1. Introduction

In the summer of 2001, in a small town outside of Houston, Texas, Andrea Yates drowned each of her five young children in a bathtub, one by one. Yates’s psychiatrist had recently taken her off of Haloperidol, an anti-psychotic medication. In previous years, she had attempted to commit suicide and was treated for major depressive disorder. During her trial, Yates pleaded not guilty by reason of insanity, and the jury ultimately agreed. Her lawyer proclaimed the verdict a “watershed event in the treatment of mental illness,” presumably because it promoted the idea that mental illness can compromise one’s free will and thus reduce one’s culpability, even for terrible acts (Newman 2006).

Some vehemently resist such conclusions, however. Almost ten years later in Texas, Eddy Ray Routh was convicted of killing two men at a shooting range, one of whom was celebrated sniper, Chris Kyle. A former marine, Routh had been diagnosed with post-traumatic stress disorder (PTSD) and schizophrenia. His counsel sought the insanity defense, but failed to convince the jury that Routh did not know his actions were wrong. The district attorney, Alan Nash, won the jury over, stating, “I am tired of the proposition that if you have a mental illness, you can’t be held responsible for what you do” (Dart 2015).

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When and how does mental illness sufficiently undermine one’s responsibility? That shall be our guiding question. While certainly not the only interesting question one can ask about the relationship between free will and mental illness, it is one of central importance. It figures heavily in legal discussions regarding both criminal liability to punishment and civil authority for private law decisions, as well as being relevant to designing public health policy and to our ordinary practices of assigning blame. Indeed, while philosophers have traditionally focused so intently on determinism as a threat, some have turned their attention to mental illness and other brain abnormalities. Walter Glannon, for example, identifies “brain dysfunction” as the “real threat to free will” (2011, p. 69).

In this chapter, we explore how mental illness affects the aptness for attributing responsibility to individuals as well as the justification for holding them responsible for their acts. We begin in Section 2 by tackling some preliminaries, both to refine our guiding question and the parameters relevant to that inquiry. In Section 3, we consider when mental illness surely excuses. In Section 4, we consider conditions that don’t excuse agents from responsibility. Section 5 looks at how the answer to the question might vary depending on one’s theory of responsibility. And Section 6 considers special cases in which a mental illness might actually enhance one’s responsibility. We hope to show both the subtle complexity involved in our guiding question, as well as the exciting nature of the discussion.²

2. The Naïve View

Philosophers commonly treat mental illness as an excusing condition. Galen Strawson, for example, identifies mental disorders as paradigm constraints on one’s freedom, including “kleptomaniac impulses, obsessional neuroses, desires that are experienced as alien, post-hypnotic commands, threats, instances of force majeure, and so on” (1994, 222; quoted in Meynen 2010). Similarly Daniel Levy (2003) labels many disorders as “maladies” of free will, including PTSD, Tourette’s, schizophrenia, alien hand, bipolar disorder, and obsessive-compulsive disorder.

Mental illness may always affect responsibility to a small extent, whether by influencing one’s choices or one’s control over outcomes. But many other factors may be relevant to some degree without mitigating blame, including one’s immediate environment, culture, genes, and mood. For example, while some emotions may hinder self-control, one is normally still fully blameworthy for, say, attacking a child during a fit of rage. What interests many philosophers and policymakers is: When does a factor, like mental illness, affect one’s capacities and abilities to a sufficiently high degree that it mitigates or eliminates responsibility?

It can be tempting to think mental illness always excuses. Responsibility and blame are the provinces of desert and punishment, and mental illness is a prime

² Our discussion is of mental illness generally, and so does not focus on any particular disorder or set of disorders. In particular, despite their relative popularity in philosophical discussions, we give no special attention to psychopathy or addiction.
candidate for removing someone from the ordinary social practices in which these notions operate. The mentally ill are to be treated, not punished. Call this the naïve view. This view has simplicity in its favor, and it treats the mentally ill as a rather uniform class. On the strict interpretation, this view holds that mental illness always exculpates, while the weaker interpretation merely extends mitigation across the board.

