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Psychopathy and Failures of Ordinary Doing

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ABSTRACT
One of the philosophical discussions stimulated by the recent scientific study of psychopathy concerns the mental illness status of this construct. This paper contributes to this debate by recommending a way of approaching the problem at issue. By relying on and integrating the seminal work of the philosopher of psychiatry Bill Fulford, I argue that a mental illness is a harmful unified construct that involves failures of ordinary doing. Central to the present proposal is the idea that the notion of failure of ordinary doing, besides the first personal experience of the patient, has to be spelled out also by referring to a normative account of idealised conditions of agency. This account would have to state in particular the conditions which are required for moral responsibility. I maintain that psychopathy is a unified enough construct that involves some harms. The question whether the condition involves also a failure of ordinary doing, as this notion is understood in this paper, is not investigated here.

KEYWORDS
Psychopathy, concept of mental illness, Bill Fulford, failure of ordinary doing, moral responsibility

1. *Introduction*

People classified as being psychopaths are characterised by a callous, manipulative and remorseless behaviour and personality.[1] In recent years, scientific research on psychopathic offenders, but also on the so called successful psychopaths who do not necessarily offend, has increased considerably. Robert Hare's *Psychopathic Checklist Revisited* (PCL-R) is a diagnostic tool that has played an important unifying role in this research.[2] There is a growing literature concerning psychopaths' functional, emotional and cognitive peculiarities, and their neural and genetic correlates or causes.[3]

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[1] In the remainder of the text, I use the term "psychopaths" to refer to persons classified as having psychopathy. However, this use is not meant to convey a possibly stigmatizing identification of these subjects with their condition.
[2] Hare 1991 and Hare 2003.
[3] For surveys, see Blair, Mitchell, and Blair 2005, Kiehl and Sinnott-Armstrong 2013 and Patrick 2006b.

Scientific research on psychopathy has stimulated and informed philosophical debates on the appropriate social response to the crimes of psychopaths. Amongst other issues, philosophers have also begun to investigate the problem whether, in general, psychopathy can be regarded as a mental illness.[4] This investigation touches upon fundamental conceptual aspects of psychiatry that are at the focus of the so called "new philosophy of psychiatry".[5]

This paper, although does not answer the question whether psychopathy is a mental illness, recommends an approach to it. At the core of this recommendation is the view that a mental illness is a unified construct that involves failures of ordinary doing that is harmful to the patient. The notion of failure of ordinary doing in this account of the concept of mental illness is inspired by the one advanced in the seminal work of the philosopher of psychiatry Bill Fulford.[6] The primary focus of Fulford's account is the first-personal phenomenology that is constitutive of the negative evaluations that confer illness status to a certain condition. This is the phenomenology faced by an agent who is not able to act in the ordinary expected ways, cannot recognise ordinary causes and reasons of this inability, and does not know how to overcome it. I argue that the notion of failure of ordinary action should also be spelled out in a third-personal way, by means of idealisations of preferable forms of ordinary agency. Specifically, when considering the illness status of psychopathy, also standards concerning moral accountability should inform these idealisations.

In the next section, first I present the construct of psychopathy as diagnosed by the PCL-R, and survey the major findings about the functional characteristics of psychopaths and the hypothesised underlying neurological correlates. Then, I argue that, under a quite liberal notion of unity, psychopathy can be regarded as a unified construct. In the third section, I maintain that psychopaths are also in some ways harmed by their condition. In addition, I criticise attempts at investigating the illness status of psychopathy by using notions of biological dysfunction. In the fourth section, firstly I describe the fundamental tenets of Bill Fulford's account of mental illness. Then, I suggest the specific formulation of the notion of failure of ordinary doing to be employed in investigating whether psychopathy is a mental illness.

[4] See Nadelhoffer and Sinnott-Armstrong 2013 and Malatesti and McMillan 2014. The other issue is whether psychopaths are morally and legally responsible for their crimes, see on this Malatesti and McMillan 2010 and Kiehl and Sinnott-Armstrong 2013.

[5] Fulford, Thorthon, and Graham 2006, is an extensive introduction to the discipline.

[6] Fulford 1989.

