

Working Toward a Legal, Scientific, and Philosophical
Conception of Mental Capacity

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FIGURE

Newspaper clipping from Pittsburg Post Gazette, May 9, 1978

Mary Northern of Nashville: Rest in Peace

BOSTON—The end, the very end of the Mary Northern story, came May 1 when the 72-year-old woman died in General Hospital, Nashville, Tenn.

The autopsy says that she died of a blood clot. The doctors' report intimates that if she had not resisted treatment, including amputation, she might be alive today.

But her epitaph says something else. It was written over 100 years ago by Charles Dickens, who ruefully observed: "It's a remarkable Christian improvement to have made a pursuing Fury out of the Good Samaritan, but it was so in this case and it is a type of many."

Miss Northern spent the last three and a half months of her life pursued by this Fury, harassed by Benevolence, a victim of Goodwill.

It was caring people, our public Good Samaritans, who chased her, all the while bewildered, because she didn't want their "help."

It was social workers who came into her ramshackle, unheated home in January, genuinely worried about her health. It was police who carried her forcibly out of her home to the hospital for treatment. It was doctors who tried to persuade her to amputate her gangrenous feet. Finally, when they all failed, it was the state—the Department of Human Resources—

which sued to have her declared "incompetent," in an attempt to save her life, even against her will.

Perhaps James Blumstein, the Vanderbilt professor of law, exaggerated when he said, "These people were killing her with kindness." But they did bludgeon her autonomy, her privacy, her independence and her legal control over her own body.

Now, the lady—labeled a "spinster" even in the wire service obituary—leaves us a legacy beyond the ramshackle old house she shared with her cats and her family memories. She leaves a reminder of how often individuals, especially the weak, the sick, the elderly and the dependent, need protection from powerful establishments. Even the Establishment of Kindness.

Her story is a fitting one for times like these when we are becoming more sensitive to the problems of doing good.

Once, protective statutes like the one that lashed the Furies on Mary Northern seemed to be entirely benevolent. We had an almost naive confidence in professional need-fillers who had, in turn, naive self-confidence. As David Rothman wrote in a small, intriguing book called "Doing Good: The Limits of Benevolence": "In

their eagerness to play parent to the child, they did not pause to ask whether the dependent had to be protected against their own well-meaning intervention."

Today, while we don't question the motives behind the social programs, we are concerned about the results. We are increasingly aware of the way a vast social-services bureaucracy can violate the rights of an individual; and we are increasingly attuned to the new social problems that arise from solutions to old problems.

In the past week, for example, while Miss Northern lay in General Hospital, the Senate Finance Committee heard a research report which showed a rise in the divorce rate following the government's offer of a minimum guaranteed family income. At the same time, several lawyers expressed concern to me about the zeal with which social workers, following up reports of child neglect, could violate the rights of parents, quite legally, under statutes written without proper procedural safeguards.

In our political life, the conservatives are attuned to these vibrations of anxiety. They offer these examples as proof of the inherent intrusiveness and coerciveness of government. And they broadcast a desire to halt many new attempts

to help people.

But it is as cruel to ignore suffering as to force "cures."

The trick of shaping and reshaping social policy is a formula that fills needs while protecting rights, a formula that abides by what Ira Glasser calls the "principle of least harm." We have to distinguish continuously between the times when neglect is benign and when neglect is immoral; when caring is helpful and when caring is coercive.

As Willard Gaylin writes, "We can degrade people by caring for them and we can degrade people by not caring for them, and in matters such as these there are neither simple answers nor simple solutions."

There is only the need for constant monitoring, tuning, to create the sort of social planning that neither ignores a neighbor's plea for help nor leaves the Furies on an unwilling victim like the late Mary Northern, of Nashville, Tennessee.

Today's Thought

He who loves me will be loved by my Father, and I will love him and manifest myself to him. John 14:21

Our mission in life is to show God's love.

In the past thirty years, cognitive research has intensified dramatically. The field of neuroscience has solidified and regimented; the field of cognitive neuroscience has been born and adapted, and neuro-imaging has evolved well past the initial days of EEG and CAT to new methods that show us brain functions, and not merely structures or corresponding electrical signals. With these innovations and others, alongside some one hundred million dollars in NIH funding toward brain research over the next twelve years¹, other academic disciplines are being brought into greater interaction with cognitive science on a level never before seen. One of the greatest areas of growth in cognitive based multi-disciplines is that of law and neuroscience, or neurolaw. Broadly speaking, there is much anticipation about what sorts of questions the cognitive sciences will be able to answer about human responsibility and action, and how those answers will affect our legal doctrine. There are scholars in both legal and neuroscientific camps that claim their respective field will win out over the other, with some legal scholars arguing that people are held responsible for actions, not their brains, while some neuroscientists might argue that

¹http://www.nih.gov/about/director/06052014_statement_brain.htm

the entire court system becomes moot if we are simply able to give someone a brain scan and determine guilt. However, most scholars do not take such extreme views and instead realize that neuroscience probably has much to inform of our legal doctrine, but that many neuroscientific discoveries are not yet, or may never be, applicable to the legal realm. Oddly silent in much of this discussion is the philosopher. I see the literature emerging in neurolaw as largely a discussion between pragmatic legal theorists on one hand, while on the other hand are many data driven scientists and researchers. While both sides have their own theoretical constructs, the debate as a whole seems ripe to benefit from a deeper theoretical analysis, one for which philosophy is well suited. Ultimately, it seems that the most workable solution to any problem will be one where theory, data, and pragmatics coexist, and our U.S. legal system should be no exception.

Herein, I aim to explore one narrow avenue of the interplay between these three disciplines. I examine the concept of mental capacity as I see it playing an instrumental role in resolving some legal questions, particularly for elderly people and people with mental illness. My approach is to look at two very distinct, albeit related places where mental capacity has up to this

point been relatively under-theorized as its own distinct concept. In the first chapter, I look to bioethics and the question of decision-making capacity, how it is measured and what it is that we are actually measuring. Within this discussion I examine some of the ways that bioethics and law inform each other, as well as try to firmly distinguish the concept of "capacity" from the concept of "competency." In the second chapter, I look at specific schizophrenic symptoms and try to make an argument that specific symptoms of some mental disorders might be indicative of an offender in fact having a mind disordered enough as to prevent a mental state requisite for criminal liability from ever forming. Through these two chapters, I hope to show that mental capacity is a concept that must be further theorized and applied within our legal system, and that it might ultimately end up filling many different roles in different contexts. Additionally, a secondary goal, when possible, will be to elucidate how and why neuroscientific data plays a crucial role in uniting theory and courtroom.

Chapter I

Decision Making Capacity and the Road Ahead

In this chapter, I examine decision-making capacity, (DMC) which in bioethics refers to the ability of a patient to make her own personal decisions regarding treatment or medical intervention. DMC is important to bioethicists because it is one of many issues in which the biomedical principle *par excellence*, autonomy, is brought to bare. The basic assumption in the literature and in practice is that patient autonomy should be observed and respected at all costs; only when the patient is deemed bereft of some relevant DMC, should a surrogate decision maker be consulted or appointed. This very simple idea has very complex and profound implications for patients, their family members, medical providers, legal scholars, legislators, and a whole host of academic disciplines. Ultimately we are faced with a question of under what circumstances we can decide that a patient no longer has the relevant capacity to make decisions about her best interest in her own wellbeing. Determining a patient to lack DMC deprives that patient of the choice about further medical intervention, the ethical consequences of which are widely considered to be justifiable only by appeal to other

equally significant moral principles, if at all. It is no wonder, then, that philosophers have long weighed in on this particular bioethical concern.²

However, like most, if not all, bioethical issues, theories about decision-making capacity in the hospital eventually depend on the legal system for enforcement in the most contestable cases. Indeed, much of the discussion about DMC comes out of legal necessity. The inherently pragmatic nature of the legal system, combined with current inconsistencies in assessment of capacity, current inconsistencies in ideas about what capacity even is, and new scientific data lead many theorists, either implicitly or explicitly, to advocate for a more empirically based approach to dealing with the question of capacity in hospitals. Following, I have two main aims: the first is to recount the different respects in which capacity is discussed and theorized in recent literature; and the second is to discuss how capacity will likely be studied and addressed in the future. Through both discussions, I hope I can sufficiently elucidate the move to "pragmatize"

² Susan Wolf. "Law and Bioethics: From Values to Violence." *The Journal of Law, Medicine & Ethics*, vol. 32 ed. 2 (Summer 2004) pp. 293.

Susan Wolf. "Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism." *American Journal of Law and Medicine*, vol. 20 (1994) pp. 395.

capacity concerns. I subsequently raise several objections to any academic move away from the basic theoretical concerns that make DMC such a pressing issue for bioethicists in the first place. Ultimately, I hope to argue that any meaningful empirical, pragmatic discussion of capacity can only take place in the presence of a fruitful philosophical notion of agent responsibility. However, due to the inherently legal nature of bioethics, whatever notion of responsibility we settle on must be sufficiently theorized and account for within the legal system as well.

A. What is Decision Making Capacity?

To begin with, we need to know not only what capacity entails conceptually, but also why it matters to bioethicists at all. Unfortunately, neither of these questions yields a simple response. So that we can understand how scholars use the term capacity, then, I first want to discuss what ethical constructs motivate our concern with capacity; then I turn to what contemporary theories see as its key elements. Finally, in this section, I will make an important distinction between the notions of capacity and competency, two related but different concepts that are often conflated or not carefully enough delineated. This distinction will preamble the discussion

in the next section about how capacity is assessed in medical practice and various problems that arise within that assessment, practically, legally, and ethically.

The least disputed aspect of capacity in bioethics is that the concern of capacity arises out of respect for autonomy. A relevant theoretical question right from the start is why this principle is so particularly important. Susan Wolf observes that from its early beginnings, bioethics has been inundated with a distinctly Kantian individualism, one whereby the ability of individuals to reason toward their own personal decisions is held sacrosanct.³ Additionally, she notes that either by intention or convention, many bioethicists are content to take a principlalist approach to all bioethical conversations. This approach is one taken by Beauchamp and Childress in their seminal work, *Principles of Biomedical Ethics*.⁴ It entails adopting "mid-level" principles and reasoning down to specific actions. As Jacob Rendtorff describes them, mid-level principles are ethical principles that fall between theoretical conceptions of "the good

³ Ibid. p. 293

⁴ Tom L. Beauchamp, James F. Childress. *Principles of Biomedical Ethics* (7th ed. 2012). Oxford University Press.

life" and ethical norms in concrete cases.⁵ For the principlists broadly speaking, autonomy is but one crucial bioethical principle. Depending on the account, it might take a leading role in determining how we prioritize and consider other principles, or it might compete evenly with other principles in our normative considerations. Beauchamp and Childress, for example, break bioethics down into principles of autonomy, beneficence, justice, and non-maleficence. On the other hand, Elizabeth Anderson argues for a priority necessarily given to dignity, whereby respect for the dignity of the human life and human body is derivative of these other principles.⁶ So within principlists, while there is great difference over exactly how autonomy gets into the picture, and where it is situated relative to other principles, it has a place and therefore begets our present concerns about capacity.

I have told only a very cursory tale about autonomy and the way it is viewed by bioethics as a discipline. And as we will see later, there are theorists who reject the

⁵ Jacob Dahl Rendtorff. "Basic ethical principles in European bioethics and biolaw: Autonomy, dignity, integrity, and vulnerability—Towards a foundation of bioethics and biolaw." *Medicine, Health Care, and Philosophy*, vol. 5, ed. 3 (2002) pp. 235.

