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PERSONALITY DISORDERS AND MORAL RESPONSIBILITY

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KEYWORDS: personality disorders, responsibility, virtue, blame

IN “PERSONALITY DISORDERS: Moral or Medical Kinds—or Both?” Peter Zachar and Nancy Nyquist Potter (2010) reject any general dichotomy between morality and mental health, and specifically between character vices and personality disorders. In doing so, they provide a nuanced and illuminating discussion that connects Aristotelian virtue ethics to a multidimensional understanding of personality disorders. I share their conviction that dissolving morality–health dichotomies is the starting point for any plausible understanding of human beings (Martin 2006), but I register some qualms about their discussion of responsibility.

Zachar and Potter target the morality–health dichotomy as it appears in Louis C. Charland’s (2004; 2006) discussions of personality disorders. They might have said more, beginning with Charland’s insights. Building on Carl Elliott’s (1996) work, Charland notes that one group of personality disorders, cluster B (American Psychiatric Association [APA], 2000, 685–686), are defined using moral concepts and can only be successfully treated if the person undergoes a moral change

based on moral effort. Most dramatically, anti-social personality disorder is characterized as “a pervasive pattern of disregard for and violation of the rights of others” shown by such things as “deceitfulness,” “reckless disregard for safety of self or others,” and “lack of remorse” for harming others (APA 2000, 706). Similarly, borderline (BPD), histrionic, and narcissistic personality disorders make explicit or tacit reference to lack of moral empathy. “Curing” these disorders requires moral effort and moral transformation, although psychological and pharmaceutical treatments can also be employed. It is essential for clinicians to acknowledge that treating cluster B personality disorders is in part a moral enterprise, for which they might not be fully prepared. This all seems to me right and important.

Charland goes astray, however, when he claims that cluster B disorders are “really moral, and not medical, conditions” (Charland 2004, 64). If anything, his emphasis on how both psychiatric and moral techniques enter into treating cluster B disorders should open, rather than slam shut, the door to an integrated moral–medical perspective. Indeed, many additional disorders in the DSM tacitly employ moral criteria in specifying “maladaptive” behavior and mental states, for example, substance dependency, pathological

gambling, pyromania, kleptomania, and pedophilia. Overcoming these problems typically involves moral transformation, as with cluster B personality disorders. More generally, I regard moral commitment as typically involved in mustering the courage, honesty, and effort required in much psychotherapy. Without collapsing vice into mental disorder, we should acknowledge that moral capacities such as minimal moral empathy and self-control inevitably shape the understanding and treatment of maladaptive habits. And rather than banishing moral assumptions from psychiatry, we should ensure the assumptions are sound (e.g., unlike the bigotry that once classified homosexuality as a mental disorder).

Zachar and Potter illuminate how cluster B personality disorders are simultaneously moral phenomena and fit generic criteria for mental disorders, such as maladjustment, distress, disability, and harm to self. They apply a multidimensional theory of personality disorders that accents lack of empathy and social relatedness and moves us beyond the DSM depictions that Charland rightly finds insufficient. They helpfully invoke John Sadler's (2005) Moral Wrongfulness Test that warns psychiatrists to take special care (to avoid inappropriate forms of moralism) to be sure health criteria are being employed to define and diagnose those conditions which are popularly condemned on moral grounds. And they remind us that much treatment involves advice and procedures that are simultaneously moral and medical.

Whereas Charland said little about moral responsibility, apart from accepting responsibility as part of moral transformation, Zachar and Potter say considerably more. I find their comments sometimes helpful but often problematic, for three reasons. First, it is important to distinguish (1) evaluating something (e.g., an act or habit) as morally undesirable and (2) assigning moral responsibility for it. We also need to distinguish different senses of moral responsibility, including (3) being morally accountable in general, (4) being morally accountable for meeting specific responsibilities (obligations), (5) blameworthiness for failing to meet obligations, and (6) actually blaming (adopting and expressing negative attitudes toward) someone for their wrongdoing or faults.

Rather than sorting out these ideas, Zachar and Potter blur them.

Consider this sentence: "The core problem [in deciding whether personality disorders mitigate responsibility for actions] is that if patients do not have control over their choices and actions, then the moral blame dished out by clinicians is itself morally inappropriate" (Zachar and Potter 2010, 105). The sentence is jarring because, quite apart from the control issue, clinicians have professional responsibilities to avoid expressing blame toward their clients. This is a special responsibility, of course, that arises as part of their largely nonjudgmental role as helpers. Zachar and Potter note that individuals with BPD are often regarded as "PIAs—pains in the ass" (2010, 104). Instead of immediately following this comment with a discussion of the special challenges to clinicians in suspending blame, the authors switch to broader feminist issues concerning whether women (who comprise three fourths of persons with BPD) are being wrongly blamed for behavior they cannot control and even for healthy forms of behavior. We are also told that "Potter is inclined to be more demanding with respect to attributing disorder status to BPD" because she questions whether the "behaviors associated with BPD are actually blameworthy, a question that requires clinicians getting clearer on the degree to which patients with BPD have control over their actions" (Zachar and Potter 2010, 113). But surely we do not want the definition of disorders to turn on matters of blameworthiness. Here it is worth recalling the DSM's cautionary statement: "The kinds of impairments involved in disorders do not turn on or answer questions about responsibility in other contexts, such as law and morality" (APA 2000, xxxvii).

Second, after distinguishing between (1) evaluating something as morally undesirable and (6) blaming persons for it, we need to distinguish between doing either of these things with regard to (7) a person's overall character, (8) specific tendencies such as impulsivity and emotional instability, (9) specific actions. For example, it might be reasonable to mitigate responsibility for having undesirable emotional tendencies and yet to hold an individual fully accountable and blameworthy for harmful actions. The presence of unhealthy and

strong tendencies for which a person might not be responsible is not an automatic excuse for acting on the tendencies in harming others.

Third, and related to the last point, I believe Zachar and Potter gesture too far in the direction of excusing wrongdoing based on etiological factors. It is one thing to say, for example, that an emotionally troubled person who was sexually abused as a child should not be blamed for her present emotional distress; it is quite another to say she should not be held morally and legally accountable for murdering her children. Although Zachar and Potter are aware of the problem, their discussion often veers in the direction of using personality disorders as excuses. They write, for example, that “freedom and responsibility . . . require not only the ability to choose between available alternatives, but also the ability to choose which desires one wants to *have*” (Zachar & Potter 2010, 105). That claim could easily be taken as inviting rampant excusing of wrongdoing by appealing to disordered desires. Again, applying virtue ethics, Zachar and Potter illuminate how habitual choices can result in inflexible and automatic habits for which we can be responsible. But they also make generalizations like this: “It is a truism that we cannot be held responsible for those things that are out of our control” (Zachar and Potter 2010, 105). Does the alleged truism mean out of control at the time of action, or viewed in terms of a lifetime of developing habits, or both?

Perhaps bringing in addictions as an analogy might help, especially addictions that grow out of our immediate control (as well as manifest lack of moral self-control) and reside at the core of our personality, but which we had ample op-

portunity to avoid developing or to have sought help for earlier. In addition, rather than focusing just on borderline and narcissistic personality disorders, more attention might be paid to antisocial personality disorder, especially when it leads to heinous acts such as murder. The entrenchment of a sociopath’s murderous desire is not an excuse. It would also be helpful to work with case studies to sharpen distinctions between issues about diagnosis and therapy from issues about moral and legal responsibility. Doing so would also make clear the complexity that arises from ethical pluralism that enters once we move beyond the minimal shared moral understanding that informs psychiatric judgments about health and disorders.

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