2. *Psychopathy: the unity of the construct*

During the last 70 years experts have advanced and intensely debated different formulations of the construct of psychopathy.[7] However, Hervey Cleckley (Cleckley 1941) has offered a seminal contribution to the contemporary articulation of this notion.[8] On the basis of his clinical work with several individuals, Cleckley individuated the following 16 traits as characteristic of the psychopathic personality:

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

Cleckley's characterisation of the psychopathic personality has been the basis of later interpretations of this construct. Specifically, Robert Hare has characterised the concept of psychopathy by revising some of the personality traits delineated by Cleckley and incorporating violent and antisocial behaviour amongst the items.[9] Hare and collaborators have thus elaborated the Psychopathy Checklist-Revised (PCL-R), and some variations of it, as a diagnostic tool that aims at establishing how a subject scores on different dimensions of behaviour and personality.[10]

The PCL-R is used by trained clinicians to evaluate by means of semi-structured interviews and intensive study of the history of the subject, supported by available file records, on 20 items:

1. Glib/superficial charm.
2. Grandiose sense of self-worth.

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[7] For historical accounts, see Andrade 2008 and Millon, Simonsen, and Birket-Smith 1998.
[8] For instance, see Patrick 2006a.
[9] Hare 1991, Hare 2003, Hare and Neumann 2010.
[10] For a survey of alterative diagnostic tools to the PCL-R, see Fowler and Lilienfeld 2013.

3. Need for stimulation/proneness to boredom.
4. Pathological lying.
5. Conning/manipulativeness.
6. Lack of remorse or guilt.
7. Shallow affect.
8. Callous/lack of empathy.
9. Parasitic lifestyle.
10. Poor behavioural controls.
11. Promiscuous sexual behaviour.
12. Early behavioural problems.
13. Lack of realistic long-terms goals.
14. Impulsivity.
15. Irresponsibility.
16. Failure to accept responsibility for one's own actions.
17. Many short-term marital relationships,
18. Juvenile delinquency
19. Revocation of conditional release,
20. Criminal versatility.

For each element in the list, there is a score ranging from 0 to 2 points; the maximum total score is thus 40 points. When a subject scores 30 or more points he/she is considered psychopathic. This cut-off value is usually adopted in North America; in Europe, a value of 25 is often used.

Answering the question whether psychopathy as individuated by the PCL-R is a mental illness requires addressing two interrelated general issues. The first one is whether the diagnosis of psychopathy is unified enough to individuate more than a mere arbitrary list of certain behaviours, inferred mental states, and personality traits. The second issue is whether these characteristics and processes, if unified in the appropriate way, involve symptoms of an illness, as opposed to certain type of behaviours, ways of thinking, feeling and personality traits, which, although different or deviant given certain non-medical standards, cannot be regarded as pathological. Let us consider the first problem.

Establishing in general whether a psychiatry diagnostic tool individuates a unified construct requires engaging with difficult issues. It has to be established which features of that instrument and the associated classification should be taken into consideration and when they offer evidence for the desired notion of unity. These issues are debated within psychiatry; but they also involve conceptual problems that have been the focus of intense philosophical investigation.[11]

One of the least problematic aspects of the unitary nature of a certain psychiatric kind is the reliability of the diagnostic tool used to diagnose it. This reliability depends on the amount of agreement amongst its users. The *inter-rater*

[11] See, for instance, chapters 13-14 of Fulford, Thorthon, and Graham 2006.

reliability is given by the amount of agreement that different users reach in applying the classification to a certain individual. The *test-retest* reliability is specified by the consistency in the use of a classification by the same observer of the same case in a period of time. At least in research settings, different trained users of PCL-R would agree in the assignment of scores and thus in their diagnosis of psychopathy.[12] Of course, from these results it does not follow that PCL-R is used reliably or should be used in other and more sensitive contexts. For example, there is evidence that in civil commitments proceedings different evaluators assign significantly different PCL-R scores to the same individuals.[13] In any case, even complete diagnostic reliability across contexts could not confer alone unity to what is so classified.

Besides commanding agreement amongst the evaluators, a psychiatric classification has to be valid. Generally and clearly enough, a valid psychiatric classification should characterise features that are shared by several individuals or similarities between them that are theoretically important. These similarities should at least enable unitary explanations and predictions of relevant behaviours and mental states and, eventually, efficacious treatment.[14] Spelling out in detail this basic characterisation of validity involves addressing other interrelated problems.

