor 2) aspects of psychopathy were negatively correlated with executive function. Across the different studies, they found no consistent results indicating a significant correlation between the affective-interpersonal aspects of psychopathy and increased executive function ability (Maes and Brazil 2013). Although there were more negative associations between factor 2 and executive functions than factor 1, the majority of these associations were non-significant (Maes and Brazil 2013). It is therefore too early to tell whether psychopathy factors predict executive function abilities, or whether executive function abilities predict scores on the PCL-R.

Recent studies of executive functions within subsets of psychopaths indicate that even unsuccessful psychopaths may not do worse on tasks testing "cool EFs" (non-emotional

[7] It should be noted here that Gao and Raine's study included psychopaths who were diagnosed as such using different measures. This leaves open the possibility that the set of individuals was even more heterogenous than we would expect using just one measure, for instance the PCL-R.

[8] The WCST is used to assess the following frontal lobe functions: strategic planning, organized searching, shifting of cognitive sets, considered attention, and modulating responses (Ishikawa et al. 2001).

tasks, often tested by the Wisconsin Card Sorting Test). One study by Pera-Guardiola et al. (2016) indicated that prisoners with lower scores of psychopathy may suffer from EF deficits tested by the WCST (a "cool" task) in comparison with prisoners who score higher on the psychopath diagnostic and those without a psychopathy diagnosis. This study thus seems to indicate that higher scores on the PCL-R don't necessarily indicate higher deficits in "cool" EFs. Instead, the study indicated that antisocial personality disorder might more accurately track deficits in "cool" EFs as opposed to scores on the PCL-R (Pera-Guardiola et al. 2016).

Some psychopaths, however, may suffer from deficits in tasks testing "hot EFs" (tasks involving emotion, often tested by gambling tasks). Such tasks touch upon both of the characteristics of psychopathy that may make it harder for psychopaths to be law-abiding: emotional deficits may impact cognitive control of behavior or the ability to inhibit action, especially in response to a psychopath's understanding the nature and/or consequences of one's actions. In comparison to non-psychopathic controls, both successful and unsuccessful psychopaths perform worse on gambling tasks (Mitchell et al. 2002). Psychopaths, when compared to controls, show non-risk-aversive behavior, making them more likely to sustain major losses.

However, Jurjako and Malatesti argue that deficits in performance in "hot" EF tasks are not significant enough to be exculpatory because they are so context-dependent and, as discussed above, may be corrected for (Jurjako and Malatesti 2018b). As already mentioned, in conditions where psychopaths pay attention to certain aspects of the gambling game, and pause before making a decision, psychopaths perform as well as controls. This seems to indicate that deficits on "hot" EF tasks may be primarily due to problems of affect and can be ameliorated with "cool" EFs such as attentional focus. In addition, persons who have difficulty making good moral decisions due to strong emotional responses may also have opportunities to control their emotional reactions via limiting their exposure to the environments or conditions that trigger such responses (Roskies 2012).[9] Jurjako and Malatesti conclude that once variability between psychopaths on EF tasks is taken into consideration, "it is not clear that there is sufficient evidence indicating that psychopaths suffer from general impairments underlying the control capacities" (Jurjako and Malatesti 2018a, 1018).

5. Conclusions

The DSM-5 does not classify psychopathy as a standalone mental illness or disorder; instead it is best understood as sub-type of Antisocial Personality Disorder. While on some definitions psychopathy may be properly conceived of as a disorder (e.g., because it exhibits both dysfunctionality and harmfulness), we have argued that a diagnosis of psychopathy will frequently be insufficient to ground a successful legal insanity defense. This is because the group of individuals subsumed under the diagnosis is so heterogeneous that many psychopaths are not mentally incapacitated in a way relevant to responsibility.

We claim that evidence of a mental disorder is only weakly relevant to establishing legal insanity, which means that on the MPC test for legal insanity – which we feel is fairer to

[9] Examples may include a person avoiding extended time with children if he finds them sexually attractive, avoiding alcohol if a person knows it leads him to impulsive or aggressive behavior; and a person avoiding others who tend to make him anxious or upset.

defendants than the M'Naghten test – a mental disorder must be shown to result in substantial impairment of either cognitive or volitional capacities. These capacities could be impaired by the two primary symptoms of psychopathy, affective deficits and problems with cognitive control. This is because these symptoms could deny a defendant a fair opportunity to be law-abiding by impacting his ability to understand moral and legal rules, and to exert control over his behavior to avoid breaking such rules (Brink and Nelkin 2013). However, current science indicates that psychopaths are a heterogeneous group with regard to both affect and cognitive control, and thus, with regard to how such symptoms might impact a defendant's cognitive or volitional capacities. This means a diagnosis of psychopathy using the standard diagnostics does not provide evidence or proof that a defendant is legally insane. At best, the diagnosis may indicate to the court that further psychological testing for substantial mental impairment is required to establish whether the requirements for legal insanity might be met.

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