Severe Personality-Disordered Defendants and the Insanity Plea in the United States

This thesis is dedicated to those offenders whose cry for justice stimulated my search for possible hidden biopathological factors behind their criminal behaviors and to the many scholars whose research gave me the possibility to do so.

Severe Personality-Disordered Defendants and the Insanity Plea in the United States: a Proposal for Change

Verdachten met een persoonlijkheidsstoornis en de ontoerekeningsvatbaarheid in de Verenigde Staten

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam
op gezag van de
rector magnificus

Prof. dr. H.G. Schmidt

en volgens besluit van het college van Promoties.
De openbare verdediging zal plaatsvinden op
Woensdag 21 april 2010 om 15.30 uur
door

George Benito Palermo
geboren te Tarquinia, Italië

Boom Juridische uitgevers
The Hague
2010

PROMOTIECOMMISSIE

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ISBN 978-90-8974-258-2
NUR 824

www.bju.nl

Preface

During the past decades, working as a forensic psychiatrist, I have examined thousands of offenders—misdemeanants and felons for whom I testified in courts of law, for the defense, for the prosecution or when appointed by the judge. Among these offenders, those who were classified as suffering from a severe personality disorder, even though they had gone through a decompensation into irrational behavior, whether brief or more lengthy, were dissuaded by their defense attorneys from a plea of non-criminal responsibility (insanity) because, in the United States, after the 1982 John Hinckley case, those offenders labeled as personality disorders were no longer allowed to enter such a plea. John Hinckley had attempted to assassinate then-President Ronald Regan and was successful in his plea of non-responsibility, even though he was thought by the prosecution to be a narcissistic paranoid personality and not a schizophrenic.

Among the many personality-disordered offenders, there are many who malinger mental illness. However, there is also a group of offenders who suffer from a bona fide severe personality disorder, such as a Borderline Personality Disorder, Paranoid Personality Disorder, Schizotypal Personality Disorder, Schizoid Personality Disorder, and last but not least, the Antisocial Personality Disorder, who, when under severe stress, may clinically decompensate into fleeting micropsychotic episodes. During those moments of impulsive irrationality, they at times commit serious crimes, even murder. It has been difficult to support their criminal non-responsibility because of the prejudicial attitude of the courts of law, especially after the 1984 Federal Reform Act, which stressed that the only justification for an insanity plea was that due to active mental illness. In addition to that, most triers of fact lacked good psychiatric or psychological knowledge.

During the past decades, European, and some American, jurists have attempted to change the requirements for an insanity plea from the rigid definition of mental illness to the offenders' psychopathological state of mind at the time of the alleged offense. At the same time, recent new technologies, such as neuroimaging studies (CAT, MRI, fMRI, SPECT and PET) of the brains of offenders suffering from severe personality disorders have revealed structural and functional similarities with the brain neuroimaging of psychotic patients (schizophrenic, bipolar, paranoid).

It is argued in this thesis that the serious personality disorders are prepsychotic conditions and that, under inner or outer stress, those persons suffering from them may lapse into transient psychotic behavior during which they offend, later reintegrating into their previous non-psychotic mental state. Because of this, after a presentation of the psychiatric and legal literature, supported by case studies and

examples of landmark legal cases, I argue that, if supporting evidence is available, all such offenders should be given the opportunity to enter a plea of non-criminal responsibility, or at least of diminished criminal responsibility, as was possible prior to the 1984 Federal Insanity Plea Act. I further argue that the exclusion of these offenders from such a plea is contrary to due process of law and present-day scientific knowledge. I firmly believe in this and I hope that my reflections in this thesis will bring about not only more awareness of what I consider to be a legal injustice but will contribute to necessary legal reforms.

Contents

Introduction

People who live in society are bound together by laws based on duties and rights. Even though primarily born out of acceptance and respect for one another, these laws, part of an ethical system of communal life, are also utilitarian in their essence. Though accepting the above postulates, people are at times the subject of feelings, drives, and actions contrary to respectful interaction with others. Society has, therefore, created criminal laws, codified through the centuries, with the purpose of controlling the deviant and impulsive behavior of some of its members in order to maintain, in as much as possible, societal homeostasis.

Ethical principles, such as beneficence and non-maleficence, especially in a democratic society, are basic to legal systems whose purpose is to dispense justice in its various courts of law, where victims and miscreants, represented by their respective advocates, contend over guilt and exculpation. The majority of criminal cases involve mentally competent persons, who maliciously do not conform to the requirements of the law and, furthermore, often do not conform to basic moral values. A small percentage of those who break the law suffer from a severe mental disorder, which, if present at the time of a crime, may annul or greatly diminish their mental capacity to appreciate the nature, quality and consequences of their criminal behavior or their capacity to conform to the requirements of the law. These persons are allowed by the law to enter an exculpatory plea and to attempt to prove at trial that they were legally insane at the time of an alleged offense.

There is, in addition, a substantial cohort of persons who suffer from a severe personality disorder for whom entering a plea of not guilty by reason of insanity in United States courts at present is typically a futile exercise, even though their behavior at the time of their alleged crime was bizarre, confused and irrational. The futility of their plea stems from the practical reality that their disorder is not recognized as a mental illness.They cannot take advantage of the insanity plea because of the prevailing legal view that they cannot meet its threshold criterion. Even if they were in a court that would allow them to surmount that hurdle, they would still be subjected to exceptionally strict scrutiny.It is the argument of this thesis that, in regard to individuals suffering from a severe personality disorder, in the United States the criminal law operates if not from unfounded prejudice certainly from a foundation that disregards current scientific knowledge.

The premise underlying this argument is that persons with a severe personality disorder (many of whom are capable of only marginal functioning in daily life), under severe stress, may at times undergo a personality disintegration that is tantamount to a frank psychotic episode, which should make them eligible for an insanity plea. However, United States courts, including the United States Supreme Court, have held explicitly that criminal defendants have no due process right to

how the insanity defense is framed or worded, what sorts of conditions it may cover or exclude, or even whether they may have the benefit of an insanity defense at all—or any number of other exculpatory concepts. (See, e.g. Montana v. Egelhoff, 518 U.S. 37 (1996); Clark v. Arizona, 126 S. Ct. 2709 (2006)). Elementary fairness suggests they ought to be allowed to assert their non-accountability in the context of an insanity defense or any other defense. Of course, it is well known that offenders at times attempt to malinger mental disorders, or to greatly exaggerate any existing mental pathology. That is a risk that is run with any offender. However, it is better to free ten guilty people than to convict one innocent one. It serves as the justification for requiring, that is, an extraordinarily high standard of proof (beyond a reasonable doubt) in criminal prosecutions. The argument of this thesis is that the preclusion to plead insanity or the non-credibility of those rare personality-disordered offenders who are allowed to enter the plea, is based on socio-political factors rather than psychological and psychiatric ones.

Chapter 1. Basic Thesis Proposition

This thesis proposes an expansion to the recognized psychopathologies acceptable to the legal parameters of the insanity defense in the United States. Currently, the US conceptualization of the Not Guilty by Reason of Insanity (NGRI) defense only extends to individuals who are suffering from a *bona fide* mental disorder (typical examples include Schizophrenia, Bipolar Disorder and Delusional Disorders). This thesis will illustrate that individuals with severe personality disorders can experience, under severe stress, micro-psychotic episodes during which time they may commit a crime. Accordingly, it will be argued that such severe personality aberrations (inclusive of some temporary state of psychosis) should be legitimately encapsulated and thus accepted within the legal parameters of the NGRI defense.

1.1. Research Methodology

Design

The fundamental research design employed in the present thesis is that of an embedded multiple-case case study research design (Yin, 2003). In developing the central proposition of the thesis a series of individual case study analyses will be undertaken to illustrate many of the proposed concepts (Hamel, 1992; Perry & Kraemer, 1986). Beyond a basic holistic approach to case study analysis the present thesis will make use of multiple common sub-units of analysis within each of the respective case studies (referred to as the 'embedded' case study methodology (Yin, 2003)) to further explore, illustrate and compare concepts.

Units of Analysis

As stated, the present thesis employs an embedded multiple-case case study approach. Consequently, the units of analysis within the thesis can be conceptualised as embodying both primary units (the general context of each case) as well as specific sub-units within each of the respective cases. The distinctions in the analyzed units and the various cases should not, however, be conceived as sampling units for the purpose of *statistical generalization*. Instead, the case study

methodology is characterized by *analytical generalization* of the features inherent to each case. In this context, each examined case is conceived as representing a conceptual experiment upon which the propositions of the thesis are illustrated and examined. In this way the use of multiple cases which may support a proposed theory represents a form of replication within the case study research methodology paradigm.

In adopting this approach the employed units of analysis are as follows:

Primary Units

The primary units are 14 individual cases involving forensic psychiatric patients personally examined by the author. The cases are representative of severe personality disordered-offenders, who, like many similar others, underwent more-or-less sudden mental decompensation under severe stress and committed a felony while in a state of mind akin to psychosis, during which, it was concluded by the author, they did not possess substantial mental capacity to appreciate the wrongfulness of their actions or conform to the requirements of the law (American Law Institute Model Penal Code definition of insanity).

Sub-Units

Within each of the 14 examined cases the following sub-units will be examined and discussed within the overall context of the thesis proposition:

- Sources of information: Criminal charges; police record; records reviewed
- Purpose of examination and statement of non-confidentiality
- Social and personal data
- Criminal history
- Medical/psychiatric history
- Pertinent data
- Mental status examination
- Psychological and other tests
- Psychiatric diagnosis
- Defendant’s account of offense
- Criminogenesis: Predisposing factors; precipitating factors; risk factors
- Victim data when available
- Psychiatric forensic examination of offender
- Psychiatric forensic opinion
- Commmentary

Data Collection

Two broad forms of data were collated for the present thesis. First, to inform the theoretical development of the thesis proposition an extensive review was undertaken of the scholarly literature and available case law concerning personality-disordered individuals and the admissibility or rejection of this type of evidence for the insanity defense from the second half of the twentieth century to the present.[1] To augment the consideration of the literature the author also consulted numerous forensic psychologists, psychiatrists, legal and judicial scholars concerning their views on changes to the NGRI defense due to the offender suffering from a severe personality-disorder.

The second main form of data collected for this thesis consisted of 14 detailed cases. These cases originate from the author's own extensive clinical experience as a practicing forensic psychiatrist for over approximately four decades, during which time he has encountered and examined hundreds of patients in both traditional clinical and forensic contexts. Each of the selected cases relates to a patient the author personally examined who was found to be suffering from a severe personality disorder and had committed a criminal act while under severe stress and a micro- or macropsychotic decompensation. As these individuals did not, however, have an established history of *bona fide* mental illness they were dissuaded by their attorneys from entering an NGRI plea or were not allowed to do so by the court because of the current limitations of the law following the Federal Insanity Reform Act of 1984 or, if allowed to enter the plea, the forensic reports supporting their defense were rejected by the courts at trial. The Federal Insanity Reform Act of 1984 was passed after John Hinckley was found not guilty by reason of mental disease of the attempted assassination of then-President Ronald Reagan in 1981.

Additionally, the methodology is grounded in ethnography, autoethnography and historiography. It is historiographic in that, besides presenting the 14 forensic psychiatric case histories, it reviews a body of historical work: the development of legal responses to forms of psychopathology; the evolution of the insanity defense in the United States, including pre- and post-Hinckley court views of the insanity plea; and recent developments in neuroimaging of the brain applied to mental disorders. In so doing, it provides a social history for the topics presented and acknowledges that there is a story to be told, one that reveals shifts and developments in forensic psychiatry, especially those surrounding the personality disorders and the insanity plea.

[1] It should be noted that a significant paucity of such cases currently exist. Nonetheless, the few bench opinions that were found are presented and, notably, often refer to the definition of mental illness for legal purposes.

This thesis also makes use of ethnography, a naturalistic method of research that studies real people in the real world and their behaviors. It attempts to fully describe a variety of aspects of a group (severe personality-disordered offenders) to enhance the understanding of their antisocial psychopathological behaviors. During the investigation, the author has both an outsider and an insider perspective.

The thesis is autoethnographic, viewing autoethnography as a reflexive assessment of the author's personal experiences as a practicing forensic psychiatrist, evaluating and diagnosing for the legal system offenders suffering from psychopathological conditions, with particular reference to severe personality disorders. Autoethnography is a qualitative research strategy and through the case illustrations the author presents his personal understanding of the insanity defense as a direct observer of the medical-legal changes that have been made, such as legal decisions regarding total or diminished capacity of individuals suffering from personality disorders.

Through the multi-type methodology, case studies, historiography, ethnography and autoethnographic experiences, the author wishes to demonstrate that the present insanity defense doctrine in the United States is too limiting. He proposes a change, which would remove the presence of psychosis as a prerequisite for such a defense, substituting it with a more inclusive definition, such as a psychopathological state of mind that interferes with an offender's capacity to understand the wrongfulness of his actions and his capacity to conform to the requirements of the law. The intuitive familiarity with socio-psychological theories allows one to see patterns in the data that others may miss.

1.2. Case Study Characteristics

The case studies presented in this thesis were drawn from the large number of offenders examined by the author during his forensic psychiatry practice. They are, therefore, a sample. The case diagnoses are: Borderline Personality Disorder (3); Paranoid Personality Disorder (2); Schizoid and Schizotypal Personality Disorder (2); Antisocial Personality Disorder/Psychopathy (Sadism, Narcissism) (1); Dependent Personality Disorder (1); Obsessive-Compulsive Personality Disorder (3); and Passive-Aggressive Personality Disorder (2). Basically, the interviewing method was a biopsychosociological one; the Minnesota Multiphasic Personality Inventory (MMPI-2*)* was utilized as a psychological assessment when indicated.[2]

[2] The MMPI/MMPI-2 is an objective personality test composed of items that the subjects scores as true or false. The original version of the MMPI contained ten scales for clinical assessment

The forensic assessment was concerned with eliciting the characteristics of the offender, the circumstances of the offense, the possible motivation for the offense, and any criminogenic factors. Among the documentation reviewed in each case were the statement of the offender to the police when apprehended, the criminal complaint, available hospital records, witness statements, and any other pertinent material available. This information aided in the formulation of the author's forensic psychiatric opinion, always to a reasonable degree of medical certainty. The diagnosis reached led to conclusions regarding the each offender's criminal responsibility in the offense. This is the interface of psychiatry and the law as van Marle (2008) wrote in his assertion that forensic psychiatry and the law have something in common, concepts used in law, defined by law, but to be filled in by forensic psychiatry, 'which will fulfill the purpose of the forensic psychiatric assessment (that) is to inform the judges about the person and personality of the (offender) with regard to the offense he has been charged with' (p. 27).

The commentary at the end of each legal psychiatric case will briefly attempt to explain the offender's impairment in mental functioning and his appreciation of the offense committed, which is a part of the ALI test used in many states in the United States and has a broader meaning than the dichotomous knowing/not knowing of the M'Naghten rule. It will note any presence of malingering, present a differential diagnosis when indicated, and any causative link between the mental disorder and the crime committed. The rationale for the forensic psychiatric diagnosis and for the finding of the offender's diminished or total non-responsibility for the offense will be presented. In reaching a diagnosis, textbooks of psychiatry, psychiatry and law, forensic psychiatry and forensic ethics, as well as the various editions of the *Diagnostic and Statistical Manual* were consulted.

It is argued throughout this thesis, persons with severe personality disorders may, under stress, become psychotic. During this period of psychosis they may commit a crime and then, within a brief period of time, ranging from hours to one month, reintegrate into their previous personality disorder. These persons often have a history of previous arrests for unruly behavior and at times have been hospitalized in psychiatric institutions. When they appear in court for trial, the fact that they were psychotic at the time of the offense is not taken into due consideration because they do not have a diagnosis of mental illness. Also, at trial, having reintegrated, they appear to be non-psychotic. It can, therefore, be understood how difficult it is for these individuals to prove that at the time of an offense they did not possess

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and three validity scales to assess a person's test-taking attitude and candor. Other tests of this type include the California Psychological Inventory and the Millon Clinical Multiaxial Inventory. Potential indices of dissimulation on the MMPI/MMPI-2 include elevators and configurations of the traditional response style scales (L, F, and K and the K-F index). However, the F-K index validity for malingering is questionable, depending on the psychopathology of the testee (Melton, Petrila, Poythress & Slobogin, 2007).

substantial (not total) mental capacity to appreciate the wrongfulness of their crime and refrain from it.

If the law regarding the insanity defense were to change as is proposed in this thesis, it is doubtful that the judicial system would be inundated with a plethora of insanity pleas. To be considered is that the mentally ill have been criminalized following the deinstitutionalization process that began in the 1960s and offenders who are found to have been mentally ill at the time of an offense are mandated to forensic institutions for treatment (Palermo, Smith & Liska, 1991). The length of such treatment for mentally disordered offenders is generally longer than a jail or prison sentence for a similar crime committed by non-mentally disordered offenders. In the author's experience, many *bona fide* mentally ill offenders denied their mental abnormality in attempt to escape from psychiatrization and a longer period of confinement in a forensic hospital (Palermo, Gumz, Smith & Liska, 1992). In the event that the proposal for change made in this thesis is accepted, the insanity plea would become more comprehensive and flexible and the judicial system more just and ethical. Justice and ethics should not be concerned with a possible increase in the number of persons who might enter an insanity plea, but rather in the rights of all persons accused of a crime, which includes their possibility to be heard in a court of law and to be thoroughly assessed on the basis of evidence that can be put forward in their defense.

1.3. Rationale for Thesis Argumentation

It is assumed that argumentation stands for effective reasoning. The claim made in this thesis is that at times, because of severe stress and lack of resilience, persons suffering from severe personality disorders undergo a brief decompensation into a Brief Psychotic Break. It is proposed that if they commit a crime during that period of psychological/psychiatric decompensation they should not be precluded from entering in court a plea of not guilty by reason of mental disease (NGRI) or a plea of diminished responsibility. Since the Federal Insanity Reform Act of 1984, however, those persons suffering from a personality disorder, even a severe one, cannot enter such a plea. Evidence supporting the claim presented in this thesis includes:

- case studies of individuals examined by the author
- extensive review of pertinent psychiatric and legal literature
- pre- and post-Hinckley period legal case decisions
- statements pertinent to the claim made by legal and psychiatric scholars
- *Diagnostic and Statistical Manual* (American Psychiatric Association, 2000) listing of Brief Psychotic Disorder among the recognized psychiatric entities.

The purpose of the argumentation of the thesis is to prove that a personality-disordered offender should not be precluded from entering a plea of non-responsibility or diminished responsibility if, at the time of the offense with which he is charged, he did not possess substantial (not total) mental capacity to appreciate the nature, quality, consequences and wrongfulness of their actions and because of their mental disorder he could not refrain from acting out as he did and therefore was unable to conform to the requirements of the law.

1.4. Pre- and Post-Hinckley Case Law

In *Black's Law Dictionary* (Black, 1990), the concept of legal insanity is described as a social and legal one, rather than a medical/psychiatric one. It indicates a condition which 'renders the affected person unfit to enjoy liberty of action because of the unreliability of his behavior with concomitant danger to himself and others' (Slovenko, 2002, p. 248). The term legal insanity is quasi synonymous with mental illness or psychosis. It is used to decide the degree of mental disorder which annuls the individual's legal responsibility in a criminal case.

From the time of the Wild Beast Test until the eighteenth century several legal rules or tests of legal insanity have been used, including the M'Naghten Test (1843), which states that the person who is legally insane is unable to know the nature and quality of his acts, and specifically, the wrongness of his or her acts because of mental illness; the Durham Test (1960-1970), which is a disease-defect-product test, by which an accused is not criminally responsible for his unlawful acts, because the act was the product of mental disease or defect; and the American Law Institute Model Penal Code (the ALI test), the one most used at present in the United States court system, which originated in the 1960s. The ALI test states that a person is not responsible for his criminal conduct if, at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law. The ALI test excludes an abnormality of the mind that manifests itself only by repeated criminal or otherwise antisocial conduct (psychopathic behavior). Also in the ALI test, wrongfulness of behavior refers to a defendant's emotional and affective attitudes about the crime. Explanations of the above tests are given to jurors who, unless a trial is a bench trial, make the ultimate decision about the legal responsibility of a defendant who has entered a plea of not guilty by reason of mental disease or defect.

1.5. Personality Disorders and the Insanity Defense Pre- and Post-Hinckley

The question of whether a personality disorder may be the basis for an insanity defense has plagued the courts for years. It was supported in the United States v. Solava (United States v. Solava, 978 F. 2d 320 (7th Cir 1992)), which rejected a government argument that expert testimony on the insanity defense should be excluded because the defendant's diagnosis did not qualify as 'severe' for purposes of 18 U.S.C. §17, while in Beiswenger v. Psychiatric Section Review Board (Beiswenger v. Psychiatric Sec Review Bd (84 P. 3d 180 (Or Ct. App 2004)), the expert's opinion that the defendant's diagnoses of antisocial and paranoid disorder was severe was accepted.

Extensive research (legal reference books, Lexis-Nexis and Internet searches, including key words such as personality disorders and criminal responsibility, personality disorders and the law, the insanity defense, diminished responsibility, mental illness and the law) conducted regarding case law concerning personality-disordered individuals and their admissibility or rejection for the insanity defense from the second half of the twentieth century to the present found a paucity of such cases. The few bench opinions that were found are here presented and often refer to the definition of mental illness for legal purposes.

1. In Stewart vs. United States (Stewart vs. United States, 214 F.2d879 (D.C. Cir.1954)), the District of Columbia Circuit Court of Appeals wrote: 'As a question of fact, the jury alone has the right to determine which types and degrees of mental abnormality fall within the meaning of "disease or defect" ' (Slovenko, 2002, p. 253).

2. In Briscoe vs. United States, (Briscoe vs. United States, 248 F.2d 640, (D.C. Cir.1957)) it was stated that it is erroneous to affirm that psychosis is the only legally sufficient disease (for an insanity defense) and other illnesses are not (Brakel & Brooks, 2001).

3. The case of Blocker vs. United States in 1957 referred to Comer Blocker, a sociopathic criminal who had pleaded not guilty by reason of insanity. At the time, the St. Elizabeth Hospital administration and staff had decided that sociopathy would not be regarded as a mental illness and Blocker was found guilty of first-degree murder. Less than a month after Blocker's trial, however, Dr. Winfred Overholser, superintendent of St. Elizabeth Hospital at the time, agreed that a sociopathic personality disturbance should be considered a disease. This brought about a reversal of a subsequent Blocker conviction in 1961 (Blocker vs. United States, 294, F.2d 572 (D.C.Circ. 1959), 288 F.2d 853 (1961)).

In 1961, Judge Warren Burger (U.S. Court of Appeals for the District of Columbia) wrote that there was a lack of definition of what mental disease or defect

is and that 'not being judicially defined these terms mean, in any given case, whatever the expert witnesses say they mean' (Slovenko, 2002, p. 250).

