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Why It's Crazy for a Psychiatrist to Talk About Insanity

Martin Blinder, M.D.*

Almost any psychiatrist, addressing his own medical colleagues, could enumerate the kind of disturbed individual who, without meaning to, might commit a serious, gratuitous crime; and he could discuss the kinds of stressful or noxious experiences likely to elicit such behavior, all without stirring up controversy among his listeners. The diagnostic classifications of people likely to breakdown in a criminal way, and the nature and mechanisms of the stresses most likely to bring them to this critical point, psychiatrically speaking, are rather well defined.

For example, there are people in this world who are psychotic.

Psychosis is a state of severe emotional and mental disorganization, characterized by the displacement or distortion of reality by confusion, delusions and hallucinations. A psychotic person, not hearing and seeing the same things other people are, his thinking fragmented and twisted by his disease, would likely have quite a bizarre notion as to the meaning of the activities around him and of even his own acts. He could well commit a terrible offense believing he was performing a great public service. It wouldn't take much to set him off; psychosis is a highly personal and internal process which often operates independently of environmental stimuli. The psychotic might harm a benign acquaintance or perfect stranger who has innocently and unknowingly become incorporated into his assailant's delusions.

There are paranoid personalities.

A *paranoid* individual, though able to reason in an orderly, non-psychotic fashion, always begins from the delusional premise—indeed, an unremitting conviction—that he is being victimized by those around him. No amount of persuasion can convince him otherwise. Utterly neutral situations are perceived as hostile or threatening, and from these observations he proceeds,

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logically enough, to "defend" himself, often with tragic consequences. He may consume himself in endless futile lawsuits or, exasperated and enraged by his puzzled "tormentors," may "take the law into his own hands."

Then there are the people who are perhaps only a little bit crazy.

There are *compulsive and cyclical neurotic disorders* which affect men and women rational in every way, save for an abiding and almost irresistible preoccupation with a single aberrant thought or behavior pattern. The compulsion may be to exhibit oneself sexually, to set pointless fires, to throw away salaries and life savings in one disastrous gambling binge, or to shop-lift items of no particular value. Someone with such a disorder is totally committed—loyal—to his particular urge, and throughout his life is no more likely to exchange it for another than he is to give it up. Some compulsive behavior may incidentally be against the law, and this unpleasant fact may be clear to the offender, yet helps little in his efforts to arrest his ceaseless urges.

By way of contrast, there is *hysterical disassociation*, where an ordinarily normal individual becomes so overwhelmed by stress or provocation that reason abdicates: the conscious, controlling, judgmental part of his mind is briefly overcome by the unconscious, automatic, instinctual part, which may then discharge some antisocial, even violent impulse, unfettered by a need to conform to, or even by an awareness of, the law. Minutes later, when rationality and self-control return, the individual does not remember—indeed disbelieves—what he has done. On a deep emotional level, he may have "wanted" to do it (and possibly it may be reasonable to say of his victim that he long deserved it). But the criminal act does not fit the offender's makeup, and is not performed out of his conscious wishes. Usually, he is as genuinely shocked as is everyone else by what he has done, and is most unlikely ever to do anything like it again.

Likewise, trauma or intoxicants, notably alcohol, can totally incapacitate a man who may then commit acts he would at other times reject. There are other physical conditions of the brain which may produce aberrant and unintended behavior: epilepsy sometimes takes the form of automatic, repetitive, antisocial behavior rather than the classic convulsive fit; and mental retardation may cause a chronologically mature but intellectually defective individual to make gross errors of judgment or succumb to childlike impulses which place him in violation of the law.

Condensed in this fashion these descriptions sound a bit squeezed and dehydrated, but they are reasonable and straightforward. The great majority of psychiatrists would accept them without protest. Nomenclature changes a bit from place to place and from time to time, but the patients represented

are real enough, and most psychiatrists will describe them in pretty much the same way, whatever their "school" or treatment philosophy.

But bring any two psychiatrists into court and all hell breaks loose. When a man's mental disability has expressed itself in crime and his legal sanity is the issue, be prepared to extend the trial an extra week with protracted, tedious, wordy battles in the courtroom about "sanity" versus "insanity," or what constitutes "diminished responsibility."

By and large, psychiatrists are uncommonly conscientious and honest; what's more, left undisturbed in their quiet offices, far from the din of adversary proceedings, they have little trouble agreeing amongst themselves as to whether or not a man is crazy. In truth, almost anyone can tell readily when an unfortunate fellow's ideas just don't hang together. We can tell when he doesn't see or hear the same things everyone else does, when he is in great emotional distress far out of proportion to any cause we can discover, or when he cannot even carry out his own definition of acceptable behavior. When a defendant's mind lacks some basic cognitive elements or has been in some other way significantly deranged, psychiatrists, attorneys, judges and most jurors—indeed any reasonably alert observer—must sense it quickly enough. If there is one thing to which we are sensitive, it is the mental outsider, the one whose mind functions differently from ours. It doesn't matter much if you label him "mentally ill," a "social misfit," "emotionally maladjusted," or "mentally defective." Labels are simply verbal conveniences. The man himself is real enough and few of those exposed to him for any length of time would disagree that there was something seriously wrong with him. A happy, competent, well-adjusted individual doesn't go about raping ten-year-old girls or risking a gun battle for the fifty dollars in a grocer's till.