First of all, given that psychiatry deals also with "mental" processes, there can be diverging views about the kind of basic properties or similarities that should ground the desired unification and thus the validity of the psychiatric kind. Depending on general views on the nature of the mind, the unifying features or similarities would have to be found in the spectrum that goes from the mental level to the physical one. Moreover, there is the issue of how characterising the extreme and the intermediate points of that spectrum. Some think that mental states and processes should be specified behaviourally, other that they should be individuated functionally by means of characteristic causal roles, other by means of refinements of folk-psychological accounts or by specific psychological theories.[15] Similarly, also the individuation of the relevant neural properties of the brain can be open to different requirements concerning the appropriate type of modelling and its level of abstraction.[16]

This paper cannot address all the previous difficult issues that fall under the mind-body problem rubric. Instead, I set out some "liberal" requirements for the underlying unity of a psychiatric construct that appear to have a role in the current psychiatric practice. The first requirement is that the unifying features or similarities between members of a psychiatric kind can be individuated at different

[12] See Hare and Neumann 2006, 66-67.
[13] See Boccaccini, Rufino, and Turner 2012.
[14] See Cooper 2007, chapter 4.
[15] For a survey of these theoretical options in philosophy of psychology, see Bermúdez 2005.
[16] See for instance, Churchland and Senjowski 1992, Chapter 2.

levels, without providing an ultimate account of the relations between these levels and establish which one them is the most fundamental and most relevant for prediction and explanation.

Although the PCL-R has been used as a unifying diagnostic tool in scientific research, some worries about the unity of the construct of psychopathy as measured by the PLC-R stem from the inclusion of criminal and antisocial behaviour amongst the criteria. One of the traditional criticisms to the antecedents of the current notion of psychopathy was that these constructs involved a circular inference from criminal and antisocial behaviour to a supposed criminal personality and then would involve explaining the same behaviours on the basis of that personality.[17] In addition, it has being argued that PCL-R is defective because a clinical assessment should identify personality traits that lead to particular behaviours as opposed to the assessment of behavioural symptoms to determine a diagnosis.[18]

However, the PCL-R is also taken to measure inferred personality traits that do not coincide with antisocial behaviour. Moreover, there is evidence of a correlation between scoring highly on the PCL-R and specific behavioural responses in controlled conditions. These latter behaviours, that correlate higher with psychopaths than non psychopaths, are not part, at least evidently, of the behavioural symptoms registered by the PCL-R. Thus, as a first possible dimension of unity of the construct diagnosed with PCL-R, we can count certain specific behaviours in controlled conditions that are shared by those who score high in it. In addition, these behaviours are highly suggestive of cognitive and functional differences that might be taken to offer evidence of the unitary nature of the construct of psychopathy as individuated by PCL-R. Let us rehearse briefly these behaviours and inferred functional and cognitive differences.

Functional impairments related both to emotional and cognitive spheres appear to be correlated with psychopathy as measured by PCL-R.[19] Studies suggest that psychopaths manifest reduced levels of anxiety that are manifested by reduced physiological reactions to threatening stimuli, including imaginary situations. In addition, psychopaths show certain instrumental learning shortcoming in controlled. Finally, there are results, perhaps more controversial, concerning the reduced attention capacities of psychopaths.

There are also studies that have focussed on the empathic reaction of psychopaths to distressed people. Psychopathy associates with reduced emotional responses, as measured by skin conductance, to the observation of the administration of punishments. Psychopathic offenders, when compared to non

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[17] See, for example, Haksar 1965, Wootton 1959.

[18] See Blackburn 1988.

[19] For a recent survey, see Blair 2013. In addition these results are presented a discussed in the different chapters of Patrick 2006b.

psychopathic ones, manifest insensitivity to the distinction between moral and conventional transgression.[20]

Although experts agree that we have not an ultimate account of the neurological causes of psychopathy, several researches have associated the specific functional profile of psychopaths with hypothesis concerning neurological correlates and causes. So, it has been argued that psychopathy correlates with dysfunction in frontal lobes and the prefrontal cortex in particular.[21] Others argue that the hippocampus might have a primary role in psychopathy.[22] Finally, James Blair and colleagues suggest that dysfunction of the amygdala are the key neurological causes of psychopathy besides impairments in orbitofrontal and ventrolateral cortex.[23] Thus, we might derive some further evidence for the unity of psychopathy construct that is offered by PCL-R by the fact that it enables the formulation, within the available scientific knowledge, of hypothesis about specific neural correlates or event causes of the personality traits and behaviours it classifies. Similarly, this construct, is increasingly employed in research concerning the genetic basis of psychopathy.[24]

The validity of a classification is related also to the predictive powers it confers. With the PCL-R based diagnosis of psychopathy, understandably, a primary focus has been on its capacity to predict criminal behaviour and recidivism. Supporters of PCL-R have offered evidence for the thesis that psychopaths are more likely to recidivate violent crimes.[25] Even authors that criticise the claim that PLC-R is an "unsurpassed standard" in the prediction of criminal behaviour and recidivism, recognise its good predictive capacity.[26]

