THE

OF THE STORM

BEHAVIOR THAT USED TO BE CONSIDERED UNETHICAL OR IMMORAL IS NOW OFTEN BLAMED ON ILLNESS AND NOT THE INDIVIDUAL. WHAT'S THE LINE BETWEEN BEING WRONG AND BEING ILL? WHEN DO THE BAD GUYS TURN INTO THE SICK GUYS?

PSYCHOLOGY

By MELVIN KONNER MD

When I heard that Wade Boggs, the Boston Red Sox third baseman, had publicly declared himself a sex addict, it set me to brooding about responsibility.

Now, I admit I'm inherently lazy. Not enough to avoid thought altogether, but enough to keep it within certain channels. Boggs, however, got me thinking about some questions I had not taken an interest in since college. For 20 years or so I've been thinking about human behavior scientifically—first in anthropology, later in medicine. I was interested in the *causes* of behavior—normal or abnormal. If you could explain what caused a behavior, you could, if you wanted to, try to change it with some sort of treatment.

But the notion of Wade Boggs as a sex addict brought me up short. I knew about sex addiction, but (like most health professionals, including most psychiatrists) I was dubious about the category. I associated compulsive sexuality *as an abnormality* with women who were allowing themselves to be widely and consistently used. I knew that there were compulsively promiscuous men, but I just thought of them as bad guys. In a world where the risk of sex is so much greater for women, and where men typically have more power, my natural impulse didn't lean toward medical sympathy for fellows like Boggs. I suppressed the possibility that a medical explanation existed.

Of course, this was naive; in a few minutes I myself could have chosen a label from the American Psychiatric Assn.'s official diagnostic manual—probably something in the range of impulse-control disorders, although a more pervasive personality disorder might produce the same symptoms. But in the case of Boggs' celebrated affair with Margo Adams, for some reason I tried to avoid labeling. I thought back on others who have come, at a certain point in life, to regret the sexual excesses of their youth—St. Augustine, for instance, and Leo Tolstoy. But here something was missing. *They* were saying words like, *I did something very wrong. I repent of it now. You should think ill of me, and you probably should punish me—with censure, if nothing worse—but please, ultimately, forgive me.* I tried to understand why this bothered me; it was not merely the spectacle of a powerful man abusing his power and then requesting sympathy. What troubled me was the medical question at the heart of the spectacle: How much can the concept of illness expand at the expense of the idea of responsibility? When do the bad guys turn into sick guys?

Although the question ranges far beyond that of illegal acts and into the realm of the purely moral, most Americans have had this issue brought to their attention in the 1980s by two celebrated criminal cases. First John Hinckley, who had attempted to assassinate President Reagan, was determined by some court psychiatrists to be / *Continued on Page 36*

ILLUSTRATION: HUGH SYME

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mentally ill—and more important, to be mentally ill in a way that meant he was not guilty as charged. Interestingly, a then-new technique known as computed tomography—CT scanning—was used to study his brain, and it showed what some experts called an abnormal shape, pointing to a greatly expanded future—even futuristic—role for technology in answering moral questions. Second, Dan White, who had killed the mayor of San Francisco and one of his aides, claimed in his defense that he had eaten a junk food diet high in refined sugar, and that this diet had diminished his ability to restrain his violent impulses—the celebrated "Twinkie defense." This suggested that almost any medical fad, however poorly supported by evidence, could influence the judicial process.

Both defenses convinced the courts, and there are similar cases all the time. They come up within a framework of legal reasoning that emerged in the 19th Century, often referred to as the M'Naghten Rule (pronounced "MikNAW-tn"). Daniel M'Naghten, in a crime foreshadowing the Hinckley case, had attempted to kill the English Prime Minister in 1843. M'Naghten had been in the grip of paranoid delusions, but his exculpation produced a public outcry as well—despite the fact that he was committed permanently to an asylum. A committee convened by Queen Victoria arrived at the first formal rules for an insanity plea: The accused had to not know either "the nature and quality of the act" or the fact that "he was doing what was wrong." Later an emotion-based defense was added to the essentially knowledge-based approach of M'Naghten. Although it is usually called "irresistible impulse," the emotion does not have to be sudden for this defense to work. The main point has to do with the loss, due to "mental disease or defect," of the power to choose.