⁶ Elizabeth M. Anderson. "Bioethics at the Beginning, Middle, and End of Life." *Notre Dame Journal of Law, Ethics, and Public Policy*, vol. 17 ed. 1 (2003) pp. 1.

principalists' starting point, but now I turn to the more specific discussion about what capacity actually is. The above discussion about autonomy does not strictly apply to decision-making capacity, because capacity is but one issue that derives from autonomy as a principle. As already broadly defined, someone deemed to have DMC is allowed to make her own decisions while someone deemed lacking sufficient capacity has decisions made for her either by a doctor or by a surrogate decision maker. Paul Applebaum is one of several theorists that hold that, for a patient to be deemed as having DMC, he actually needs four things:

Ability to communicate effectively;
Ability to reason and deliberate about medical choices;
Ability to understand information presented;
Ability to appreciate the medical consequences of decisions.⁷

In this case, evaluation of a patient could deem the patient incapable of making medical decisions for lacking any one of these abilities.

Another important aspect of DMC is that it is a property of degree. Imagine an elderly patient with moderate to severe dementia, which as a result is frequently unable to understand where he is. Many doctors might be willing to accept that this patient cannot make

⁷ Paul S. Applebaum. "Assessment of Patients' Competence to Consent to Treatment." *The New England Journal of Medicine*, vol. 357 (2007) pp. 1834.

sufficiently informed decisions about whether or not to approve a very invasive treatment for cancer, but might still have enough awareness to reasonably refuse acetaminophen for minor pain. This brief example illustrates what is known as the proportionality aspect of capacity. The basic idea here is that as the gravity of the decision increases, so does the level of capacity we expect an individual to have in order to be allowed to make that decision. Regardless of our justification for proportionality, it is another aspect of capacity that bioethicists generally embrace despite other theoretical differences.⁸ This notion of capacity as a matter of degree renders it distinctly different from another close concept, that of competency. Often in the literature, capacity for making decisions and competency to stand trial are conflated.⁹ Equally prevalent, however, is the tendency to use them as distinct concepts. As I use them here, capacity is a matter of degree and applies to an individual's ability to make various decisions. Often I will speak of sufficient capacity as a means of noting that the patient has a mental capacity sufficient for the decision in

⁸ Alec Buchanan. "Mental capacity, legal competence and consent to treatment." *Journal of the Royal Society of Medicine*, vol. 97 (September 2004) pp. 415

⁹ Ibid.

question. Competence, on the other hand, is used here as a legal concept that indicates a person is competent to communicate with his lawyer at a reasonably rational level, and able to comprehend the facts of the proceedings at hand.¹⁰ As I discuss below, maintaining this distinction is a necessary aspect of appropriate assessment for capacity in hospital patients. Given that the legal system is prone to evaluating competence as a yes/no binary, and medical practitioners are likely to evaluate their patients along a spectrum (of more or less capacity pertaining to more or less serious medical decisions) the two concepts seem destined not to match up. For now, I maintain the two concepts as separate; however, later I will consider whether or not the two concepts can in fact be unified.

B. Assessing Patient Decision Making Capacity

If determining patient capacity were an easy matter, the issue would have significantly less print in the bioethical literature. As it is, trying to determine patient capacity and respect patient autonomy with regards to the patient's best interest is likely to leave many clinicians dissatisfied. The assessment of capacity is a

¹⁰ Paul G. Nestor, Dawn Daggett, Joel Haycock, Marilyn Price. "Competence to Stand Trial: A Neuropsychological Inquiry." *Law and Human Behavior*, vol. 23, no. 4 (1999) pp. 397.

difficult one to get "right" in many cases, and given that it comes in degrees, there is not often a well defined cutoff point at which someone can merely be deemed as sufficient capacity, especially in cases of mental disorder where it is unclear exactly which individual capacities the disorder affects.¹¹ In this section, I examine some of the literature on common problems with assessing DMC in patients as well as some of the proposed avenues of augmenting capacity assessments. First I examine the occurrence of different assessments of capacity in the same patient by different medical professionals. Second I will discuss some of the present methods for assessing a patient's DMC. Lastly, I will discuss some of the proposed ways forward in assessing DMC via neuropsychological approaches.

Assessing capacity in patients need not always be a formal venture. In fact, the vast majority of cases present clinicians with obvious assessments of their patients' DMC or else no reason to question it initially.¹² Unfortunately there are many complicated and borderline cases where the informal assessment of the physician is insufficient and a

¹¹ Ibid.

¹² Buchanan, 2004.

special assessment of capacity must take place.¹³ As physicians become more aware of the profoundly ethical nature of capacity assessments, bioethicists are called upon more frequently to provide additional analysis and consultation regarding difficult capacity assessments. One recent article examined the common disagreement that bioethicists and psychiatrists frequently have when determining a patient's DMC.¹⁴ Once the assessment of capacity moves beyond the attending physician, it is usually the psychiatrist that first administers the assessment, with a bioethicists adding an additional opinion or being a "tie-breaker." While many psychiatrists and bioethicists are willing to use capacity and competency interchangeably, the authors observed that the two groups were often employing the two concepts separately when they came to disagreement about a particular patient. Often the psychiatrists were concerned with evaluating legal competency while the bioethicists evaluated medical DMC. Brought into conversation about evaluative standard, the

¹³ One quite unfortunate fact is that these almost exclusively happen when a patient refuses a suggested treatment, which raises the question of whether or not capacity assessments might be a sort of gateway to a "new paternalism."

¹⁴ P. L. Schneider, K. A. Bramstedt. "When psychiatry and bioethics disagree about patient decision making capacity (DMC). *Journal of Medical Ethics*. Vol. 32 (August, 2005) pp. 90.

two could often reconcile their evaluations. Indeed, some of the most troubling cases were ones where the psychiatrists and bioethicists ultimately agreed that the patient lacked DMC yet likely retained a competency sufficient to hold up in court. Clearly in these cases the problem troubling medical professionals is whether the medical considerations in capacity are sufficient to justify one action that, legally, they may not have recourse to if the patient can prove legal competency. As long as these two concepts exist separately in practice, the best that can happen is for a more thorough testing measure to be adopted for capacity, one that will be able to more adequately inform questions and standards of competency as well.

Currently, there are many different instruments for testing, measuring, and assessing DMC in patients. Many of these rely on multiple point questionnaires that present patients with vignettes and relevant scenarios involving illness and treatment and assessing the reasonableness of patient responses.¹⁵ Several of the most consistent and trusted mechanisms take a good amount of clinical time to administer, and often are intended to be given at least informally across many points in time so as to account for

¹⁵ Applebaum, 2007.

fluctuations in the patient's mental state as well as to allow clinicians to better understand the baseline mental functions for that patient. Even the most reliable of these instruments, however, runs into several problems.¹⁶ These instruments bias favorable results to those patients that are willing and capable of consistent verbal or written communication, which often might not be the case. It is almost impossible for any given score to be absolutely indicative of limited capacity, so other contextual factors will still have to be taken into account by the assessor. Additionally, if the assessor is not well versed in the scoring criteria, or merely misinterprets answers in a particular way, it is possible that she will score a patient differently than another assessor using the exact same instrument.¹⁷ Lastly, many recent feminists and race theorists critiques have looked at capacity assessments and found them remarkably lacking in contextual considerations appropriate to real patients. That is, several of the instruments seem to be blind to how race, gender, income or

¹⁶ Dilip V. Jeste, Laura B. Dunn, Barton W. Palmer, Elyn Saks, Maureen Halpain, Alison Cook, Paul Appelbaum, Lawrence Schneiderman. "A collaborative model for research on decisional capacity and informed consent in older patients with schizophrenia: Bioethics unit of a geriatric psychiatry intervention research center."

Psychopharmacology. (May, 2003) pp. 68.

¹⁷ Wolf, 1994.

insurance status might significantly affect a patient's responses regarding which treatments seem reasonable.¹⁸

As it becomes obvious that significantly more data needs to be collected, and more tests need to be administered in order for medical professionals to better understand capacity, other problems inevitably arise as well. One recent article from the Bioethics Council at UCSD looked at the need for more information regarding capacity in elderly patients with schizophrenia.¹⁹ The authors note that while elderly patients and patients with mental disorder make up the vast majority of capacity cases a bioethicists might see, very little has been studied about individuals that fit both demographics. Many concerns are especially heightened in this group, as the elderly are likely to have multiple medical conditions, and thus have multiple different prescriptions whose reactions with antipsychotics are unknown. Additionally, most capacity testing methods are developed on younger demographics, and so their efficacy with elderly patients is unproven. And ironically, the same capacity considerations that make them desirable test subjects also make them difficult ones to procure. IRB procedures for medical research require very

¹⁸ Ibid.

¹⁹ Jeste et al., 2003.

explicitly informed consent, and the studies the authors desire to undertake are expressly about how to get informed consent from elderly patients with schizophrenia. Through repeated exposure to information on consent forms, as well as adapted means of presentation of critical and difficult portions of the forms, the researchers found they were able to significantly increase comprehension and retention of consent forms for research subjects. This finding supported their hypothesis that diminished capacity is not necessarily an irreversible state and that at least certain specific capacities can be augmented with improved presentation of information.

A second goal of this study was to use the findings to supplement the current capacity assessment instruments, or else devise a new one. One key aspect of informed consent in the studied demographic is discerning how much of the relevant information in the consent form is understood. Within many of the existing instruments, "failure to appreciate" pertinent information is often scored any time the patient disagrees with the physician's intended course of action. This occurrence is troubling, as it seems likely to indicate a scoring bias that favors patients who agree with their physician over ones who do not. It is also indicative of a common misconception that formal assessment

is only obligated when the patient disagrees with the doctor.²⁰ However, many have argued that assessment of DMC should occur any time there is risk of cognitive impairment, and not only when disagreement occurs.²¹ As an important tool for addressing this problem, the researchers developed and piloted the California Scale of Appreciation (CSA), whereby clinicians explicitly measure a patient's appreciation of relevant medical information based evaluating a patient's beliefs about suggested practices and outcomes. Contrary to many current instruments, this test has yielded a high rate of consistency between assessors.²²

This study indicates great need for more thorough and consistently administrable assessment mechanisms for discerning patient DMC. In an effort toward achieving this goal, many neuropsychologists have taken an increasing interest in DMC, and contend that neuropsychology has much useful input in the future of capacity questions. Karen Sullivan argues that there are many basic ways that

²⁰ Buchanan, 2004.

²¹ Linda Gazini, Ladislav Volicer, William A. Nelson, Ellen Fox, Arthur R. Derse. "Ten Myths About Decision-Making Capacity." *Journal of American Medical Directors*, vol. 6 (2005) pp. S100-S104.

²² In some studies, clinicians asked to assess patients based on video interviews with patients performed no better than chance with regards to their consistency in evaluation. See Wolf (1994), Jeste et al. (2003).

neuropsychology can help DMC assessments. She notes there is still not a single and standardized method of assessment, and that rather than relying on physician questionnaires that vary wildly, a standardized model of what capacity actually entails might be able to drive a more consistent assessment mechanism. Her approach specifies conceiving of DMC assessment as a two-tiered process; the first tier is to assess general capacity and the second is to assess specific relevant capacities to the medical decision in question.²³

Other neuropsychologists have already taken a similar approach to the question of legal competency and made useful observations that could be relevant in medical DMC. In examining individuals committed to a Massachusetts psychiatric hospital, Nestor et al. evaluated patients with differing assessments of Competent to Stand Trial and Incompetent to Stand Trial along many various cognitive axes. These cognitive dimensions compared various cognitive and brain functions of the patients, with the theoretical assumption being that such functions represent important characteristics of specific sets of brain structures that interact to support higher level functions. Such an

²³ Karen Sullivan. "Neuropsychological Assessment of Mental Capacity." *Neuropsychology Review*, vol. 14 no. 3 (September 2004) pp. 131.

approach might be used to understand specific cognitive capacities that are essential for higher-level functions, or at least to discover correlations between dysfunctional capacities and assessment of IST. One highly studied metric was that of comparing episodic and semantic memory across groups. Semantic knowledge is largely factual, and is heavily biased by cultural influences. Episodic memory is personal and confined to experiences that an individual had herself. Additionally, intelligence, attention and concentration, academic abilities and executive functions were all studied. These last two were found to have little to no correlation with assessment of IST or CST, while measures of verbal memory, attention, and social intelligence were all relatively good indicators of assessment outcome. These summarized results are telling: in determining legal competence, individual cognitive capacities appear to play a much greater role in determining assessment outcome than does mere knowledge of the current situation, recollection of facts, or academic skills; this finding is a desirable one as these last aspects are significantly affected by many social circumstances, as opposed to the highly correlated measures thought to be more internalized to the cognition of the individual in question. This seems to be a promising

connection between the concepts of legal competence and medical DMC moving forward.