4. In 1962, the District of Columbia Court of Appeals, in McDonald vs. United States (312 F.2d 847 (DC Cir. 1962)), attempted a legal definition of legal disease or defect and at that time the jury instructions stated that mental disease or defect included 'any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls' (Slovenko, 2002, p. 250). That was the time of the Durham experiment, which lasted from 1954 to 1972. In the case of Durham (Durham vs. United States, 214F. 2d 862, 874-75 (D.C. Cir. 1954)), mental illness itself was the sole incapacitating condition (Brakel & Brooks, 2001). Because of the implication that mental illness or defect themselves were the exculpating factors in criminal responsibility, the Durham Rule produced a large number of successful insanity defenses. It should be noted that during the 1960s and 1970s in the United States there was a widespread belief in psychiatry, promoted by Karl Menninger, that all mental illnesses, although differing in quantity, are basically of the same quality (Slovenko, 1995, p. 54).

In McDonald vs. United States (312 F.2d 847 (D.C. Cir. 1962)) it was stated that a strictly legal definition of mental illness narrows the choices for the jury and the experts, particularly because it excludes mental conditions from the evidence that the jury might want to entertain in reaching a verdict. Therefore, for the purpose of helping to reach a verdict, jury instructions should state that 'a mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls' (Slovenko, 2002, p. 262).

5. In United States vs. Brawner (United States v. Brawner, 471 F.2d 969 (1972)) the United States Court of Appeals for the District of Columbia Circuit set aside the Durham ruling, arguing that the ruling's requirement that a crime must be a 'product of mental disease or defect' placed the question of guilt on expert witnesses and diminished the jury's role in determining guilt. Under this proposal, juries are allowed to decide the 'insanity question' as they see fit. Basing its ruling on the ALI Model Penal Code, the court ruled that in order to be found not criminally guilty of a crime the defendant, '(i) (must lack) substantial capacity to appreciate that his conduct is wrongful, or (ii) (lack) substantial capacity to conform his conduct to the law' (Slovenko, 2002, p. 248). Herbert Fingarette (1972), in *The Meaning of Criminal Responsibility*, stated that '…if the person has a mental makeup which is such that he lacks even the capacity for rationality, then the responsibility is vitiated. If he has the capacity but simply fails to use it, responsibility is not precluded' (pp. 200-201).

In the wake of the Hinckley trial, the American Psychiatry Association (APA), sensitive to people's reaction to the verdict of not guilty by reason of insanity in the case, stated that in order to qualify for a plea of non-criminal responsibility mental

disorders must be serious and impair cognition, not just control, similar to a psychosis. It excluded the personality disorder category. The American Bar Association (ABA) followed suit and stated emphatically that mental disease must be 'a substantial process of functional or organic impairment rather than a defect of character or strong passion' (Slovenko, 2002, p. 257). However, the ABA affirmed that an acute psychotic break would be considered to be a mental disorder in the absence of an underlying enduring psychotic disorder.

In addition to the ABA, the Criminal Justice Institute subscribed to a criminal responsibility test that requires '(i)mpairment of the mind, whether enduring or transitory, or mental retardation which substantially affected the mental or emotional processes of the defendant at the time of the alleged offense' (Slovenko, 2002, p. 257). Since 1984, the Federal Courts have adopted a statute that states:

> 'It is an affirmative defense to a prosecution under any federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of the act. Mental disease or defect does not otherwise constitute a defense' (Slovenko, 2002, p. 258).

This brought into the ruling the term *appreciate* and the term *severe*. The first refers to a state of mind or disposition, more refined than just knowing—a knowledge that includes the affectivity of the defendant, whose mental disorder must be severe and because of its severity be causative of the antisocial behavior. However, Ralph Slovenko (2002) reported that Glanville Orleans, a leading law commentator, stated in the last century that 'a mental disorder, though not severe, could deprive the accused of intention or control of what he was doing' (p. 258).

Following the Hinckley trial, courts in the United States have dissuaded or openly rejected attempts by persons diagnosed as suffering from severe personality disorders to enter a not guilty by reason of insanity plea. Nevertheless, reported legal cases that may be interpreted as in favor of or against such rejection put into evidence judicial ambivalence regarding the issue and the legal weakness of the barriers so far applied, out of a probably-justified desire to control antisocial behavior, but which may be seen as contrary to due process of the law, a constitutional guarantee:

1. Hines v. Bowen (Hines v. Bowen, 872 F. 2d 56, 59 (4th ir. 1989)) states that 'The synergistic effect of…two disorders results in substantial impairment of respondent ability to function in society and control his behavior' (see also, Ake v. Oklahoma (disability context)). Indeed, the synergistic effect of several minor conditions may result in major disability.

2. In Ake v. Oklahoma (Ake v. Oklahoma, 470 U.S. 68, 81, 84 L.Ed. 2d 53, 105 S.Ct. 1087 (1985)) the Supreme Court held that the due process clause of the United

States Constitution actually requires that the government provide competent psychiatric services.In Ake v. Oklahoma the respondent was suffering from two personality disorders, Antisocial Personality Disorder and Borderline Personality Disorder, and the severity and interaction of these two disorders '(resulted) in substantial impairment of his ability to control his behavior' (p. 4. Dr. Mark Hazelrigg). This combination rose to the point of constituting 'a severe mental illness' (Dr. Hazelrigg's report). Dr. Corvini was of a contrary opinion, even though making the same diagnosis: 'Respondent violent propensities would more appropriately be addressed through the criminal justice system (Dr. George P. Corvini).

3. Foucha v. Louisiana (Foucha v. Louisiana, 504 U.S. 71, 118 L. Ed. 2nd 437, 112 S.Ct 1780 (1990)) held the same opinion as that of Dr. Hazelrigg in Ake v. Oklahoma, stating that if the circumstances indicate that because of mental disease or defect the defendant was incapacitated to the point of not being able to distinguish between right and wrong in reference to the conduct in question, he should be exempt from criminal responsibility.

4. In United States v. Prescott (United States v. Prescott, 920 F. 2nd 139, 146 (2nd Cir 1990)), the trial court finding was that the defendant's severe Borderline Personality Disorder was not a mental disease or defect under § 4244.

5. United States v. Rosenheimer (United States v. Rosenheimer, 807 F 2nd 107, 112 (7th Cir. 1986)) upheld without explanation that personality disorder is an entity distinct from mental disease or defect as did United States v. Riggin (United States v. Riggin,732 F. Supp. 958, 964 C SD. Ind 1990).

6. In United States v. Denny-Shaffer (United States v. Denny-Shaffer, 2 F.3d 999, 1016 (10th Cir 1993)), after distinguishing personality quirks or traits which cannot be construed as mental disease or defect, Judge Wilson stated that a personality disorder is a systemic impairing psychiatric abnormality that can 'dominate the person's mental state to the point where they experience significant functional impairment or subjective distress' (Brakel & Brooks, 2001, p. 142). Judge Wilson concluded, as Brakel and Brooks wrote, that such personality disorders may be construed as a mental disease or defect and the court finding was that under the insanity defense a multiple personality disorder was a severe mental disease or defect.

7. Kansas v. Hendricks (Kansas v. Hendricks, 504 U.S. 71, 118 L.Ed. 2nd 501 117 § S.Ct 2072 2080 (1995)) found constitutional the involuntary commitment of an individual with a personality disorder, (Antisocial Personality Disorder) as suffering from a mental abnormality that makes it difficult if not impossible for the person to control his dangerous behavior.

8. In United States v. Murdoch (United States v. Murdoch, 98 F. 3d 472 (9th Cir 1996) cert. denied, 138 L. Ed. 2d 1019, 117 S.Ct. 2518 (1997)), Murdoch was diagnosed as suffering from 'Personality Disorder, Not Otherwise Specified, with

Narcissistic and Passive Aggressive Traits, and found not guilty by reason of insanity and committed to a medical facility.' The District Court concluded that the defendant's 'personality disorder constitutes a mental disease or defect which presents a substantial risk of danger to others' (p. 3).

9. In the case of David Troy Henley (United States v. Henley, 8 F. Supp. 2d 503, 507 (E.D.N.C. 1998) June 2, 1998, the United States District Court for the Eastern District of N.C., Western Division, disposed and recommended that David Troy Henley, diagnosed as a severe personality disorder (antisocial) and a severe Borderline Personality Disorder, be found to be suffering from a mental disease or defect as a result of which his release from detention would create a substantial risk of bodily injury to another person or serious damage to the property of another (dangerousness criterion). Because of his dangerousness, Henley was sent for treatment to a state forensic mental hospital.

In the case of sexual predators, usually suffering from a personality disorder, at present the courts apply a constitutionally accepted categorization of mental abnormality which, more likely than not, would predispose them to recidivate and, even though not suffering from a *bona fide* mental illness, they legally commit many of them for an indefinite period of time, justifying the commitment as necessary for treatment. Such treatment may continue for years and at the time of a possible discharge they must undergo a reassessment of their mental condition and their propensity to recidivate. To this effect, the State of Washington Supreme Court said regarding R.E. Young (State of Washington Supreme Court v. R.E. Young, 122 Wash. Sec. 2d 1,857, P. 2nd, 1993), citing the caveat in *DSM-III-R* (p. xxix), 'Over the years, the law has developed many specialized terms to describe mental health concepts,' such as the argued term of mental abnormality in the sexually violent predator statutes. The court further stated, 'Indeed, the *DSM* explicitly recognized…that the scientific categorization of a mental disorder may not be 'wholly relevant to legal judgments' (Slovenko, 2002, p. 259). However, as Slovenko wrote, the terminology 'mental abnormality,' even though not part of the *DSM*, is accepted and used in describing the sexually violent predator statutes, but the legislature has invoked a more generalized term that covers a much larger variety of disorders. More specific about the definition of mental illness, the Washington Supreme Court added that the *DSM* is not sacrosanct but is an evolving and imperfect document.

In 1997, in a five to four decision, the United States Supreme Court upheld the Kansas Violent Predator Act and civil commitment for sexual predators. Many legal and mental health scholars have questioned the constitutionality of the law, which has gradually extended over many other jurisdictions in the United States; however, at present it is constitutionally accepted. The dialogue about the proper terminology, excluding the term mental illness in the case of sexual predators, was reinforced by Justice Clarence Thomas, who stated that substantive due process does not require

that this condition be a mental disorder recognized by treatment professionals. Justice Thomas stated,

> 'Not only do psychiatrists disagree widely and frequently on what constitutes mental illness…(but) the term mental illness does not carry talismanic significance….(and we have traditionally left legislators the task of defining terms of a medical nature that have legal significance' (Slovenko, p. 260, re: Kansas v. Hendricks, 521 U.S. 346 1997).

These legal dispositions regarding sexual offenders, as supported by United States Supreme Court Justice Clarence Thomas, point out that the legal definition of a state of abnormality of the mind may substitute the mental illness definition. As the definition is applied to sexual offenders, it should apply as well to severe personality disordered offenders.

1.6. Method of Study

The following steps will be taken to prove the argumentation of this thesis. This chapter has described the methodology, case study characteristics and argumentation of the thesis. The pre-and post-Hinckley case laws were presented in order to point out the different legal conclusions reached by United States Courts in assessing legal responsibility prior to and after the passage of the Federal Insanity Reform Act of 1984. The reform act was the direct consequence of the John Hinckley trial for the attempted assassination of then-President Ronald Reagan in 1981. This is the foundation of the thesis, which intends to prove the unfairness of the drastic reform, especially towards offenders diagnosed with a personality disorder, and its socio-political motivation.

In Chapter Two, a description of the personality and aggression will be presented. It will describe the various personality disorders, their structure and psychodynamics. Object relations theory, with special reference to Otto Kernberg's psychotic personality organization will be discussed. The chapter will lay the foundation for a better understanding of personality-disordered offenders in reference to aggression. It will support the tenets of the thesis that some severe personality-disordered offenders may, under stress and due to a lack of resiliency, decompensate into a full-blown micropsychotic episode. Their predisposition is inherent to their personality structure and functioning, as described by Kernberg.

The pre-psychotic state of severe personality-disordered offenders will be further supported in Chapter Three, which will point out the structural and functional neuropsychological and neuroimaging findings in psychotic disorders (Schizophrenia, Delusional Disorder, Bipolar Illness) and the similarities to

neuropsychological and neuroimaging findings in severe personality-disordered offenders (e.g., Borderline, Schizotypal, Antisocial). This chapter will further reinforce the argument of the thesis that, because of micropsychotic episodes at the time of an offense, these offenders should not be precluded from entering a plea of not guilty by reason of insanity (a Brief Psychotic Disorder) for the crime with which they are charged. In addition, they should not be looked upon with prejudice and should be allowed full disclosure of all exculpatory evidence.

Chapter Four, with its pertinent discussion of competency to stand trial, criminal responsibility and diminished responsibility, will introduce Chapter Five, which will illustrate various international approaches to the insanity defense. The reader will see that some countries have already amended or changed their insanity plea in general, introducing a more flexible approach and a more inclusive requirements, instead of the dichotomous and rigid approach of the M'Naghten Rule, especially in regard to offenders diagnosed with a personality disorder. In those countries, this group of offenders is viewed as suffering from a mental disorder and in need of treatment and rehabilitation. Special reference will be made to the court assessment of mentally disordered offenders and the therapeutic approach to personality-disordered offenders in the Netherlands.

Chapters Six will briefly illustrate the concept of due process of law, basic to impartial justice, and the attitude of jurors to the insanity defense. A discussion of the *Diagnostic and Statistical Manual* will clarify its limitations as a guiding manual of psychiatry when applied to legal issues, such as criminal responsibility, and any possible impact on it if the Federal Reform Act of 1984 is repealed.

Chapter Seven, together with Chapter One, is basic to the argument of this thesis. Chapter Seven will give a description of the manner in which the clinical forensic assessment of an offender is carried out. That will be followed by the presentation of the case studies of 14 personality-disordered offenders examined by the author, representative cases of similar offenders he has examined in his many years of forensic psychiatry practice. The case studies will be presented in order to demonstrate to the reader the rigidity of the Federal Insanity Reform Act of 1984, its blindness to new psychiatric scientific findings, and its antiquated legal approach to offenders, especially those offenders who suffer from a psychopathology that is at the basis of their antisocial acting out.

The concluding chapter will present a review of the argument of this thesis, its rational and methodological approach and the steps followed to prove its validity. A reiteration will be presented of the argument that the Federal Insanity Reform Act of 1984 should be amended to allow severe personality-disordered offenders to be given the opportunity to fully benefit from the due process of law and obtain the judicial attention that they deserve as members of a humane society.

Chapter 2. Personality and Aggression

As psychiatrist Mario Tobino (1963) wrote, 'Mental disease is such a mystery....(and) mental disturbances have multiple manifestations and, like an octopus, they branch into different areas of life, including the legal arena' (p. 47). Thus, before discussing individuals affected by personality disorders, their psychopathology, and their involvement in antisocial/criminal behavior, it is important to present a concise, illustrative reminder of what is intended by a *normal* personality and what are its principal components.

Personality is defined as the totality of emotional and behavioral traits characterizing a person's day-to-day living. It is relatively stable and rather predictable under ordinary conditions. It is the complex of psychosocial attitudes of humans that determines the way in which they react to the environment in virtue of their interests and needs, their goals, their behavior, and their psychological manifestations. Even though stable, it is not fixed and unchangeable; it evolves through the experiences of an individual's personal history. At its basis there is an idiosyncratic predisposition due to the biological self. For the purpose of this argument it may be said that, 'Personality is an organismic unity, embracing both physiological and psychological manifestations. Biological maladjustments can lead to serious disturbances in the cognitive and emotional life of individuals' (*Encyclopedia Britannica*, 1967, p. 695).

It is difficult to classify personality due to its variability, since each individual is unique. Nevertheless, attempts to classify it can be found in various groups of characterological typologies, whose use, however, is mainly facilitative. Personality is thought to be formed by various strata, including the vegetative-instinctive and temperamental functions, and, at a higher level, those designated as superior mental functions. Its homeostasis is ensured by the quasi-harmonious equilibrium among its different components. Since a continuous harmonious equilibrium is utopian, in different personalities one or the other of its components is more evident at different times.These components are affectivity, volition, impulsivity, and/or rationality.The personality types derive from these components.

Sociologically, personality signifies the functioning of the whole person and the unique organization of individuals that distinguishes them from their fellow human beings, with their particular functioning, distinctive traits, drives, attitudes and habits. It usually enables people to adjust to society and to themselves. An individual's personality style is exemplified by typical behavior patterns and characteristic responses to life events and stresses.The term personality traits describe these patterns and responses.Various scholars in the past, including Galen

(Chamorro-Premuzic, T., & Furnham, A., 2005), Kretschmer (in Thorpe, 1938), Freud (1960), Jung (1923), and, closer to us, Allport (1937), and others, have attempted to classify personality into types.

From a psychoanalytical point of view, persons with a mature personality are identified with the 'genital character of Rycroft (Charles Frederick Rycroft, English psychoanalyst), hypothetical, idealistic or utopian, which, having fully resolved the Oedipal complex, is totally free from…infantile dependency' (Giberti & Rossi, 1996, p. 304). Such normal or genital personalities should be free of the narcissistic and ambivalent tendencies of childhood, and have reached personal and interpersonal stability, not only in their sexual lives but in their capacity to be more flexible in their decisions and to conduct themselves adequately within the family and at work. They should be trustful of others and willing to share with them their successes and failures. At the same time, they should be adaptable to social changes. Sigmund Freud (1961) believed that mature persons have a substantial capacity to enjoy life in everything they do. They should be altruistic, have a sense of humor and be able to use sublimation, repression and the postponement of important plans or events when necessary.

Persons with a mature personality will demonstrate not only the courage of their own convictions but, at the same time, show consideration for the feelings and convictions of others.They should have a feeling of self-worth and personal security, and should be able to share prestige, recognition, profits and decision making, depending on the circumstances. Also, these persons should be able to design realistic goals to be achieved in the present or future; to reduce tensions by reducing the goals to be attained; to express feelings and opinions; to reduce conflicts between the self and social demands; to achieve a compromise, if necessary, between ego and super-ego; and to attempt to achieve a good degree of identification as a social being in a cultural milieu.

In summary, psychologically, persons with a mature personality are well integrated, of average or bright intelligence, with a consistent, even mood, and able to relate easily to others. They are free from gross anxiety, suspiciousness, inadequacies or feelings of grandiosity.

2.1. The Role of Character

Character connotes the personality in action. Therefore, before taking into consideration present-day views of the many disordered personalities that will be discussed, it is important to touch upon the concept and development of character. According to George Engel (1962), the formation of character is a process taking place during the latency period, from about age six to approximately age twelve,

when the child begins his relationship with people outside of his family. Engel stated,

> 'As the child assumes more and more responsibility for his own behavior and learns what is expected of him, the various patterns of ego defense concerned with impulse control tend to become crystallized in characteristic ways for each child. He now begins to show habitual patterns of reacting to external as well as to internal demands. These patterns in the aggregate make up what is generally known as character' (p. 133).

According to Engel's theory, the child first forms object relations and identifies with his parents, and then moves towards the outside world and the emancipation of the self and a better delineation of his character. There, he will be helped by teachers, peers, or others who have become important role models; at times, these may even be casual acquaintances or movie or television characters. In normal development, the child, through his new relationships, and while continuing his education, will usually be able to make the social adjustment that his family and peer groups expect of him, learning how to interact with others, both people he knows and those he does not, and his socialization and maturation is furthered.

Benigno DiTullio (1971), an Italian criminologist, was of the opinion that an individual tends to develop his character on the basis of his natural instinctive and affective propensities, aided in his maturation by the environment and education, all of which lead to habit patterns that become an intrinsic part of his daily activity. Character, then, is the composite of distinctive qualities, mental and ethical, which, stimulated by an individual's emotional sensitivity and habitual mode of reaction, give to each personality its dynamism. It is aided by the temperamental propensity of the individual. It is the outcome of life experiences, of togetherness, of give-and-take, of a conscious or unconscious adaptation of id and ego tendencies to the social dictates or appropriate modes of practical, moral and ethical behavior when confronted with choices. An absence of character or a bad character is found behind much senseless crime. This is evident in the person who suffers from a personality disorder, and is especially present in the interpersonal behaviors of the antisocial type.

2.2. Instincts

In order to better understand instinctual theories, such as those of Freud (1961), and of object relations theorists such as Melanie Klein (1935), Edith Jacobson (1964) and Otto Kernberg (1992), and the role that emotions and feelings play in the genesis of rage, hostility and aggression, the meaning of instinct should be clarified.

In animal life, instinct is equated with that internal *quid* which promotes actions useful to the life of the animal itself, for example, the survival instinct. In people, that can be translated as the natural propensity of the individual to perform acts or behave in ways, usually specific in themselves, to achieve anticipated aims. In psychology, the characteristics of what are called instincts are that they are inborn, unchangeable and heritable; for example, the survival, the maternal, and the sexual instincts. Basically, they are, by their own definition, independent from intelligence, even though a certain degree of memory is essential for their expression. In human behavior, instincts are less determinant of behavior than in animals, because neo-cortical humans use their intellectual capacities to inhibit or modify their instinctive reactions. Indeed, in the process of emotional growth, humans also develop notions and emotions that aid in controlling their basic instinctual tendencies.

2.3. Drives

Freud (1961) theorized that people are under the dominance of two major drives: *eros* and *thanatos*, two Greek words respectively meaning love and death. This apparently manicheistic approach of Freud is exemplified by the two oppositional forces of life and death. It may be interpreted in a general sense as a form of polarization used in the past to define human existence—the *alpha* and *omega* of the ancient Greeks, the beginning and the end. This interplay between the forces of life and those of death—Eros and Thanatos—seems to be central to peoples lives.

Freudian psychoanalysis recognizes the presence in all humans of a libidinal force which, when properly directed, helps the individual to achieve cherished goals. Freud (1961a) viewed aggression as being a reaction to frustration, consequent to the thwarting of the successful pursuit of libidinal inclination. In his later writings, in devising his theories regarding the various defense mechanisms, he came to view human aggression towards others as a displacement of a primary aggression against the self. Freud stated that primary aggression against the self, the death instinct, when turned away from the self becomes an aggressive, destructive force against others. In fact, he went so far as to suggest that because people are basically and naturally violent, if they were to collectively curb their interpersonal aggression, self-destructive impulses would cause their own annihilation. This shows possible distrust of the will power or the epicritical faculties with which people control their emotions. He believed, however, that aggression may be sublimated.