What has the naïve view got going for it? At least some mental illnesses, as recognized by the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-V), do seem to give (obvious) full excuses. Consider, for instance, narcolepsy, characterized by abnormal sleepiness during the day or lapses into sleep, and often accompanied by cataplexy, or sudden muscle weakness that often makes patients collapse. Suppose a narcoleptic is prone to sudden, unpredictable cataplexy, and during one such episode, drops the priceless vase he was carrying. Ordinarily, one might be blameworthy for dropping a vase. But it seems the narcoleptic has a ready, and full, excuse. His narcolepsy excuses him in a way that one who simply tripped or was distracted is not.

Despite this initial support, we must be careful not to generalize too quickly. The worry here is that ‘mental illness’ does not denote a homogenous class. Different illnesses have different properties, they affect different capacities, and the ways they affect those capacities can vary widely (cf. Feinberg 1970; Arpaly 2005; Meynen 2010). It would be surprising if, despite these differences, they all amounted to full excuses. Considering Tourette’s syndrome is instructive. Many people assume tics are entirely unintentional or involuntary and thus clear candidates for excusable actions not performed of the patient’s own free will. But patients with this syndrome often report acting voluntarily; it’s just increasingly difficult to overcome the impulse (Schroeder 2005). While those with Tourette’s syndrome may still lack responsibility for their tics, this case illustrates that matters are often more complicated than they seem. So the naïve view is just that, naïve, for it fails to draw any meaningful distinctions between different types of mental illness.

We can emphasize the point by reconsidering narcolepsy. The reason it seems to excuse so completely is that the narcoleptic’s condition is relevant to his dropping the vase in a way that does not hold true of every mental illness. Contrast narcolepsy with someone suffering from obsessive-compulsive disorder (OCD) who experiences intrusive and unwanted thoughts (which cause anxiety). In many cases, even an episode of such intrusion will have no bearing on their ability to carry the vase. And so their mental illness will not significantly affect their responsibility for dropping the vase, should they drop it. Thus, it seems that one’s mental illness must not only compromise a capacity relevant to responsibility, but it also must be relevant to the act in question. As Joel Feinberg puts it, even if exhibitionism is “an excuse for indecent exposure,” this wouldn’t be “a plausible defense to the charge of income-tax evasion” (1970, 273).

If the naïve view is not plausible, we must look more carefully at the distinctions among kinds of disorders, as well as the features of individuals most
relevant to their responsibility. Alas, simplicity must give way to complication.3 In the next section, we consider some illnesses for which it is plausible that they always (or almost always) excuse. While there is tremendous variation in extant philosophical accounts, there is broad consensus about the sorts of things that matter to whether one is responsible or not. We also draw some distinctions between kinds of disorders useful for supporting some rough generalizations about how they excuse.

3. When Illness Surely Excuses

Moral responsibility is importantly tied to agency. It seems only agents can be responsible for their actions (in the relevant sense), and, importantly, it seems that when individuals are responsible for an action it is due to features of their agency or its exercise. Agents believe things, intend things, and desire things. They make and revise plans, reflect on their motivations, and judge ends to be more or less worth pursuing. They seek to make their actions intelligible and conform to norms they accept. At least some of these are likely part of the story for why it is that responsibility requires agency.

Mental illness surely excuses, then, if its symptoms yield an action that bypasses one’s agency. Narcolepsy is again an obvious example given that it can result in outcomes that were either the result of no action at all or an entirely unintentional one. One might also include dissociative identity disorder as an example of a mental illness that can unequivocally excuse. After all, the dominant personality might seem to lack any responsibility for the actions of what appears to be a distinct mind in the same body. Some patients with this condition have failed to avoid criminal liability, but others have succeeded—one for kidnapping an infant from a hospital (see the 1993 “Denny-Shaffer Case” in Sinnott-Armstrong & Behnke 2000). In any event, dissociative identities pose difficult questions about personal identity that must be settled prior to assessing the responsibility of a given individual.

Other disorders might clearly excuse yet involve more of one’s agency. For example, in the famous case of Clark vs. Arizona (48 U.S. 735 2006), the defense argued that Clark did not kill the police officer intentionally because he thought the officer was a space alien, due to his paranoid schizophrenia (discussed in Morse 2011). Now the Supreme Court thought Clark still knew this was wrong, but other delusions might lead one to do something that, from their own delusional perspective, should be counted as morally permissible. People who suffer from schizophrenia often have delusions and hallucinations that preclude a proper understanding of what they are doing. In such cases, while certain aspects of agency

3 It is worth noting that many disorders have high comorbidity with other disorders. This introduces further complications, since in any particular case there may be multiple disorders at work, all or only some of which may be relevant to the conduct in question, and relevant in differing ways. Moreover, while one disorder might not itself exculpate under the circumstances, multiple disorders in combination might.
are required to commit an act, say of homicide, the defendant may not have known he was doing so. Having the relevant belief about what one is doing is a core component for intentionality, which greatly informs judgments of wrongdoing and blame (Cushman 2008).