To recapitulate, it seems that high scores in the PCL-R individuate a class of individuals that appear to be significantly more likely to reoffend than controls who share certain functional impairments that are not evidently associated with the behaviours that are involved in the diagnostic criteria. Moreover, there is enough evidence for advancing hypotheses about the possible underlying neurological correlates or causes of the disorder. Some use these features of the PCL-R to conclude that it individuates a unified construct.[27] It seems more plausible to maintain that there is evidence for claiming that PCL-R is an "enough" unified construct, given some liberal requirements on the notion of unity

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[20] Blair et al. 1995, however, see for contrasting results Aharoni, Sinnott-Armstrong, and Kiehl 2012.

[21]See Raine 1993.

[22] See Raine and Yang 2006.

[23] See Blair, Mitchell, and Blair 2005.

[24] See Viding, Fontaine, and Larsson 2013, Waldman and Rhee 2013.

[25] See Hemphill and Robert D. Hare 2004, Leistico et al. 2008 and Douglas, Vincent, and Edens 2006.

[26] Gendreau, Goggin, and Smith 2002, but see also the response to this criticism in Hemphill and Robert D. Hare 2004.

[27] See, for instance, Nadelhoffer and Sinnott-Armstrong 2013.

at issue. However, the issue of the unity of psychopathy as diagnosed with PCL-R is open and hostage not only to further empirical research but also to philosophical insights concerning conceptual problems about the nature of the validity of psychiatric and scientific classifications in general. However, let us assume that, under a plausible account of validity, psychopathy as measured by PCL-R is a unified construct; does it follow that is a mental illness?

3. *The illness status of psychopathy: some harms*

It has been argued convincingly that one necessary condition for illness in general is involving harm or distress to the patient.[28] Once this condition is endorsed, a lot remains to be spelled out. Clearly, it has to be specified what are the relevant harms. Usually, death, pain, shortening of life, limitations or absence of reproductive capacity, lack of social integration, lack of stable and harmonious relationships, capacity for work and so forth are mentioned in this respect. However, the list can be extended and things might be further complicated by adding, when it is applicable, "thresholds" of tolerance and duration to these harms. In addition, it has to be clarified in which way the condition at issue should relate the subject to these harms. It might be required that the condition actually causes the harm or just it predisposes the subject to it, perhaps with a given probability. It can then be debated whether the patients have to recognise some of these harms as such or their presence can be detected independently from the patients' insight. Finally, there is the question of the justification and nature of the standards that should specify these harms. For instance, some concede that they can be socially sanctioned while others require that they have to be universal harms recognisable in any culture.

Despite these difficulties it seems that, broadly speaking, psychopathic offenders are harmed by their condition.[29] For instance, if we admit that the harm relevant to mental illness can be specified with reference to the values of our culture, they suffer harms. Their antisocial behaviours deprive them of socially valued things such as freedom that they lose due to incarceration, friends, and relationships. In addition, their different ways of reasoning and learning might explain their lack of academic and other achievements that are valued by society. Finally, psychopaths tend to die earlier than non psychopaths, even within the incarcerated population, due to correlations between psychopathy, violence, and various kinds of risky behaviour.[30]

[28] For a classical account of this type, see Glover 1970, chapter 6.
[29] See Nadelhoffer and Sinnott-Armstrong 2013.
[30] See Nadelhoffer and Sinnott-Armstrong 2013.

In any case, satisfying the harm condition cannot guarantee the illness status. Many clusters of behaviours, mental states and personality trait might be, for instance, conducive of the relevant harms listed above without being symptoms of an illness. It seems that illnesses should involve harms or distresses that result specifically from deviances of the body or the mind from certain standards of health or proper functioning.

Several authors have thought that we should recur to the notion of biological function and dysfunction, understood in evolutionary terms, to offer, at least, a necessary grounding to the notion of mental illness to be integrated with the harm condition.[31] Although these doctrines differ in details, especially in the way of articulating the notoriously difficult notion of biological function and thus dysfunction, they share an important assumption. According to these views, an account of mental illness should involve and objective grounding in value-free scientific notions such as, the supposedly so, concept of biological function. So, the harmful dysfunction analysis might be used to assess the illness status of psychopathy.