2.4. Emotions

As drives are important in determining violent behavior, or any type of behavior, so are emotions. Emotions, so important in the genesis of human conduct, normal or pathological, are difficult to define. One of the definitions (derived from the Latin *e-movere*—to move from) is 'a psychic and physical reaction (as anger or fear), subjectively experienced as strong feeling and physiologically involving changes that prepare the body for immediate vigorous action' (*Merriam Webster's Collegiate Dictionary*, 2001, p. 378). In other words, an emotion is a state of psychophysical agitation that moves the self away from a state of calmness. An emotion also can be defined as a feeling state or a feeling tone, present in an individual at a certain time, or as an augmentation beyond a certain level of a feeling that may be of joy, sadness, anger, fear, anguish, surprise, shame, disappointment. It may be the outcome of an external stimulation perceived by the individual or an imagination internal to the individual himself. It may be that psychic and physical manifestations of emotions are 'dressed-up' drives, the expression of phylogenetic drives, vested with ontogenetically derived feelings.

The universality of basic emotions argues strongly for their biological nature. As Dylan Evans (2001) wrote,

> 'If basic emotions were cultural inventions, their ubiquity would be very surprising indeed. If we suppose, however, that they are part of humanity's common biological inheritance, then their presence throughout the world is easy to explain. Just as all human beings have the same kind of body, with minor variations, so we all have the same kind of mind. This universal human nature is encoded in the human genome, the legacy of our shared evolutionary history' (p. 13).

Indeed, emotions are recognized as the *primum movens* of any human interaction. In an imaginative comparison, one could equate an emotion with the engine of a car. A car, even though having a beautiful chassis, is of no practical use unless supplied with power by its engine. It is especially through the power of the emotions that facial mimicry and body attitudes portray love or hostility, fear and aggression. When balanced in its oppositional antinomic feelings an emotional life becomes homeostatic and allows an individual to develop in accordance with the moral dictates of the society in which he or she lives.

In analyzing aggression and violence, one sees that the individual's instincts usually come under the control of emotions and the power of human rationality.

Emotions are frequently described, whatever their quality, as shallow, superficial, even, appropriate, congruous or incongruous with the thought content, intense and/or uncontrollable. They are strictly connected with affect and mood and their interplay forms that dynamic force, the *élan vital* of Henri Bergson (1988), that motivates behavior. But at times people suffering from severe personality disorders show irrational, or, more often, arational, emotions.

William James (1884) suggested the so-called periphery theory of emotion, which explains them as a confused perception of some physiological dysfunction of the human body. Sante de Sanctis (in Semerari & Citterio, 1975), an Italian psychiatrist, instead, in 1926, in attempting to explain the origin of emotions, proposed the so-called circular theory which stressed that for an emotion to be felt people had to first become aware of and recognize a particular affective value in perceptions. This would be followed by physiological changes that would, in turn, bring about, he said, a complete emotional state.

There are positive and negative emotions of different intensity, and violence, at times, reminds one of the 'vigorous action' described by James (1884), the anger turned into vengeance of Aristotle (1975), the passions of René Descartes (1985) or David Hume (1888), or of Freud's (1915) projections and displacements onto others of self-directed, hostile feelings. 'It is assumed,' wrote Chesire Calhoun and Robert C. Solomon (1984) 'that emotions are essentially the same in all people, the world over (but) there is some evidence that suggests that emotions may be different in different cultures' (pp. 33-4). However, contrary to the idea also proposed by Calhoun and Solomon, that emotions are rational and purposive, sudden violence gives the impression of irrationality, confusion, and lack of purpose.

The most common emotions behind violent crimes are rage and hatred. Rage, the primary affect of the frustrated infant, may become the major component of future aggressive behavior. Basically the precursor of hatred, rage is present in the child as a desire to eliminate an all-bad object relation and restore an all-good one. 'Clinically,..the analysis of rage reactions…always reveals an underlying conscious or unconscious fantasy that includes a specific relation between an aspect of the self and an aspect of a significant other' (Kernberg, 1992, p. 22).

Hatred, instead, is a complex affect through which an individual expresses deeply buried, ambivalent feelings towards the object of the hatred and a conscious desire to destroy that object as it is related to his fantasies or consciousness. It reflects the psychopathology of aggression and the predisposition of an individual to it. 'An extreme form of hatred demands the physical elimination of the object and may be expressed in murder or in a radical devaluation of the object that may be generalized in the form of a symbolic destruction of all objects' (Kernberg, 1992, p. 23). Sadistic tendencies and wishes to humiliate the objects and dominate it may be part of the feelings of hatred. Rage and hatred lead to hostility and aggression when a combination of angry thoughts and feelings are acted upon. With this shift, previous

attitudinal thinking is changed to motor or action oriented behavior. The aggressive act consists in the process of approaching another person with the intent of doing harm; the quality and the intensity of the aggressive act are referred to as violence.

2.5. Impulsive Aggression

Aggressivity is frequently connected with impulsivity, especially in the most explosive destructive acts. During a rage reaction, unable to contain their feelings, people behave in a socially unacceptable way and, careless of the boundaries of good interpersonal civilized conduct, do not weigh their thoughts or their feelings, but suddenly lash out in antisocial behavior. This is often observed in the Antisocial Personality Disorder (psychopath), the passive-aggressive personality disorder, and the paranoid and Borderline Personality Disorders. It is remindful of children who are unable to exercise their reflective capacity to the maximum of their potential because they are still immature.

Impulsive aggression also may be the outcome of overwhelming feelings of boredom and monotony in a lonely life, or of psychotic thinking, such as agitated schizophrenia or delusional schizophrenia. As Daniel Goleman (1995) wrote, 'There is perhaps no psychological skill more fundamental than resisting impulse. It is the root of all emotional self-control, since all emotions, by their very nature, lead to one or another impulse to act' (p. 81). Sudden acting out may signify a call for attention, acknowledgment, or for love.

Alan Swann (2003) stated that impulsivity should be viewed as a complex act defined as one 'without the ability to consider the consequences to one's self or others....a failure of a normal process by which, over about one-third of a second, a potential behavior is screened before it enters conscious awareness' (p. 26). Indeed, an impulsive act of aggression is rapid and acted upon without reflection, and the aggressor's behavior is frequently out of proportion to the contextual situation. Impulsive behavior is frequently part of severe personality disorders and of substance use disorders, at times as a predisposing factor and at times a resultant in the latter.

A distinction should be made between the so-called biologically inherited aggressiveness, which is obviously instinctual, and the hostile type of aggressiveness, which usually has an interpersonal origin and arises during the course of early life when the infant incorporates the mother's attitudes, including her hostility.

Psychologically, at the basis of impulsive hostility and aggressivity, one may find feelings of dependency, passivity, helplessness, a need to be loved which was frustrated in childhood, or a way to recapture a primitive maternal relationship, as Donald Winnicott (2008) proposed. A wish to control or dominate, the latter usually a reaction formation against tendencies to dependency and passivity, may be

present. At other times, fearing abandonment, an individual who has avoided any close relationship, often lonely and resentful, may exhibit explosive, inexplicable behavior towards those against whom he harbors ambivalent feelings or even against persons who are unknown to him. Often, an upsurge of feelings of frustration precedes such destructive acting-out, and at times confused, irrational behavior. Such feelings are usually long-standing and deeply buried within the unconscious or the subconscious of individuals suffering from severe personality disorder.

Neurotic, repetitive negative behavior is often a façade for more deeply based hostile and aggressive thoughts, a compromise that some people make during their lifetime in order to avoid narcissistic injuries, either realistic or fantasized. At times, feelings, usually negative in character, are ego dystonic and are perceived by the individual as dangerous to the psychological homeostasis of the self. Frieda Fromm-Reichmann (1959) believed that while humans usually tend to repress their basic hostile aggressivity, this repression is often unsuccessful and may manifest itself not only in physical illness, which is the most common form, but also in disruptive personality-disordered conduct. Karen Horney (1945) felt that hostility and the urge to kill or injure someone were often the result of feelings of humiliation or abuse suffered by the individual during earlier periods of his life, although both are certainly also experienced later in life.

2.6. Psychodynamic and Object-Relation Theories of Aggression

Anger, hostility, aggression and violence should be viewed as progressive manifestations, in a stepwise fashion, of the displeasure felt in and about life by a person with a shaky emotional equilibrium. Aggression is a behavior that is destructive of the self, of others, and/or of other people's property. Aggression can be distinguished as primary aggression and reactive aggression. Primary aggression is a goal-directed self-assertion of a hostile nature and destructive in character. Reactive aggression, instead, is usually concomitant to, and part of, an emotional reaction brought about by frustrating life experiences. Societal violence is representative of these two types of aggression: programmed/organized and impulsive, often expressed by the behavior of persons affected by severe personality disorders. Aggression can be subdivided into premeditated aggression, impulsive aggression and aggression caused by medical illnesses.

Emotional aggressive states are, at times, similar to the anger attacks described by Maurizio Fava and Jerrold Rosenbaum (1993), and are also a frequent part of a depressive reaction. Depressed individuals may be agitated and irritable and show psychomotor retardation. When treated with antidepressants they may act out in a violent way against others. This reaction seems to support the assumption that hostility and aggressivity are often repressed and that depression is the only possible

compromise that some people can make in dealing with these feelings. Anger attacks, preceded by irritability, are also part of the dyscontrol syndrome described by Karl Menninger (1963), and the limbic syndrome described by Russell Monroe (1978). They may occur when, for fear of losing a love object or a cherished relationship, a person turns his or her aggression against the self.

Freud, in his book, *Civilization and Its Discontents* (1961a), wrote, 'Men are not gentle creatures who want to be loved, and who at the most can defend themselves if they are attacked; they are, on the contrary, creatures among whose instinctual endowment is to be reckoned a powerful share of aggressiveness' (p. 68). On the basis of his theories, Freud hypothesized that behind some criminal actions there may be a conflict at the level of the Oedipal relationship for which the crime itself could be the means to call upon oneself punishment for the Oedipic guilt.

Not all aggression is negative. Paul Schilder (1942) proposed that as the child grows in the definition of his body image he becomes more active and tries to master the world around himself. That requires a certain amount of aggressivity, which at times is mixed with sexuality. Eventually, however, helped by the positive controlling influence of the family and social mores, the child masters this aggressivity.

Several theories on the psychological development of the infant shed light on the development and understanding of aggressive behavior. Heinz Kohut (1971) theorized that a child achieves individuation and self-esteem when he is able to tame the archaic, grandiose and exhibitionistic self. Kohut believed that this is a necessary process for an ego-syntonic purposeful adult personality development. However, he also thought that due to a narcissistic trauma in early infancy, the child may not progress towards maturation and may still retain within himself the presence of a disappointing parental imago. At the core of his psychological self, even during his adult life, there would then be the presence of what Kohut refers to as an archaic transitional self-object, usually required for the maintenance of a narcissistic homeostasis.

2.7. Margaret Mahler

Margaret Mahler (1972) proposed that the child, through a process of individuation, achieves intrapsychic autonomy, and with the separation from his mother obtains differentiation, distancing, boundary structuring and disengagement. She stressed the importance of the necessity for the optimal emotional availability of the mother in a mother-child relationship, believing it to be essential for a wholesome resolution of a prior symbiotic relation and for the achievement of the child's autonomy and self-concept. She felt that an infantile neurosis may ensue when the child becomes frustrated in his effort to force the mother to be an extension of his omnipotent self.

During this period, according to her hypothesis, the child also fears being reincorporated by the mother and thus unable to separate himself from her.

Mahler's ideas are pertinent to the problem of aggression because she believes that the foundations for aggression are laid down in a child's psyche during the period of early infancy. At that time, delusions of omnipotence, feelings of dependency, and also self-denigrating tendencies, are part of the budding psyche of the child. It is during this period that the child may also become aware of his rage and hatred towards a castrating mother about whom he is highly ambivalent. Mahler's thoughts may be one explanation for aggression in contemporary society, and are particularly pertinent to rape. The past history of many offenders often reveals ambivalent feelings about their mother, who, by force of circumstances, assumed both paternal and maternal roles during their upbringing and, in so doing, increased their ambivalent attachment to her. Emotional separation from her, then, often becomes difficult, provoking feelings of hostility, frustrated dependency and rage. At times these feelings may be part of their violent behavior, especially towards women.

2.8. Melanie Klein

Important in understanding personality disorder are an individual's internal object relations. To this effect, the work of Klein (1964), Jacobson (1964), and Kernberg (1992) are paramount. Klein (1935) believed that the child necessitates a good relationship with his mother, and that the first few years of life are very important for resolving the early paranoid anxiety generated by the introjection and projection of those good and bad 'imagos...fantastically distorted pictures of the real objects...in the outside world...(and) also within the ego,' (p. 145). She proposed that during this early period of life the child perceives the mother's breast both as a source of nourishment and as a frustrating object and that this may lead to later tendencies towards depressive states and to paranoid fears.

Klein developed a theory of internal object relations that is intimately linked to drives. She realized the importance of unconscious intrapsychic fantasy. She postulated that the ego, in self-defense, may go into a splitting process and accepted Freud's postulation of the death instinct expressed by aggression, hatred, and sadism. She emphasized the persecutory anxiety of the child, subsequent to his ambivalence towards the mother and due to his fear of retaliation by the bad mother. She also viewed a paranoid-schizoid position as a consequence of the child splitting his experiences into good-bad (good mother-bad mother), followed by a depression position due to his hostile-sadistic fantasies against his mother and his consequent guilt.

2.9. Edith Jacobson

Edith Jacobson (1964), also an exponent of object relations theory, was of the opinion that

…..'the ego and self-images and object images exert reciprocal influences on one another's development….Satisfactory experiences lead to the formation of good or gratifying images, whereas unsatisfactory experiences create bad or frustrating images. Normal or pathological development is based on the evolution of those self images and object images' (p. 256).

2.10. Otto Kernberg

One of the most influential object relations theorists is Otto Kernberg (1992). Kernberg's theory is basically derived from his studies of the Borderline Personality Disorder. He emphasizes splitting of the ego, good and bad self configuration, and object configuration.

'Although he has continued to use the structural model, he views the id as composed of self-images, object images, and their associated affects. Drives appear only to manifest themselves in the context of the internalization of interpersonal experience. Good and bad self-relationships and object-relationships become associated, respectively, with libido and aggression….The dual instincts of libido and aggression arise from object-directed affective states of love and hate' (Kaplan, Sadock & Grebb, 1994, p. 256).

The term borderline personality organization, coined by Kernberg, is a composite of ego weakness, absence of superego integration, lack of identity, presence of splitting and projective identification (primitive defense mechanism) shifting into primary process thinking if necessary.

After Kohut, Kernberg is the best commentator on the issue of narcissism in contemporary object-relations theory. He gave importance to Kohut's object-relations and to Freud's and Klein's drive theory, and to the emergence of aggressive impulses of the narcissistic patient within the context of therapy exemplified by the analysand's grandiosity: 'You are nothing. I am great' toward the analyst and using the analyst as a 'lavatory' into which all aggressive and envious impulses are discharged. That is the essence of the pathological narcissism so common among psychopaths and serial killers, which involves exaggerated infatuation and obsession with one's self to the exclusion of others, chronic pursuit

of personal gratification and attention, personal ambition and social dominance, lack of empathy for others and use and abuse of others to meet whatever is necessary for their *aggrandissment*.

Kernberg (1992) subscribed to an artificial division between object libido (energy directed at people) and narcissistic libido (energy direct at the self). Pathologic narcissism, according to Kernberg, depends on the relation between the representation of the self and the representation of objects. It is the libidinal investment in a pathologically structured self rather than in a normal integrative structure of the self. The self of the narcissist is devalued and often prone to aggression.

Kernberg (1992) posited the idea that the infant is prewired to form destructive schemes of himself and others. Cognitive and affective potentials facilitate, he said, the relationship of the infant with his mother. Object relations are initiated by 'a central biological function of inborn affective patterns with their behavioral, communicative, and psychophysiological manifestations' (p. 15) and signal the infant's needs to the environment (the mothering person) and thus to initiate the communication between the infant and mother that marks the beginning of intrapsychic life. He postulated that the infant's affective memories of earlier experiences (good and bad mother perceptions) are stored in the limbic system. They may be reactivated later in specific relationships.

> 'The memory structures constitute the early precursors…of more specialized and adaptive ego functioning...which are gradually integrated into the affective memory structure and also contribute to the later stages of integration of total consciousness' (p. 16).

It is assumed that the infant has many gratifying and concrete experiences with his mother and the environment that will form a complex world of affective object relations which are internalized as good object relations. According to Kernberg (1992), 'Love and hate thus become stable intrapsychic structures…for organizing psychic experience and behavioral control…through various developmental stages' (p. 20). That will give birth to libido and aggression, which will later become driving affects. In the normal formation of character, defenses 'push the dynamic unconscious deeper and deeper into the psychic apparatus' (p. 19) contributing to the concomitant formation of ego and id. *This dynamic unconscious and its pathological primitive complexes at times erupt into consciousness, especially in persons with severe personality disorders as well as in those with psychoses.*

2.11. Donald Winnicott

Donald Winnicott (2008) was the central figure of the British school of object relations theory. His theory of multiple self organizations included a true self, which develops in the context of a responsive holding environment provided by a good-enough mother. However, after traumatic disruptive experiences, a false self emerges that monitors and adapts to the conscious/unconscious needs of the mother and, in so doing, provides a protective exterior behind which the true self is afforded the privacy that it requires to maintain its integrity. Transitional objects, Winnicott wrote, such as a substitute mother, give a soothing sense of security. Important for the argument here presented is that Winnicott viewed impulsive deviant behavior as the way in which a child hopes to recapture a primitive maternal relationship.

2.12. Other Object-Relations Theorists

In his explanation of violent behavior, Otto Fenichel (1945) subscribed to the theory that views frustration as a prerequisite of aggression. In fact, many violent offenders report having encountered a great deal of abuse and frustration throughout their childhood and adolescence.

John Dollard and collaborators (1939) theorized that frustration brings annoyance and that a continuous reinforcement of the frustrating situation will promote feelings of hostility and eventually an aggressive response. That response, however, can be modulated in its expression by inhibitory forces when the individual realizes the possibility of ensuing punishment. Gratification versus punishment is, indeed, a dilemma that the individual faces in determining the degree of aggression that he will express. Only a small percentage of people encountering frustration show aggressive behavior in dealing with others, however. It is probable that aggressive reactions are due to factors idiosyncratic to each person, or that some people may be able to contain their aggressivity through the restraining effect of moral values to which they were exposed during their upbringing. It is only at a later point in their life, during stressful and frustrating situations, that their removed hostility may unleash itself.

It is doubtful that the frustration-aggression theory, even though interesting, can totally explain violent behavior. There is no doubt, however, that an early positive relationship between the child and his mother, and the child and his environment, is essential for healthy emotional development. One can safely assume that the lack of development of feelings of trust, security and love in the child may be fertile ground

for a propensity to hostile, aggressive, or destructive behavior, not only in childhood and adolescence but in adult life as well.

John Bowlby (1988) suggested that the exposure to good parenting enables the child not only to develop normally and to become emotionally balanced but also to develop the capacity for a certain degree of resiliency that will enable the child/adult to withstand frustrating and unpleasant events that are often encountered in life. When, during its developing years, a child does not have the possibility of internalizing parental dictates, either because there are no parents present, or because there is only one parent who is often overwhelmed by myriad stresses, the child becomes easy prey to the many frustrations and negative emotions that may lead to aggressive behavior.

Other scholars have also attempted to explain the origin of aggressive violent behavior. Gunter Ammon (in Semerari & Citterio, 1975), like Mahler and Klein, described aggression as the result of a primary disturbance in the very early mother-child relationship. Heinz Hartmann (1958) thought it to be a reaction to feelings of dependency. Menninger (1963) described such behavior as a progressive 'dyscontrol' type of reaction. Carl Jung (1957) thought it was the expression of an unconscious drive. Jules Massermann (1961) stated that aggressive behavior is an attempt to eliminate any obstacle found on the way to self-interest and pleasure. In fact, at times the interplay between loss of self-esteem and conflictual narcissistic aspirations may result in explosive dyscontrolled behavior.

Deviant identification, as Ronald Blackburn (1993) suggested, could be another way of becoming delinquent and aggressive. This implies that the delinquent behavior in a son of a father with a history of violence and criminal activity is the reflection of normal identification with that criminal father, the son having introjected his fathers attributes.

2.13. Philosophical Notes

The view that brain dysfunctions may contribute to criminal behavior is not new in the history of philosophy, psychiatry or the law. Plato (429-347 BCE) seems to have supported a disease theory of crime when he stated, 'For no man is voluntarily bad; but the bad becomes bad by reason of an ill disposition of the body…(which) happens to him against his will' (in Redding, 2006, p. 55). Plato, upholding the Socratic paradox, also wrote, 'No one does wrong willingly' and asserted that all crime is involuntary, in the sense that the criminal has been 'conquered against his real wishes, by ignorance or anger or bad education or pernicious environment' (Saunders, 1975, p. 32).

In his book, *The Rationality of Emotion*, Ronald de Sousa (1987) reminds us that Plato, in assessing the soul (at the time the soul was considered to be the seat of

emotions), used a model which included not only emotions, but also reason and desire. Aristotle (384-322 BCE), instead, viewed the soul of a person—the psychic part of a human—in a functionalistic way, assuming that the soul's faculties were 'layered series of increasingly complex capacities, where the higher presupposed the lower: nutrition and growth, sensation, movement, desire, emotion, reason' (p. 21). De Sousa writes about what he terms 'the *Walberg view* in honor of Horace Walpole and Henri Bergson' (p. 287), combining both the Platonic and Aristotelian views with their componential and functional aspects, viewing man as the dynamic expression of the interplay of different faculties.

Plato, in *The Republic*, discussing the importance of the formation of an individual's character, advocated uprightness. He suggested that, ideally, character training should precede intellectual training (Hare, 1982). Indeed, he believed that right thinking and right ideas, leading to right habits and dispositions, should first be implanted by non-intellectual training so that a person might acquire the necessary knowledge of the *Good* in order to determine which opinions are right; it would then be safe, at a much later age, to introduce people to philosophy. This has been partially the conditioning that parents have exercised on their children for centuries, generally with good results on the children's moral character formation.

While Plato stressed the formation already in childhood of good character and right thinking, important in the acquisition of a moral life, Aristotle believed that '...character produces plans that express an overall unity of the ends of life. Such planning is carried out by the *deliberative capacities* and a capacity to make *rational choices* (*prohaireseis*). These choices involve the assessment of actions as they cohere within some overall system of good living...' (Sherman, 1989, p. 58). Further expanding on his ideas, Aristotle added that in order to have rationality one must think of oneself as connected with the future. He maintained that making reasoned choices gives the individual a sense of self and purpose and enables him to acquire practical wisdom (*phronesis*). The above qualities are not part of the personality or character of an individual with an Antisocial Personality Disorder (psychopath) or of individuals with other personality disorders who are frequently involved in antisocial acts.