Together these rules made it possible for mental illness to bring a person under the protection of two ancient legal concepts: ignorance and coercion, either of which, in certain circumstances, could limit guilt for crime. In the legal tradition that has come down to us today, mental derangement—temporary or long term—can be used as evidence that the defendant was in the grip of an "irresistible impulse," or that the illness so clouded his judgement that he was ignorant of the moral meaning of what he did as he did it—in the common phrase, "he couldn't tell right from wrong."

Wade Boggs' self-confessed "sex addiction" is no crime, but a wide spectrum of acts of questionable morality—whether legal or not—are now falling under the rubric of "illness." Even as certain categories of human behavior—homosexuality in America, for instance, and perhaps now political nonconformity in the Soviet Union—are being "delisted" from the ranks of psychiatric categories, new diagnoses are being added. Increasingly, doctors—rather than pastors or prosecutors—are taking charge of these acts by labeling them with a new kind of language. And with these labels they are shaping our emotional reactions to deeds that we once would have said, quite simply, were wrong.

Consider three cases. Once, in a medical school psychiatry clerkship, I attended a hearing in which the state was trying to show that a man convicted of homicide but found to be mentally ill should continue to be kept in a prison hospital for the criminally insane. His family retained a lawyer who presented a theory of why the young man had gone on a rampage assaulting a series of people with an ax. The lawyer had read some studies claiming to show that too much copper was a cause of irrational violence. Now, the young man was said to have drunk enormous amounts of milk as a child. According to other studies, milk reduced the absorption of copper. Since, went the theory, an excess of copper could cause violence, probably a deficiency of copper could too.

This extremely far-fetched argument was not successful—indeed, it was difficult to see its purpose, since the young man was already deemed mentally ill, and was being given treatment rather than (merely) being / *Continued*

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imprisoned. Yet I was stunned: a completely baseless and self-contradictory "scientific" argument was politely heard by all concerned, with no form of reprimand to the lawyer, who had no basis for a claim of expertise.

A year later, returning to the same prison hospital with a psychiatrist-teacher, I helped him interview a young man who had confessed to killing a woman when she reprimanded him for urinating on her lawn. He had been working for a lawn-care company, and was apparently exposed to large quantities of organic phosphates, which he was required to handle as fertilizer. The psychiatrist was preparing a case based on the notion that the organic phosphates in the fertilizer had given the man an uncharacteristic violent impulse. I pored through the doctor's stack of copied research papers. Organic phosphates in large doses certainly could cause nerve damage, which the young man did not have. Rarely, they had apparently caused brain damage too, but almost always in association with nerve damage. Nowhere in the literature was there a case of brain damage caused by organic phosphates and resulting in violence.

I couldn't help thinking that 30 years earlier a psychiatrist with a Freudian orientation would have seized on the interpersonal situation—a young man urinating in the wrong place is surprised and reprimanded by an older woman—and related the violent outburst to deep problems stemming from his childhood, complete with Oedipus complex and castration anxiety. Now, in the '80s—the era of biological psychiatry—we had instead an equally tortuous, and equally unsupported, biochemical theory.

The third case came closest to home. I was approached by a criminal defense lawyer and asked to testify on behalf of his client. This was a man who, under supposedly extreme provocation, had killed his lover in a fit of jealousy. The lawyer had read a book of mine about human nature, in which (among many other things) I described situations similar to his client's as occurring in cultures throughout the world, and indeed as having parallels in many animal societies. He wanted me to testify to these facts of anthropology, which he would then argue diminished his client's responsibility for the homicide. This was not an insanity defense, but intended instead to show that the man did not have "mens reus"—the criminal intent needed for complete guilt.