Robert Hare, who has devoted his scientific career to refining PCL-R and defending the validity of the relative construct of psychopathy, is not inclined to regard psychopathy as a mental illness. Contemplating the evolutionary hypothesis that psychopathy might be an adaptive life strategy, but without discussing its merits, he claims that:

> … we should consider the possibility that the actions of psychopaths reflect cognitive, affective and behavioural processes and strategies that are different from those of other people, but for reason other than neuropathology or deficit, in the traditional medical and psychiatric sense of the term. (Hare 2013: vii)

The first premise of Hare's reasoning is disputed. Some defend the hypothesis endorsed by Hare.[32] Others, however, have argued that psychopathy is not adaptive.[33] This is an extremely important debate that touches, amongst other things, upon the feasibility and specific formulation of evolutionary psychology and psychiatry. However, what about the second, implicit, premise in Hare's reasoning? Does involving a biological dysfunction represent a necessary condition for mental illness?

Bill Fulford, amongst others, has questioned the possibility to individuate value-free biological functions that could offer such an objective grounding of the notion of mental illness.[34] Others have advanced more pragmatic considerations

[31] Amongst the most influential proposals, see Boorse 1975, and Wakefield 2007.
[32] See Mealey 1995 and Krupp et al. 2012.
[33] See Nadelhoffer and Sinnott-Armstrong 2013.
[34] See Fulford 1989.

against using biological dysfunctions to characterise mental illnesses. The debate on the adaptive nature of psychopathy illustrates the type of difficulties that can be found in establishing the evolutionary underpinnings of different mental disorders. Once we consider the practical nature of psychiatry, having to wait for the completed evolutionary account of our mind, would mean undermining much of current psychiatric practice. This clearly has very high practical costs that we might not be ready to pay.[35] Finally, there are conceptual reasons for rejecting the idea that mental illness requires the notion of biological dysfunction.

Rachel Cooper has argued convincingly that we can conceive plausible instances of biologically functionally or adaptive mechanisms that produce outcomes that we could still take to be disordered.[36] For example and for the sake of argument, let us consider the hypothesis that agoraphobia is an adaptive trait for the kind of dangerous environments where human used to live.[37] Despite we could regard agoraphobia as being biologically functional; we would still regard a person who has this type of phobia, in the type of society we are living in, as having an illness or disorder. So, keeping in place the harm condition, where should we look for to establish whether psychopathy is a mental illness? Bill Fulford has suggested that we have to focus directly on our everyday experience as agents to clarify the notion of disorder at the core of the concept of mental illness. Let us consider this account in the next section.

4. *Failures of ordinary doing and moral responsibility*

Bill Fulford has argued that debates concerning the notion of mental illness have been vitiated by the assumption that while mental illness and disease are value laden concepts, physical illnesses are objective features. Instead, he argues that both the notion of physical illness and that of mental illness are species of the value laden notion of illness. According to him, at the core of the notion of illness in general there is a failure of *ordinary doing*.[38] Ordinary doings are intentional actions that we do, as opposed to things that happen to us. Specifically, Fulford considers the ordinary doings that do not involve any special attention or reflective assessment of the situation. He wants to call our attention onto what would be like to experience the inability to act in the ordinary way, without being capable to determine what is obstructing our action. Given that it is hugely important to us to act as we wish, this would be something that we would value as negative and dysfunctional, as something that ought not to happen given the

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35 See Bolton 2008, 160-61.

36 See Cooper 2007, 33-34.

37 This thesis is defended in Nesse 1987.

38 See Fulford, Thorthon, and Graham 2006, 129 -134, and Fulford 1989.

usually relative effortless nature of this action. In addition, this phenomenon would be something that happens to the agent, as opposed something that she can do.

According to Fulford, these basic considerations show that the primary experience of illness, as instantiated in the case of bodily movement, can be analyzed as a failure of "ordinary doing" in the perceived absence of understandable, from an ordinary perspective, obstructions or oppositions. In particular, this analysis of illness offers an insight in the specific values and harms that are involved in shaping the idea of illness as opposed, say, ethical or aesthetic values. In fact, intentional actions involve intentions that, in turn, involve positive evaluations and certain preferences. In addition, intentional acting is supported or constrained by expectations or norms about our capacities, about what we should be able to do effortlessly, about the kind of obstructions we might expect and so forth. Prevented actions associated with illness involve the existence of obstructing events that are not of the usual type. These action failures are thus experienced as (or even are) outside our control.