There is an obvious difference between the ways in which Plato and Aristotle looked at character. Plato thought of it as the outcome of conditioning first and of intellectual knowledge later, while in Aristotle's view the opposite is true. Even though these two views are still being debated in society, it is probable that they are not mutually exclusive.

Aristotle wrote that 'the ability to plan, schedule, and integrate will be pointless in a life devoted to the cravings of the moment' (Sherman, 1989, p. 109) as, for example, is the case of the psychopathic personality disorder. He was also skeptical that persons living should a life would have the capacity to change. Indeed, he believed that what he termed 'the vicious person' does not have the ability to study

and see human goodness. He thought that passion would yield to force rather than reason and that 'such (an unreasonable) person does not listen to arguments that dissuade him, nor understand them if he does' (Sherman, 1989, p. 113).

Much later, during the Enlightenment, philosophers, such as Immanuel Kant (1724-1804) and Arthur Schopenhauer (1788-1860), reflected on human nature, mental illness, free will and criminal responsibility. The thinking of Kant, the philosopher of the categorical imperative, substantially influenced the question of accountability in forensic psychiatry. In *The Metaphysics of Morals* (1996), he reflected on crime: 'Crime is a public act (*crimen publicum*)' (p. 105), he wrote. A crime is directed in a sense against the law itself while violating another person's freedom and treating him as an object. Kant believed that if, at the time of an offense, an offender possessed understanding and judgment, he should be punished because he knew what he was doing. That punishment, he believed, should be retributive and by the State, in order to protect society. For Kant, punishment by a court (*poena forensis*) would restore the legal order disrupted by the crime. However, he cautioned that before any punishment was given, the court must be certain that an offender was guilty.

Kant indirectly addressed insanity or diminished capacity when discussing guilt, blame and punishment. In discussing the notion of the freedom that any person should be able to exercise, he laid the foundation for the legal accountability that is so important in forensic psychiatry.

Kant described the psychiatric entities as amentia, dementia, insania and versania. In amentia (*Unsinnigkeit*), 'the imagination is so lively and chaotic that understanding is unable to put intuitive knowledge into any sort of order.' In cases of dementia (*Wahnsinn*) 'understanding is able to create order, but because imagination has run wild, fantasies are taken for sensations….' (and in insania (*Wahnwitz*)), 'the intuition is intact, but the faculty of judgment is disturbed so that consistence is based on no more than vague analogies' (Mooij, 1998, p. 339). Kant described versania (*Aberwitz*), instead, as a disorder of the function of reason, most resembling what is now called schizophrenia. After giving an explanation of how intuition, imagination, understanding and fantasies play together in creating these disorders, he concluded that the causes are either hereditary or endogenic. This somewhat supports recent views on the underlying scientific findings not only in psychosis but also in severe personality disorder as will be discussed.

Schopenhauer, one of the most important German idealist thinkers, believed that the will acts as a reaction to external stimuli and that cognition must be actively involved for free exercise of the will. He thought that if cognitive functions are sufficiently disturbed freedom is compromised and 'a will so afflicted is not free…(and) the offender should not be punished' (Feltous, 2008, p. 17). Regarding criminal responsibility Schopenhauer advanced the notion of partial criminal

responsibility when a criminal act was due to emotions or to intoxication, because at those times intellectual freedom is partially impaired.

2.14. From Kraepelin to Kernberg: The Psychotic Personality Organization

Descriptive psychiatry laid down the essential foundations for a future deeper understanding of the workings of the human mind. Emil Kraepelin (1915) focused his observations on disturbances of the cognitive processes, delusions and hallucinations. Eugen Bleuler (1911/1960) proposed that psychoses have dysfunctions of associations, affect, autistic thinking and ambivalence (the four As). Kurt Schneider (1959) described the first-rank and the second-rank symptoms of schizophrenic psychosis. And Gabriel Langfeldt (in Kaplan et al., 1994) differentiated true schizophrenia from schizofreniform psychosis.

Later, Sigmund Freud (1960; 1961; 1964), Carl Jung (1957) and Paul Federn (1952) delved into the inner dynamics of a person's psyche, and the understanding of the psychological functioning of the human mind further progressed. Human irrational behaviors began to be seen as due to ego weakness, unconscious conflicts, ambivalent relationships with parents, sexualized drives, frustrated anger, hostility, aggression, and a search for affection and love. The Oedipal and the Electra complexes were born, along with the topographical model of the mind with its conscious, preconscious and unconscious systems, as well as libido, libidinal drives and libidinal aggression.

Freud codified the psychosexual development of the child and the tripartite structural model of Ego, Id and Superego. He later defined aggression and sadism as two separate instincts. One of the interesting proposals of Freudian theories was that human behavior is partially driven by intrapsychic unconscious complexes, which could be revealed through analysis. Through such analysis a person's motivations and behaviors could be understood and dealt with when necessary.

In the United States, Adolf Meyer (1957), even though accepting a dynamic approach to mental disorders, established a psychobiological approach to them. For a long period thereafter, especially following the advent of psychopharmacology, psychoanalysis in its various forms lost its therapeutic preeminence.

The present-day interest in a behavioral approach to psychiatric disorders attempts to change behaviors without delving into the reasons behind them, the inner unconscious conflicts that psychoanalysis and dynamic psychiatry believed to be the primary factors for neurotic and psychotic conditions. This only partially-therapeutic approach is more evident in the diagnosis and treatment of people suffering from severe personality disorders, who frequently use what Wilhelm Reich (1945) called

'character armor,' a characteristic defensive style used to protect oneself from internal impulses and interpersonal anxiety in significant relationships. Indeed,

> 'the unique stamp of personality on each human being is largely determined by the person's characteristic defense mechanisms….(W)hen defenses work effectively, patients with personality disorders are able to master feelings of anxiety, depression, anger, shame, guilt, and other affects' (Kaplan et al., 1994, p. 733).

In order to fully understand the occasional destructive psychotic behavior of those individuals suffering from severe personality disorders, about whom this thesis is concerned, it is important to have a clear understanding of the pre-psychotic and psychotic personality organization, as the object relations theorists have attempted to do. Object-relations theory offers a greater social view of psychological development than the Freudian one, as pointed out earlier. It sees the individual as formed in relation to, and seeking connection with, other individuals; and it emphasizes a gradual differentiation of the self through the reflections of experiences that the infant/child has had with real people, especially the primary objects, which eventually will be transferred into internal objects. Central to object-relations theory is the primary relational attachment of the infant to his mother.

Among the most relevant ideas for the present argument are those of Otto Kernberg (1984; 1992) and William Meissner (1984; 1988). Their object-relation theories, a further development of Freudian thought and ego psychology stressed the early psychopathology in the infant/child's development, which will later influence his behavior.

2.15. Kernberg's Psychotic Personality Organization

Kernberg's description of the psychotic personality organization is basic to the understanding of patients suffering from severe personality disorders, such as the Borderline, the Paranoid, the Schizotypal, Schizoid and the Psychopathic Personality Disorders. His (1984) model of self- and object-development comprises five stages. These stages are not static and basically involve the internalized object-relation unit, which refers to the representation that the infant/child has of his parental unit or parental surrogate unit.

- First Stage: A state of normal autism, which goes from birth to one month. Margaret Mahler (1972) called this normal autistic phase a state of half-sleep, half-wake. The main task of this phase is to achieve homeostatic equilibrium with the environment.

- Second Stage: This stage goes from two months to six-eight months. There is an inability to integrate opposing affective valences. Libidinally invested and aggressively invested representations are strictly separated with a 'good' self object representation and a 'bad' self object representation. (Up to five months of age the infant has only a dim awareness of his caretaker.) During this stage, the child is still apparently in a state of undifferentiation or fusion with the caretaker. After five months he is more alert and able to do comparative scanning, comparing what is and what is not the mother.
- Third Stage: In this stage, from six-eight months to 18-36 months, differentiation between the good self and the good object and the bad self and the bad object take place. The separation between the self and others is called splitting. This will protect the good representation from the contamination by a bad representation of the mother. The failure of the child to differentiate between himself and others results in a psychotic personality organization.
- Fourth Stage: There is an integration into a definite self system and a total object representation of the good (libidinally invested) and bad (aggressively invested) self and object representation. The child is able to understand that the Self and the Other (mother) may have positive and negative characteristics at the same time. An inability to proceed in this task results in a borderline, pre-psychotic personality organization, and the child regresses to Stage Three.
- Fifth Stage: There is a consolidation of the Superego and Ego integration. Ego, Superego, and Id become definite intrapsychic structures. Through interaction with others the child's good and bad affects become consolidated and shaped into libidinal (good affect) and aggressive or destructive (bad affect).

Kernberg (1984) also proposed three broad mental structural organizations corresponding to 'neurotic, borderline and psychotic personality organizations' (p. 5) whose function is to stabilize the mental apparatus of the individual. These personality organizations have idiosyncratic characteristics reflected by 1. degrees of identity integration; 2. type of defensive operations used; and 3. capacity for reality testing.

Psychotic personality structures are dominated by the defense mechanism of splitting (Freud, 1964). Reality testing is good in neurotics, still present in borderline personalities, but severely impaired in psychotic organization. 'Borderline and psychotic structures…are characterized by a predominance of primitive defensive operations, especially the mechanism of splitting' (Kernberg, 1984, p. 15). Splitting

is a mechanism that protects the ego from conflict and anxiety by keeping apart by means of dissociation contradictory experiences of the self and important others.

In splitting, aspects of self and others are defensively separated into 'all good' and 'all bad' representations. The individual sees and experiences others and the environment on the basis of internal splitting. It is a defense against aggressive impulses, which the individual fears may dominate and destroy the good part of the self and the good object representation. Splitting can be considered a safeguard. Its purpose is to aid the individual not to feel the emotional pain of abuse, neglect, or plain disappointment in the original relationship with important object relations (mother, father, or parental substitutes).

The inability to fuse, to overcome the splitting, is due to the intensity of negative feelings that overpower the positive ones, and makes it impossible for them to join in a single object relationship. The good and the bad create an ambivalent state of mind with the behavioral manifestation proper of the borderline or psychotic individual—chaotic, changeable, unexplainable—driven by an underlying ego weakness, with poor impulse control, poor frustration tolerance, a proclivity to primitive ego defenses, identity diffusion and affective instability. That follows a continuum that ends with the psychotic personality organization in which reality testing is grossly impaired.

A psychotic personality organization, as well as a borderline pre-psychotic personality organization, uses defense mechanisms such as primitive idealization, projective identification, denial, omnipotence, and devaluation. These primitive mechanisms serve to protect the individual from further disintegrating the rapport between self and object.

Primitive idealization consists in increasing artificially and pathologically their quality of 'goodness' and 'badness' (and) creates unrealistic, all-good and powerful images. *Projective identification* is the tendency to experience the impulse that is 1. simultaneously being projected onto another person; 2. fear of the other person under the influence of that projected impulse; 3. the need to control the other person.

Denial, according to Kernberg (1984), is manifested by 'a complete lack of concern, anxiety, or emotional reaction about an immediate, serious, pressing need, conflict or danger in (a) patient's life….(and) his own apparently indifferent or callous attitude about himself or important others' (p. 17). *Omnipotence and Devaluation* consist in the 'activation of ego states reflecting a highly inflated grandiose self relating to depreciated, emotional degrading representations of others' (p. 17).

Identity diffusion refers to a personality organization that is not integrated or cohesive, but is based on multiple contradictions and self images or object images that are poorly integrated or not integrated at all. Because of that, the individual changes opinion rapidly and often spontaneously, regarding the self and others. At one time he seems to evoke one self image or one object image, and at another time

different ones. This state of psychological (inner) confusion seems quasi irrational and is not conducive to a comprehensive view of the self or objects, and the pre-psychotic/psychotic individual experiences a sense of emptiness. This instability also involves the affective sphere with irritability, hostility and aggressivity that alternate with love, praise and the overvaluing of self and objects. One could think, as does Meissner (1984; 1998) that, from an ego-psychology approach, the identity diffusion and affective instability follow a pattern of strength and weaknesses in a spectrum of levels and degrees of pathological personality functioning.

The ego also serves to keep the anxiety tolerance high, to exert active control and aid in sublimation. A psychotic personality organization reveals 'impairment in superego integration.., (and) primitive sadistic and idealized object representation' (Kernberg, 1984, p. 21). Nevertheless, the pre-psychotic borderline personality organization, in spite of severe psychopathology in various areas such as identity integration, object relations, and defensive organizations, may still have a fairly good superego integration. What and how the individual experiences object relations is idiosyncratic and determines in both the borderline and psychotic organizations the persistence of chaotic drives and fears, a state of pansexuality, and an aggregate of unsuccessful pathological attempts to unconsciously resolve the quandary in which he finds himself.

As stated earlier, in trying to further clarify the object relations theory of development, Kernberg (1984) stated that the infant organizes his object-relations experiences as positive or negative (splitting), all good or all bad objects. Later, around the age of two-three years, splitting is substituted by libidinal object constancy, meaning that the child is able to maintain a constant emotional image of the mother or mother substitute as basically good but also having bad qualities. In other words, the child acquires more objectivity as he develops neurologically and becomes more independent. For Mahler, object constancy, which occurs from 24 to 26 months in the developmental phase, consists in the child having a mental representation of a reliable and stable mother (Kaplan et al., 1994, p. 262).

While Kernberg thought that in the borderline and the psychotic personality organizations the primary failure is one of integration of good and bad self images around the age of two or three years, depending on the maturation of the child, Gerhard Adler (1985) believed that the failure of integration is due, instead, to the absence or the functional insufficiency or instability of a special type of introject. He called it the *holding introject*. According to Adler, the person with a borderline personality has had difficulty in internalizing this type of introject and because of the lack of its holding and soothing, he continues to be dependent on the other. Basically, if the child feels accepted and loved, cuddled and fed, he develops trust in his mother or mother substitute. And, once emotionally comfortable, he will be able to easily integrate the bad and good object images and will see others in their entirety, accepting them as holders of both positive and negative qualities.

William Goldstein (2008) opined that it is not always deprivation, privation or neglect that bring about the borderline or psychotic personality organizations but that it may be due to the opposite, that is, an engulfing, overindulgent, overintrusive, overstimulating mother or caretaker, who does not allow the infant/child to become autonomous and separate. As a result, the infant/child remains fixated in a quasi-symbiotic relationship with the important other. (See also, e.g., Masterson & Costello, 1980; Rinsley, 1982).

This is remindful of the schizophrenogenic mother of Frieda Fromm-Reichman (1959), the cold, distant and neglectful, but all engulfing mother. Goldstein believes that the pre-psychotic borderline individual has two basic problems: one is the lack of positive (holding and soothing) introjects, and the other the difficulty in integrating positive and negative introjects.

In addition, in the person with borderline personality organization, reality testing, thought processes, interpersonal relations and adaptation to reality appear to have relative intactness, even though with profound fluctuations due to relative ego weakness. These persons easily break down in various degrees in differing situations. However, on closer scrutiny they share with the psychotic personality a certain weakness of the ego, poor tolerance for frustration, poor impulse control, identity diffusion and affective instability, and the tendency to use primitive ego defenses. These weaknesses are beneath the surface but are quite visible during regressed states.

2.16. Reality Testing

Reality testing is negatively influenced by primitive defense mechanisms as they change a person's perception of the self and others. *Reality testing* for Kernberg (1984) is 'the capacity to differentiate self from non-self, intrapsychic from external origin of perception and stimuli, and the capacity to evaluate realistically one's own affect, behavior, and thought content in terms of ordinary social norms' (p. 18). Clinically, reality testing is free from hallucinations or delusions and bizarre affect, thoughts or behaviors. The individual has the capacity to empathize. Usually, reality testing is poor or absent in the psychopathic personality organization but present and fluctuating in the borderline personality organization. It is interesting to note that Federn (1952), through his phenomenological ego studies, came to the conclusion that the ego's capacity to discriminate between ego and non-ego, or between what he called 'inner mentality' and 'external reality,' is due to the immediate perception of 'real' and 'unreal,' independent of any reality testing, by a particular sense which he called 'sense of reality' (Weiss, 1960, p. 6).

2.17. Summary

In this chapter, a description of the normal personality is presented. Personality is defined as the totality of emotional and behavioral traits characterizing a person's day-to-day living. Every individual's personality is unique and stable, with distinctive traits, drives and attitudes. The stable personality has a certain degree of flexibility depending on circumstances. A descriptive analysis of basic instincts and emotions and their interplay in the development of both a mature, stable personality and a disordered personality is offered. Instincts are the natural propensity of an individual to behave in a certain way in order to achieve anticipated aims. Emotions, viewed as the *primum movens* of all human interactions, are defined as a psychological and physical reaction (e.g., anger and fear) experienced as strong feelings and a physiological preparation to immediate reaction, such as in the expression of love, or the fight or flight reactions. They can be positive or negative, and they can be intense, as for example in hatred or violence.

The importance of character for a well integrated and consistent personality is also described. Character is defined as the personality in action. Character, the composite of distinctive qualities, both mental and emotional, expresses a person's dynamism in his interpersonal relationships.

In the section on philosophical notes the reader is briefly acquainted with the ideas of Plato regarding the importance of an individual's character formation in his moral life and his deliberative capacity. A reference to Plato is important because already in the fourth century BCE, he believed that no one wishes to be bad, but becomes so because of an unwanted physical and mental predisposition. This idea supports the argument of this thesis.

Reference is made to the many scholars who studied the interplay of emotions, affect, mood and impulsive aggression. They include Henri Bergson, William James, René Descartes, Sigmund Freud, Donald Winnicott and Otto Kernberg. While Winnicott (2008) describes the emotion of impulsive aggression as a way to recapture the original maternal relationship, Kernberg (1992) posited that an extreme form of hatred leads to the physical elimination of the hated object. Such behavior is observed at times in offenders with personality disorders.

Anger, hostility and aggressive violence are described as progressive manifestations of negative feelings, as well described in the dyscontrol syndrome of Karl Menniger and in the limbic syndrome of Russell Monroe. The object-relation theory of aggression is briefly presented and the theories of Heinz Kohut, Margaret Mahler, Melanie Klein, Edith Jacobson, Otto Kernberg and Donald Winnicott are viewed as shedding light on adult aggressive behavior. Indeed, through the process of individuation, and the tendency of the child to achieve self-esteem and intrapsychic autonomy, he may develop, because of a poor relationship with his mother, early paranoid anxiety and distorted introjected good and bad imagoes (e.g.,

nourishing or frustrating mother's breast). This is of paramount importance in the child's future relationships as an adult and it may play into his later experience of feelings of rejection, hatred, love, aggression and violence.

Kernberg (1992) postulated that the infant's affective memories of earlier experiences are stored in the limbic system. These memories may be reactivated in specific relationships. At times, when under stress, the dynamic unconscious and primitive pathological complexes erupt into consciousness in persons with severe personality disorders, as well as in those with psychosis. Kernberg's pathological narcissism is frequent among psychopaths and serial killers. It derives from the chronic pursuit of personal gratification present in infants.

A reference to Immanuel Kant's description of the various dementias is introduced because Kant believed that the state of mind of the demented person who lacks understanding and judgment is probably due to hereditary or endogenic factors. This strengthens the idea that abnormalities of the brain, anatomical and functional, presently noted in static and functional neuroimaging, were already envisioned in the nineteenth century.

Mention is made of Arthur Schopenhauer, who believed that if a person's cognitive functions are sufficiently disturbed the will is not free in its choices. An offender with such a dysfunction, he thought, should not be punished. He upheld partial criminal responsibility in such cases. This is the basic argument of this thesis.

At the end of the chapter, after briefly acknowledging the most important scholars of the descriptive, psychoanalytic and dynamic periods of psychiatry, a further discussion is presented of object relations theory, which emphasizes the gradual differentiation of the self through the reflective experiences that the infant/child has with his primary objects (mother and mother substitutes). The resolution of the child's inner feelings towards his introjected bad and good imagoes is pivotal to his proper development and its improper resolution could have negative consequences in his adult relationships. Subsequently, the five stages of Kernberg's model of Self and Object development are reported and the stages of undifferentiation, differentiation, understanding of self and other, and the formation of Ego, Superego, and Id structures are briefly discussed. The neurotic, borderline and psychotic personality organizations and the defensive mechanism of splitting are briefly touched upon. Special mention is made of reality testing.

Chapter 3. Neuroimaging Studies in Schizophrenia

Schizophrenia is a disorder of the brain with characteristic abnormalities in thinking, emotions and behavior. It is a major psychosis. The diagnosis is made based on a particular constellation of symptoms that are divided into positive and negative. The negative symptoms (primary) are emotional blunting, apathy, and avolition. The positive symptoms (secondary) are delusions, hallucinations or irrational behavior. These key features of schizophrenia are the specific diagnostic criteria approved by the American Psychiatric Association in the *DSM-IV-TR* (2000).

The primary symptoms of schizophrenia negatively affect the social and occupational lives of the individual, and the illness, if untreated, has a chronic progressively deteriorating course. The symptoms may also include derailment of thought, tangentiality, incoherence, ideas of reference, delusions of being controlled, thought broadcasting, thought insertion, grandiose and religious delusions, persecutory paranoid ideas and hallucinations. The affect is usually described as flat or largely incongruous with the thinking. At times, genetic and sociological factors are at the basis of the illness. There are several types of schizophrenia, of which the paranoid, the hebephrenic and the chronic undifferentiated are the most common.

Comparative neuroimaging employing CAT scans (computerized axial tomography) and MRIs (magnetic resonance imaging) of the brains of patients diagnosed with schizophrenia and of those diagnosed with personality disorder has found similarities in structural and functional abnormalities. CAT scans documented in schizophrenic brains the presence of an enlargement of the lateral ventricles, cortical atrophy or thinning with enlargement of the cortical sulci and increased width of the third ventricle (Goodman et al., 2007). It has been reported that studies of schizophrenic brains show a reduction in cortical volume, some lateral ventricle enlargement and cerebral asymmetry on CAT scan, as well as MRI findings consisting in reduced volume of both hemispheres, but more on the left; and also reduction of the hippocampal-amygdala complex and reduction of the limbic system structures (Kaplan et al., 1994). PET (positron emission tomography) studies found frontal lobe hypoactivity and basal ganglia hyperactivity.

More specifically, it is reported that schizophrenic brains show a 25 percent loss of the fronto-temporal and parietal grey matter. Studies also show that the amygdala of schizophrenics are enlarged. Functional MRI (fMRI) found a decreased function of their prefrontal and frontal cortices. It should be noted that the function of the frontal cortex is planning and discriminating, basic to executive functioning. Further, cortical thinning of the temporo-frontal lobe regions is shared by persons

diagnosed with schizophrenia and with Antisocial Personality Disorder (psychopaths). Indeed, unsuccessful criminal psychopaths show a reduction of prefrontal grey matter along with asymmetry of the hippocampus and abnormalities of the corpus callosum (Kotrla, 1997). Other studies using SPECT (Single photon emission computed tomography) and PET found hypofrontality in schizophrenics, particularly in the prefrontal and left frontal cortices (Fu & McGuire, 1999).