Neuropsychology assumes functional psychological models based on knowledge of brain systems, and generalizes from empirical data collected from subjects based on these models. Many have also argued for a more neuroscientific approach to DMC assessment, particularly in determining diagnosis of brain disorders like Minimally Conscious State.²⁴ As opposed to cases of Persistent Vegetative State, where conscious awareness is never recoverable, MCS patients have some minimal level of awareness, and given the appropriate therapies are sometimes able to make dramatic, albeit slow, recoveries.²⁵ One of these cases is dismally hopeless, yet the other might inspire a reasonable degree of hope from loved ones, and assuredly demands greater ethical considerations from physicians. We are currently aware of several instances where patients have been in undiagnosed MCS for years, during which time any number of egregious medical acts may have occurred. These could range from no or poor pain management, to basic and

²⁴ Thomas Nadelhoffer, Walter Sinnott-Armstrong. "Neurolaw and Neuroprediction: Potential Promises and Perils." *Philosophy Compass*, vol. 7 ed. 9 (2012) pp. 631.

²⁵ Eelco F. M. Wijdicks. "Minimally Conscious State vs. Persistent Vegetative State: The Case of Terry (Wallis) vs the Case of Terri (Schiavo)." *Mayo Clinic Proceedings*. (September, 2006) pp. 1155.

complete isolation of a partial consciousness. Undiagnosed MCS might reasonably be akin to medically induced solitary confinement. According to Joseph Fins, the first and greatest ethical duty we have to MCS patients is diagnosis of their condition, and requisite in this diagnosis is a decision about what and how much mental capacity a patient has.²⁶ In our present clinical state, the best methods for such diagnosis appear to be functional neuro-imaging. This process uses brain-imaging techniques like functional MRI to examine which brain areas are active in a patient. Coupled with an adequate theory of functional brain areas, such imaging can yield a hypothesis about which cognitive functions a patient maintains, even if that patient is seemingly unconscious. Often, a MCS patient will not have any DMC, yet given the appropriate resources for recovery, it is possible that many such patients will eventually recover a great deal of their cognitive capacity. Given that such recovery necessarily occurs within the medical system, proper appraisal of DMC is essential throughout the recovery process.

²⁶ Joseph J. Fins. "Affirming the right to care, preserving the right to die: Disorders of consciousness and neuroethics after Schiavo." *Palliative and Supportive Care*, vol. 4 (2006) pp. 169.

Assessing capacity is a necessary part of ethical medicine. Yet the process of doing so currently faces many difficulties, and though there are equally many promising advances in our knowledge, the way forward remains vague. So far we have seen that much of the question over capacity lies in its assessment. Moreover, we have seen a prominent role for more empirical study into various issues regarding capacity. Next I want to consider one prominent position that takes the necessity for more empirical research further by demanding that we deliberately focus our intellectual concerns about DMC on empirical evidence and pragmatic practice. Susan M. Wolf's view is a useful one to consider, because not only does she argue for pragmatic turn in questions of capacity, but in bioethics in general, and in doing so places much emphasis on the continued interaction between bioethics and law. Following a discussion of her view, I argue that theory and philosophy must remain an equally pertinent discipline of bioethics, and that DMC is not a notion that can function in a philosophical vacuum as Wolf might imagine it can.

C. Turning Toward A Bioethics of Law

In this section, I consider two arguments made by Susan Wolf: the first is that bioethics is in the midst of and should embrace a pragmatic turn; the second is an

argument for an increased bioethics of law—that is, a scheme in which bioethical principles and concerns greatly inform and drive bioethical legislation, rather than bioethics merely being beholden to the law for enforcement. The turn to pragmatism in her view is motivated by new considerations seemingly unanswerable by traditional bioethical theory combined with the apparent usefulness of empirical inquiry into many bioethical problems. The argument for an increased bioethics of law motivates from consideration of the historical and necessary link between the fields of law and medicine within bioethics. These arguments will be taken in turn.

In bioethics, Wolf observes that there is an increasingly strong movement away from principlism, a movement she sees as coupled with a strong turn to pragmatism.²⁷ Recall that principlism within bioethics is the selection of specific “mid-level” principles that govern norms in specific cases. In general, principlism assumes that the specified principles should always be upheld, with rare exceptions occurring when two or more principles conflict. Necessarily, principlism is highly ideal; it condenses an infinite number of highly specific ethical situations into a handful of broad principles that

²⁷ Wolf, 1994.

must always be observed. Generally speaking, patient autonomy is often considered the most important principle—that is—the most basic principlists assumption is often that all patients should make their own informed decisions when possible. Movement away from principlism in general has profound effect on our considerations of DMC, since the general approach to assessing DMC in practice is to assume autonomy and ask questions later. Rejection of principlism is motivated from many considerations. The first is that principlism tends to heavily idealize situations, and this heavy degree of idealization misses or ignores important contextual information about gender, race, class, and insurance status that all weigh heavily in medical decision making. To put the consideration bluntly, the current bioethics is one of privilege, where often the cases that are considered as theoretically relevant assume a patient has a specific educational, familial, and socio-economic background as well as completely glosses the issue of whether or not or how much a patient is insured. Decontextualizing bioethics into highly ideal theory seems to be problematic.

However, this objection is not specific only to bioethics, but is one seen across many philosophical disciplines, and even within bioethics it does not seem

particular just to our issue of DMC. The relevant issue arises when we start to assume patient autonomy as a starting point, and we equally assume a certain kind of reasonable or rational decision making, but then ignore contextual factors that often constrain the kinds of decision a patient could make, even were she completely "reasonable." Furthermore, empirical studies of physicians and their justifications for decisions about patient capacity tend to heavily indicate that bioethical principles seem to rarely drive decision making, but rather are invoked as post hoc justification for decisions already made. So a more specific argument is that principlism seems ill suited to the bioethical arena; it defines parameters of debate but does not prescribe how decisions should be made, nor does it effectively account for "emotions and realities" of decision making. Lastly, even if our principle of autonomy is applied correctly and effectively, deeming a patient incapable of making medical decisions comes with its own problems. Other studies have shown that in surrogate decision making for medical issues, surrogates perform little better than chance at making decisions that patients would make themselves had they retained the capacity to make them. Related to this occurrence is the fact that many patients do not even

desire to make autonomous decisions, but would rather their physicians act on and use their best judgment; these patients place particularly high emphasis on the professional and specialist role of the physician. Both of these final objections underline how autonomy may not be that desirable a principle in the first place, and that even if it is, it may not be one that can be consistently or justifiably practiced. Hence, we see the problem with starting from midlevel principles without defending the adoption of those principles in the first place. Many bioethicists are content to assert principles or explain how they work but the defense of midlevel principles often seems to stand on rather unstable foundation, or else a foundation that is unfortunately shallow.

The goal, then, on Wolf's view is not to augment or adapt our theory, but rather to move toward a more developed pragmatic empiricism with regards to bioethics. Empirical studies, she argues, are capable of demonstrating bias, considering contextual social issues, and reporting statistical results that reflect the way issues are actually decided. To consider another example, Wolf points to advanced directives. These are supported on the principlalist account by a notion that in the event of diminished capacity, a patient has already determined

several medical decisions at a time when his capacity was not diminished. However, researchers have shown a great degree of variation in how patients intend the instructions in these documents to be upheld—i.e. strictly versus loosely—and many doubt whether an advanced directive can be said to be a direct extension of a patient's agency at all.

Wolf sees a similar turn happening in the legal context in addition to the bioethical one. Her fear is that if we make laws first, and then seek out our data later, we run the risk of making laws that do not align with the situation as it stands. The greatest problem with a legal down approach is that it often does not translate well to clinical practice.²⁸ She points to many instances where health law has been made independent of bioethical considerations, often driven by public or political morality rather than clinical observation, and subsequently the laws have significantly restricted the efficacy of medical providers. In some cases, such as criminalizing drug addiction in pregnant women, an empirically unverified ethical principle drives a legal decision that then harms patients; women and their fetuses are harmed when women are discouraged from seeking appropriate medical care during pregnancy. Because of this and similar instances, she

²⁸ Wolf, 2004.

argues, we must attain a bioethics of law in addition to our current law of bioethics.

A bioethics of law, on Wolf's view, "would involve asking [...] whether we are using law responsibly in pursuit of ethics goals."²⁹ Results from clinical practice would then not only be used to formulate laws at the outset, but laws would also be held accountable to their consequences in clinical practice in a way we do not currently see. The hope would be to have a legal structure that is affected by bioethics to a similar degree that bioethics is affected by law; such a structure would necessitate greater bioethical input at the lawmaking level. Considering this argument, principlism does seem insufficient, but it is hard to see how Wolf offers a sound alternative. She argues that we should engage in ground up, inductive, and empirical reasoning about bioethical principles and practices as opposed to top or mid-level down deduction from principles to norms. Below, I argue that she is only half right, and that top down theorizing is necessary for bottom up induction to have any relevance in bioethics. With issues of capacity, certain philosophical conversations are necessary for any empirical or legal outcome to make sense.

²⁹ Ibid. pp. 300

D. An Interdisciplinary Approach to Understanding Capacity

Susan Wolf probably does not see philosophers having a long and continued involvement in the bioethical discussion about capacity. Concluding her discussion of bioethics and health law, she says:

"We can continue in both fields down the well trod road of conversations among experts, governed by top-down theory and the elegance of abstract pronouncements, largely inattentive to differences of race, ethnicity, gender, and insurance status. Or we can head down a different path, one more winding and complex. This is a path shaped by the twists and turns of empiricist investigation, with detailed attention to context."

In considering and responding to Wolf, I reject this dichotomy of options in favor of a third possibility. Rather than concluding that the failures and shortcomings of principlism means we should reject top down theorizing, I contend that we need to bring top down theorizing into constant conversation with ground up empirical research.

To begin with, I am not sure that Wolf has rejected principlism as sufficiently as she thinks she has. I agree that any bioethical view that begins by stipulating a principle will quickly find itself in some hot water, but in order to reject the principle of autonomy, say, there might be more to the story than the highly impoverished notion of autonomy Wolf characterizes. That is to say, at most, by pointing out relevant shortcomings of the current

conception of autonomy alongside feminists and race theorists, the most that Wolf has done is shift the burden of the argument back to the principlalists. It is quite possible that a wider and more socially conscious conception of Beauchamp's and Childress' principles could encompass the objections she raises. Indeed, someone adhering to their model might not even have to revise much, but rather might contend that all of her socially based objections to autonomy can be addressed by the principle of justice in its current formulation.

Wolf has shifted the burden of argument to principlalists, and it is plausible that they have a reasonable response to her concerns. I am hesitant to agree with the principlalists, still, however, on grounds of political coercion. Wolf acknowledges that our bioethics laws are as equally coercive in nature as any others. Without diverging greatly from the discussion at hand, I think principlalism is going to run into the problem of public reason in justifying bioethics laws. This is not to say that principlalists are particularly coercive, but rather to say that bioethics necessarily acts through the arm of the law, and as such, it seems that a principlalists defense of any law will be more difficult to justify publicly. That is, I see an easy Rawlsian response to

principalist bioethicists arguing that starting with a basic ethical principle might not be publicly justifiable in a reasonably pluralistic society. A similar criticism might just be that the principalist seems arbitrary in deciding on some principles and not others. Responding to either of these objections requires the principalists to justify the first ethical principle, but if he is capable of doing this, then it is unclear why we started with that principle in the first place instead of the principle that justifies it.