I wrestled with the ethics of this gambit: Would I be wrong to lend myself to it? Or, in our advocacy system of justice, would I be wrong to refuse to state what I knew?. But then I was let off the hook by the lawyer, who had found another defense. This too was instructive: his client had taken barbiturates by prescription before the crime, and they had found a psychiatrist who would testify that this could have impaired his capacity to act in accord with the law. The lawyer did not want to confuse the jury by invoking two sorts of exonerating expert testimony, and he was more comfortable with a psychiatric theory of an abnormal state of mind than with an anthropological theory of a passionate, predictable one.

Either way, and in every one of these cases, the decision should be made by a judge and jury. Only the common sense exercised by the jury and the common law interpreted by the judge should count, not the expert testimony. But in reality judges and juries are influenced by experts—including those who go far beyond scientific knowledge in their testimony. And in the cases like Boggs' noncriminal questions of moral judgement, we as a society, and even ethical advisers like ministers, priests, rabbis and teachers are inevitably influenced by changing cultural concepts of illness and responsibility. The extremes in this controversy

were staked out by many years ago. Karl Menninger, a distinguished psychiatrist for whom (among other physician family-members) the famous clinic in Topeka, Kansas is named, has been a longtime advocate of the use of medical diagnoses of criminals. He wrote as early as 1928, "the time will come when stealing and murder will be thought of as a symptom, indicating the presence of a disease, a personality disease." And almost a half-century later, in response to the notion that wicked people exist, he said, "I don't believe in such a thing as the 'criminal mind.' Everyone's mind is 'criminal'; we're all *capable* of criminal fantasies and thoughts."

By the late 1950s psychiatry was at the peak of its power. Freudian psychoanalytic theory, in a modified American form, appeared to have won the day, and the courts were showing signs of accepting Menninger's thesis. Clergy, for their part, were mastering the art and science of psychotherapy. We seemed, as a culture, to have gone well down a path toward defining—medically—wickedness out of existence, and with it, punishment. There would only be illness, treatment, and ultimate reintegration of the normalized individual into society. The courts and the churches alike were scrambling to avoid being left behind as the new science led the community in a race out of the sphere of moral judgement, having jettisoned outmoded concepts like responsibility.

Just at this moment Thomas Szasz—a psychiatrist who has been his own profession's most severe critic—appeared on the intellectual landscape. His 1961 book, "The Myth of Mental Illness," challenged almost every aspect of psychiatry and publicly declared its legal authority to be illegitimate. The book's subtitle, "Foundations of a Theory of Personal Conduct," was significant. "Human behavior," he wrote, "is fundamentally moral behavior." He argued that individuals must be allowed to take / *Continued*

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drugs, commit suicide, and do harm to others without prior restraint and take the consequences of their acts—addiction, death, or the full force of the law—regardless of psychological conditions. "The concept of mental illness," he wrote elsewhere, "is betrayal of common sense and of an ethical view of man."

A summary added to the book in 1974 stated, "Psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others" and, "The introduction of psychiatric considerations into the administration of the criminal law—for example, the insanity plea and verdict, diagnoses of mental incompetence to stand trial, and so forth—corrupt the law and victimize the subject on whose behalf they are ostensibly employed." Szasz, like Menninger, has been consistent over the course of a long career. In 1972, he wrote an article in the British medical journal, The Lancet, called "Bad Habits Are Not Diseases." And in a letter to the New York Times published on June 12, 1989, he wrote that even the most severe crack addicts, if violent, are "criminals first and patients second, if at all."