These cases ignore various complexities, however. There are many ways in which mental illnesses might (or might not) affect or undermine the exercise of one’s agency. To begin, it is useful to draw two cross-cutting distinctions that can be applied to categorize how disorders might present themselves. First, a disorder can be episodic or static. Episodic disorders present themselves in (more or less) discrete instances. Narcolepsy, again, is a good example. The associated loss of consciousness comes in discreet instances. Though a narcoleptic is always possessed of their condition, it is only episodically activated, as it were. Other examples might include dissociative identity disorder, PTSD, bipolar disorder, and various phobias—each of which can manifest in discrete episodes, sometimes in response to specific triggers.

In contrast, some mental illnesses are more static, like autism, depression, psychopathy, dementia, and generalized anxiety disorder. The ways in which they affect their possessors is more likely to persist over time, with no clear boundaries. Perhaps their effects can wax and wane, but we wouldn’t (at least naturally) carve them up into discrete episodes.

The second distinction concerns the degree to which a disorder impinges on one’s agency. Narcolepsy, for example, has quite global effects: loss of consciousness undermines the affected agent’s abilities across the board. In contrast, certain disorders may only be relevant to a subset of agential abilities, yielding more local effects. For instance, kleptomania, as a compulsion, presents as strong urges to steal, but it leaves other elements of an agent’s psychology relatively untouched. Specific or “simple” phobias are another kind of example, as they are tied to certain cues, e.g. spiders, heights, or blood.

These distinctions cross-cut, so either element of each can pair with either element of the other. Narcolepsy is an episodic, global condition, while severe schizophrenia may be a static condition, but still with global affects. Anxiety disorders may have localized effects, despite being static conditions, while some episodic conditions, like specific phobias, will similarly only present locally.

Drawing these distinctions is important for helping us refine our guiding question. We can differentiate between global disorders that preclude responsible action in any context and those that don’t. In addition to narcolepsy, conditions that involve constant severe delusions, like schizophrenia, or those that seriously affect a whole host of cognitive abilities, like dementia or dissociative disorders, may also belong to this category. The principal considerations here are whether the condition operates globally on an agent’s capacities or takes a limited scope, and whether it operates in episodes (like narcolepsy) or as a passive condition that persists (like catatonia). A disorder that only affects some subset of an agent’s abilities or whose primary effects are distributed into discrete episodes may still allow an individual significant opportunity for responsible action elsewhere.
4. When Illness Doesn’t Excuse

Mental illness will not so clearly excuse wrongful acts when it doesn’t bypass one’s agency entirely. Consider, for example, attention-deficit/hyperactivity disorder (ADHD), which, in addition to children, afflicts some adults. ADHD does not appear to disrupt one’s general capacity to form intentions and act on them. When someone with this disorder acts, they do not necessarily have diminished control. One’s ability to focus may be limited, but this may not distinguish ADHD from more ordinary conditions like being tired or upset. In this way, focus is not obviously a core aspect of one’s agency. (Various mild forms of anxiety disorders may be similar in this respect.)

Moreover, some wrongful acts do not chiefly involve the capacities that a disorder affects (locally instead of globally). Suppose an adult male with ADHD assaults an individual at a sporting event after an angry confrontation that escalated from a disrespectful gesture into violence. ADHD involves difficulties in paying attention, staying focused, and organizing one’s life for success in, say, school or work. Given the nature of this disorder, it is unlikely that it played a crucial role in generating an aggressive action, especially one that would typically arise in anyone without ADHD, as it simply involves normal emotional reactions to a show of disrespect.

Now, ADHD can involve increased impulsivity, in which case the symptoms of the disorder may play a crucial role in an act of aggression. A similar analysis seems appropriate for conduct disorders affecting impulsivity, such as kleptomania, which can obviously play a key role in an act of stealing. Even if it’s controversial whether kleptomania can excuse or mitigate responsibility, this is a case where the disorder quite clearly influences the act in question, such that someone in similar circumstances but without kleptomania likely would not steal. In the same vein, however, kleptomania would appear irrelevant to a case of acting out of aggression.