Even if we agree with Wolf and reject principlism in bioethics, we are still not committed to taking on a heavily empiricist and pragmatic view of bioethics. In fact, I am not sure that she could do so herself. To elucidate this point, I want to again consider the distinction between legal competency and medical DMC. Close examination yields somewhat distinct differences in our interests for deciding either state. In the case of legal competency, we are often concerned with deciding whether a defendant can be held criminally liable for his actions. With DMC, we are concerned with giving the utmost respect to the desires of the patient. These aims appear quite different. However, one obvious similarity is that both considerations require a level of acceptable communication

and understanding between a layperson and a professional. It seems like these considerations are possibly derivative from the same basic consideration about what sort of power a specialist or professional has over a layperson without the same body of knowledge. This consideration actually agrees with Wolf when she says that bioethics must always be concerned with power relations.³⁰ However, at a deeper level, underlying both of these concepts is a concern with enabling the layperson to make her own decision without being wrongfully coerced by the professional. At this deep level, what we are concerned about truly is who is responsible for the decision at hand. So ultimately our notion of legal competency and our notion of medical DMC are predicated on some understanding of agent responsibility, namely, an account of what it is that makes an agent able to be held responsible for an action.

The question of agent responsibility is one that philosophers have weighed in on for a long time, and an issue with which they frequently enter into discourse with legal scholars, and more recently with various cognitive scientists. It makes sense that the same academic players interested in how we account for agent responsibility are also interested in the biomedical issue of capacity, as the

³⁰ Wolf, 1994.

latter is derivative from the former. Given the apparent importance of agent responsibility on notions of capacity, much more will be said in the next chapter about agent responsibility and how it relates to the specific discussion at hand.

Going forward, it looks like philosophers, cognitive scientists, bioethicists, medical practitioners, and legislators all will continue to have much to say about medical DMC. Importantly, it looks like no single discipline is going to have the final say. Whereas philosophers are responsible for figuring out what our conceptual framework actually entails, and maybe even what the deeper ethical implications might be for our bioethical principles, it is easy for the degree of abstraction present in philosophical theorizing to be very far from the experience of the people whose lives we ultimately affect when we do bioethics. Cognitive scientists will likely play an enormous role in providing empirical data to ground or refute our theoretical conceptions, but must realize that the sort of data they collect will always be subject to interpretation, and reliant on theory for connection to real meaning. Bioethicists will likely continue to be a pair of boots on the ground, as it were, trying to integrate and apply lessons from the other disciplines, as

well as weighing theory and empirical evidence with actual pragmatic decision making with real patients. Medical practitioners inevitably bear the brunt of tough decision-making, and ultimately all of the other disciplines are failing if they do not provide physicians with effective theoretical, physical, and practical tools for evaluating patient DMC. And lastly, all of this is little more than ink on paper without the enforcement of the law to back up our concerns and protect patients and physicians when medical decisions are made.

E. Capacity and Competency

Up to this point, I have been primarily arguing for a model of interaction between the disciplines involved in bioethical discussion of decision-making capacity. Before moving to the next chapter, I want to take more time to fully address the capacity/competency distinction. As already mentioned, there is great ambiguity in literature and in practice with regards to these terms. Moving forward, it seems that both terms must be used synonymously or else as separate terms entirely to avoid continued confusion. I shall argue that the two terms most reasonably mean distinctly different things, and that they should be differentiated in legal practice.

To briefly recap the common use distinctions of the

terms, competency typically refers to an individual's ability to stand trial and is often a binary ruling by the court. In many cases there might be distinctions determining an individual competent to stand trial, but not to self represent, or even distinctions that juvenile defendants are or are not competent to stand trial as an adult. While competency examinations pertain to something mental about the defendant, the typically binary nature of the ruling makes it an ill suited concept for mentally ill defendants that might have predominantly intact mental faculties, but suffer from delusions that only inhibit particular types of decision making. As I will argue in the next chapter, it is possible that specific mental disorder symptoms might affect cognitive processes in a specific enough way that an individual is competent to stand trial, and additionally that diminished capacity and criminal insanity defense do not seem to fully capture the nature of the situation.

With regards to the concept of mental capacity, especially as it is used in bioethical DMC, we have a term that is applied in degrees. Someone can have the capacity to make a decision to take ibuprofen, but not have the capacity to say yes or no to brain surgery. The flexibility of this concept makes it significantly more useful, as it

allows us to aim for the most specific analysis of the person in question. Recall Wolf's desire for us to contextualize our bioethics to the individual patient. Moving toward a capacity centric model as opposed to a competency centric one would be a dramatic step in that direction. As neuroscience and cognitive science develop increasingly better testing mechanisms, both imaging and functional, it seems highly likely that capacity measurements will get more accurate and become more readily available. With this in mind, my hopes are twofold: First, I endeavor that mental capacity become a more heavily theorized legal concept so that it might replace the notion of competency altogether; Second, I believe that such a concept of capacity has dramatically useful application in realms outside of bioethics, such as criminal law. In the next chapter, I aim to explore one of these, namely in positing an improved scheme for evaluating mentally ill defendants.³¹

³¹ For a classic example of a challenge to DMC, see the attached newspaper clipping from the Pittsburg Post Gazzette from May 9, 1978 for a brief recap of the infamous Mary Northern case.

Chapter II

Schizophrenia and Capacity for *Mens rea*

In our legal system, there are three common evaluations of defendants suffering mental disorders that serve to determine legal responsibility. The one that is more commonly recognized in our society is the legal insanity defense whereby a defendant attempts to prove that his mental disorder prohibited or affected his understanding of his actions or their moral wrongness. Much can and probably should be said about the insanity defense and the ways it possibly fails to account for the experience of some mental disorders or their symptoms, but the insanity defense itself is not the focus of this chapter so much as positing a possible alternative to it. A second way our legal system acknowledges mental illness in criminal cases is through the diminished capacity plea. These two differ significantly. The insanity defense is essentially a not guilty plea, whereby if deemed guilty the defendant is sentenced to psychological hospitalization rather than criminal punishment. The diminished capacity plea is one that accepts criminal liability, but requests mitigated punishment based on diminished mental capacity. This plea already sounds very much like the intended subject of this paper, even employing the word capacity.

However, what I argue for in this chapter is a more significant understanding of mental capacity whereby lack of appropriate mental capacity might be sufficient not only to mitigate sentencing, but sufficient to rule out criminal liability altogether. The difference between this scheme and criminal insanity is that I argue that such an evaluation of mental capacity can and, for many mentally ill defendants, often should, take place at the outset of court proceedings. Specifically, I argue that an evaluation of defendants for mental capacity relative to *mens rea* might be able to excuse some mentally ill defendants from criminal liability.

Mens rea is the notion of the "guilty mind" or criminal intent of an action. While an individual might be responsible for an act, he is not thought to be criminally responsible unless there was also a relevant mental or intentional state that the act do some sort of harm. The reason *mens rea* is in particular need of evaluation is because insanity defense cases presuppose that the defendant did in fact have the requisite guilty or intentional state of mind. However, there are specific symptoms in some mental disorders that seem not to be captured by current applications of *mens rea*. In particular, I will examine schizophrenia and some of its

symptoms with the aim of showing that very important theoretical objections might be raised as to whether or not the schizophrenic defendant is capable of forming a requisite *mens rea*. The goal is to provide a case for adopting a conception of mental capacity as it applies to *mens rea* with the hopes of showing that some mental disorder symptoms may prohibit the relevant *mens rea* from ever forming.

This argument will proceed in several steps. The first will be to offer a theoretical and philosophical account of some of the schizophrenic symptoms that seem not to fit under our current tests for *mens rea*. Secondly, I consider some ways in which *mens rea* is currently used in our courtrooms and how those might be inadequate. Importantly then, the third part of my argument is that neuroscience and neuroscientific data will be necessary in the courtroom to substantiate the claims of defendants incapable of *mens rea* by means of their schizophrenic symptoms. Let us then turn to the theoretical framework that upon which we will build later sections.

A. A Philosophical and Psychological Account

Before we can begin our theoretical account of why schizophrenic symptoms might conflict with *mens rea*, we need first broaden our philosophical scope. In considering

questions of legal responsibility, I assume that any viable theory must itself be constrained in a broader theory of responsibility per se. In particular, in criminal cases we are concerned with agent responsibility, the condition that an individual acts in such a manner as to be responsible for the occurrence of that action. Additionally, I have already alluded to questions of capacity being necessarily bound up in theories of agent responsibility. Therefore, I must first offer a working account of agent responsibility. Once that account is in place, I give a cognitive neuropsychological account of schizophrenia and how that account fits into agent responsibility. Then I will outline two of the many possible schizophrenic symptoms and how they might give insight into the question of *mens rea*. Lastly, I will argue how capacity for *mens rea* is compromised by some schizophrenic symptoms, and briefly suggests some limitations on what sorts of symptoms might be exculpating of *mens rea*.

i. Agent Responsibility

I assume that any functional conception of legal responsibility must fit within a plausible and applicable theory of general responsibility—that is, a theory of what entails responsibility of an agent for his actions. To proceed along this line of reasoning, I will make two

qualifications: the first is that responsibility necessitates a conception of freedom of will, which I will address and support momentarily; the second is that we need only be concerned with responsibility per se in this context so far as it encompasses our objectives—legal insanity and schizophrenia. That is, I recognize that agent responsibility has many forms and theories behind it, but I only address a very narrow conception of it relative to this argument. Before I argue for a theory of responsibility, then, let me set the stage by offering the theory of freedom of will upon which it will be built. For this theory, I turn to Harry Frankfurt.

Harry Frankfurt³² gives an account of free will that, in light of various arguments for determinism, argues that freedom of the will is based not upon desires of the first order, but rather volitions of the second order. First order desires are our every day wants and inclinations such as "Stacy wants ice cream." Second order desires are desires about desires like "Stacy does not want to want ice cream." On Frankfurt's account, what is necessary for freedom of will is complete freedom of second order

³² Frankfurt, Harry. "Freedom of the Will and the Concept of a Person." *Journal of Philosophy*. 68/1 (1971) 5-20. Reprinted in *Free Will*. 2nd ed. Watson, Gary. Oxford University Press, 2003. p. 322-336.

volitions—the freedom to will what you want to will—and this freedom of will is analogous to freedom of action—being free to act how you want to act. This sort of second order freedom is necessary, by Frankfurt's account, for the very conception of what it means to be a person. An individual may not be a person but may, in fact, be a "wanton" if he lacks any second order volitions or if his freedom to will is hindered or obstructed. In either case, we would say that the wanton is unfree. One other crucial aspect of Frankfurt's conception of personhood and freedom is that to be a person, one must have rationality and must have the ability to apply that rationality to his desires, thus rendering him capable of second order volitions and not merely second order desires. All of that is to say that a wanton might be capable of second order desires, "Stacy does not want to want ice cream," but without the ability to evaluate and will those desires, the wanton remains unfree and not a person in the conceptual, morally relevant sense.

Susan Wolf captures Frankfurt's sense of second order volitions as necessary for freedom and extrapolates that sense to account for responsibility. She argues that to be

responsible, an agent must also be sane.³³ The idea of a "deep self" advocated by Frankfurt and others allows us to understand how some individuals might be held less blameworthy for their actions despite having apparent desires to act. Sanity, on Wolf's view, assumes a certain rational connection with the world and relevant environmental factors. The augmented "sane deep-self" view of responsibility that she advocates then integrates several points. The agent responsible for his actions must have a sane deep-self whereby he is rationally connected to the world and able to respond appropriately to environmental stimuli—an agent responsible for his actions must first be responsible for his mental and intentional states.³⁴ One necessary condition for that responsibility is freedom of second order volitions in the Frankfurtian sense, but a second necessary condition is the ability to constantly evaluate and *improve* second order volitions. Wolf recognizes determinists might claim that various

³³ Wolf Susan. "Sanity and the Metaphysics of Responsibility." In *Responsibility, Character, and the Emotions*. 46-62. Cambridge University Press. 1987. Reprinted in *Free Will*. 2nd ed. Watson, Gary. Oxford University Press, 2003. p. 372-387.