Partly under his goad, and further stimulated in the '80s by the Hinckley case and the "Twinkie defense," a public outcry has altered the insanity plea as it stood in common law and in the Model Penal Code of the prestigious American Law Institute. The penal code in the 1950s helped standardize the common law traditions and affected law in many states but its influence has weakened since Hinckley. The American Bar Assn. and the American Psychiatric Assn. both proposed an elimination of the "irresistible impulse" rule. In 1984 the Federal Criminal Code adopted this suggestion, and also abandoned the wording "substantial incapacity" in favor of "complete incapacity." In practical terms very few cases were affected—most crimes are tried under state law—but the message was influential. More than half the states, including California, have followed suit on "irresistible impulse." In addition, several states have adopted a new verdict: "guilty but mentally ill," which defense lawyers feel destroys the insanity plea, undermining a traditional pillar of justice.

This public reaction against the insanity plea was understandable; highly publicized cases had begun to make it seem as if the very idea of right and wrong was being abandoned. Yet the reaction was based in part on major misconceptions, which could swing the pendulum too far away from the psychiatric concept of criminal actions—a highly legitimate approach in certain situations. But before one passes judgement on the insanity defense, three things should be considered. First—contrary to Menninger's sweeping prediction, and despite the famous cases—only a fraction of criminal defenses invoke the insanity plea, and only a fraction of that fraction succeed. Also, studies of arrests show that few crimes, and even fewer violent crimes—under 5%—are accounted for by former mental patients. Popular fears aside, few mental patients are dangerous. Second, experts are not in charge of the decision—a jury and judges are in charge. They review the evidence, hear the expert testimony on both sides, and make the kind of judgement that courts have made for centuries before psychiatry was invented. Third, a successful insanity defense need not "get the guy off the hook and out on the street" promptly, as many fear. On the contrary, this outcome is rare. In almost all states a verdict of "not guilty by reason of insanity" requires at least the consideration of commitment, and in some, commitment is mandatory.

The recent near-release of Arthur Jackson from prison shows what can happen if a sick criminal is *not* medically labeled. Jackson was convicted of attempted murder in the 1982 assault of actress Theresa Saldana outside her West Hollywood apartment. Though he attacked her with exceptional brutality—stabbing her so hard and so many times that his hunting knife bent—and then, while in prison, repeatedly threatened to kill her upon release, Jackson was about to be released early from an ordinary criminal sentence, for good behavior. In June, however, the California Board of Prison Terms delayed his parole for 270 days for breaking prison windows and resisting guards' efforts to subdue him. Jackson had a long history of mental illness before the assault. Ironically, if he had been found guilty by reason of insanity, his continuing psychosis would have allowed authorities to keep him behind bars in a prison mental hospital indefinitely.

The idea of using the concept of illness to lengthen detention beyond what the criminal sentence would have dictated is anathema to civil libertarians. Yet it was narrowly supported by the Supreme Court in 1983, and it may be the most appropriate response in many cases. Some violent crime *is* the result of mental illness. If detention and deterrence are two of the goals of justice, then they may sometimes be attained more effectively through a medical approach.

In the heyday of psychiatric exoneration, psychiatrists claimed to know more than they knew. They claimed to be able to predict future behavior, and to be able to cure the mental illnesses that cause crime. As is pointed out by Szasz and by Jonas Robitscher, who was doubly trained in psychiatry and law, these claims were greatly exaggerated. Robitscher's 1980 book, "The Powers of Psychiatry," showed some of the limits of the claims, and studies over the past decade have proven him right. Prediction is almost impossible, cure is always partial at

best, and even diagnosis cannot be agreed upon by experts in conflict. In Robitscher's words, "the medical basis for psychiatric authority must continue to be questioned."

Nevertheless, such authority must also continue to be considered. If cures for most mental illnesses elude us, diagnosis is in a more advanced state—much better, in fact, than it was even in 1980. Judgements must somehow be both moral and medical. If a jury identifies a crime, it can, with the consultation of experts, also identify an illness. Whether the illness is treatable, resulting in a shorter period of incarceration than simple imprisonment, or untreatable, resulting in a longer detention, a fair approach to wrongdoers cannot omit this consideration.