Another reason mental illness clearly doesn’t always excuse lies in the notion of capacity. By definition, mental disorders affect mental capacities, and some of these capacities are integral to freedom and responsibility. However, diminished capacity does not entail lack of capacity (Glannon 2011, ch. 3). Many disorders, such as autism, involve a varied spectrum. Some patients with autism may appropriately be described as having an inability to pick up on non-verbal social cues or even navigate the social world successfully whatsoever. Others, however, have only a minor deficit in this respect. Indeed, many disorders—from depression to bipolar disorder to psychopathy—are recognized to present along a “continuum”. The upshot is that, for many disorders, being diagnosed does not necessarily affect one’s responsibility. Regardless of theoretical differences, sometimes the symptoms will be so slight so as to hardly diminish a relevant mental capacity.

One might go further and argue that mental illness will rarely excuse, because once one becomes aware of the disorder one has a responsibility to manage its affects. Suppose, for example, that a patient with schizophrenia responds well to
treatment with an anti-psychotic medication like loxapine. If she discontinues use, however, she typically has haunting hallucinations that cause her to violently attack those around her, misperceiving them as imminent threats. In such cases, where symptoms are expected and their effects can be mitigated, one might be responsible for harming others, even if it is due to hallucinations, because the patient knows such situations can be prevented by staying on the medication. In such cases, we might attribute responsibility for an outcome that resulted from diminished agential capacities by transferring the responsibility one has for not allowing those capacities to diminish in the first place (cf. the “transfer principle” in Summers & Sinnott-Armstrong forthcoming).

However, such scenarios may be rare, as symptoms often first present without warning or can't be managed anyhow. More importantly, even when one can knowingly manage symptoms, it remains controversial how best to justify transferring responsibility to outcomes from failures to take suitable precautions (King 2009; 2014).

5. When Illness Might Excuse

Unsurprisingly, there is an enormous philosophical literature on the necessary and sufficient conditions for responsibility. We cannot possibly canvas it all here. Instead, we propose to highlight a few features of agency that different theories of responsibility have emphasized, exploring the ways in which different disorders will be more or less threatening to those features. The aim is not to present a thoroughgoing typology of theories, but rather to examine some ways in which the answer to whether or not mental illness excuses may be theory-dependent.

We will focus on three features of agency that are central to discussions of moral responsibility: choice, control, and coherence. These features may overlap, and there is certainly room for disagreement as to which are necessary for moral responsibility. But, as our aim here is not to adjudicate between competing theories, we will speak fairly broadly, hoping to consider elements familiar to a wide variety of approaches to the questions of free will and responsibility. (Additionally, we are skeptical that a single theory's preferred feature of agency can be privileged as the common sense thinking on the matter—cf. May 2014.)

Some theories emphasize the notion of a free choice between genuine options. On such approaches, what responsibility requires is that the agent select from a range of available alternatives, electing and enacting one of them, unconstrained from external forces (Kane 1996). Accounts will vary, of course, as to the strength and stringency of these requirements. Nevertheless, these views often stress the agent's ability to consider a range of actions they might perform, and choose without constraint which one to execute. (While not required, these accounts tend toward accepting the incompatibility of responsibility and determinism. The thought is that determinism would preclude alternatives from which an agent could meaningfully choose.)
Other theories focus less on choice among alternatives and more on exercising effective control. On some views, it is appropriately recognizing and responding to the reasons one has (Fischer & Ravizza 1998). Other views favor characterizing control as a power to cause one’s actions in a particular way (Clarke 1993). Uniting these views is the thought that the realm of the intentional is unique and uniquely important for responsible agency. Responsibility for what we do depends on our ability to identify and assess reasons, reasons upon which we can then act. These views also highlight how lack of control often undercuts one’s responsibility. When an agent does something entirely by accident, it looks as though they are (to some extent) excused.