³⁴ This is not to argue that to be responsible for one's actions, one must always act rationally or responsibly, but rather to say that there is always an *ability* for one to rationally adapt one's second order desires in a way that is relevant to environmental stimuli.

factors make our deep selves unavoidable, or predisposes us to certain second order volitions. However, on her view determinism does not pose an imminent threat since sanity requires only the ability to evaluate and improve second order volitions rather than any particular second order volitions. It is the mistakeness of second order volitions in insane individuals that makes them not responsible, not the unavoidable nature of their volitions. Therefore, any individual that is not capable of both willing what he wants to will and also capable of evaluating and improving such volitions is not responsible.

George Graham argues that mental disorder, as a concept, can be understood along these lines.³⁵ In considering how mental disorders come about, Graham recognizes roughly seven categories of cognition that might be affected or deficient in mental disorder. We can consider a couple of them here. Regarding **self/world comprehension**, Graham states,

"[...] without knowing whether the food in my refrigerator is poisonous, if my car is safe to drive, whether my neighbors are trustworthy, or if the hot cup of coffee on my kitchen counter is too hot to hold, my ignorance is dangerous and deleterious."

And regarding **bodily/spatial self location** he says,

³⁵ Graham 2010, pp. 144, 145

"We persons must be able to identify our somatic or bodily position in the environment/the world, so that we can utilize our motor capacities in the service of bodily movement and self-maintenance as well as other forms of goal pursuit."

And individual with a disorder of self/world comprehension is not able to will what he wants to will. A schizophrenic with paranoid delusions might be convinced his neighbor works for the CIA and is spying on him. This individual may not be able to maintain a reasonable second order volition regarding how he understands his neighbor. Someone with disruption in her bodily/spatial self-location might not be able to improve second order volitions regarding how appropriate is the thought, "This arm is attached to my body, sure, but it is not mine." Regarding delusional schizophrenic patients, Graham says,

"Understanding the phenomenon of delusion requires understanding a deluded subject's failure to control or direct their own cognitive activities in a satisfactory and prudent or reason-responsive manner."

That control or direction refers to the second order volition itself, and the qualification of "in... a reason responsive manner" recognizes the need to be able to improve second order volitions based on rational reflection. It is apparent, then, how this Frankfurt/Wolf model might be used to appraise certain schizophrenic symptoms. It is also useful to see, as in the example

above, how certain premises of the Frankfurt/Wolf model of responsibility are already incorporated into existing accounts of mental disorder and schizophrenic symptoms.

Additionally, I said above that notions of capacity and competency are both preceded by an underlying idea of agent responsibility. The very idea of assigning legal blame is predicated upon assigning that blame to someone. To do so, we must have conditions that prescribe blameworthiness. If we are evaluating someone for legal competency, or a capacity to make decisions, or in the case of this chapter, a capacity to even form a requisite mental state, then it is already assumed that we are trying to decide whether or not to blame them, or how much blame we can hold them accountable for. Even the principalist makes this assumption when invoking the principle of autonomy. In that case, the aim is to enable the patient to be as responsible as possible for the decision being made. Broadly speaking, when we seek to excuse an individual of responsibility on mental grounds, we do it in one of three ways, according to Carl Elliot. We either say that in individual was somehow ignorant of relevant factors of her actions, or we say that an individual was mentally unhealthy enough as to have been compelled to act as she did. The third option is for a person to be so mentally

unfit as to fall outside of the realm of responsibility altogether. In all three of these cases, what is somehow lacking is an individual's intent to commit the act.³⁶ However, we must be careful to note that when we speak of intention here, what we are speaking of is actually second order intention, and not first order intention. A deluded individual could very well intend to attack the person she perceives as an alien imposter of her spouse, but it is her second order intention that is compromised in this situation. An appropriate second order volition would be based on the environment relevant response (that the person in this situation is not an alien imposter, but actually her spouse). Thus the model still holds.

ii. A Psychological Account

As we turn now to consider philosophical and theoretical accounts of schizophrenia, we will keep in mind the Frankfurt/Wolf model of responsibility and sanity. Our objective is to understand one possible theoretical framework for schizophrenia broadly conceived so that in the next section we can look at specific symptoms of schizophrenia and understand how they diminish or abolish agent responsibility. The contention will be that

³⁶ Elliot, Carl. *The Rules of Insanity: Moral Responsibility and the Mentally Ill Offender*. State University of New York Press. 1996.

responsibility is abolished because the capacity for reason responsive self-reflection does not exist. In large part, the following theory is that put forth by Christopher Frith.

Frith argues that the disorder of schizophrenia presents as three component parts.³⁷ Disorder of Willed Action is the first component. Schizophrenic patients, particularly those with negative symptoms, display truncated or impaired ability to act coherently, to execute plans, or to initiate action as opposed to mere stimulus response. Resulting are perseveration of action, inappropriate action, and poverty of action. Next is Disorder of Self-Monitoring. As opposed to willed action, this deficiency refers to inability to monitor or recognize willed *intention*. Such disorder results in many delusions and hallucinations experienced by schizophrenics. Lastly, Monitoring the Intentions of Others rounds out the characteristic defects of schizophrenics. Inability to appropriately recognize the intentions or beliefs of external agents leads to delusions and hallucinations as well, but often of a different kind.

Admittedly, trying to reconcile all of these different categories of disorder and their respective symptoms seems

³⁷ Frith, 1992, p. 122-124

difficult. Frith's approach examines these individually in an attempt to find a single underlying cognitive mechanism that might be able to explain the whole breadth of schizophrenic symptoms. The single cognitive mechanism that he believes adequately accounts for the range of schizophrenic symptoms is metarepresentation. Metarepresentation is equally understood as second order thought. Second order thought, broadly conceived, is thought about other mental or intentional states. Corresponding to the three disorders within schizophrenia, Frith finds three possible categories of meta-representation: knowing about goals, knowing about our own intentions, and knowing about the intentions of others. Deficiencies or errors in meta-representation lead to the symptoms experienced by schizophrenics:

"... (1) [W]ithout awareness of goals there is poverty of will. This leads to negative and positive behavioral abnormalities; (2) without awareness of intentions there is a lack of high level self-monitoring. This leads to abnormalities in the experience of action; (3) with faulty awareness of the intentions of others there are delusions of persecution and delusions of reference," (*Ibid.* p. 125).

Frith's theory dovetails into our Frankfurt/Wolf notions of responsibility. If this theory holds, then the schizophrenic, in some aspect, cannot appropriately recognize shortcomings in second order volitions, cannot modify second order volitions with appropriate regard to

actual circumstances, or has no second order volitions at all. Any of these three deficiencies renders an individual not responsible for self, and therefore not responsible for his actions. Let us recall that to be responsible for self, and so also responsible for action, an individual must have second order volitions and must also be capable of improving them. In the following section, we will examine two of the many possible schizophrenic symptoms within our new expanded framework in order to demonstrate that some schizophrenics cannot be held morally, or perhaps criminally, responsible for certain of their actions.

iii. Two Symptoms

To see how this theoretical framework actually applies to real symptoms, we will now look at two of them: thought insertion and Capgras delusions. Thought insertion is just what it sounds like; it is the delusional belief that certain of one's thoughts are actually inserted into one's conscious awareness by an outside or alien consciousness. Capgras delusions are delusions of mistaken identity particularly applied to people or things that are close to the delusional individual. Both are positive symptoms of schizophrenia with relevant implications to our theory above. Each will be examined in turn before I have a brief word about delusional beliefs in general and then conclude

this section with some notes on schizophrenic symptoms more broadly. Throughout the chapter, I will return to these two symptoms to exemplify points, but I in no way intend to imply any greater import of these symptoms than of other schizophrenic symptoms. Similar arguments could be made from a whole host of possible symptoms of schizophrenia. That I choose to work with specifically these two symptoms is arbitrary.

a. Thought Insertion

"Thoughts are put into my mind like 'Kill God.' It is just like my mind working, but it isn't. They come from this chap, Chris. They are his thoughts," (Frith, 1992 p. 66). The notion of a thought existing in our minds that is not ours is a difficult one to comprehend. Many theorists, therefore, have attempted to account for both the causation and the experience of inserted thoughts. One theory, though in some ways ambiguous, accounts for the experience of inserted thoughts as from an external source as follows:

A person feels that a thought is alien because he cannot voluntarily control its occurrence in himself.

This person also denies agency of this thought because he cannot explain the thought in terms of his own internal psychology.

This person then willfully ascribes the thought to another agent because it exhibits "recurrent subject-specific semantic content."³⁸

Another theory, accounting for phenomenological experience of inserted thoughts hypothesizes that in the same way we can feel and identify a difference when we move our arm versus when someone else does it for us, there is a feeling of familiarity and recognition associated with thought also; schizophrenics experiencing delusions of thought insertion experience "inserted" thoughts (as opposed to thoughts they feel they are responsible for) with a similar phenomenological quality to when someone moves our arm for us versus when we initiate that movement ourselves.³⁹

Where these and other theories interest us, with regards to agent responsibility, is in the way that they acknowledge the inability of the individual to improve upon second order thoughts. The individual experiencing inserted thoughts is experiencing a disorder of self-monitoring. More will be said about the possible mechanisms of this disorder later, but for now what is important is how this disorder relates to metrepresentational failure and our

³⁸Graham, George and Stephens, G. Lynn. *When Self Consciousness Breaks: Alien Voices and Inserted Thoughts*. The MIT Press. 2000.

³⁹ Gray, David M. "Phenomenological Warrant and the Ascription of Thought." Under Review.

necessary conditions for responsibility. Disorder of self-monitoring in this case is the metarepresentational failure of the schizophrenic to monitor his own intentions. The thought disorder patient is unable to recognize certain thoughts as her own, and so ascribes the intentional states of those thoughts to other external consciousnesses. Let us look at a second symptom of schizophrenia, Capgras delusions, so that we might further understand our theoretical framework above and how it more specifically might relate to *mens rea*.

b. Capgras Delusions

Frith and Johnstone, (2003 p. 140) summarize the Capgras delusion as a "belief that a person has been replaced by an identical or almost identical other. The person who has been replaced is usually someone close the [delusional] patient..."⁴⁰ Frith (1992) and Garety (1998) both acknowledge theories for Capgras and other delusions of misidentification that suggest the cognitive phenomenology is directly resultant from anatomical failures in certain types of information processing.⁴¹ In particular, they each

⁴⁰ Frith, Christopher and Johnstone, Eve. *Schizophrenia: A Very Short Introduction*. Oxford University Press, 2003.

⁴¹ Garety, Phillipa Garrety. "Insight and Delusions." In *Insight and Psychosis*, 1998. Edited by Amador, Xavier F. and David, Anthony S. Oxford University Press. 1998.

cite Ellis and Young (1990) in their account that focuses on two particular pathways of facial processing: the first identifies faces as physical features and recognizes them based on information learned and stored in memory (e.g. my wife) while a second pathway is responsible for ascribing emotional content to faces of people that hold emotional connotations to us. In this way, the account suggests that there can be normal functioning in one stream of processing—the identification of a face—but failure in the another—my emotional attachment to the face of my wife—that leads a patient to experience a feeling of alienation or suspicion of the person that looks and seems like my wife, but does not *feel* like my wife. She does not trigger the emotional attachment that I associate with my wife when I see her, and so seems to be a different, albeit physically identical, person.

Like the patient experiencing thought insertion, the Capgras patient experiences disorder of self-monitoring and failure to understand or represent his own internal mental states. The patient cannot adequately locate or understand the source of his altered experience of his loved one. While such delusions are often relatively inconsequential, "In one extreme case, a patient who believed his stepfather

had been replaced by a robot subsequently decapitated him to look for batteries and controls in his head," (Frith and Johnstone, 2003). This case is very striking relative to our inquiry, as it seems that the delusion was in some way directly causally relevant to the patient's action.