3.1. Neuroimaging Studies in Major Depressive Disorder

Major depressive disorder is characterized by the occurrence of episodes of depression in between which patients return to more-or-less normal functioning. Depressive episodes usually come on gradually, with irritability, depressed mood, pessimistic ideas, decreased self-esteem and difficulty with concentration, memory and sleep. The intensity of symptoms may have a diurnal variation. Persons with this disorder may suffer from delusions, hallucinations and catatonia, the latter of which may take an impulsive, explosive form. Some may feel oppressed and suffer from anhedonia, agitation, inattention, panic and anger attacks. Insomnia is frequent. They may have mood-congruent or mood-incongruent psychotic features. The first consists of typical depressive themes of guilt, death and nihilism, and the second of delusions of various types. They may become violent and have what is termed an autonomic arousal.

PET studies of depressed patients have shown decreased metabolic rates in the left antero-lateral prefrontal cortex. Also, less blood flow to the frontal area and the left medial prefrontal cortex (hypofrontality) has been demonstrated (Fu & McGuire, 1999). In general, PET studies show abnormal prefrontal cortex and abnormal limbic function. Some patients have also shown abnormalities of perfusion in the temporal cortex (Kotrla, 1997).

3.2. Neuroimaging in Severe Personality Disorders

Neuroimaging changes are not limited to the brains of schizophrenics and major depressive psychotics; they have also been reported in the neuroimaging of the most important personality disorders, as described below. These changes appear to be of the same quality but of somewhat lesser quantity. This is supporting evidence that personality disorders are an early stage of psychotic illness.

3.3. Neuroimaging Studies in Borderline Personality Disorder

Various investigators have found that the impulsive aggression of Borderline Personality Disorder is most probably the consequence of a disruption of the emotional modulation circuits. These circuits include the anterior cingulate cortex (ACC), the orbital frontal cortex (OFC), the ventromedial prefrontal cortex (VMC), and the dorsolateral prefrontal cortex (DLPFC). The ACC and the OFC have extensive connections with the amygdala and it is thought that they are 'involved in the evaluation of emotional stimuli, responses to conflict, regulation of emotional responses and play an inhibitory role in regulating the amygdala' (Goodman et al., 2007, p. 101). The DLPFC, which integrates emotion with cognition to better control emotions, on PET studies is neurophysiologically deficient in Borderline Personality Disorder, as in schizophrenia. Also, structural neuroimaging studies of the brains of patients suffering from Borderline Personality Disorder show a significant reduction in volume of the right ACC and of the total frontal lobes, as in schizophrenia. The finding of a reduced concentration of N-acetylaspartate of almost one-fifth (19%) supports a reduction of neuronal density in the DLPFC (Goodman et al., 2007). The amygdala and the hippocampus are smaller in volume, as are the left OFC and the right ACC. On the basis of MRI and fMRI findings, the Borderline Personality Disorder also is described as a hyperarousal-dyscontrol syndrome, due to the lack of inhibitory control by the frontal lobe and to the hyperactivity of the amygdala. This is also referred to as a deficit of the top-down control of negative emotions. In impulsive aggression by Borderline Personality Disordered patients there is an actual frontal disinhibition and this finding is important in the assessment of their legal responsibility in alleged criminal acting out. A deficit of the neurotransmitter serotonin has also been reported in these persons.

3.4. Neuroimaging Studies in Schizotypal Personality Disorder

The Schizotypal Personality Disorder basically has a cognitive-perceptual disturbance similar to schizophrenia. Also, in this personality disorder the activities of the prefrontal regions are reduced (Goodman et al., 2007, p. 104). On MRI examination, the lateral ventricles are sometimes found to have a larger volume and when that is so the Schizotypal Personality Disorder is of greater severity. Other neuroimaging findings are a larger right hippocampus and increased pointedness of the caudate nucleus.

3.5. Neuroimaging Studies in Antisocial Personality Disorder/Psychopathy

Neuroimaging findings in Antisocial Personality Disorder on sMRI (Structural Magnetic Resonance Imaging) show that the prefrontal grey matter is diminished in volume (thinning) and the volume of the amygdala is decreased, especially when the level of psychopathy is high (Raine, et al., 2000). On fMRI the activity of the amygdala is at times decreased. Also, the amygdala, the PFC and the DLPFC show dysfunction. One study found that in 'criminal psychopaths, the fMRI showed decreased activity in the amygdala, hippocampal formation, parahippocampal gyrus, ventral striatum and anterior and posterior cingulated gyrus' (Goodman et al., 2007, p. 103).

3.6. Summary

Disparate scientific approaches have attempted to delve into the workings of the mind. Neuroanatomical and neurophysiological studies throughout the years have defined the normal structure and functioning of the human brain, while neuropathology and neuropsychology have established the neurophysiopathological bases of mental disorder. It has been only during the past decades, however, that neuroimaging techniques have given further supporting objective evidence that pathological brain structures and their dysfunction in the various mental disorders may contribute to mental impairment leading to abnormal behavior and even crime. These fast-evolving techniques (CAT, fMRI, sMRI, PET, SPECT) are continuously improving our understanding of the neurobiology of psychiatric disorders. This chapter discussed the above.

At present, scientists have found that disturbances of thinking and conduct have specific brain structural and functional correlates. Obviously, that does not imply that brain physiopathological correlates, evidence supported by neuroimaging, are the only determining factors of human behavior. It is, indeed, the interaction between the underlying cerebral dysfunctions and the biopsychosocial factors that determine the abnormalities of mind and those behaviors that constitute what are called mental disorders.

Functional neuroimaging, by pointing out specific abnormalities in regions of the human brain, has led to better diagnoses and more appropriate treatment in psychiatry. It is one piece of good evidence the expert should rely on in determining the extent of neuropathology. Emerging neuroimaging data, for example, can

identify specific neural biomarkers that may help distinguish patients with bipolar disorders from those with unipolar disorders as well as determine which treatment is best suited to a patient (Tucker, 2007). Such neuroimaging may also have the potential to 'identify correlates of illness which are subclinical, perhaps preceding the onset of clinical symptoms or persisting after an apparent remission' (Fu & McGuire, 1999, p. 1366).

In this thesis, the author proposes that the underlying structural and functional brain similarities in psychotics and in severe personality-disordered persons evidenced by neuroimaging techniques should add credence to the fact that the latter are suffering from a latent prepsychotic condition that under severe stress decompensates temporarily into clear psychotic behavior. Those severe personality-disordered people are frequently the offenders in felonies and serious misdemeanors on whom the courts have to pass judgment on responsibility. As Raine (1999) wrote, 'Responsibility and self-reflection are not disembodied, ethereal processes but are firmly rooted in the brain' (p. 8).

Functional neuroimaging has clearly pointed out that irrational aggressive behavior is often the outcome of a top-down dysfunction of the brain in which, for example, the frontal cortex loses its control on lower structures, such as the amygdala. These techniques, fairly well established in psychiatry, will have to pass reliability standards, such as the Frey and Daubert rules, before they become exculpatory or mitigating evidence at trial.[3]

However, it can be envisioned that not only will these new techniques pass that test in the near future, but that new, extremely precise and more reliable high-resolution scanners will be devised and will be used to detect pertinent neuropathology in aggressive behavior. It is assumed that, because of that, modern neuroscience will change the way in which the law views and assesses criminal offenders. It would be unfair, indeed, to persist in blaming and punishing individuals who lack substantial capacity for rational behavior or substantial control over their behavior at the time of an offense. The possibility that a neuropsychopathological dysfunction may be at the basis of disinhibited behaviors may add to the claims concerning impairment in the capacity for rational conduct at the time of a crime, an impairment of the mind that this type of offender should have the opportunity to present and attempt to prove in a court of law.

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[3] The Frey rule (Frey vs. United States, 1925) states that the admissibility of scientific evidence should be based on its being 'sufficiently established to have gained general acceptance in the particular field to which it belongs' (Melton et al., 2007, p. 20). The Daubert rule (Daubert vs. Merrill-Dow Pharmaceutical, 1993) states that a scientific opinion must be based on an inference or assertion derived by the scientific method; the court should decide 'whether the reasoning or methodology underlying the testimony is scientifically valid and whether that reasoning or methodology properly can be applied to the facts in issue' (Melton et al., 2007, p. 20). It revolves around testability, error rate, approval by peer review, validity, relevance and reliability

Chapter 4. The Will and Decisional Capacity

The two mainstays that permeate the law in the United States are the assessment of competency to stand trial and that for criminal responsibility. Both assessments follow a structured legal definition. On the basis of a defendant's mental state, either at the time of an alleged crime in the criminal responsibility issue or at the time of trial in the fitness to stand trial issue, the opinion of the expert forensic psychiatrist or psychologist offered to the judge may help the court to adjudicate an offender, either as incompetent to stand trial or as not guilty of the offense with which he is charged.

4.1. Competency to Stand Trial

In the 1960s, the United States Supreme Court, in Dusky v. United States, set forth the standard of competency to stand trial. Competency refers to the mental capacity of a defendant to understand the charges filed against him in a criminal case, his awareness of courtroom procedures, and the roles played by his representing (defense) attorney, the district attorney (prosecutor) and the judge. Primarily, the defendant has to possess substantial (not total) mental capacity to rationally communicate with his representing attorney and to be able to help his attorney in preparing his defense.The defendant should realize the implications of the charges against him and the legal consequences in case he is found competent to stand trial, meaning the pleas that he can choose from, such as: guilty; non guilty; not guilty by reason of mental disease or defect; or no contest.

The competency hearing in a criminal court takes place before a judge, who, after listening to expert witnesses and to the attorneys for the defense and for the prosecution, rules on the competency of the defendant and his fitness to stand trial. The Supreme Court stated that it is not enough, as was the case prior to their decision, for the trial judge to simply find that the defendant is oriented to time and place and has some recollection of the events. The Court, in essence, must thoroughly acquaint itself with the defendant's mental condition (Slovenko, 2009a).

In addition to the forensic interview, in assessing competency to stand trial instruments may be used, such as the Competency Assessment Instrument (CAI) and the Fitness Interview Test-Revised (FIT-R). The FIT-R includes an assessment of the reason for suspected incompetence (e.g., mental illness) and malingering when suspected. Among the various forms of competency the following are the most

pertinent: to stand trial; to confess; to waive the right to counsel and represent oneself; to plead; to refuse a plea of not guilty by reason of insanity.

4.2. Not Guilty by Reason of Insanity

A proper assessment of legal responsibility should determine whether the individual who entered an insanity plea appreciated the wrongfulness of his action at the time of the crime (cognitive capacity) and had an unimpaired decisional capacity that allowed his free and conscious deliberation to carry out the act (i.e., to behave in that particular manner). This has not been the case in the United States since the Federal Insanity Reform Act of 1984, because with the Act the volitional prong was abolished from the legal responsibility defense (see e.g., Melton et al., 2007; Slovenko, 2002). The Reform Act states: as a result of mental illness, the defendant lacks the capacity to appreciate the nature and quality or wrongfulness of the act.

The Reform Act was the first comprehensive federal legislation governing the insanity defense and the disposition of individuals suffering from a mental disease or defect who are involved in the criminal justice system. The Reform Act modified the standard previously used in federal courts. It placed the burden of proof on the defendants to establish their defense by clear and convincing evidence; limited the scope of expert testimony on ultimate issues; eliminated the defense of diminished capacity; created a special verdict of 'not guilty only by reason of insanity' and created specific commitment proceedings; and further provided for federal commitment of persons who became insane after having been found guilty or while serving a federal prison sentence. Seriously impaired cognitive capacity in an individual at the time of a crime may *ipso facto* exclude his responsibility. Although this impairment is found in many psychotics, at times it may be present in people who are suffering from mental disorders and who experience a psychotic break at the time of committing a crime while exhibiting irrational thinking and behavior.

People who suffer from a psychotic illness, however, may be partially or fully responsible for their criminal behavior if, at the time of the crime, they knew what they were doing and willingly carried out their behavior. Their degree of responsibility also depends on the type of crime—felony or misdemeanor—and the substantial capacity to appreciate the nature and quality of the crime and to conform to the requirements of the law (capacity to control oneself). Indeed, a person suffering from a *bona fide* mental illness charged with shoplifting merchandise worth $20 may be found legally responsible, even though mentally ill, because supposedly his cognitive impairment may still allow him to understand the simple act he was carrying out. If he were, instead, to be charged with a felony such as homicide, depending on the circumstances, he could be found not responsible for the crime due to his mental disease, because such an offense is more complex, requiring

the presence of greater mental capacity to fully appreciate the actions and their consequences.

Cognitive capacity is understood as the capacity to assess one's own actions. This capacity may be impaired because of damage to particular brain areas, usually involving the frontal and prefrontal regions of the brain, the seats of cognitive processes that can signal and trigger prepackaged emotional reactions. Cognition contributes to the concomitant presence of emotions by 'giving us the ability to make decisions about what kind of actions should occur next, given the situation in which we find ourselves now….(and) it allows this shift from reaction to action' (Le Doux, 1996, p.175).

Decisional or volitional capacity, instead, is the ability to reach a free and voluntary determination (will or intent) of one's own behavior. It is an intrinsic part of any decision one makes and it integrates cognitive capacity. It includes a deliberating process that requires prior reflection and the choice of a given course of action, which may or may not be executed.

There are disorders which mainly involve the decisional capacity. These include at times the obsessive-compulsive neurosis, in which the compulsion to act does not allow reflection before acting; the disinhibited behaviors of the psychopath who acts out in an impulsive, non-reflective manner; or the disinhibition in decision making in persons with personality disorders due to improper use of alcohol or drugs. When these behaviors are present in persons with severe personality disorders the decision-making impairment, although still present, may not be as evident. For example, a person with a severe personality disorder, because of his deep suspiciousness, misinterprets facts and is impaired in his decision making. People with schizoid and schizotypal personalities who have severe withdrawal and disinterested behavior may also show decisional impairment, not being totally aware of the many facets of a social situation. This becomes more evident when the individual is under stress.

Cognitive and decision-making capacities (understanding and will) normally integrate each other. In addition, for any decision to be free, an adult individual must be aware of his surroundings (the reality around him), of his own and other's behavior, and of the consequences of his actions or non-actions. Further, he must have the capacity to be able to choose in conformity to the laws, ethics, and moral and social standards of the society in which he lives, and to recognize the social value of the acts he is performing.

It is difficult to understand why, as a reaction to the Hinckley decision, disorders of decisional capacity—lack of control—have been thought to be of secondary importance in an insanity defense. Although it is true that there is no accurate scientific basis for measuring one's capacity for self-control and what would be the proper degree of acceptable control, and that it is difficult to distinguish an irresistible impulse from one that is willingly not resisted (Redding, 2006), for the experienced forensic expert, the above are just rhetorical questions. It is, in fact,

possible to determine to a reasonable degree of certainty, on the basis of reported life history, facts and behavior of an offender at the scene of a crime, whether the criminal acting out was an irresistible act or whether that act could have been resisted had the individual so desired.

The United States Court of Appeals for the Eleventh Circuit in United States v. Freeman (United States v. Freeman, 804 F.2d 1574, 1576 (11th Cir 1986)) stated that in part the definition of the insanity defense in the Federal Insanity Reform Act of 1984 was based on the fact that frequently there is disagreement among forensic experts on what constitutes an irresistible impulse. However, it is also possible that the disagreements that are occasionally observed in the courts are part of the adversarial system and even, at times, due to the lack of expertise of some forensic experts. Indeed, even Judge David Bazelon, who defended the presence of psychiatry in the courtroom, aptly stated in 1973: 'My experience has shown that in no case is it more difficult to elicit productive and reliable expert testimony than in cases that call on the knowledge and practice of psychiatry' (1973, cited in Robinson, 1996, p. 240).

The importance of emotions in decision making has been recognized since time immemorial and is well-represented by Greek tragedians such as Aeschylus in *The Oresteia*, and later by Shakespeare in *Othello* and *Macbeth*, but the tendency of wanting to quantify emotions is questionable, because emotions are feelings, often fleeting, and apt to be forgotten. Indeed, during a forensic examination for the assessment of culpability it is often difficult to assess the veracity of the offender's recollections. It would be better to assess the *emotional state* of the accused, taking into consideration any reported violent or disruptive behavior at and around the time of a crime. That should be compared with reports of irrational behavior given by police or witnesses. This can help the forensic expert to reach a decision regarding the defendant's degree of dyscontrol and possibly his capacity to resist an impulse at the time of an offense. That could overcome the 'mental health professionals' difficulty in measuring and quantifying control (Redding, 2006, p. 104).

In the context of criminal responsibility, rulings in Morisette v. U.S. (Morisette v. U.S., 342 U.S. 246 (1952)) and in U.S. v. Currens (United States v. Currens, 290 F.2d 751, 773 (3d Cir 1961)) pointed out the importance of free will in criminal law and that people have the capacity to reflect and control their behavior. Henry de Bracton, a leading medieval jurist (13th century) and writer of the Wild Beast Test, wrote what appears to support the importance of the will (decisional capacity) in criminal responsibility case assessment: 'For a crime is not committed unless the will to harm be present' (cited in Felthous, 2008, p. 19). Sir William Blackstone, well-known judge and professor, considered people with want or defect of will to be 'incapable of committing crimes and exempted from legal punishment,' because if they had no understanding they could 'have no will to guide their conduct' (cited in

Felthous, 2008, p. 19). Blackstone believed that a defective understanding caused a deficiency of will which excuses one from guilt.

The will is part of a human's psychological faculties and it represents the means by which the ego, or agent, intentionally implements an action, an action that may be right or wrong. Exercising will power means exercising self-control on the basis of the cognitive knowledge that an individual possesses. Normal deliberative acts are not completely free but are the outcome of unconscious and conscious processes that take into account both internal and external stimuli, even more so in irrational moments.

Recent fMRI research provides evidence that unconscious motivations affect deliberative acts. This process involves the functions of brain structures such as the orbital frontal or anterior cingulated areas, and the hippocampal and amygdala areas. The amygdala is also concerned with decisional bias, and the orbital and medial prefrontal cortex influences rational responses. The interconnections of the various sections of the brain help to balance the deliberative capacity of the ego, the executive functions weighing the emotional responses of the amygdala with the analytical responses of the prefrontal cortex (Redding, 2006).

Even though in the United States v. Lyons (United States v. Lyons, 731 F.2d 243 (5th Cir 1984)) the Court of Appeals for the 5th Circuit agreed to abolish the volitional prong of the insanity defense, arguing that the forensic psychiatric experts did not possess sufficient accurate scientific bases to measure a person's capacity for self control, dissenters (Roger, J.L., et al. 1984) argued that the volitional prong was an essential aspect of the concept of guilt. At the same time, they stated that personality-disordered defendants, for whom the abolition of the volitional prong was basically written, made up less that one-fifth (18%) of the group of successful insanity acquitees.

In one study, forensic psychiatric evaluations conducted over a two-year period in a large Midwestern city of the United States were reviewed (Wettstein, Mulvey & Rogers, 1991, in Steadman et al., 1993). The evaluating psychiatrists were asked to indicate which of the following criteria were met by the defendants who were found to be not responsible: ALI cognitive, APA cognitive, M'Naghten cognitive, or ALI volitional (lack of ability to refrain from illegal behavior). A high correlation was found between the three cognitive standards, while less than one-quarter of those evaluated (24.4%) met only the volitional criterion. From this study, it could be concluded that a combination of the cognitive and volitional (lack of control) criteria would be better than just the cognitive one alone.

Another study took into consideration the insanity defense assessment of 1,446 defendants between 2002 and 2005. Only 416 (29%) were found to be not guilty by reason of insanity; 44 of those 416 (11%) were found to be NGRI due to volitional impairment (having been out of control). Of the same group, 372 were found to be

NGRI because of cognitive impairment; 361 had both volitional and cognitive impairment (Donohue et al., 2008).

In forensic psychiatry there are psychiatric entities, including the severe personality disorders that, because of cognitive impairment and concomitant impairment of decisional capacity, may determine a state of non-responsibility or diminished responsibility in a criminal case. That should be part of the evidence in a court of law as required by due process. Defendants who lack substantial capacity to conform their conduct to the requirements of the law (volitionally impaired) show symptoms of poor impulse control, disinhibition, delusional beliefs, mania and command hallucinations. At times, they perceive negative consequences for failing to act. These out-of-control defendants often drive while intoxicated, are involved in drug related offenses, suffer from psychosis, schizophrenia, and bipolar illness. Frequently they are charged with murder.

In forensic psychiatry the ultimate responsibility for one's actions lies with the individual (the defendant), who is viewed as an agent of locus of control until there is evidence of impairment of those faculties involved in intentional acts. Any disturbance of the decisional capacity affects the normative public policy of criminal responsibility. Norms of behavior, prescribed by law, are required for a smooth functioning of society. It will be the informed decision of the court or jury, after assessing all the available evidence, to decide the culpability of the offender. Stephen Morse (2007) wrote that all mental health laws are rationality tests and that even though some legal scholars, practicing lawyers and judges may hold contrary views,

> 'free will or lack of it is not a criterion for criminal responsibility or non-responsibility….(I)t is irrelevant to the actual practice of criminal law and, by extension, to the actual practice of forensic psychiatry and psychology that aids criminal justice legal actors and decision makers' (p. 212).

Despite Morse's statement, the importance of the will in criminal responsibility cannot be denied.The will, however, in order to function properly, is dependent on an individual's cognitive capacity.

After the 1982 trial of John Hinckley for the attempted assassination of then President Ronald Reagan, in which he was found not guilty by reason of mental disease, there was a large and forceful request (40 bills presented to the U.S. Congress) to abandon the existing insanity laws, or at least to modify them, by limiting the scope of the insanity plea. Both the American Bar Association (ABA) (American Bar Association, 1983) and the American Psychiatric Association (APA) (American Psychiatric Association, 1983) joined in these efforts. A similar professional and popular outcry had taken place in England in 1843 when Daniel M'Naghten, a Scotsman, was found not guilty of his attempted murder of the Prime

Minster of England, Sir Robert Peel, and his murder, instead, of Edward Drummond, whom he believed was the prime minister.

That finding gave birth to the M'Naghten Rule of insanity defense, still used in twenty-five of the states in United States.[4] Twenty states and the District of Columbia use some variants of the Model Standard set out in 1962 by the American Law Institute (ALI test).[5] Four states, Kansas, Idaho, Montana, and Utah, do not allow an insanity plea. One state, New Hampshire, still uses the Durham standard.