In contrast to the way in which an action or choice is brought about, some views of responsibility emphasize the coherence the action (and its motivations) has to the agent’s psychology (Frankfurt 1971; Wolf 1987). Actions can reflect or express aspects of an agent’s psychology to varying degrees and mental states can be more or less well-integrated into the agent’s overall psychology. The guiding thought here is that an agent is more responsible the more reflective of their moral selves their action is or the better integrated its motivation is. A deeply committed racist is all the more blameworthy for their racist remarks than one who makes an out-of-character insensitive comment. Responsibility is undercut, therefore, when the action fails to manifest the agent’s real commitments and values.

To see why the answer to whether mental illness excuses may be theory-dependent, it will help to consider some disorders. Take OCD, for example, which is characterized by obsessions (persistent and unwanted thoughts or urges within an individual) and compulsions (repetitive actions performed as responses to obsessions). Should someone who suffers from OCD be excused from, say, knowingly breaking a promise to attend his daughter’s piano recital in order to repeatedly wash his hands?

The answer seems to depend on which view we adopt. On views that stress the importance of choice, the fact that an action is a compulsion seems prima facie excusing. It isn’t that the agent freely selected among their options. Instead, their options were unusually constrained, much in the way a bank teller has no choice but to hand over the money at gunpoint. Similarly, on some control-based views, one may be excused if the nature of the compulsion undercuts the agent’s ability to recognize or respond to the relevant reasons. The compulsive behavior quiets an intrusive urge, rather than reflects what the agent had most reason to do.

In contrast, a control-based view that only requires the agent to control the action intentionally by exercising special causal powers could still find the compulsive responsible, if the action was brought about in that way. Most strikingly, perhaps, on a coherence view, nothing internal to the view prohibits agents from endorsing or identifying with the obsessions that motivate their behaviors. It is thus possible for such agents to achieve the sort of integration required to be responsible, even if OCD will likely excuse on most versions of a coherence view. (Indeed, OCD often varies in the degree to which patients have insight to their
disorders. Those with higher insight are presumably more aware of the irrationality of the obsessions, and so may be less likely to identify with those desires.)

Not all disorders will garner these same results. Consider major depressive disorder, partially characterized by experiences of prolonged depressed moods for most of the day, lowered motivation to engage in activity, weight loss, and feelings of worthlessness. On coherence views, such agents may be excused, for their motivations to remain indolent or shun interaction are not well integrated into their overall psychology. Nevertheless, depressed individuals may have no problems controlling their conduct, even when depressed. Their depression need not inhibit their ability to perform actions for reasons of which they are aware or to bring actions about via special causal relations. Whether or not a person with major depressive disorder is excused depends on the details.

More generally, theories premised on coherence must address whether a mental disorder expresses or masks one’s true self. Yet, as Jeanette Kennett (2007) points out, a patient’s loved ones often say, “He’s not really like this” or make similar proclamations. Many mental illnesses (e.g. schizophrenia and dementia) set in well after one has an established personality and identity. Other disorders may be more difficult to dissociate from one’s real self, especially those that tend to develop early in one’s life, such as autism, Tourette’s syndrome, and various antisocial personality disorders. Theories that do not rely on a real self, however, need not grapple so much with this issue. For example, someone with kleptomania may exhibit sufficient control over stealing some jewelry, whether or not it issued from her true self.

Just as we cannot canvas every approach to moral responsibility, we cannot consider here every disorder. We hope to have provided merely a sampling of the ways in which mental illnesses might excuse, depending on the particular approach to free will or moral responsibility employed.

6. When Illness Enhances

We often associate mental disorders with deficits in various capacities. However, what might normally disrupt an ordinary person’s life may turn out to be beneficial in certain circumstances. Or, even if categorically harmful, mental illness may elevate certain capacities beyond the norm, such that, surprisingly, one becomes, as Stephen Morse puts it, “hyper-responsible” (Morse 2006). Here we may find parallels with the enhanced responsibilities of those possessing advanced skills or knowledge (Vincent 2013), as when we hold only physicians accountable for failing to provide medical advice for someone ill on an airplane. Perhaps enhanced capabilities merely increase the number or kinds of responsibilities, rather than degrees of responsibility itself (Glannon 2011, p. 120). Nevertheless, enhanced responsibility results from an increase in mental capacity, whether from learning, ingesting a pill, or mental disorder.