Yet medical labeling must not result in the elimination of punishment. This threat must enter the mind—however diseased—of every person who contemplated a wrongful act. In a world of uncertainties, only capital punishment seems unacceptable; it obviously differs from institutionalization in a way that imprisonment does not. In fact, our frequent inability to rule out mental illness is one of the best arguments against the death penalty. That penalty aside, the decision as to who shall be incarcerated for detention and punishment, and who for detention and treatment, can tolerate a certain amount of ambiguity.

Two stories, one true and one apocryphal, give glimpses of the balance between impulse and blame as it may have appeared at the dawn of human consciousness.

The true one comes from observations by anthropologist Richard Lee of the !Kung San of Botswana—a hunting and gathering people whom I also lived with and studied for two years. These are people without lawyers or judges—without any legal forms or authority—and certainly without psychiatry. Lee showed that homicides occur among them in a frequency not very different / *Continued*

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from our own; there is sometimes revenge but there is no legal recourse. However, in one case of a man who killed three times, the community concluded that he was incurably violent. This, in a sense, was a primitive psychiatric diagnosis, but the response in this society without police or prisons, hospitals or psychiatrists, was not and could not be incarceration or medical treatment. With no other choice open to them, three men premeditated his homicide, lay in ambush for him, and killed him.

The second story comes from a Midrash—a rabbinic legend—about the conversation between Cain and God in Genesis, regarding Cain's crime of fratricide. According to the Midrash, the argument goes on for some time after Cain asks insolently, "Am I my brother's keeper?" His final challenge to God is the most intriguing one: "You made me as I am. You put the evil inclination in me. Therefore I am not responsible." Thus, without mentioning mental illness, an ancient legend raised the same philosophical problem: If evil is built into some personalities, how can we confront them with blame? But the rabbis were not much impressed by Cain's challenge. The Talmud says, "Who is strong? He who conquers his inclination." Cain, they conceded, was—like the rest of us—endowed with an evil inclination, but also with a good one, and with a rational ethical faculty designed to set and keep the balance tipped against evil.

As we enter the 1990s, we as a society will have to accept more and more evidence that a large part of what we call wickedness is also mental illness. Not only psychoses and depressions with delusional features, but also certain impulse control disorders, adjustment disorders, sexual disorders, and personality disorders are legitimate psychiatric diagnoses that might tend to cause crime or non-criminal wrongdoing. And the frontier of diagnosis is moving fast.

Consider an instance of sexual harassment of a female employee by her male boss, while he is under the influence of alcohol. He may blame the alcohol, and this tactic would work if he were involuntarily intoxicated. But we expect him to know that drinking may lead to such wrongs, and so we hold him accountable. Now suppose he is an alcoholic. He has a diagnosable substance-abuse disorder. Do we exonerate him because of this illness? Probably not; he should have known better than to drink himself into it. But now we have one last, new twist: in the '80s it has been decisively shown that some individuals are genetically predisposed to the development of alcoholism. Our man turns out to be one of them (in a few years time, a test of his DNA may be available to prove it.) What do we say now? Do we blame him for an immoral act at the end of a chain of events that began with a hereditary defect? I suspect that the answer is yes—that we help him and blame him both—but clearly the judgement is not easy.

In the realm of crime, a substantial minority of criminals has what in the past was called psychopathy or sociopathy and is currently called antisocial personality disorder. Such personalities have been extensively studied by psychologists. Compared to average people, they are sensation-seekers whose attachments to others are shallow, who experience little guilt, and who are relatively unresponsive to the threat of punishment. Strictly speaking, such people have a diagnosable mental illness. But the courts have been properly reluctant to accept an insanity plea from someone whose main symptom is repetitive antisocial behavior. Along the same line, the short-lived Durham rule, or "product test," of insanity was applied in the District of Columbia for a decade beginning 1954. It stated that the insanity plea was valid if the crime was the *product* of the person's mental illness. This rule was dropped because it threatened to widen the insanity plea to encompass most crimes. The courts have thus essentially rejected Menninger's view in "The Crime of Punishment" that all crime is evidence of mental illness. "Blame and punishment," says one recent law text, "are central to the criminal law." They are also central to the moral fabric of society.