Fulford also stresses that many illnesses are characterised by unwelcome sensations such as pain, nausea, etc.[39] However, he thinks that also these features, that specify the character of the experience of illness, are based on failure of ordinary doing. People cannot act as they ordinarily do to avoid pains that require medical intervention. For example, we avoid a burning pain by moving away the hand from hot source. However, when the burning is due to a wound, we cannot perform this ordinary action to relieve the pain. Thus, in Fulford's account, a mental illness is characterised by failures of ordinary action involving mental states and other processes that (i) directly interfere in unexpected ways with ordinary intentional action or (ii) that determine or include unwelcome or unpleasant sensations that cannot be avoided by performing normal ordinary actions.

With reference to mental illness, Fulford's account might appear primarily directed at characterising specific form of dysfunction and harm that can be appreciated as such by the person who undergoes the mental disorder. The person needs to have an experience of a failure of her ordinary acting that involves an awareness of the lack of her control. This specific lack of control would thus determine the kind of harm that, according to Fulford, is central in the experience and the notion of mental illness. Now, in order to establish the mental illness status of psychopathy, it might be surely worth investigating whether psychopaths experience their condition as involving, from their own perspective, failures of ordinary action. Their specific ways of reasoning and learning, their incapacity to have organised life plans, their impulsivity, and their emotional profile might strike them, from their own perspective, as problematic insofar they

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[39] See Fulford 1989, 135-136.

involve failures of ordinary actions, as recommended by this reading of Fulford's account. But this could be countered with evidence about the psychopaths' lack of concern and insight about these shortcomings. It seems, in any case, that Fulford's account allows a more liberal reading of the notion of failure of ordinary doing. This reading might offer us a deeper understanding of the kind of disorder and harm that might afflict the psychopath.

The fact that many mental illnesses involve a lack of patient's insight on her condition authorises the thought that Fulford's account should accommodate ascriptions of failures of ordinary doing to subjects who are not in the position to appreciate them. In this case, some shared and sharable values and standards that shape an understanding of ordinary doing and its possibilities would frame third personal ascriptions of failures of ordinary doing. This means that the suggested notion of mental illness could also have a role in practices of social control that, anyway, are currently under the domain of psychiatry. So, it is very important to add that the adoption of a specific prescriptive and idealised model of ordinary agency, to frame then the notion of failure of ordinary doing, should be morally or even legally carefully justified. However, here the task at hand is not offering a prescription and justification of any specific idealisation. Instead, we have to clarify further the general form that such an idealisation should take.

The requirements of moral accountability prescribe what should constitute the ordinary doings relevant to social interactions that are regulated by moral and other societal norms. In particular, such standards enable to classify actions along a broad spectrum from those which clearly are not caused by the will of the agent (involuntary actions) and those where there are weaker reasons for questioning the control that an agent has over that action (nonvoluntary actions).[40] In all these cases, if an action or behaviour is judged to be nonvoluntary or involuntary, it means we have a reason for questioning whether the agent is fully morally responsible for that action or behaviour.

I maintain that in addressing the illness status of psychopathy we should take into account standards that would be used to determine failures of ordinary doings that are significant for the moral responsibility of the agent. In fact, the principal harms that might afflict psychopaths derive from their morally or legally defective social interactions. If psychopathy is a unified construct and the harm brought upon psychopaths by their immoral and illegal behaviour derives from failures of ordinary doings that amount to a lack or a diminished moral responsibility, we should then confer to psychopathy an illness status. Therefore, an extension of Fulford's account of mental illness shows that the philosophical investigation on the moral responsibility of psychopaths might be regarded, at the same time, as aimed at establishing the illness status of their condition.

[40] See Feinberg 1986, p. 104.

As I have pointed out above, the explicit introduction of idealised models of preferred styles of agency and moral responsibility to establish the presence of mental illness needs to be carefully justified. However, it is also important to recognise that ascribing mental illness to psychopathic offenders, because they depart from these standards, would imply that they lack or have diminished moral responsibility. This would recommend measures of treatment as opposed to more severe punishment.

5. *Conclusion*

I have maintained that a mental illness should involve a unified condition that produces harm to the patient in virtue of dysfunctions characterised by failures of ordinary doing. Although it is important to recognise that there are open theoretical and empirical issues, psychopathy as classified by PCL-R appear to be a unitary construct. In addition, it seems that psychopathic offenders, due to their condition, are also prone to suffer certain harm and distress. The issue whether psychopathy is a mental illness, however is left open given that I have not investigate whether these harms derive from failures of ordinary doing. Instead, I have suggested that this investigation should take into account the requirements for moral accountability that should frame our understanding of those ordinary doings that have a legal and moral valence.

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