However, when called upon to discuss such behavior in the context of crime and punishment, our heretofore perceptive, objective and agreeable psychiatrists—and attorneys and jurors and citizen-observers—become partisans in a philosophical struggle in spite of themselves. All of these definitions, classifications and truths lose their self-evidence as psychiatrists, attorneys, jurors and judges align themselves in adversary positions, adjusting the color and shape of their perceptions to better fit their respective philosophies.

One position maintains that aberrant antisocial behavior is almost always the result of mental, emotional or environmental disturbances, and that it is error to perceive the offender as evil in the Biblical sense. Thus, it may be argued that the man who deliberately, compulsively and repeatedly steals for a living is acting in unconscious anger and compensation for severe childhood deprivation, and merits psychotherapy, not incarceration.

The opposing philosophy permits the concession that, strictly speaking, a given criminal is not psychologically normal, yet holds such abnormality to be irrelevant. Criminal acts must be punished if we are to be fair to those who obey the law, and if we are to provide any kind of deterrent to those who would not. To acknowledge formally and explicitly that most criminal acts do result from some kind of mental or emotional or social disability would be tantamount to providing an excuse for *all* criminal behavior and an escape from *all* punishment. Adherents to this position may well argue that, whether deprived, compulsive, deranged, or not, if a man steals, knowing it is against the law to steal, he must go to jail.¹

Picture the testimony at the trial of an alcoholic who, in *delirium tremens*, killed a policeman he thought was an agent of the devil come to cart him off to hell—knowing (as he most certainly will admit) that it is against the law to kill a cop.

Psychiatrists identifying with the first position invariably focus on the offender's symptoms and those aspects of his behavior outside conscious control, declaring him "insane," or in some way legally non-responsible. Opposing testimony may concede some psychiatric symptoms, but, emphasizing the coherent parts of his speech and behavior (and even a raving psychotic can manifest some normal functions some of the time), would maintain that the offender nonetheless is liable for his actions and legally "sane."

To the courtroom cauldron of law, medicine and philosophy are frequently added emotions; when those taking the first view feel sorry for the offender-misfit and wish to repair him, while those whose philosophy permits punishment may be angry at him for what he has done and want his victim—society—justly avenged. Psychiatrists belonging to the first group are comfortable describing the offender as having "a mental disease or defect." Those in the second group are not, and often lost in the emotional and semantic hue and cry is the central issue of *whether or not, at the moment of his offense, a particular offender had his wits about him.*

I believe that the courts would do well to move toward halting psychiatric testimony just short of the ultimate question of criminal responsibility, directing the expert simply to present to the trier of fact the kind of man the defendant has been and is, his symptoms and their severity, what was going on with him at the moment of his offense, and how the offender probably

1. Parenthetically, I might mention their other meritorious arguments—not directly germane to the thrust of this address—that most people afflicted with such aberrations nevertheless *do not* commit crimes; that vague, ill-defined labels implying mental illness can be used not only to rescue the guilty, but also to isolate from due process and permanently incarcerate those whose only crime is social or political nonconformity.

perceived his own actions at that time.² This kind of information is useful to judges and juries. They deserve to have it, if available, and defendants have a right to have them hear it. Psychiatrists are skilled in gathering it up and presenting it, and thus may rightfully be called to the stand, but should be stopped from endeavoring to draw legal conclusions from their psychiatric data, for here they may exceed their competence.³

I believe the courts can well do without amorphous, almost indefinable concepts like "chronic undifferentiated schizophrenia," and without epithets like "psychopath" or "moral delinquent." Certainly they can survive without psychiatric discourses on such legalisms as "insanity" or "diminished capacity," or other constantly shifting abstractions remote from psychobiological reality and outside the psychiatrist's expertise.

It is not the type of disorder, but its severity, pervasiveness and social context that really determine what effect it is having on a man's ability to function. A man's peers, once adequately informed, may be better able to determine the significance and relevance of his disorder in his particular community than any psychiatrist. So the latter, having completed his lay-language portrait of the man, should put down his verbal brush, depart the courtroom, and leave the jury to contemplate and name the painting—to draw its own conclusions in the light of prevailing levels of understanding, insight, compassion and anger in the community.

This is what the jury is going to do anyway, so why burden the judicial process with such indefinables as "the mental capacity to form malice," or with other deformed, grotesque congenitally defective children issuing from the unhappy marriage of law and psychiatry? Admittedly, such unions are inevitable and even necessary in our complex society, but the spouses—obviously mismatched—should be discouraged from breeding.

2. Of course, the expert must be prepared to demonstrate how he was able to gather such data, so the trier of fact can decide for itself how accurate or important the data is likely to be.

3. A man can have a diseased condition—a broken leg, a cough, a headache—and yet not be "ill." But when that condition is sufficiently generalized and systemic as to affect his overall well-being or ability to function—as in calcium depletion, disseminated tuberculosis or brain tumor (even though his disease be that of the single organ)—then we quite properly say that the man is "ill."

The same holds for psychiatric disorders. Our decision to call a man "mentally ill" must reflect the overall effect his abnormality is having on his ability to function, irrespective of diagnosis. A city dweller with a phobia about vast open spaces, or a resident of a desert island who fears elevators, both may be classified psychiatrically, but are hardly mentally ill. A smoker doubtless has—as most will admit—a serious problem of addiction, but again they should not be characterized as mentally ill unless their need for tobacco is so strong that it contaminates and adversely affects major areas of living.