There are limits to punishment; a society as complex and capable as ours only humiliates itself when it resorts to the same tactic—removal by death—that the otherwise helpless !Kung were forced to apply. Yet neither can we pretend that we have advanced very far in remediating the illnesses that partly cause crime. And if we can't cure mentally ill criminals, then we need to separate them from potential victims. To refuse to grant them treatment while they are incarcerated is simply inhumane to them; but to release them in essentially the same disordered state of mind in which they committed crimes before is inhumane to their victims—past and future.

In the realm of the moral, addictions to substances such as alcohol or habits like promiscuity do plenty of damage within the bounds of the law. Say what we like / *Continued*

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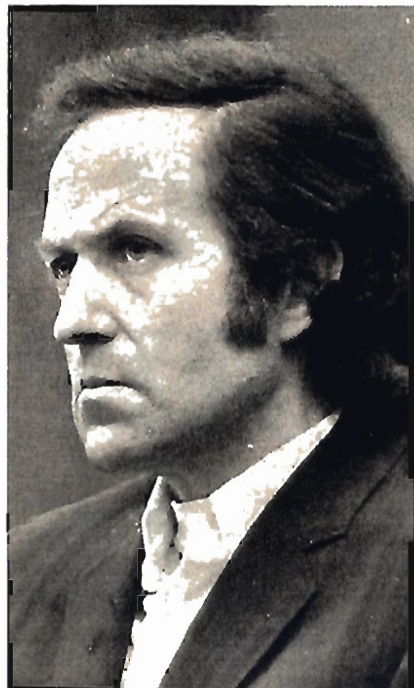
about the people with these problems—they certainly may have diagnosable mental illnesses—there must, as in criminal cases, be some sense of accountability. Even if these individuals have weaknesses that are greater than average, or impulses stronger than average, or rational ethical faculties less capable than average, we as a society must strengthen their self-control—and our own—by insisting that we all give an account of ourselves as moral agents. No amount of explanation can be allowed to stand in the way of this accounting. It is true, as Menninger said, that we are all capable of criminal fantasies and thoughts; but only some of us carry them out.

Whether we are talking about a presidential assassin, a child abuser, a street-wise crack addict, a compulsively promiscuous man, or an alcoholic celebrity drying out at a famous clinic, some expectation of moral restraint is always applicable. The tension between these two views of unwanted behavior is far from new. Aristotle's ethics include the observation that "foolish people whose folly arises from disease, e.g. from epilepsy, or from insanity, are in a morbid state," and implies that they are not responsible for their acts; yet speculates that "it is perhaps wrong to say that actions which are due to passion or desire are involuntary." The Mishnah, which contains much of the foundation of Jewish ethics, observes, "An encounter with a deaf-mute, an idiot, or a minor is bad, for you are liable and they are not;" but it also says, "Man is always responsible, whether his act is intentional or inadvertent, whether he is awake or asleep."



Dan White, above left, utilized "Twinkie defense" to explain his action. Parole of Arthur Richard Jackson, was denied due to threats voiced in prison.

And James M. Gustafson, one of the leading Christian ethicists of our time, although widely known for his compassionate liberal theology, said recently: "If all actions for which we might be held responsible are classified as addictions or illnesses, then we totally surrender the sense of moral accountability."

A famous phrase of Freud's is usually translated as "Where id was, there ego shall be," implying a rendering of the irrational to make it accessible to reality. But the passage may really mean "Where 'it' was, there 'I' shall be." This message, something like the opposite of psychological exculpation, is a far superior legacy for Freud to have left us. We would all like to point at an illness—a psychiatric label—and say of our weak or bad actions, "That thing, the illness, it did it, not me. It." But at some point we must draw ourselves up to our full height, and say in a clear voice what we have done and why it was wrong. And we must use the word "I," not "it" or "illness." I did it, I. *I.*

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