Following Hinckley's exculpation, which had been based mainly on the ALI test, there was a return to the stricter rules of the M'Naghten Rule. Law scholar Morse (1982) proposed the 'craziness test.' This test basically read: 'A defendant is not guilty by reason of insanity if, at the time of the offense, he was so extremely crazy and the craziness so substantially affected the criminal behavior that the defendant does not deserve to be punished' (Slovenko, 2002, p. 26). Further, the APA supported the decision that an insanity acquittal should be granted only for impaired cognition, such as that present in psychosis, not for impaired control, and that any personality disorder, especially an Antisocial Personality Disorder, should *a priori* be excluded from the use of such a plea. The abnormal mental condition should grossly and demonstrably impair a defendant's perception or understanding of reality. The ABA was highly supportive of the above restrictions. A new federal law statute regarding the insanity defense advised the prosecution that in such cases, in order to be found legally insane, the defendant, at the time of the offense committed, as a result of severe mental illness or defect, was unable to appreciate the nature and quality of his actions and its wrongfulness. The volitional or control aspect of the defense was eliminated. Mental illness or defect *per se* would no longer constitute a defense.

The above statute is the rule of insanity defense which many American courts have been using in non-responsibility cases in the decades following the Hinckley case. However, the volitional defense could probably be presented in severe psychotic cases, such as that of William Heirens, a Chicago teen-age serial killer, who scrawled the desperate message across a mirror with the lipstick of one of his victims: 'For Heaven's sake, catch me before I kill more. I can not control myself' (Kennedy, Hoffman, & Haines, 1947). Volitional impulsive behavior may, indeed, at times be highly irrational.

In some states of the United States a defense of Guilty but Mentally Ill is accepted by statute. This gives rise to a so-called bifurcated trial. In the first trial the

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[4] Alabama, Alaska, Arizona, California, Colorado, Florida, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Georgia, Iowa, Louisiana, Pennsylvania, South Carolina, South Dakota, Texas, Virginia, Washington.

[5] Arkansas, Connecticut, Delaware, New York, North Dakota, Hawaii, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Oregon, Rhode Island, Tennessee, Vermont, West Virginia, Wisconsin, Wyoming.

defendant's guilt is assessed and in many cases he admits his guilt. A second trial is then held to determine whether he suffers from a mental illness. If a jury or the court finds him to be suffering from such an illness, the offender will be mandated to a state mental health institution for treatment. Usually, the length of stay in the institution is equal to the length of time of his sentence. A bifurcated trial was used by the defense in the case of the serial killer Jeffrey Dahmer, but he was found to be legally sane and sentenced to prison (State of Wisconsin v. Jeffrey Dahmer, 1992). The bifurcated defense is often a strategy to avoid prison time.

The exclusion of personality-disordered offenders as candidates for an insanity plea or even a partial insanity plea (diminished capacity/diminished responsibility) has been questioned by psychiatric scholars for years. Bernard Diamond argued that special restrictive causes aimed at excluding certain specific categories of individuals from exculpation simply do not make any psychiatric sense. He wrote: 'They are as arbitrary and capricious as excluding defendants with red hair or blue eyes or negro blood from the benefit of the law of criminal responsibility' (Diamond, 1962, cited in Slovenko, 1995, p. 117). It should be remembered that it is a policy decision whether a cluster of mental characterstics is labeled 'mental illness' or not.

4.3. Diminished Capacity/Diminished Responsibility

A defense of diminished capacity or diminished responsibility (the first based on cognitive impairment and the second on cognitive and volitional impairment) is based on psychiatric or psychological expert testimony relative to an alleged offender's mental disorder or defect that has significantly impaired his mental capacity to form the requisite criminal intent for the criminal act with which he is charged. The rationale in such a defense is that the mental capacity to commit a crime, like mental illness, is not an all-or-none, black-or-white, phenomenon in every case.

Diamond (in Skolnick, 1990) supported the thesis that 'there were innumerable degrees of *mens rea* and that thus an infinitely graduated spectrum of legal responsibility was implied, corresponding to our contemporary understanding of the psychological reality of human beings' (p. 1433). Diminished capacity is, in fact, based on what is termed *mens rea*, an offender's capacity or incapacity to form mental intent. There are two types of intent: specific intent, which refers to purpose and knowledge; and general intent, which refers to recklessness and negligence (American Law Institute Model Penal Code). Specific intent has to do with the offender's subjective purpose or belief, while general intent is often determined by objective rather than subjective standards. In the latter instance, the defendant does not intend to bring about a particular event whereas in a case of specific intent there

is premeditation, for instance in a homicide case in which the offender had the intent to kill the victim. In more simple terms, diminished capacity or diminished responsibility addresses whether there was specific intent to commit the crime at the time of the offense (Slovenko, 2002).

In cases of diminished responsibility the defense challenges the prosecution's presumption that at the time of the alleged crime the accused possessed the state of mind necessary for the commission of the offense (*mens rea*), but that due to his mental disorder he was incapable of the premeditation, deliberation or malice aforethought necessary to be found responsible for the offense (*actus reus*). *Mens rea* warrants full responsibility, while its absence reduces the verdict. In murder cases, the most common crime in which this defense is offered, if the individual did not form the intent to kill, the charges against him and relative sentence, may be reduced from murder (with a possible sentence of life in prison, or, in countries where the death penalty exists, even to the death penalty) to manslaughter (with a lesser penalty).

California was the first state in the United States to admit the diminished capacity defense, but after the Dan White trial (People v. White, 117 Cal. App. 2d 270, 172 Cal. Rptr. 612 (1981)) and its so-called Twinkie defense[6] it was abolished in 1981 in order to strictly limit the insanity defense. In 1982, a vote on victims' rights in the California legislature reinforced the repeal. It was replaced by a defense of diminished actuality: did the accused actually form the intent to commit the crime? In the previous diminished capacity defense a psychiatric or psychological expert could testify to the ultimate question (guilty or not guilty); in the current actuality defense he cannot testify to the ultimate issue but can still testify as to whether the defendant was able to *form* intent, leaving it to the attorney for the defense to make the necessary logical connection before the court. However, the expert is allowed to answer the ultimate question in his written report to the court.

The defense of diminished capacity/diminished responsibility is rather confusing, so much so that the United States Senate indicated its disapproval of the creation of such new types of defense, because the jury would be presented with needlessly confusing psychiatric testimony. It disapproved, specifically, of the diminished responsibility defense that had been adopted by the California courts. Morse (1985) strongly opposed the diminished capacity/diminished responsibility defense, describing it as undiminished confusion. His arguments against it contributed to the California Legislature's decision to abolish the defense.

Slovenko (1995) wrote that in a case in which a defense of diminished capacity/diminished responsibility is employed the accused may introduce evidence of mental abnormality at trial 'to negate the mental element of the charged crime' (p.

[6] The defendant's eating habits were cited to illustrate his declining mental state and not given as the cause of the crime according to his attorney (Blinder, 1982).

152). The type of defense has been adopted by one-third of the fifty United States. It is primarily entered when a defendant is charged with murder (usually, first-degree murder). Under the diminished capacity doctrine, a criminal defendant's attorney may introduce evidence of a mental abnormality at trial to negate the mental element of the crime charged, thereby exonerating the defendant of that charge. The evidence of diminished capacity, although not quite meeting the standard of exoneration under an NGRI defense, may warrant a verdict of manslaughter instead of murder.

Evidence of diminished capacity does not call for a special plea as is done in insanity cases, in which a plea of not guilty by reason of mental disease or defect is entered, but the defense must notify the prosecutor in advance that it intends to enter such evidence. That will permit access to the defendant's past employment and criminal records, if present, as well as any prior forensic examinations of him. Psychiatric testimony regarding a defendant is irrelevant in a general intent crime but is important in a specific intent crime, because it is used to negate the intent.

The United States Supreme Court in Fisher v. United States (Fisher v. United States, 328 US 463, 66 S Ct 1318, 90 L Ed 2d 1382 (1946)) wrote that the states are not compelled to recognize a defense of diminished capacity/diminished responsibility. In addition to California, Montana, Oregon and Wisconsin have abolished the defense. In People v. Patterson (People v. Patterson, 39 N.Y.2d 288, 347 N.E.2d 898 (1976)) diminished capacity/diminished responsibility was viewed by the court as a type of ameliorating defense based on the nature of the offender and the conditions which produced some degree of excuse for his conduct (Slovenko, 2002).

The origins of the diminished capacity/diminished responsibility are found in two cases from California: People v. Wells (People v. Wells, 33 Cal.2d 330, 202 P.2s 53 (1949)) and People v. Gorshen (People v. Gorshen, 51 Cal. 2d 716, 725, 336 P2d 492 (1959)). In People v. Wells the California Supreme Court considered the conviction of a person for assaulting a prison guard with 'malice aforethought, a more serious offense than simple assault. The defense attempted to show through expert testimony that the accused misinterpreted and overreacted to external stimuli to the point that he believed himself to be in danger and reactively defended himself' (Brakel & Brooks, 2001, p. 194). The judge in the case rejected this testimonial assertion.

On appeal, the California Supreme Court, following a strict *mens rea* approach, held that the trial judge should have admitted the evidence, because if the defendant had acted in self-defense 'he could not have planned the crime in advance and therefore could not have acted with malice aforethought or *mens rea*' (Brakel, p. 194). In other words, the defendant could not have entertained the required mental state (thoughts) to have a *mens rea*.

Culpability or innocence are not based on what a defendant actually perceived or intended, but on what an ordinary person would, or should, have perceived or intended in the same situation. Nevertheless, in the great majority of cases, says Slovenko (2002), 'evidence concerning a defendant's abnormal mental condition as it relates to *mens rea*, will, if believed, reduce the grade of the offense' (p. 285).

In the case of People v. Gorshen (1959) the California court took into consideration the distinction between evidence of intent and capacity to form intent, holding it as evidence to assess whether the individual could not or did not deliberate about committing a murder. In that case the court stated that in the assessment of *mens rea* in cases of murder attention must be paid to premeditation and deliberation in the offender.

In People v. Henderson (People v. Henderson, 60 Cal. 2d. 482, 490-491, 35 Cal. Rptr. 77, 82, 386 P.2d 677, 682 (1963)), the trial judge wrote,

> 'Under the Wells-Gorshen rule of diminished responsibility, even though a defendant be legally sane according to the M'Naghten test, if he was suffering from a mental illness that prevented his acting with malice aforethought, premeditation or deliberation, he cannot be convicted of murder of the first degree' (Brakel & Brooks, 2001, p. 169).

In People v. Wolff (People v. Wolff, 61 Cal.2d 795, 821, 394 P2d 959, 40 Cal. Rptr. 271, 287 (1964)), the California Supreme Court recognized the defense of diminished responsibility. The case involved a defendant who had planned and executed several murders and rapes. The psychiatric expert concluded that the defendant was insane. The jury, on the contrary, returned a verdict of sane. On appeal the California Supreme Court considered whether the evidence supported the defendant's guilt for first- or second-degree homicide, in order to determine whether he had reflected sufficiently prior to the offense. A retrial was ordered and full psychiatric evidence was permitted.

At times diminished capacity/diminished responsibility is considered by a judge at his own discretion at sentencing in cases in which the mental condition of the defendant does not warrant an insanity defense but is serious enough for a finding of partial responsibility. This is the case of persons with severe personality disorders who, at times, go through brief psychotic episodes when under severe stress (Slovenko, 2002).

Recently, following strict guidelines which diminish the importance of psychological factors in crime, in United States Federal Courts discretion is used by the prosecutor during the pre-trial and trial stages if the mental conditions of the accused do not seem to support *mens rea* and *actus rea*.

In the State of New York, the issue of diminished capacity/diminished responsibility is still unclear. Indeed, in People v. Segal (People v. Segal, 54 N.Y.2d

58, 444 N.Y.S.2d 588, 429 N.E.2d 107 (1981)) the opinion of the judge was that even though proof of mental defect other than insanity may not have acquired the status of a statutory defense and will not constitute a 'complete' defense in the sense that it would relieve the defendant of responsibility for all his acts…it may in a particular case negate a specific intent necessary to establish guilt. Indeed, in People v. Moran (People v. Moran, 249 N.Y. 179, 179,180, 163 N.E. 553 (1928)), the New York Court of Appeals referred to the fact that mental disorder may be properly considered in determining whether a homicide has been committed with a deliberate and premeditated design to kill, even if the mental state (disease or defect of mind) of the offender did not reach the level of an insanity defense (Slovenko, 2002). Further, in People v. Henderson (1963) the court stated:

> 'It can no longer be doubted that the defense of mental illness not amounting to legal insanity is a "significant issue" in any case in which it is raised by substantial evidence. Its purpose and effect is to ameliorate the law governing criminal responsibility prescribed by the M'Naghten Rule…' (Brakel & Brooks, 2001, p. 169).

More recent cases have also rejected constitutional challenges to the exclusion of psychiatric testimony on the issue of *mens rea*. (See e.g., Muench v. Israel)Muench v. Israel, 715 F.2d 1124 (7th Cir. 1983) and Campbell v. Wainright (Campbell v. Wainright, 728 F.2d 1573 (11th Cir. 1984)). In the words of Paul Appelbaum and Thomas Gutheil (2007), diminished capacity/diminished responsibility

> 'supplements, rather than replaces, the insanity defense, allowing evidence of any interference with the normal functioning of the mind (thought in some incarnations of the defense such interference must once more be the result of mental disease or defect) to be introduced to prove that the defendant did not have the ability to formulate one of the specific mental elements required for the crime charge' (p. 228).

As previously reported, Diamond (1962) suggested that *mens rea* should be looked upon as having an infinitely graduated spectrum of legal responsibility.

4.4. Summary

This chapter points out that in the assessment of an insanity plea, in addition to the cognitive capacity of an offender, it is important to consider his decisional capacity. In the United States, the Federal Insanity Reform Act of 1984 excluded the assessment of whether an individual charged with a crime did or did not have the

capacity, because of mental disturbance, to make a free and conscious deliberation to carry out the alleged criminal act. While cognitive capacity is the capacity to assess one's own actions, decisional capacity is the ability to reach a free and voluntary decision (will/intent), after reflection, to carry out any action. Indeed, any form of behavior should be looked upon as the resultant of cognitive and decisional capacity. This is often not the case in offenders suffering from a severe personality disorder, such as the psychopath, the person with a Borderline Personality Disorder or a person in the manic phase of a bipolar illness, who often act out without reflecting. A case study regarding the decisional capacity is presented and some pertinent case laws are given.

Chapter 5. Criminal Responsibility in Personality Disorders: International Legal Codes

Recent psychiatric/scientific approaches attempting to explain mental disorders are multifaceted and take into consideration not only psychological and sociological factors but also biological ones. It is hoped that these more open approaches will broaden the assessment of imputability of people who have committed crimes and who suffer from severe personality disorders. However, a broadened concept of non-imputability for severe personality disorders has to be supported by showing a direct cause and effect between the personality disorder and the crime, in addition to an individual's mental incapacity to appreciate at the time of the crime the legal and moral wrongness of the behavior. The penal codes of many nations are progressively changing along the above lines.

The word imputability is not commonly used in the United States. However, it means that a person who is alleged to have committed a crime may be charged for that crime. Responsibility, instead, means that the person has been found responsible in a court of law for the criminal actions with which he or she has been charged. Plato, Aristotle, and even Thomas Aquinas, believed that people determine their own actions and are basically responsible for them. Freedom goes hand in hand with responsibility or, better yet, with the possibility to be considered responsible and the concept of responsibility has a place in every ethical model which considers humans as having a privileged condition in the scale of values (Bandini & Gatti, 1990).

The determination of legal responsibility of the mentally ill or of those suffering from any other mental disorder who have committed a crime varies among European countries, the United States, and other English-speaking countries. It is generally assessed on the basis of the following criteria:

1. The first is the psychopathological method, also referred to as the biological/psychiatric method. In this methodology, there is the presence of a serious mental pathology which automatically excludes or diminishes the imputability of the offender without considering the relationship between mental illness and the type of offense perpetrated by the offender. This is similar to the Durham Rule followed in the United States between 1960 and 1970.
2. The second criterion is the psychological/normative one. It is based essentially on the offender's capacity to discern right from wrong and on

his willingness to commit the offense at the time of the act with which he has been charged. If one follows this particular criterion, the person who is incapable of understanding and willing is found to be not imputable regardless of the presence or not of a mental disease. This has some similarities to the M'Naghten rule used in some of the English-speaking countries'.

3. The third criterion is the psychiatric/forensic one. This particular method of assessing the imputability of the accused individual takes into consideration the psychiatric pathology with which the individual is suffering, the way in which this pathology reflects on the intellectual and volitional processes of the individual, and whether the mental condition is relevant to the offense within the norms established by the law. This criterion has some similarities with the ALI test.

In some European nations the requirement for non-imputability is based only on the clinical diagnosis of a serious mental pathology without assessing the interface between mental illness and crime. In other countries, the psychiatric diagnostics are the first level in a subsequent medico-legal assessment of the case. In still others, the legal aspects and evaluation are of extreme importance as well. In 1985, at the Council of Europe in Strasbourg (VII Criminological Colloquium, 25-27 November), it was established that the assessment of the psychopathological aspects of the supposedly mentally ill offender and the assessment of the juridical normative aspects (responsibility and similar concepts), are the two most important approaches in the determination of the imputability of the mentally ill offender. It was also decided that the psychiatric expert should limit himself or herself to the assessment of the mental state of the offender, to the psychiatric diagnosis, and to the influence that any possible mental illness might have in regard to the appreciation of reality—whether the individual was or was not in touch with reality at the time of the offense. The above limits the role of forensic psychiatry to a psychopathological diagnosis of the case and to the possible treatment when necessary.

In 1992, at a meeting of the International Academy of Legal and Social Medicine, not only were the above ideas subscribed to, but suggestions were made that mentally ill offenders should be referred without delay to psychiatric social services or should be mandated for treatment in special psychiatric institutions; the tendency was to not pursue the incrimination of psychiatric patients. The nations represented at the meeting seemed to be concerned with recidivism and measures that might limit or diminish the criminal behavior of the patient by organizing therapeutic programs within the community; some nations stressed the necessity of hospitalization in order to control the mentally ill offender.

The conclusion was that dangerousness cannot be predicted; that only the court should determine it in the case of the mentally ill offender; and that, as stated earlier,

the expert should limit his or her assessment to the mental state of the offender at the time of the offense and at the time of the examination, and should determine the type of treatment needed if any (Ferracuti & Bruno, 1990).

5.1. Dutch and United States Courts: A Brief Comparison

In order to appreciate the way the Dutch legal system deals with personality disordered-offenders in comparison to the American legal system, it is necessary to briefly point out some of the differences that exist between the two systems in structure and functioning (Chorus, Gerver & Hondius, 2006; Taekema, 2004). In the Netherlands the crime investigation is led by the prosecutor who, as a magistrate, also guides the investigation. He presents the charges in an inquisitorial dossier or he may dismiss a case because of lack of evidence. In the United States the crime investigation is basically done by the police department. The prosecutor prepares the case and draws up the charges that he will defend orally at trial. He, too, may dismiss a case because of a lack of evidence. Arguments are presented verbally in United States courts while those in the Netherlands are written.

The biggest difference is that the system in the Netherlands is inquisitorial and that in the United States is adversarial. In an adversarial system the two parties, the prosecution and the defense in a criminal case, gather and submit evidence and present their arguments in court, with the testimony of witnesses as necessary. The parties, to some extent, control the process. In an inquisitorial system, it is the judge who investigates the evidence, judges its quality and relevance, interviews witnesses and renders a decision. In a United States court, the judge's role is that of an independent arbiter, assuring that the prosecution and defense respect the rules of law.

The adversarial system has various shortcomings. One is that a wealthy defendant may be able to retain a more skilled and experienced lawyer and expert witnesses than a person lacking financial assets. A second drawback is that a clash between attorneys in a case may become more important than reaching the truth. The inquisitorial system, instead, does not have such a contest between the two parties. It is thought that judges or magistrates are better acquainted with the intricacies of a trial and are able to better appreciate the written/oral reports of expert testimony than are members of a jury.

In addition, the adversarial system is often slow and cumbersome, but it is contended that the control of the process by the parties preserves the neutrality of the judge and jury and protects the offender from abuse of power and manipulation. On the other hand, the inquisitorial system is thought to be more just and equitable, since rather than resolving controversies between opposing parties, its goal is to find the ultimate truth. The system, is however, open to prejudgment and possibly to bureaucratic prejudice.

Cross-examination is a mainstay of the United States trial system. Attorneys for the prosecution and the defense may question the defendant and witnesses, as opposed to the Dutch system in which only the judge is allowed to question the defendant and witnesses. Attorneys for both sides may, however, submit to the judge questions they wish to have asked.

In the Netherlands an indigent defendant may select his own attorney and the state will pay for it. His confession may be written by the police and his signature on it is not required; it has equal validity if written by the police. The defendant is required to testify in court. In the United States, an indigent defendant is provided with the service of a government-paid attorney selected by the judge from a roster of public defenders. He does not have the possibility to select his own attorney. Although he may take the stand in his own defense, he is not obligated to do so. He can use his constitutional right to not incriminate himself if he so wishes. Although his confession may be written by someone else at times, if it has not been signed by the defendant it is not valid.

In the United States a trial may be held before the bench (the judge only) at the defendant's request or before a judge and a jury of citizens chosen by attorneys for both parties during a process called a *voir dire*. (One negative thing about a jury is that there is the possibility that it may be chosen on the basis of a partisan, utilitarian approach.) After deliberating over the testimony they have heard and the evidence available to them, the jurors reach a decision about the defendant's guilt or innocence and present their decision to the presiding judge in the courtroom. The judge, in a period of time that varies from case to case, listens to sentencing arguments by the attorneys and, at times, to victim statements, then proceeds to sentence the defendant. In all cases, including those of defendants diagnosed with a personality disorder, the judge applies sentencing guidelines and case precedent when determining the sentence. In a Dutch trial there are from one to three judges (the latter in felony cases) but no jury. In the case of a defendant diagnosed with a personality disorder the judge, at sentencing, follows a five-tier scale of responsibility (accountability): undiminished, slightly diminished, diminished, severely diminished, and non-responsible.

A court trial may have a certain deterrent effect on recidivism but at present, because of the large number of cases in the judicial system many cases are settled through plea bargaining.This is a practical solution that vastly reduces the overcrowding of the court dockets but that deprives some offenders of their day in court and the due process of law.

On the basis of the above comparison, it appears that the Dutch system is more pragmatic and expeditious in dispensing justice than that in the United States. When applied to the assessment of offenders with personality disorders, and especially those who have experienced a brief psychotic decompensation at the time of an offense, it also seems more realistic, fully applying a succinct approach that is more

understanding and compassionate. Certainly, it is less punitive in the assessment of these types of offenders, which is not an easy process, and it is more flexible in judging their guilt and the degree of culpability, even though the rise of crime in recent years and society's fears resulting from it have enforced the 'law and order' approach. The Dutch system is very sensible in its use of the five-tier scale of responsibility. This is important for the reason that, because of individual cognitive and emotional differences, behavior, normal but even more so abnormal, cannot be strictly codified. And that is the reason why, the author, as a forensic psychiatrist with a long experience under various codes of law and who has examined thousands of persons, both normal and mentally disordered, proposes a change in the insanity law for the group of personality-disordered offenders.