Conditions that increase attention are natural candidates. Consider, for example, disorders involving episodes of hypomania, such as bipolar disorder (cf.
Morse 2006; Vincent 2013). Unlike mania, episodes of hypomania don’t severely disrupt one’s life, but in either case patients often need much less sleep (e.g. “feels rested after only 3 hours of sleep”), have a “flight of ideas,” and increased “goal-directed activity” (DSM-V, 124). Some of these symptoms read as desired effects of cognitive enhancers, like amphetamine or modafinil, even if they can be rather disruptive in many contexts or when combined with other typical symptoms (e.g. engaging in risky behavior). However, it is important to note that patients often don’t have knowledge of, or control over, when they will have any purportedly enhanced capacities during hypomania, and thus it may seem inappropriate to hold them more accountable (Turner 2010), at least in many circumstances.

Perhaps this is less of a limitation for another candidate for enhancing responsibility: OCD. The obsessive thoughts are often tied to a specific anxiety or source of distress, such as uncleanness (e.g. excessively washing hands) or danger (e.g. locking a door repeatedly). Those with scrupulosity, in particular, are especially concerned to behave morally, often concerning others believed to be in need (Summers & Sinnott-Armstrong forthcoming). Such hyper-awareness and sensitivity to morally relevant considerations may, in certain circumstances, enhance capacities relevant to freedom and responsibility. For example, suppose Saul leaves the door unlocked and a family of raccoons ransack the house. We might hold Saul more responsible given his hyper-awareness of whether the door is locked. Similarly, while we might praise Sally for mindlessly locking the office door and preventing a robbery, we’d likely praise Saul even more if it resulted from his heightened concern for safety.

Finally, simply having a mental disorder might put one in position to incur special obligations yielding a kind of enhanced responsibility. For example, those who are autistic, like Temple Grandin, are in a better position to know what it’s like to deal with autism and the special challenges one faces in daily life. Grandin’s family might not hold an old man accountable for hugging her after she helps him find his lost dog, but they would expect a friend with autism to know better. (Compare holding one’s grandfather less responsible for his racially insensitive remarks, because he “doesn't know any better.”) Having a disorder can make one more in control or aware of social situations involving others who have similar experiences, preferences, and goals.4

7. Conclusion

Let’s briefly return to the legal cases with which we began. Since these are actual events, they are complex and we certainly lack sufficient evidence to know all of the relevant facts. Nevertheless, we can try to apply some of the lessons developed here. In both cases it is plausible that symptoms from their mental illnesses did contribute to the criminal acts in question. In Yates’s case, her psychiatrist warned

4 In addition to affecting the role of excuses, then, mental illness may also be important to a full understanding of the ethics of blame, those norms and principles governing our interpersonal practices of holding each other responsible.
about having a fifth child when Yates attempted to commit suicide soon after having her fourth. So it seems her major postpartum depression and various delusions plausibly contributed to her intention to end her children’s lives just months after the birth of her fifth. In Routh’s case, his PTSD plausibly contributed to the murders, as his attack was on two military veterans at a shooting range. However, arguably these illnesses do not typically yield actions that bypass one’s agency entirely. Thus, as far as morality is concerned, we may unfortunately be left with theory-dependent considerations—e.g. about whether these defendants lacked sufficient choice, coherence, or control. Arguably, these are precisely the sorts of considerations to which the law should be sensitive, even if current practice has yet to be suitably responsive.

Our discussion of mental illness and moral responsibility has revealed that there is no simple or essential connection between these two notions. We concur with Nomy Arpaly, who writes that, “while many mental disorders do seem to provide exempting, excusing, or mitigating conditions, some do not, and with others things are complicated” (2005, 291). This may appear harsh on the victims of mental illness, suggesting that there are many circumstances in which they are responsible, even for acts substantially influenced by their symptoms. However, the more nuanced picture developed here also allows us to treat many who suffer from mental illness as autonomous agents whose decisions about how to live we should respect. This fits with the movement to refer to people as having mental disorders—e.g. a “person with schizophrenia”—rather than as being essentially disordered—e.g. a “schizophrenic” (Morse 2011). It also points to ways in which those with mental illness may exist on a spectrum with the more ordinary agent, who nonetheless may be exhausted, hungry, or prone to distraction, recalcitrance, or fear.5

5 For helpful feedback on earlier drafts, we thank: Justin Caouette and Jesse Summers.
Related Topics
Marginal Agency, ...

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**Suggested Readings**