B. Delusional Beliefs and Responsibility

Let us now return to the notion of responsibility. My argument that certain schizophrenic experiences reduce or absolve responsibility for action demands a certain standard of relevance. I intend in no way to argue that schizophrenia as a diagnosis precludes individuals from having a relevant *mens rea* to criminal prosecution, but rather that *specific symptoms* prohibit specific cognitive capacities necessary to form or hold a *mens rea*. For schizophrenic patient to be excused of responsibility for an action as result of any of his symptoms, they must be relevant to his actions in two very specific ways. The first is that the symptomatic mental state must actually relate to the crime. Hallucinating that all the dogs in the neighborhood work for the KGB to urinate in her yard would probably not excuse a paranoid schizophrenic for stabbing her former employer, for example. The second sort of relevance lies in how a symptom affects the mental states relevant to the act. In his seminal piece *Alternate*

Possibilities and Moral Responsibility,⁴² Harry Frankfurt argues that, regarding moral responsibility for actions, "a person is not morally responsible for what he has done if he did it *only because* he could not have done otherwise," (emphasis mine). In this case, since we consider individuals who are mentally ill, we will need to revise his thesis slightly. Drawing on our earlier recognition of Frankfurt, Wolf, and Frith, I suggest that a schizophrenic individual be excused of responsibility for an action if the causal mental state in question is *relevant* to the act and held *only because* he could not have willingly intended or thought otherwise, i.e. if disordered cognitive mechanisms prevent reason responsive evaluation of the thought. The schizophrenic symptom in question must have compromised his ability to evaluate or reasonably alter his second order volitions. In such a case, he is not morally responsible for his criminal act.

The thought insertion patient above surely does not want to intend the thought "Kill God", but the thought still occurs within his mind. He might even be capable of having second order thoughts about the delusions, but none of these thoughts lead him to recognition that the

⁴² Frankfurt, Harry. 1969. "Alternate Possibilities and Moral Responsibility." *Journal of Philosophy* 66: 829-839.

delusional belief is itself false. Even if the patient evaluates his own thoughts and arrives at a second order volition "I do not want be motivated to act by the thoughts Chris puts in my head," that volition is still about an intentional state that does not actually exists because its subject does not exists either. This case violates our necessary condition for agent responsibility of being able to improve second order volitions in a reasonable manner, and so this individual is neither responsible for these thoughts, nor for himself.

Imagine our Capgras patient that decapitated his stepfather. He committed this act because he did not have the capacity to recognize his father as that person. Obviously evaluation of any such desire by a rational individual would lead to an improvement of second order volitions, as reality suggests that an entity who looks and acts like his step-father is probably not a robot, is probably a person, should probably not be decapitated. This patient could not possess *mens rea* because he could not understand that his actions affected another person. In both of these cases, even if our patients have second order volitions, those volitions are not about entities that exist. Individuals that hold second order volitions about non-existent entities, and have no way of evaluating or

improving those volitions with regard to reality, cannot and should not be held responsible for actions that result from those beliefs. They do not have a capacity to form a *mens rea* in any morally relevant sense.

C. A Note about Negative Symptoms

In this paper I have given account only of instances of positive symptoms of schizophrenia. Positive symptoms are symptoms that are abnormal because of their presence, such as hallucinations, delusions, compulsive behavior, and others. Conversely, negative symptoms are abnormal by their absence; flattening affect, social withdrawal, poverty of speech, poverty of action and so on, all greatly decrease activity in the schizophrenic in ways that are unlikely to cause criminal action. It is difficult, though not impossible, to conceive of examples of how depression or less coherent speech might result in cases where we would consider whether or not an individual was responsible for his action in any sort of moral or criminal sense. That is to say that negative symptoms appear to be significantly more internalized in their consequences, often resulting in individuals that are hospitalized or else completely withdrawn from any sort of intellectual or social interaction, and thus difficult to consider within the framework I advocate here. I fully accept that an account

might plausibly be given of a negative symptom that affects capacity for *mens rea* in accordance with my argument. I am not opposed to such an account, if it is possible, but rather find that such an account would likely yield less application, and thus emphasize positive symptoms.

D. *Mens Rea* and Legal Insanity as Separate Concepts

In this section, I begin by briefly considering the legal insanity defense and the difficulty in overcoming that requirement for many schizophrenic symptoms. These difficulties make the insanity defense traditionally seem like the legal heading that should encompass more schizophrenics. Furthermore, as Morse and Hoffman argue, the current legal precedent is that "the *mens rea* issue is entirely distinct from the legal insanity issue, even if precisely the same evidence would be relevant to adjudicating both claims," (Morse and Hoffman p. 1096). After examining the legal insanity defense, I will consider more carefully what it would mean to embrace a model of *mens rea* that more heavily relies on a notion of mental capacity.

i. Legal Insanity

Let us begin by looking at some of the current tests for legal insanity as well as the responses to them posed by some prominent legal theorists. The definition of legal

insanity adopted in the Model Penal Code put for by the American Law Institute is as follows:⁴³

"...[A] person is not responsible for his criminal conduct if, at the time of the conduct, as the result of a mental disease or defect, he lacked substantial capacity to:

1. appreciate the "criminality" (or "wrongfulness") of his conduct; or
2. to conform his conduct to the requirements of the law."

An older test for criminal insanity, the M'Naughten test, is simpler but similar:⁴⁴

"...[A] person is [criminally] insane if at the time of the criminal act, he was laboring under such a defect of reason, arising from a disease of the mind, that he (1) did not know the nature and quality of the act he was doing; or (2) if he did know it, he did not know what he was doing was wrong."

These definitions are similar in that both contain a "volitional" and a "cognitive" prong. The former addresses whether the person in question understands what his actions actually are and the latter addresses his understanding of their moral implications. While there are many varied objections to the current tests for legal insanity, I intend to object only in a sense most relevant to the argument as it has been laid out so far.

The main problem with the current tests for legal insanity can be understood by invoking yet again our

⁴³ Lexisnexis Capsule Summary: Criminal Law. Chapter 15, "Insanity."
<www.lexisnexis.com/lawschool/study/outlines/pdf/crim.pdf>
Accessed 20 April, 2013.

⁴⁴ *Ibid.*

Capgras case. Using the current standards, we could easily establish *mens rea* in the traditional sense; our patient does wish to harm someone. We then have to turn to the two prongs of our test and inquire as to which, if either, might be sufficient to exculpate this patient. It is easy to imagine that this patient might agree entirely that harming another person is wrong. There goes the volitional prong. Next, considering the cognitive prong, it does not stretch the imagination any further to imagine that this patient could also acknowledge that harming his father is against the law, and still to acknowledge that nothing *made* him harm his father. He might therefore have the *mens rea*, the understanding of the legality of an action and an appreciation for its moral weight, and be liable for criminal prosecution. However, if my argument holds any water, then we should not hold our Capgras patient criminally responsible for his action that resulted from his delusions because he is not even responsible for these actions in a moral or theoretical sense. The current tests for criminal insanity give account only to mental states as they exist or might have existed in the mind of the defendant at the moment of action. They do not account in any manner for the formation of those states or for the ability of the defendant to modify those states at all. The

question of whether or not the defendant is able to recognize the victim as his father is not one that is answered, despite its seemingly obvious relevance to the verdict.

ii. *Mens rea*, Schizophrenia, and Courtroom Proceedings

As was mentioned at the outset, *mens rea* is a requirement in our legal system for criminal liability. It is a necessary condition for an act to face criminal prosecution; the other necessary condition is the *actus reus*, or the actual criminal act itself. As such, being held criminally liable requires both *mens rea* and *actus reus* be proven by the prosecution. Most criminal litigation occurs with in proving the *actus reus* occurred and not that the defendant had the requisite *mens rea*. In general, cases involving mental disorder still assume that the defendant had the relevant *mens rea* and, should they consider the relevance of the disorder, confine that consideration to either a legal insanity defense or else to questions of diminished capacity or mitigated punishment. Therefore, most considerations of mental disorder in our legal system occur in the midst of guilt determination or afterward, but my argument concerning *mens rea* would require that determination of agent responsibility be considered, at least in part, at the outset of a criminal trial. *Mens rea*

defenses are based on a *prima facie* negation of one of the necessary conditions for a criminal act. In the United States, one case that both exemplifies some of the standard conceptions of *mens rea* as well, as exemplifies some of the problems with the status quo at which my argument is aimed, is *Clark v. Arizona*.

In *Clark*, the U.S. Supreme Court upheld the insanity defense in Arizona. In that state, mental health evidence is inadmissible to try and show that the defendant did not possess the relevant and requisite mental state at the time of the commission of the crime. That evidence is only admissible under the standard insanity defense rules. Therefore, in Arizona, *mens rea* is assumed before an insanity defense can be made, or else guilt is admitted under a diminished capacity plea, but the concept of *mens rea* itself is all but washed out.

Stephen Morse and Morris Hoffman offer a strong critique of the Supreme Court's decision in *Clark* that emphasizes many points my argument means to address.⁴⁵ One of their many critiques is that the majority opinion in the

⁴⁵ Morse, S. J., & Hoffman, M. B. (2007). The uneasy entente between legal insanity and *mens rea*: Beyond Clark V. Arizona. *Journal of Criminal Law & Criminology*, 97(4), 1071-1149. Retrieved from <http://search.proquest.com.proxy.library.vanderbilt.edu/docview/218441636?accountid=14816>

Clark decision frequently conflates the notion of legal insanity and *mens rea*, and even rules that Arizona was within its constitutional parameters to "channel" all considerations of *mens rea* into a consideration of legal insanity as per the *Mott* rule established in that state. I agree with Morse and Hoffman that the *mens rea* defense should necessarily be kept separate from the insanity defense for two main reasons.

The first reason is that the insanity defense varies widely between states and some states do not even have an insanity defense. Some state, similar to Arizona, have even begun to set precedent that any evidence introduced to try and disprove *mens rea* in cases of mental disorder must instead be introduced as part of an insanity defense plea. Therefore, there can be quite broad inconsistencies between jurisdictions on how and when and how *mens rea* evidence and testimony are received. The insanity defense does not receive the same legal clout in many jurisdictions as *mens rea*, so equating the two reduces the status of *mens rea* to a less important legal consideration. *Mens rea*, because it is relatively consistently regarded and applied across all jurisdictions in the United States, is held to more consistent precedent between jurisdictions. Equally important as maintaining the current precedents regarding

mens rea are the possible implications of setting any new ones. One state setting a new precedent regarding the application of *mens rea* and mental disorder is much more likely to have an effect on other states than any new ruling on the insanity defense since application of *mens rea* is more homogeneous.

The second reason I believe *mens rea* should be inherently separate from the insanity defense is because, as mentioned above, it is one of two necessary conditions for criminal responsibility for an act. So long as a state maintains a distinction between strict liability and criminal liability, *mens rea* must necessarily exist. So long as *mens rea* exist, it exist as a necessary condition for a criminal act, and therefore must have the ability to exculpate a mentally ill defendant if any reasonable doubt exist that he lacks *mens rea*. That is, the reasonable doubt standard must be equally applied between any necessary conditions of criminal liability, whatever those happen to be. Conflation of *mens rea* and legal insanity, as in the *Clark* case, reduces *mens rea* from a primary and necessary condition of criminal guilt to lesser legal consideration akin to diminished capacity. If we must prove guilt beyond a reasonable doubt, and guilt has two prongs (*actus reus* and *mens rea*), then we must give equal evidentiary weight

and consideration to both. In mental disorder cases, then, it could benefit courts to fact-find on the *mens rea* issue before the *actus reus* issue since early determination of no *mens rea* would necessarily end litigation.

In *Clark*, the court considers many arguments regarding the capacity to form *mens rea* and how these arguments should be regarded or admitted. Morse and Hoffman are critical of such arguments, stating, "Asking about a defendant's capacity to form a mental state never provides better information than inquiring directly whether the *mens rea* was formed in fact..." (Morse and Hoffman, 2007, p.1087, 1088). They share concern with the court that questions about diagnosis or capacity to form specific mental states are subject to too much interpretation and disagreement from expert witnesses. By ignoring questions and theories of capacity, they argue, we are able to limit our arguments and considerations in fact finding to whether or not the defendant had the specific guilty mental state at the time of an act necessary for criminal liability. I disagree with this point; capacity considerations can be significantly more insightful than Morse and Hoffman claim. Certain schizophrenic symptoms might inherently affect the capacity to form a *mens rea*. In addition, there is nothing inherently easier about discovering someone's capacity to

form a mental state at a certain time versus discovering whether or not they actually had it. In fact, if we have record of a diagnosis pre-dating the incident, and appropriate confirmation of that diagnosis during courtroom proceedings, it might be easier to extrapolate conclusions about capacities than about specific thoughts.