5.2. The Netherlands

In the Netherlands, there are two types of legal sanctions: *penalties* (retribution) and *measures*, which are used both for the therapy of the offender and the protection of society. *Penalties* derive from the classical view of punishment, while *measure*s derive from modern penal law. In accordance with the deterministic view, the modern legal law movement views a person as acting in an antisocial way because of inevitable social and environmental factors, which diminish his choice and his responsibility for his actions. This is contrary to the classical non-deterministic view.

According to the Netherlands' penal code (Sec. 9) penalties are sanctions reserved for offenders found responsible for their actions, while measures are used for those who are found not responsible for their actions. There is a wide range of options for the judge, and penalties increase in severity, ranging from fines, community sanctions, detention and/or imprisonment. Sentences, or part of a sentence, may be shortened or suspended. Fines may be imposed and if not paid may lead to detention. Some prisons have special departments for vulnerable people who are addicted to alcohol or drugs, who have been diagnosed with a mental disease or mental immaturity, or who are mentally disturbed.

A finding of non-responsibility is accepted by the court only if the individual suffers from a mental illness or a psychopathological condition which has affected his normal development or his behavior, especially at the time of a crime. A distinction is made between undiminished responsibility, somewhat diminished responsibility, diminished responsibility, severely diminished responsibility, and irresponsibility.

> ‘Undiminished responsibility means that the person had complete access to his free will at the time of the crime with which he is charged and could therefore have chosen not to do it. Irresponsibility means that the person had no free will at all with which to choose at the time of the crime…’(Van Marle, 2000, p. 527).

Measures may also be imposed on offenders who are not found responsible for their actions. There are measures that deprive a person of liberty—for example, when a person is sent to a penal center for addicts, placed in a psychiatric hospital (Sec. 37 Penal Code), or entrusted to a forensic psychiatric hospital, Terbeschikkingstelling (TBS). This includes persons found to be mentally ill and dangerous (including those with severe personality disorder (DSPD) who are detained in the TBS at the pleasure of the government. That generally occurs if an offense is serious, the sentence is at least four years, and there is a risk of recidivism. The offender must have suffered from a psychiatric disorder at the time of the offense or from a developmental disorder leading to any degree of diminished responsibility. Two independent experts (a psychiatrist and a psychologist) assess the offender, testify to the presence of a mental disorder at the time of the crime, and offer an opinion as to the degree of diminished accountability and the risk for reoffending. Both experts must advise the court that a TBS order is necessary to protect society (Drost, 2006). If the court accepts the expert testimony and conclusions, the offender may spend time (1-2 years) in a prison before beginning his treatment under the TBS order (Ministry of Justice, 1999). It has been claimed that a combination sentence of prison and TBS is illogical, because the offender would be punished for an offense for which he is not responsible or only partially responsible (van der Landen, 1993).

In the Netherlands, forensic hospitals assess the personality of offenders/patients and their risk for violence using various risk-assessment instruments, including the Personality Disorder Questionnaire-Revised and the Risk Assessment Tests HCR-20 and SVR-20. The use of risk-assessment instruments is important because of their contribution in evaluating the progress of treatment (van Marle, 2008). The patients in the hospitals undergo cognitive behavioral treatment and according to one recent study the results are positive with a more lenient and graduated approach to patients who are mentally disordered and a good percentage of them improve (de Ruiter & Trestman, 2007).

The legal rights of a patient under a TBS order are protected by regular psychiatric and psychological expert evaluations to help the court determine if they still pose a danger to society. These evaluations take place every two years at the end of each extension period. After six years in TBS, an independent examination by two experts appointed by the Ministry of Justice is obligatory (Ministry of Justice, 1999). At the time of the six-year examination, the experts are questioned about the patient’s prognosis and whether the individual is receiving the proper

treatment. At that time, the patient may be transferred to a long-term treatment facility if still mentally ill and dangerous. If the mental disorder is still present but the recidivism risk (dangerousness) has decreased, further extension will not be supported. If the individual has improved during the last year of a two-year extension, he will undergo rehabilitation and progressive reintegration. In summary, the TBS period has four types of assessment: pre-trial, regular extension, six-year extension, long-term unit. Appeal is available to both offender/patient and prosecutor.

In 1990, TBS patients numbered 527 and in 2001 there were about 1,300 patients in the system; by 2006, the number had increased to 1,650. TBS orders are normally imposed for violent offenders (91% of the total). More than one quarter (27%) are diagnosed with psychoses, one-half (50 %) are deemed to have personality disorders. The average TBS patient stays five months in a TBS unit and 69 months in custody (McInerny, 2000). It has been claimed that as the TBS system has grown throughout the years, it has become threatened by the qualitative and quantitative scarcity of properly qualified experts (van der Landen, 1993).

Once released from TBS, the patients are usually directed to outpatient clinics, which are under the supervision of the Ministry of Health. A new approach to TBS patients leaving psychiatric hospitals is scheduled to begin in 2009. From the time of their release, their aftercare will be supervised by both the TBS clinics and the probation services. The probation services will be engaged when the clinics feels that resocialization may begin. Involvement of the probation services will begin while the patient is still hospitalized, allowing them to learn about the patient before his return to society. This will allow them to make earlier preparations for resocialization and to better recognize and react to indications of recidivism (Justitie, 2008).

5.3. Other Representative European Nations

Austria: In Austria, Article 11 of the penal code defines as not guilty the person who, at the time of a crime, was affected by a psychological or psychiatric disturbance of a serious degree and part of the psychiatric illnesses contemplated by the juridical norms and who, because of his pathological state was, at the time of the offense, unable to understand and/or control his behavior. In Austria, the penal system does not contemplate partial imputability.

However, at the time of sentencing those defendants who have been diagnosed as suffering from an abnormal psychological state which contributed to their offensive conduct may receive a mitigated sentence. If the offender is thought to be dangerous and possibly recidivistic, for his own sake and that of the community, he may be mandated to a maximum security psychiatric hospital, with a possible indefinite

stay. However, this can be done only if there is a high probability that the individual will recidivate (Prof. Dr. Reinhard Eher, personal communication, 6/23/2008).

Belgium: In Belgium, as in France, non-imputability refers only to those persons who suffer from a demented state or, at times, those who were unable to resist an impulse. There is no semi-infirmity in the Belgian penal code. Nor does it provide any security measures for those persons found not guilty because of mental infirmity. However, they may be civilly committed if their mental status requires it.

France: In France, non-imputability is only applied to the demented. Since 1994, the French Penal Code has included, in Art. 122.1, conditions such as 'psychological or neuropsychological disorders' as exculpatory in some crimes (Simon & Ahn-Redding, 2006). The term dementia for the court system includes mental disturbances which undermine the intellectual and discernment capacities of the individual. This type of approach eliminates any possibility of diminished mental infirmity which may, however, be taken into consideration at the time of sentencing as an attenuating factor. The determination of psychiatric treatment of these persons is not the competency of the judge but lies with the administrative health authorities upon the request of the family of the offender or the request of the prefect of the region. This approach has been highly criticized because it takes away from the justice department, the judge in this case, the possibility of initiating a concrete disposition that would be useful for the defendant or the welfare of the community.

Germany: In the Federal Republic of Germany those offenders who are found to be affected by a psychopathological disturbance due to a psychosis—either organic or functional—or who are affected by mental retardation or any other serious mental anomaly, are usually excluded from imputability. In cases of moderate developmental disturbance the imputability is diminished. The pathological forms at the basis of non-imputability include *even non-psychotic disorders*, which, however, must interfere with the offenders' decisional capacity at the time of the offense. The German Penal Code, for example, has inserted among the possibly exculpatory psychotic conditions 'other serious psychological abnormalities' (Para. 20-21, German Penal Code) (Simon & Ahn-Redding, 2006). This applies not only to those suffering from so-called total insanity but also to those with a partial insanity or semi-mental infirmity.

If the offender is not imputable he or she may be found not guilty and dismissed, while in cases of partial mental insanity the punishment is diminished. However, if there is a possibility of recidivism, both types of offenders may be directed to a psychiatric hospital for treatment, especially those offenders who might repeat serious felonies. This is done for the benefit of the offender and for the community

at large. The treatment may be indeterminate in length, with an annual reassessment, and it cannot go beyond the mandatory period of the sentence.

Italy: The Italian criminal law is similar to the American approach to the determination of imputability and responsibility. However in Art. 89, the Italian criminal code considers and accepts diminished imputability. In Sentence 1963, March 8, 2005, the Italian Penal Code included severe personality disorders, until then not accepted as exculpatory, as a diminishing or annulling factor in the assessment of criminal responsibility at the time of a crime. For such a defense to be accepted, it must be proved that there was a causative link between the personality disorder and the crime. In other words, the person suffering from a severe personality disorder must prove that the mental abnormality caused his inability to appreciate the wrongfulness of his actions and his incapacity to conform to the requirements of the law.

A landmark case in Italian jurisprudence (2005)
GR:

At 4 a.m. just after Christmas Day 65-year-old GR fired his handgun against V, 45 years old, in front of the door of his apartment in a condominium where they both lived in a small town in Italy. They had previously quarreled because GR blamed VA for unspecified noises originating from his apartment, presumably from the hot-water heater, which GR claimed kept him from sleeping.The victim was struck by two shots to the head and neck. When his wife and the police reached the crime scene VA was found lying dead on the floor. GR, brandishing the gun and extremely agitated, was threatening to kill those present, especially the victim's wife, and it was necessary to immobilize him in order to disarm him.

The case went to court and, after admitting his action but not his guilt, GR was found guilty and legally responsible for his actions (in other words, he was aware of the wrongfulness of his actions and would have been able to control himself if he had so desired). On appeal the psychiatric experts were divided on his mental responsibility and the case was sent to a higher court which confirmed the sentence of the lower court.

However, he was thought to be suffering from a Paranoid Personality Disorder by some experts and from a delusional psychotic disorder by other experts. GR then appealed to the Italian *Corte di Cassazione* (Supreme Court).

The sentence of the Italian *Corte di Cassazione* first asserted that, on the basis of the latest scientific discoveries, persons with severe personality disorders should be included among those suffering from mental disorders who may be allowed to enter a plea of non-responsibility. Indeed, the mental state of these persons, when under intense stress, may at times progress into a state of legal insanity, either total or partial. Further, the court added that, in accordance with modern psychiatric and psychological thinking, in a forensic assessment today's present definition of mental illness as the only basis for a plea of legal insanity should be substituted by an all-inclusive diagnostic definition of psychopathological impairment of the mind at the time of a crime. The elimination of a classical mental illness definition would extend the possibility of entering a plea of insanity to psychopathological syndromes which are not typically considered to be mental illnesses but that nevertheless impair the understanding and will of an individual at the time of a crime. In addition, in order to reach an objective conclusion regarding legal responsibility, the Italian *Corte di Cassazione* stated that it is necessary that a forensic expert ascertain not only the emotional and mental condition of an offender prior to, during and at the time of an offense, but also that any psychopathological impairment found must be a causative factor in the commission of a crime, impairing the offender's understanding of his action and his will to act.

The writer of the above sentence took a clear and definitive position regarding the new concept of the legal assessment of severe personality disordered offenders, contrary to the rigid classification previously used. Taken into consideration was the possibility that the extension of the non-responsibility plea to those offenders would lead to a flood of insanity pleas, but cognizant that other countries that have adopted similar changes have not experienced such an increase, the court subscribed to the change. The Italian *Corte di Cassazione* remanded the case to the lower court for reassessment with the above recommendation.

Commentary: The diagnosis in this case is Paranoid Personality Disorder, decompensated into Psychotic Paranoia. This offender suffered from a paranoid personality most of his life. He became more rigid, suspicious and distrustful of others as he grew older, and basically believed that people were trying to harm him. His history revealed that his paranoid personality often created interpersonal conflicts within his family, with friends and with people at work. Because of aging, his paranoid traits increased and his ability to cope with stress

grossly diminished. It is possible that his cortical control diminished and under stress his amygdaloid disinhibition (as will be discussed later) allowed his repressed hostility to erupt.

Portugal: In Portugal, Art. 20 of the legislation states that an offender should not be found imputable if, because of psychiatric or psychological anomalies of the mind or mental illness, he was incapable at the time of the offense of understanding the wrongfulness of his actions, and/or was unable to act according to the law. The penal code also accepts a plea of diminished responsibility in the case of an offender who can prove that, at the time of a crime, his capacity for understanding, his awareness of the wrongfulness of the action, and his self control were diminished. At the time of sentencing, the judge assesses whether the defendant may benefit or be positively influenced by the deterrent effect of punishment. This is a mixed method of assessment, employing the psychopathological approach and the normative one. An offender who has been found to be not responsible for a crime because of mental illness or mental psychopathology at the time of the offense is usually directed to a mental institution for treatment or for security reasons, especially when the court may anticipate recidivism. The hospitalization usually terminates when the individual regains normalcy. During the hospitalization, beginning in the last two years of the sentence, the defendant may be allowed to visit his family. That will help the assessment of his ability to live in the community. This is called experimental liberty (Simon & Ahn-Redding, 2006).

Spain: In Spain the imputability of mentally ill offenders is assessed according to psychiatric criteria. Mental illnesses are included under the generic diction of alienation, which may include not only the classic types of mental illness but also other classifications that may eventually be recognized as such. This psychopathological method has been found to be very restrictive, and therefore the court often follows a psychopathological method together with an integration of the normative method. However, the most important facet of the Spanish penal code in regard to mental illness and offending is concerned, is that the experts are required to define exactly the degree of pathology and the influence of the pathology on the offenders' comprehension and capacity to be aware of their surroundings, their actions and their conduct. The penal code allows for a determination of *diminished imputability*. Offenders who have been found to be not imputable, and therefore not responsible, may at times be allowed to receive psychiatric treatment on an outpatient basis. If the case is very serious, however, they are detained in a state psychiatric institution.

The Spanish Legal Code (1995), Art. 20,123, includes at present statements supporting the severe personality disorder as a possible exculpatory state at the time

of a crime, such as every abnormality of the mind or psychological disturbance and/or transitory mental disorder (Simon & Ahn-Redding, 2006).

Switzerland: In Switzerland, Article 10 of the penal code previously stated that an offender is not imputable when, at the moment of the offense, because of a mental disease or mental weakness or serious disturbance of consciousness, he was not able to understand the wrongfulness of his behavior, and thus unable to behave according to the law. However, since January 1, 2007, a revised version of the Swiss penal code is in effect. In this new version, Art. 19 deals with criminal responsibility (Schweizerisches Strafgesetzbuch, Bundeskanzlei, Bern, 2007). A diminished state of imputability is reserved for those offenders who are affected by a non-psychotic pathology or mental disorders not due to organic causes, such as the various personality disorders, psychopathies and neurosis. However, a personality disorder is rarely considered for a diminished state of imputability and usually Swiss courts consider such offenders to be fully responsible. Since 1971, the fact of being non-imputable does not automatically imply that the individual must be mandated to a security hospital; only those people found to be seriously mentally ill need inpatient treatment. This is done, as in other countries, on the basis of societal security and the welfare of the offender. The length of stay is indeterminate and as soon as the individual's mental condition is improved the treatment may be continued on an outpatient basis.

5.4. Nordic Countries

Denmark: In Denmark, an individual is not punishable when found to be not-imputable because he is suffering from a mental illness or a *severe psychopathological condition*, or a very serious mental deficiency or retardation. The above refer only to psychotic conditions of intellectual deficits of a certain gravity, excluding mental disorders of a non-psychotic type, or the so-called psychopathies or mental retardation of a mild type. The latter, however, can be taken into consideration at the time of sentencing. A certain differential is also applied to those cases that are found to be not imputable because of psychotic illness. Indeed, considering the possibility of recidivism, a psychotic person found to be not imputable may be referred to an outpatient psychiatric service for treatment, may be committed to a public hospital, or confined to a maximum security hospital. The length of stay in these institutions is decided by the court and only the court can discharge a person from such a mandate (Johanson, 1990).

Finland: In Finland an individual is not imputable if his actions were due to mental illness, mental retardation, or mental incapacity due to age or other causes, such as

organic illnesses. Also, imputability is excluded if the offender was in *a state of temporary dyscontrol*. When the mental condition is not serious enough to exclude complete imputability, the individual may enter a plea of *semi-mental infirmity* which brings about a less severe type of punishment. Also in Finland, those offenders who are found not imputable but dangerous are committed to a psychiatric hospital (Johanson, 1990).

Norway: The imputability of a mentally ill offender in Norway is fairly limited. Indeed, any person who suffers from either a psychotic disorder, a condition of unconsciousness, or serious mental retardation or deficiency that expresses itself in a pathological disturbance of the psychological activities, or a state of mental confusion, is not imputable. Actually, non-imputability has come to include those psychological disturbances which do not classify as a well-defined mental pathology. Usually, the mentally disturbed or mentally ill individual is referred to specific hospitals wherein they are security measures of varying degrees. Until recently, the period of hospitalization was indeterminate, but it has now been established that the hospitalization will be for a specific period depending, obviously, on the primary illness of the individual and his improvement during the period of hospitalization (Johanson, 1990).

Sweden: In Sweden the law states that those offenders who have committed a crime but who are suffering from mental disease, what is termed intellectual weakness, or any other abnormality of mind, *should not be directed to a prison but should be mandated to alternative measures than detention*. This may be a pecuniary sanction, supervision by social services or, in case of the necessity of hospitalization for a mental condition, direction to an institute or hospital specializing in treating people suffering from mental illness (Simon & Ahn-Redding, 2006). This approach does not take into consideration the seriousness of the offense and its congruity with the punishment. There are those who support a more traditional approach that would exclude the legal responsibility of the mentally-ill person, but would commit him or her for treatment in a mental health institution for a determinate period of time.

5.5. English-Speaking Countries

Australia: The Reformulated Defense of Insanity in the Australian Criminal Code Act 1995, as described by Bernadette McSherry (1997), set out a new defense in lieu of the common law defense of insanity (the old M'Naghten rule). Chapter 2, Sec. 7.3 (1) states: A person is not criminally responsible for an offence if at the time when he or she carried out the conduct constituting the offence he or she was suffering from a *mental impairment* (emphasis added) that had the effect that: (a) the

person did not know the nature or quality of his or her conduct; or (b) he or she did not know that his or her conduct was wrong (that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or (c) the person was unable to control his or her conduct (p. 184). In Sec. 7.3(a) mental impairment is defined to include 'senility, intellectual disability, mental illness, brain damage, and severe personality disorder' (p. 184).

As in the Canadian Penal Code, exemplified by *The Queen v. Ratti 1991* (*R. v. Ratti*, (1991) a S.C.R. 68) in which the Canadian Supreme Court interpreted wrong also as morally wrong, the Australian Criminal Code adheres to the moral interpretation of wrong. In doing so, it excuses from criminal responsibility those persons who 'by reason of disease of the mind were incapable of knowing that an act was wrong according to the normal and reasonable standards of society, even though they were aware that the act was formally a crime' (McSherry, p. 186). Both penal codes, the Canadian and the Australian, reject a volitional test.

As stated above, within the definition of mental impairment, the Australian Criminal Code (1995) includes the severe personality disorders. Indeed, Sec. 7.3(1)(c), states, 'A person could be found not criminally responsible on the ground that he or she had a severe personality disorder that had the effect that the individual was unable to control his or her criminal conduct.' That means that under the code, *a person with a severe personality disorder qualifies for entering a plea of legal insanity, which will have to be proved at trial*.

Further, the Queensland Mental Health Act states: Defendants who suffer from a mental illness or mental disorder are taken out of the criminal justice system and placed under the care of a Mental Health Tribunal. The tribunal will inquire about the mental condition of the defendant and will determine his insanity (Boettcher, 2008). Brian Boettcher (2001), a forensic psychiatrist and Director of Forensic Psychiatry Services for North Queensland (Australia) suggests that to reach a finding of diminished responsibility in murder cases a personality disorder diagnosis is insufficient and that other factors, such as a short-lived psychotic reaction due to severe stress is necessary. He believes that such a psychotic decompensation triggered by severe stress may enable the court and the jury to entertain the possibility of lesser charges and a lesser verdict; for instance, manslaughter instead of murder. *That is exactly what this thesis argues, strongly supporting that such an approach should be adopted by United States jurisprudence and extended even to lesser offenses*. Obviously, the necessity for mandated treatment and the consideration of possible dangerousness to self, others or other people's property must also be considered in these cases.

Canada: The Canadian Penal Code seems to be among the most inclusive regarding personality-disordered offenders, allowing them to enter a plea of insanity. Indeed,

in *R. v. Cooper* (*R.* v. *Cooper* (1980) 1 SCR 1149, 51 C.C.C. (2d) 129, 13 C.R. (3d) 97) it is stated,

> 'The term "disease of the mind" (substituting the term mental illness) embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning,…The disease must, of course, be of such intensity as to render the accused incapable of appreciating the nature and quality of the violent act or of knowing that it was wrong' (Schneider & Nussbaum, 2007, p. 162).

Further, in *R. v. Chaulk* (*R. v. Chaulk* (1990), 62 C.C.C. (3d) 193, (1990) 3 S/C/R/ 1303, (1991) 2 W.W.R. 385), it is stated that wrong means legally wrong and morally wrong, and it is specified that legally wrong means that the individual is aware that the act is contrary to the law, while morally wrong indicates that the individual is incapable of knowing that the act was something that he ought not to have done. In other words, the act was morally wrong according to the moral standards of society (Schneider & Nussbaum, 2007). Also in *R. v. Cooper*, it was asserted that a narrow interpretation should not be given to the term *disease of the mind*, and that the term personality disorder has been recognized as constituting a disease of the mind (in Schneider & Nussbaum, 2007).

In *R. v. Oommen* (*R. v. Oommen* (1994), 91 C.C.C. (3d) 8, (1994) 2 S.C.R. 507, (1994) 7 W.W.R. 49), the Supreme Court of Canada further stated that in addition to the moral and legal conceptual ability of right and/or wrong the accused must have had the ability to apply that knowledge in a rational way at the time of committing a criminal act. That is, if the mental disorder deprived the accused at the time of the criminal act of rational perception of the criminality of the act, and rational choice about the rightness or wrongness of the act, he may be exempted from criminal liability (Schneider & Nussbaum, 2007).