Recall Capgras delusions. Capgras patients frequently believe that an imposter, an alien, a robot, or something else has replaced someone close to them. Morse and Hoffman would likely agree our patient that killed his stepfather lacks *mens rea*, but they miss the relevant possibility that *all* Capgras patients lack a certain capacity to form *mens rea* toward the replaced person. It seems that even in cases where the patient believes another person has replaced his wife, if he desires to harm her, his desire is still to harm *the imposter* and not the actual person that is his wife. We could categorically say that Capgras patients never act toward "replaced" individuals in a legally responsible way because they do not intend such acts toward any person that actually exists. Therefore, it is quite possible that certain classes of schizophrenic symptoms could exculpate defendants for specific actions based on the capacity of those defendants to form *mens reas* relative to those actions. Recognizing such theoretical

possibilities might be equally as important, if not more so, than attempts to determine exact mental states at the time of a crime. It is quite possible to debate about the mental state of a person based upon circumstantial facts about the event itself. However, as long as a schizophrenic defendant can be surely said to have been experiencing X symptoms at the time of his action, and those symptoms are such that they result in loss of capacity for *mens rea*, we can completely skirt around questions of what the defendant's mental state was in that exact moment solely because of considerations of specific mental capacities.

Another point upon which I agree with Morse, Hoffman, and the courts in *Clark* is that the current schemes for psychological diagnoses vary to such a degree as to hinder our judicial system in many cases. There are many disorders with very ambiguous criteria for diagnosis, possibility for disagreement about relevant symptoms among clinicians, or even diagnoses that are not thoroughly accepted within the psychological or medical communities. Therefore, what I propose with regards to the legal system's consideration of schizophrenia is what many clinicians, scientists, philosophers, and medical professionals have already begun advocating, and that is analysis of schizophrenics on the basis of their specific symptoms rather than their overall

diagnosis (Frith, 1992, p. 11). Indeed, some entire investigative and theoretical works examine specific symptoms for the sake of giving real and productive accounts of those symptoms without the unwieldy backdrop of broader formal diagnoses (Graham and Stephens 2000).

In a similar fashion, regarding schizophrenia and *mens rea*, the legal system might be best served by addressing specific symptoms as having certain implications regarding *mens rea* whereas others do not. The advantage of such an approach is that someone like Eric Clark can be evaluated along a much narrower scale, say of paranoid or persecutory delusions, rather than along the very broad scale of a schizophrenic diagnosis overall. Secondly, as I advocated above, certain symptoms might have greater implications for the capacity of *mens rea* than others. Such considerations might allow construction of a comparative scale for evaluating *mens rea* capacities that allow quicker court indexing of schizophrenics without relying as heavily on competing expert testimony.

Given such prospects, there are still obvious limitations. Some considerations will always exist, such as the possibility of a malingering defendant, as well as considerations inherent to the admission of expert or scientific testimony. But these exist and will continue to

exist in many other fields of criminal litigation and should not pose any special concern here. However, clinicians and professionals still disagree in their expert opinions, even over more narrowly constrained symptoms in cases of mental disorder. It is for this reason that continually emerging neuroscientific data must be verified and implemented into our standard evaluations of *mens rea* in schizophrenic defendants pursuing such a defense. Such data, though still debatable, provides more inherently concrete evidence to support claims of specific symptoms or cognitive capacities. More will be said about the neuroscience specific to schizophrenia and *mens rea* shortly, but for now I want to integrate everything covered far so that we might have perspective moving forward.

I propose that there be a specific evaluation standard for capacity for *mens rea* in cases of schizophrenia, one that should be extrapolated to other cases of other mental disorder as well. While I believe many of the details are still to be hashed out, there is a relatively intuitive form such an evaluation could take; this form is very similar to my condition for moral agent responsibility established earlier:

An agent is not criminally liable for an action if mental disorder or defect affects cognitive capacities relevant to the purported act such that the defendant held the relevant

mental state *only because* of said mental disorder or defect.

Under such a standard, it would be possible to evaluate schizophrenic symptoms with hopes of determining the maximum degree of *mens rea* possible to them. In an ideal situation, such determinations would be made by a confluence of psychologists, neuroscientists, legal professionals, philosophers and ethicists, and medical professionals. The aim should be to figure out which, if any, symptoms completely exculpate schizophrenics regarding specific actions or mental states, and which others might inherently mitigate responsibility to a degree. It is to this end that the cognitive sciences are of paramount importance to the continued development of a theory of capacity. As we have seen in consideration of DMC, cognitive neuropsychology is already yielding increasingly better tests for certain kinds of capacity. Such tests, coupled with advances in functional neuro-imaging, are likely the best way forward for collecting and formulating the data to drive our legal theory forward.

E. The Neuroscientific Link Between Theory and Courtroom

All of my argument becomes highly moot if it is not actually applicable in the courtroom. To this point, I have suggested a theoretical mechanism for determining that some

schizophrenic symptoms might inherently lead to partial or complete loss of ability to form *mens rea* in some patients; I have also argued how such theoretical considerations are legally relevant. Now it is our goal to examine how such theoretical considerations can actually be played out in courtrooms. The above theoretical and legal considerations are only relevant if they can be proven in the court of law. That is, they need certain kinds of testimony and evidence to be presented in trial.

The fundamental basis of a theory that encourages more evaluation of defendants is that our legal system is actually capable of consistently and concretely categorizing them. In the case of schizophrenic patients and their symptoms, nothing will be more crucial in the future than establishing the neuroscientific data relevant to the legal considerations at hand. In accounting for neuroscientific evidence to evaluate the capacity of schizophrenic subjects to form *mens rea*, we need to examine what types of evidence give us the information we need. That is, we need to ask ourselves what relevant neuroscientific data should tell us about schizophrenics in order to exculpate them via *mens rea* defense. In order to answer this question, we will first return to our cognitive neuropsychological account above in order to see what types

of physical relationships we could reasonably hypothesize moving forward. Secondly, we will examine some of the existing neuroscientific methods and ask ourselves in what ways the theories might limit the neuroscience or vice versa. Additionally, we will want to keep in mind general considerations and limitations regarding neuroscientific evidence. Finally, we will conclude with some thoughts on what directions neuroscience should take relative to schizophrenia and capacity for *mens rea*.

i. A Return to Theory

This chapter has thus far attempted to tackle, in a very narrow way, some very broad topics: schizophrenia, neuroscience, and capacity to form *mens rea*. It is important that we continue to narrow and limit the scope of our discussion so as to keep our objective in sight. When considering the idea of neuroscientific evidence, then, there are some kinds of evidence that seem more plausibly applicable to cases of schizophrenia and *mens rea* than others. I will argue for and give account of some of these, but my account is by no means exhaustive. To reiterate, my aim is not to provide the exact concrete basis upon which the legal system should restructure itself, but merely to provide an initial sketch of what one kind of such a restructuring would look like. Before we apply cognitive

neuropsychological theory to our question of what neuroscience should relevantly tell us, I should note a couple of assumptions. The first, and one that hopefully will show some support, is that much of what we understand to be deficient in schizophrenics is functional as opposed to anatomical. That is, as opposed to brain lesions, tumors, or trauma, schizophrenia and its symptoms do not tend to present with any recognizable physiological pathologies in the brain, at least none to this point that have been capable of generating diagnosis (Frith and Johnstone, 2003, ch. 1). Therefore, the relevant neuroscience should examine the functions of different brain areas and their interactions and not simply look for obviously broken structure. The second assumption is brain imaging is more useful for detecting cognitive functions and failures than other possible approaches like molecular or cellular based approaches.

Let us return to our theoretical roots; above I argued along with Christopher Frith and others that schizophrenic symptoms result from failures in metarepresentation, and that those failures result in agents not being responsible for certain of their actions. Frith (1992) gives account of which brain areas might relate and interact in certain normal metarepresentational roles and which of these

interactions might be inhibited in some way in schizophrenics. He recognizes that there is likely no single area for metarepresentation in the brain. Indeed, according to his account, it seems that any particular metarepresentation must have at least two components whereby one is the content of the representation and the other is the particular function of that representation (Frith, 1992, p. 126-130). Thoughts about my intention to write this paper would thus minimally require the component parts of content—writing a paper—and willed intention—my endeavor to actually act. There are likely many other brain areas involved, but we know this particular metarepresentation is going to at least involve areas active while writing or composing and areas active while willing or intending. Such a cognitive approach then allows us to begin theorizing relative to certain symptoms what parts of the brain we would be interested in examining with various brain imaging techniques.

Let us now consider again the case of Capgras delusions. Ellis and Young (1990) argue that Capgras patients experience delusions of mistaken identity because

of an error in facial processing.⁴⁶ They advance a view that there is (at least) a primary ventral route of conscious recognition of faces and a secondary dorsal route that attaches emotional significance. The former is hypothesized to run from visual cortex to temporal lobe via inferior longitudinal fasciculus whereas the latter is supposed to run from visual cortex to limbic system via inferior parietal lobe. Given such a theory, we would then want neuroscience to show active pathways normal patients and failures in those pathways in schizophrenics. Such data could, for instance, compare in controls the difference in activity between the two pathways when viewing unknown faces versus known and emotionally charged faces. It could then compare these differences to schizophrenics viewing unknown faces, known emotional faces, and known emotional faces believed to be imposters. Could this type of data set be normalized, it would give us a cognitive pattern to look for in neuro-images taken of schizophrenic defendants claiming relevant Capgras delusions.

A similar consideration can be given to delusions of thought insertion. Many theorists (Frith and Done, 1988,

⁴⁶ Ellis, H. D. and Young, A. W. "Accounting for Delusional Misidentifications." *The British Journal of Psychiatry*. 1990, 157:239-248.

Frith, 1992, Gray, forthcoming) all appeal to the notion of reafferent copy to understand, at least partially, the phenomenon of inserted thoughts.⁴⁷ This notion refers to our brain's mechanism for monitoring actions that we will as compared to actions that we carry out. When I look across the room, my brain controls the muscles that do the looking but also send out reafferent information to other systems (visual cortex) coding to them that my gaze is shifting and they need not be alarmed. Corollary discharge, as reafferent information is sometimes called, is also supposed to affect voluntary movement (Frith and Done 1988). If we recall an analogy from earlier, I feel an obvious experiential difference between someone moving my arm and me moving my arm. The different experience of these two situations is due to the fact that no reafferent information is coded when someone else moves my arm. Thus, we might conclude that the phenomenal experience of an action as my own is dependent upon reafferent information or corollary discharge. It is further supposed that schizophrenics experiencing alien thoughts experience those thoughts as externally generated because there is not

⁴⁷ Frith, C. D. and Done, D. J. "Toward a Neuropsychology of Schizophrenia." *The British Journal of Psychiatry*. 1988, 153:437-443.

corollary discharge necessary to "account for that thought within [the individuals'] personal psychology." What areas of the brain, then would we want to explore for errors in or defects in corollary discharge? A logical beginning would be the prefrontal cortex, which is believed responsible for goal setting and intentions. Barch (2005) offers two more possible areas of interests.⁴⁸ A possibility might be areas responsible for the "central executive" function, particularly with regard to context processing. An area possibly responsible for errors in central executive function is commonly thought to be the dorso-lateral prefrontal cortex (DLPFC). Similarly, another theory examines the possibility that the Anterior Cingulate Cortex (ACC) is responsible for monitoring errors or conflicts in cognitive processing and might be defective in schizophrenics with certain symptoms such as thought insertion.

Clearly, there is much more neuroscience to be done to attain the necessary degree of certainty demanded by our legal system. However, simply understanding what types of information we want from our neuroscientific evidence is a

⁴⁸ Barch, Deanna, M. "The Cognitive Neuroscience of Schizophrenia." *Annual Review of Clinical Psychology*. 2005, 1:321-353.

necessary point of origin. Theoretical approaches combined with anatomical knowledge can thus drive neuroscience by creating the hypotheses that neuroscientific research to investigate. Regarding thought insertion, we clearly want to know what parts of the brain must function and interact properly such that an individual can experience his thoughts as his own; we want to know what parts of the brain are responsible for corollary discharge in our thoughts and not only our voluntary actions. Therefore we have given researchers a target, but also given lawyers a standard by which to measure the relevance of evidence relevant to this symptom.

**ii. Goals and Methods of Neuroscience Relative to
Schizophrenia and Mens Rea**

Having examined how theoretical considerations can easily translate to neuroscientific ones in schizophrenia, we should now examine not only what kinds of information we might want from neuroscientific data specifically, but also what sort of answers we should seek out and what methods we might be able to use to do so. As mentioned earlier, research into schizophrenia seems to indicate a large functional role of interactions across multiple brain areas. While we may have theories on what cognitively is happening in the conscious perceptions and thoughts of

individuals, we still need functional data from brain systems to substantiate these theories in a court of law. Ultimately, various technologies for brain and brain function imaging will continue to provide both theoretical support and courtroom evidence for schizophrenic symptoms in the future.

I advocate a categorized evaluation of schizophrenics for the capacity to form *mens rea*. Such a scheme easily leads to what types of neuroscientific data we would want in court. For one, as I already mentioned, metarepresentation likely has no one area in the brain. Therefore, each classified schizophrenic symptom will need its own comprehensive functional, cognitive, anatomical theory backed up by the relevant neuroscience. For any given symptom, the ideal would be to have specific neuroscientific data to show sufficient conditions for inhibited capacity for *mens rea*. There are then two important directions that our theory and science should move. The first is to examine functional brain data in patients in order to establish conditions that are present *only* in individuals with a given symptom. The second is that we should study schizophrenic brains equally to how much we study "normal" brains to figure out their pathologies. We want to make sure that we are not reporting

brain phenomena in schizophrenics as unique to them when in fact those events occur functionally in all or even most brains.

In the event that we cannot determine functional brain states that exist as sufficient conditions only in symptomatic individuals, our theory is not totally dashed. Biting the bullet and assuming a less concrete scale in favor of one that trends toward plausibility rather than statements of fact does not put us outside of a role already frequently taken on by our court system. Even if the neuroscience is not able to concretely back up each schizophrenic symptom, theoretical considerations such as mine still provide ample reason to at least make the burden of proof higher for the prosecution of schizophrenic defendants. That is to say, we can use this approach to demonstrate some schizophrenic symptoms show increased propensity to distort or prohibit capacity for *mens rea*. We can back up those probabilities with neuroscience interpreted much as it is now, and even this more mitigated line of argument is likely to cause doubt sufficient to impair successful prosecution of many schizophrenics unable to form *mens rea*.

I would like to end this chapter by acknowledging that neuroscience has feasible limits, at least for the time

being, that pose some problems for its role in our legal system. Regarding various types of neuro-imaging, critics are right to constantly point out that such images do not give as concrete information as some experts might indicate. Images only show differences in activity in the same brain area at different times:

"An abnormal image does not tell us what is happening causally between the abnormality and the brain region, or the abnormality and the behavior in question... a brain image does not show us what criminal intent, or a "bad" thought, looks like."⁴⁹

Other problems, just to name a few, are:

Establishing what a "normal" brain looks like,
Eliminating noise biases within imaging machines,
Variation in the interpretation of data,
How the data can be presented to juries,
What data can be presented to juries,
What types of conclusions an expert witness is able to draw,
And many others.

I never argued that neuroscience was perfect, nor that it was the sole solution to a problem, but instead argued that it was but one necessary piece in the puzzle of properly accounting for conditions that seem capable of exculpating some schizophrenic patients of criminal liability based on their symptoms. My hope is that the problems schizophrenic

⁴⁹ Tancredi, Laurence R. and Brodie, Jonathan D. "The Brain and Behavior: Limitations in the Legal Use of Functional Magnetic Resonance Imaging." *American Journal of Law and Medicine*. 2007, 33:271.

delusions can pose to the necessary condition of *mens rea* has sufficiently warranted a reevaluation of the status quo in spite of the limitations of any single part of my argument.

F. Summary

Schizophrenia is a mental disorder that presents with many different symptoms and pathologies. While these symptoms come varied in expression and degree, I have argued that some affect the consciousness and cognitive abilities of individuals to a point that absolves them of agent responsibility for certain actions and so also absolves them of criminal liability for those actions. These individuals are not criminally liable for their actions because, regarding those specific actions, they lacked the capacity to form the necessary *mens rea*, and so *de facto* also lacked the *mens rea* itself. The cognitive impairment behind these and other schizophrenic symptoms is based on failure of the schizophrenic to represent thoughts of the second order—to have metarepresentations—of certain types. Contrary to arguments by some legal theorists, considerations of capacity are important in the discussion of *mens rea*. In the case of schizophrenia, these considerations are important because metarepresentational failures inherently alter or prohibit certain cognitive

capacities, and sometimes these capacities affect one's ability to form appropriate mental states toward others. Furthermore, because *mens rea* is such a broad legal consideration, and one that carries a legal burden of proof equal to that of the *actus reus*, it must be established or assumed at the outset of criminal litigation. Therefore, a better evaluation of *mens rea* must exist if we are to properly and fairly consider schizophrenic and other mentally disordered individuals for criminal liability. While the diagnosis of schizophrenia is not enough to exculpate an individual, it should be sufficient to warrant a deeper examination of capacity for *mens rea* based on the "relevant/only-because" standard I articulated above. This standard, I argue, can be evaluated on a case-by-case basis, but should be capable of a different kind of categorical determination based upon the diagnosed symptoms of a defendant. That is, a categorical scheme can and should be implemented regarding symptoms of schizophrenia (and other disorders) that mitigate some or all capacity for relevant *mens rea* in a crime. I then argue that each symptomatic standard should be upheld by court deference to neuroscientific data that accounts for the relevant impairment of metarepresentation in that symptom.

Every symptom of schizophrenia has a basis somewhere in the brain. Ideally, each one of these functional defects should be accounted for and all symptoms relevant to capacity to form *mens rea* should be included under the evaluative scheme I propose. The reasons for such changes in evaluation stem from the fact that the insanity plea is not universally recognized in our country, nor is it uniformly defined, nor do the same standards apply across states. Meanwhile, *mens rea* is a necessary condition for criminal liability in all jurisdictions, and so a universal approach to expounding upon *mens rea* will be both further reaching and more immediately tangible. It will put the mental and cognitive abilities of mentally ill defendants at the forefront of courtroom proceedings, rather than in the midst of other fact finding. Such a reevaluation can and will only benefit both our legal system and those it serves. Ultimately, even should my account fail to provide the warrant I intend, I hope it nonetheless provides warrant for continued interaction between legal theorists, psychological theorists, and neuroscientists in order to maximize fairness and respectful concern for the experience of schizophrenic symptoms in mentally ill defendants.

Conclusion

At the outset, I claimed that my goal was to show that mental capacity is a concept that can and should be better theorized in our legal system. One primary reason for better theorizing this relatively underused concept is that it will allow us to better track constantly evolving and emerging cognitive data. Much in the way that many researchers and theorists have found it useful to theorize and measure schizophrenia by individual symptoms, a useful way to evaluate mental status as our tools improve will likely be by individual capacities. A second reason to build up a better legal theory around mental capacity is that many of the terms we currently employ, such as competency, legal insanity, and diminished capacity, actually serve different and often insufficient roles. Continued implementation of these legal tools will likely continue to marginalize and underserve patients and defendants in our hospitals and legal system. Given the dramatic difficulty that comes from simply trying to understand the experience of someone suffering from severe and perplexing delusions, it only seems just that significantly more nuanced legal theory exist so as to better be able to characterize and capture her experience.

In Chapter I, I examined the notion of Decision Making Capacity, particularly in hospitals and as discussed by bioethicists. The first of two major goals within that chapter was to show one emerging area of theory that particularly involves mental capacity and already shows a good track record for informing every day medical practice, and with hopefully obvious legal ramifications. The second goal was, while arguing for and against Susan Wolf, to put forward a limited argument about how law, philosophical theory, and emerging science should interact with one another. The primary point of emphasis from Wolf's argument is that, regarding bioethics, our laws should be informed first by bioethical concerns, and not merely vice versa. The primary take away from my addendum, however, was that top down theory still has a highly relevant place in driving and directing bottom up inductive research that Wolf sees as ultimately regulating our bioethics much better than classical midlevel principlism. The third and final aim of Chapter I was to show how a closely related concept to capacity, that of competency, serves a different role and truly occupies different conceptual space. I then argued at various points that the two are best theorized separately as distinct concepts from one another, so that

they may be tested and written into our legal doctrine accordingly.

Chapter II saw a different approach to mental capacity; rather than examining a debate within bioethics the context was moved to the sphere of criminal litigation and decisions about when mentally ill defendants can be held criminally liable for their actions. The mental capacity under examination here is not that of decision making, is rather the capacity of defendants to form a particular mental state relevant to the criminal act in question. The argument broadly runs that if a mental disorder prohibits a defendant from forming or holding the particularly required criminal intent, or *mens rea*, then that defendant cannot possibly be held criminally liable. To make this argument, I confined myself to examining only two of many symptoms of schizophrenia, one of many mental disorders. My goal in such specificity was to show how highly complex and nuanced an undertaking this sort of theory of capacity will likely be, and also to show how theory, law, and cognitive science can and should coexist throughout the process. Basically, I hoped to model a bioethics of law approach to these individual symptoms. Similarly to the first chapter, I attempted to show how related legal concepts failed to do conceptual justice to

some members of our society. Specifically, the way I employ capacity for *mens rea* works almost like a hybrid of the two existing concepts of diminished capacity and legal insanity. On the one hand, it is decided at the outset of court proceedings, much like a diminished capacity plea would be, but on the other hand it exculpates the defendant of criminal liability in favor of hospitalization and treatment. The reasons for the distinction are that diminished capacity accepts criminal liability as a lesser evil often where there should be none, while the criminal insanity defense often faces strict or peculiar evidentiary rules, already assumes *mens rea* where maybe one was impossible, and is inconsistently applied across states.

Ultimately, in Chapter II I argued for a legal system whereby evaluation of mental capacity could allow for better classification of mentally ill defendants at the outset of court proceedings. Much in the same way DMC exists in degrees, I assume that other capacities exist in degrees as well, and having a neurolegal taxonomy of mental capacities would allow a highly specific legal treatment of mentally ill people encountering our legal system in the criminal context. As far as my starting point of schizophrenia, this particular illness offered some stark benefits as it has many bizarre and obvious symptoms to

choose from that are well documented and chronicled in literature across cultures. However, the illness also suffers some theoretical drawbacks in that so little is known about its physiological causes that theorizing future legal theory based on the illness itself is speculative at best. However, there seems to be more promise if we continue to look at specific symptoms and their cognitive mechanisms rather than the illness as a whole. Additionally, there are many more mental capacities that could be reasonably added to our legal doctrine than the two I have posited here. I hoped to provide a glimpse into one that is already well theorized and seeing increasingly promising results in practice, DMC, as well as one that is not fully acknowledged for its useful potential in the future. Mental capacity is a very broad and far reaching concept, but one that I hope can play more of a role in our legal theory in the future. If the amount of cognitive science being generated each year is any indication as to where our legal system is headed, then philosophers and bioethicists are going to have their hands full fitting new knowledge about our mental lives into legal doctrine and medical practice. It is an exciting time to work in such an interdisciplinary environment, but also a time in which we must begin looking to new theoretical tools that can handle

the increasing workload provided by the complex interplay between theory, data, and practice. Law, neuroscience, and philosophy would all greatly stand to benefit from adding and expounding upon the concept of mental capacity as one means of adding to that toolbox.

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