Great Britain and Ireland: The Anglo-Saxon countries of England and Ireland follow different rules. Indeed, in England the M'Naghten rules are still used. The non-imputability and non-responsibility of an offender are based only on a disease of the mind that creates the incapacity to understand the wrongfulness of the act that was performed; usually, the individual has to be found to have suffered from a psychosis at the time of the commission of a crime. That includes all those forms of mental psychopathology that might influence the understanding and behavior of the individual. The English approach does not take into consideration the will or decisional capacity of the offender—in other words, whether he intended or not to commit the criminal act. If an individual is found not guilty by reason of insanity, he can be mandated to a psychiatric hospital for an indefinite period, especially if deemed to be dangerous to the community or to himself. These hospitals are part of the prison system; usually they are maximum security hospitals, national or

regional, instituted at the time of the Criminal Procedure Act of 1964 and the Mental Health Act of 1982-1983. Discharge from these psychiatric security institutions can only be ordered by the Home Secretary. The court may also mandate the offender who was found not guilty by reason of insanity to a public mental hospital for treatment for a six-month period of time. This period may be extended upon the request of mental health physicians. In these cases the treating doctors may decide whether to discharge the patient/offender without the order of the court or the Home Secretary. Also, the offender may be directed to an outpatient type of treatment (Simon & Ahn-Redding, 2006).

In 1957, England adopted the diminished responsibility defense, a statutory part of the Homicide Act, based on a definition of a state of mind bordering on, but not amounting to, insanity. In Wales, personality-disordered offenders may make use of a diminished responsibility defense as long as the diminished responsibility is substantial. In addition to the insanity defense for mentally ill defendants, Scotland, England and Wales provide a diminished responsibility defense for an offender with a mental disorder whose criminal action was perpetrated without premeditation, aforethought, or malice. In those cases, the jury decides on the admissibility of psychiatric testimony (Simon & Ahn-Redding, 2006).

After a period of restriction in its availability, Scottish lawmakers enacted a new criterion for diminished responsibility. A plea of diminished responsibility should not require a state of mind bordering on insanity but only the presence of an abnormality of the mind that substantially impaired the ability of the accused to determine or control his actions. Alcohol intoxication and psychopathic behavior were excluded as impairing factors (Scottish Law Commission, 2003).

In Ireland the legal procedure is similar to that in England when the offender enters a plea of total insanity, a defense which may be entered only in cases of homicide. The defendant who is successful in his not-guilty plea is usually hospitalized in a psychiatric hospital—a so-called central mental hospital that is usually part of a maximum security prison—for an indeterminate length of time that can be revocated only by the sentencing court. Those suffering from minor degrees of mental illness may be hospitalized in the public mental hospitals of their region (Simon & Ahn-Redding, 2006).

In the Republic of Ireland, the enactment of Criminal Law (Insanity) Act 2006 became effective on June 1 of that year, abrogating a previous rejection (1984) in People v. O'Mahony (People (DPP) v. Joseph O'Mahony ILRM 244), adopting the partial defense of diminished capacity/responsibility for charges of murder. In such cases, a successful defense will result in a verdict of manslaughter instead of murder. This type of defense has been adopted in other countries and it is frequently used in murder cases when a defendant is mentally disordered but not insane (Bolard, 1996).

5.6. Other Countries: Greece, Turkey, Russia

Greece: The Greek penal code, Art. 34, states that the perpetrator of a crime is not imputable if, at the time of the commission of the act, he or she lacked the capacity to understand the wrongfulness of the action or the capacity to act coherently while understanding what he or she was doing. The Greek penal code excludes imputability in cases of psychosis, such as schizophrenia or manic-depressive psychosis. It follows the psychopathological, alias the biological/psychiatric method.

However, for all the other disorders, which include, for example, febrile delirium, neurosis, and psychopathies, the Greek code follows the mixed method, integrating the psychopathological one—that is, the diagnosis of the illness suffered by the offender—with the normative method—the legal codes. Diminished imputability is part of the Greek penal code for those persons who suffer from mental disorders considered to be not serious in which the offenders' capacity to understand and to act according to the law is reduced. Persons who have been found to be not imputable are punished if the crime requires a sentence longer than six months. In such a case, the offender is mandated to a state therapeutic institute. Defendants who have been found to show diminished imputability but are considered to be dangerous are mandated to a maximum security psychiatric prison for an indeterminate period of time, time that cannot be less than half of the maximum penalty established for the particular crime. This incarceration in a mental institution or the psychiatric section of a prison may be reviewed periodically and may be changed if the court no longer deems necessary a period of detention in an institution for the entire length of the sentence. The case is reviewed every three years or any time the judge deems it necessary (Ferracuti & Bruno, 1990).

Turkey: Under the Turkish penal code, an individual who commits a crime is not imputable if the act was due to psychotic or delusional behavior, during which his decisional capacity was not free and he was not able to recognize the consequences and wrongfulness of the act. Section 46 of the Turkish penal code states: 'No punishment should be given to that person who has committed a crime and who, while committing the crime, is suffering from mental disturbances that impede him to act freely and with complete awareness of what he is doing' (Songar, 1990, p. 234). In Turkey, the assessment of an offense takes into consideration the following: 1. the objective aspect of the crime, which may be either by commission or by omission—such as negligence; 2. the juridical aspect—the action is or is not against the law; and 3. the moral aspect of the crime. This aspect indicates the necessity to assess whether the individual had the intention to commit the crime and that that intention was against the law. The Turkish criminal code accepts diminished responsibility if an individual suffers from transitory confusional states, epileptic

attacks and manic/depressive episodes. In these cases, non-imputability may also be supported.

Russia: In Russia, the imputability of a mentally ill offender takes into consideration not only the mental illness from which an offender may suffer, but also his mental status at the time of the offense. Whether the offender was conscious of his or her actions and capable of controlling them is very important in the legal assessment. The Russian approach takes into consideration two distinct criteria: the psychopathological/psychiatric one and the normative one, as follows: 1. temporary disturbances of the mental activity (reactive states, exceptional states); 2. chronic mental illnesses, such as schizophrenia, bipolar disorder, delusional disorder; 3. other pathological states of the mind, such as mental retardation and some extremely serious psychopathic states; and 4. character pathology.

It is interesting to note that in Russia the imputability of the offender is excluded when the offender who was imputable and therefore responsible at the time of the crime becomes obviously mentally ill before sentencing. In such cases, as in the United States, the defendant, is declared incompetent and is mandated to treatment for competency and will return to court when competency to stand trial is regained. The mentally ill offender found not imputable and therefore not responsible is mandated to a penal psychiatric hospital. Generally, offenders who are found to be mentally ill and not imputable are sent to a hospital within a maximum security prison for forced treatment, or at times to hospitals which are situated close to their families to allow the possibility of visits (Bukhanovsky & Gleizer, 2001).

5.7. Summary

In this chapter, a brief excursus is presented of various international penal code models. It is interesting to note that the majority of the codes reported have a more flexible legal assessment of mentally ill offenders than those used in the United States at present. Specifically, several nations allow persons suffering from severe personality disorders to enter a plea of non-responsibility if, at the time of an alleged crime, they were under such severe stress that they decompensated into a mental state during which they were unable to appreciate the nature, quality and consequences of their behavior. It seems that the international judicial tendency is to do away with the rigidity of a mental illness definition as a prerequisite for a justification for criminal responsibility and veer towards a psychopathological approach that would support the rationality or irrationality of an offender at the time of an alleged offense under the umbrella definition of mental impairment, total or partial, at the time of an alleged crime.

Diminished rationality of various degrees should be at the basis of a possible finding of non-responsibility. At present, three judicial verdicts are possible: guilty, not guilty and not guilty by reason of insanity. In cases in which there is inadequate proof of an offender's complete irrationality at the time of an alleged crime, but there is supporting neuropsychological, clinical and neuroimaging evidence of mental impairment that would support a plea of diminished responsibility, such a plea should be allowed to be presented and should be taken into due consideration by the court in the legal assessment of the case.

Chapter 6. Criminal Responsibility in Personality Disorders

Christopher Slobogin (2000) stated that the 'blunderbuss approach' to the insanity defense, exemplified by the exclusion of all personality disorders (a category which includes paranoid, schizotypal, schizoid and borderline disorders), prevents people with very bizarre thought content and processes from arguing for an excuse for their criminal actions. The federal test's word 'severe' in the context of personality disorders may raise the same problem. Gianluigi Ponti and Isabella Merzagora (1986) wrote that in forensic psychiatry rigid working classifications should be avoided. Instead, an open system, which does not place a person in a closed frame of reference within rigid and deterministic parameters, should be used, one that is respectful of the infinite, ontogenetic individual variables, during which the individual can be observed from different perspectives. The assessment of an individual's freedom in acting against the law and his moral responsibility are also of paramount importance in the evaluation of sudden, motiveless behavior, or crimes that are disproportionate to the motive and incongruous with the perpetrator's *modus vivendi*.

A reading of the aforementioned cases of ambivalent legal opinion regarding personality disorders evidences that in forensic psychiatry the classification of disease is of minimal help. Dynamic psychiatry can do no more than unearth some of the conditions or factors in the life and thought of a defendant and sentiments culminating in an unlawful behavior. In the assessment of criminal responsibility, an individual's inability to appreciate the wrongfulness of his action and the will to commit or not to commit that action are the important issues. Unfortunately, the legal system continues to endorse a test for insanity that approximates the Wild Beast test of 1724 (Robinson, 1996).

6.1. Due Process of Law

Due process of law is the constitutional guarantee found in the Fifth and Fourteenth Amendments of the United States Constitution, where it is stated that the government will act fairly when it attempts to deprive a person of life, liberty or

property. That underlies the fact that it is reasonable and just that judges in a criminal trial should guarantee fundamental fairness.

The due process concept dates back to the Magna Carta (1215 A.D.) when King John of England, in Chapter 39, proclaimed, 'No free man shall be taken or imprisoned or disseised or exiled or in any way destroyed, nor we will go upon him nor send upon him, except by the lawful judgment of his peers or by the law of the land' (Yale Law School, 1996-2007). The specific wording *due process of law* first appeared in a statutory rendition of the Magna Carta in 1354 A.D. under King Edward III of England and reads, 'No man of what state or condition he be shall be put out of his lands or tenements nor taken, nor disinherited, nor put to death without he be brought to answer by *due process of law* (emphasis added)' (Yale Law School, 1996-2007). This was confirmed during the reign of Queen Anne of England in the case of Regina v. Patty in 1704.

In the United States Constitution, which took effect in 1789, a Supremacy Clause specified that the Constitution would be the supreme law of the land. Since then the terms *law of the land* and *due process of law* have been used somewhat interchangeably. Due process of law is divided into procedural and substantive parts. Procedural due process is specifically based on the concept of fundamental fairness and states among the various rights that any individual has the right to be adequately notified of charges or proceedings against him and to have the opportunity to be heard at the proceedings (to which the author would add, without prejudice). This is supported by the Declaration of Human Rights (ONU, 1948) and the Council of Europe (Rome, 1950; Paris, 1952) which state that all people are entitled to and expect the courts to protect their rights.

For the past fifty years, the average defendant charged with a crime in the United States goes through a process of plea bargaining in which expediency has replaced classical due process, with its many constitutional guarantees. Already in 1967 Abraham Blumberg wrote: 'The overwhelming majority of convictions in criminal cases (usually over 90%) are not the product of a combative trial-by-jury, but instead merely the sentencing of the individual after a negotiated, bargained-for plea of guilty has been entered' (p. 18). The purpose of plea bargaining is to expedite the cases of the high number of defendants charged with criminal acts in the United States. It is constitutionally approved and it is thought to be 'successfully used to achieve case resolutions that are as equitable to the state and to the defendant as a jury trial would be' (Nasheri, 1998). Nevertheless, even though the defendant still has a right to counsel, the formal structure of due process, with its exclusionary rules of evidence, fact finding processes in an adversarial system, and factual determination in a procedural fashion, with the primary purpose of ascertaining the truth, is mostly lacking.

A number of states in the United States have found the right to assert an insanity defense to be an essential part of due process and fair treatment that must be

provided to a juvenile charged with delinquency (see e.g., Chatman v. Commonwealth (Chatman v. Commonwealth, 30 Va. App. 593, 601, 518 S.E.2d 847, 851 (1999); Interest of Causey (Interest of Causey, 363 So.2d 472, 474 (La. 1978).

6.2. Juror Attitudes towards the Insanity Defense

Juror attitudes towards the insanity defense vary. On the one hand, some argue that it is morally wrong to punish the mentally ill, while on the other there are those who are utterly frustrated by individuals acquitted of a crime on the basis of an NGRI defense who are not held blameworthy, and hence, not morally culpable, even for crimes that elicit community outcry (Bloechl, Neumann & Erickson, 2008). Thus, one potential problem to be considered in the proper assessment of an NGRI defense is juror bias. Most jurors have little or no background in mental health and they rely on their own implicit model of insanity and, as Finkel and Handel (1988) wrote, 'Mock jurors will reach similar verdicts in insanity cases, whether or not they are given any instructions at all' (p. 75).

The acceptance by jurors of the notion that mental illness or disorder may affect a defendant's cognition and volition may influence their verdict. 'Jurors who accept the notion that mental disorder can interfere with rational intentionality' are less willing to assign blame and guilt when compared to those who 'do not accept that severe mental illness is an appropriate mitigating factor in the attribution of responsibility' (Roberts, Golding & Fincham, 1987). Also, it seems that the political affiliations of jurors may be a potential variable, as C.E Tygart (1982) suggested, affecting the attitude towards the insanity defense—liberals more accepting of the insanity defense while conservatives are more likely to oppose it.

Therefore, it is not only the possible biases on the part of the legal system but also on the part of the jurors that may influence the insanity defense attitudes in those cases of persons with severe personality disorders who would like to enter a plea of non-responsibility for an alleged offense. Angela L. Bloechl and collaborators (2008) are of the opinion that 'if negative misconceptions towards the insanity defense (perceptions of overuse of the insanity defense) are to be overcome, disseminating accurate information about its actual use and success is critical to undermining the "abuse" hypothesis' (p. 158).

From a historical point of view, it is interesting to note that in 1869 Judge Charles Doe of the New Hampshire Supreme Court, in State vs. Pike (State vs. Pike, 49 N.H. 399 (1870), instructed a jury that mental illness defies definition and that no test is applicable to every case. The jury, he said, 'must decide the case on its individual merits….(and not on) a single rigid test of mental disease' (Slovenko, 2002, p. 249). It was a common practice of juries in the nineteenth century to return

verdicts of guilty with a recommendation for mercy or mitigation of a sentence to reflect any extenuating circumstances (Arenella, 1977).

6.3. The *Diagnostic and Statistical Manual* and the Legal System

During the past three decades, American courts have been using the *Diagnostic and Statistical Manual* (*DSM*) (American Psychiatric Association, 1983; 1994; 2000) in its various editions in support of civil and criminal mental health cases, especially in the process of determining criminal responsibility, competency or disability determination. In a cautionary statement regarding its use, the *DSM-IV* offers as guidelines for making diagnoses specific diagnostic criteria for each mental disorder and states that, in addition to a body of knowledge, the proper use of these criteria requires specialized clinical training. Thus, the widespread use of the manual in courtrooms by attorneys and judges appears to be contrary to those guidelines and improper.

The experience of psychiatrists, psychologists, attorneys and judges often has been that the application of a *DSM* supportive diagnosis does not generally facilitate the assessment of cases involving psychiatric diagnoses. The *DSM-IV*, even in its latest edition (American Psychiatric Association, 2000), remains an ensemble of diagnostic categories, and each disease category usually lists a minimum of eight to ten symptoms necessary for diagnosis. A person can be diagnosed with the same illness just by choosing at least four of the listed symptoms. Therefore, a person could carry the same diagnosis on the basis of different symptomatology. This obviously brings about confusion, especially in the field of law, where clarity and precision are of the utmost importance. It is because of the above that the *DSM* states that the categories of mental disorders 'may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination and competency' (American Psychiatric Association, 1994, p. xxxiii). However, not wholly relevant does not actually mean irrelevant

Further, the manual reads:

> 'When the *DSM-IV* categories, criteria and textual descriptions are employed for forensic purposes there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in the clinical diagnosis' (American Psychiatric Association, 2000, pp. xxxii-iii).

Indeed, a *DSM* diagnosis may not be completely useful in aiding the fact-finder in the evaluation of the type of functional impairment caused by the mental disorder

and its specific symptoms and the clinician must consult psychiatric textbooks and forensic manuals for additional information for forensic purposes. The most important information does not regard symptoms but functional impairment and how that impairment may affect the particular ability in question in a court of law. Mental impairment involving thoughts, feelings and beliefs is more important than the mere diagnosis or symptoms in achieving the resolution of issues. 'It is precisely because impairment, abilities and disabilities vary widely with each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability' (Melton et al., 2007, p. 212). As for the standards of legal competence and criminal responsibility, not only is additional information necessary but clinical reflection is needed. In addition, the *DSM-IV* diagnoses do not indicate how a clinician can determine a mentally disordered person's lack of self control (at any time, but especially at the time of an offense), which might shed light on his volitional capacity. Such a determination can be made through a stringent forensic psychiatric interview and the intensive reading of police reports and, when available, statements by witnesses at the scene of a crime.

Functional mental impairment is idiosyncratic and varies from individual to individual. It is because of such variations in abilities and disabilities within each diagnostic category that 'assignment of a particular diagnosis does not imply a specific level of impairment or disability' (American Psychiatric Association, 2000, p. xxxiii.) Also, a diagnosis is insufficient to establish the mental impairment necessary to support a plea of non-responsibility or diminished responsibility. It is the mentally disordered offender's abnormality of the mind and irrational behavior at the time of a crime which should be the basis for a finding of either diminished or non-criminal responsibility. To this effect, Slovenko (2009), in a commentary on legal issues in personality disorders stated that 'federal rules of criminal procedure do not require an expert to specify or categorize the mental condition of (a) defendant' (p.182).

In support of the argument presented in this thesis it is important to remember that the *DSM-IV* (American Psychiatric Association, 2000) includes the category of Brief Psychotic Disorder, and specifically states: 'Preexisting personality disorders (e.g., Paranoid, Histrionic, Narcissistic, Schizotypal or Borderline Personality Disorders) may predispose the individual to the development of a Brief Psychotic Disorder' (p. 330). And finally, seemingly confirming what is argued in this thesis, in a research article Barendregdt, Muller, Nijman and de Beurs (2008) wrote, 'In contrast to jurisdictions involving a sane/insane dichotomy, the Dutch five-point scale of criminal responsibility revealed that Axis II Personality Disorders turned out to be mostly associated with a diminished responsibility' (p. 619).

6.4. Summary

This chapter explains how offenders who are affected by severe personality disorders have been restricted in entering a plea of total non-responsibility or diminished responsibility since 1984, even though their behaviors at the time of their offense was grossly irrational and they were mentally impaired. As noted previously, in the United States, prior to the John Hinckley case and the subsequent Federal Insanity Reform Act of 1984 (which excluded personality disorders and the volitional capacity prong from the insanity test) such offenders, suffering from severe personality disorders, were not restricted in their presentation in court of an insanity plea if supported by irrational behavior at the time of a crime. Case law studies are presented to corroborate the above as well as to place into evidence the deliberations of pertinent courts decisions since 1984. The restriction of the insanity defense for severely mentally-disordered persons since 1984 is contrary to Due Process of Law as pointed out in a subsequent discussion.

A brief description of the *Diagnostic and Statistical Manual-IV* points out its limited usefulness in forensics, because it is too categorical and often confusing. Indeed, a particular diagnosis does not imply a specific level of impairment.

Chapter 7. Personality Disorder and Case Studies

Multiple factors determine behavior, including genetic, biological, psychological, temperamental and environmental. These factors, as Widiger (2007) rightly said, may combine to predispose an individual under severe stress to react in a certain pattern, a pattern that may change depending on the circumstances. Stress is disruptive of the ego which, having lost its integrative power, allows the breakdown of the various defense mechanisms—projection, splitting, isolation, denial and flight into fantasy—permitting unconscious suppressed instincts to come to the fore. Because of the loss of these defenses, irrational behavior may ensue.

The concept of personality disorders, which is evidenced in behavior, is culturally determined. It is used to describe regularities and irregularities of affectivity, cognitive capacities and relational disturbances. It is a chronic maladaptive disorder, with occasional unsuccessful adaptation across situations and time, and affecting interpersonal relationships. The perusal of the psychiatric and criminological literature and the writer's psychiatric and forensic experience have led him to the conclusion that people suffering from personality disorders often commit crimes while they are in a state of mind that could be called psychotic, during which time they are legally insane.

In a forensic psychiatric evaluation, the examiner is confronted by a variety of symptoms that are shared by many types of personality disorder. Patients with personality disorders are often 'impaired in their ability to adjust to stress…, will be more likely to develop depression, anxiety, psychotic or other Axis I disorders' (Stoudemire, 1994, p. 181). The diagnostic challenge with personality disorders is voiced by many evaluators who find it difficult to reach a specific diagnosis according to the classification in the *DSM-IV* and at times they feel obliged to use the diagnosis of Personality Disorder Not Otherwise Specified to the exclusion of any other (American Psychiatric Association, 1994; American Psychiatric Association, 2000). Indeed, the classification in *DSM-IV-TR* is controversial and problematic to the point that many psychiatric experts question its diagnostic reliability. It seems that the classification leads to shared characteristics and inconsistent, unstable and arbitrary boundaries between one personality disorder and another.

Proposals have been made to overcome this diagnostic confusion. The first is to integrate the various personality disorders into the Axis I diagnostic classification,

abolishing *tout court* their Axis II classification.[7] (For example, the Depressive Personality Disorder would be placed in Axis I as *Dysthymia, early onset*.) That signifies that the various personality disorders are not recognized as having a stable pattern and that is one of the reasons why, under particular stress, they may decompensate into psychotic behaviors. This change would do away with the present distinction between the personality disorder, stable and immovable, and the psychotic illnesses, viewing mental disorders in a continuum of increasing psychopathology, the personality disorder being an early manifestation of a possible future mental illness**.**

7.1. The Clinical Forensic Assessment

In the criminal arena the questions posed to the forensic expert by the court regard the mental capacity of the offender at the time of an alleged offense and at the time of trial. He will also be asked his opinion regarding possible causation: is there a link between the mental state of the offender and the offense. The task of the forensic expert is complex. He has to be able to communicate his findings in a narrative without any jargon and in a manner that will be clear to the readers, even those without any psychological or psychiatric background.

The expert must base his opinion and conclusions on objective evidence and reaching a definitive conclusion may be difficult in the behavioral sciences. For example, conclusions about responsibility and decisional capacity are not a black-and-white matter. At times medical, psychological and psychiatric records are difficult to obtain, especially immediate pre- and post-offense records. Even childhood traumatic events may shed light on an adult offenders' behavior, especially for those offenders whose resilience has been low or absent in the past. The expert must determine as accurately as possible the truthfulness of the defendant, the plaintiff, and the witnesses. The possibility that their memories may be unclear, with a tendency to exaggerate or embellish them, or that they are malingering, must be considered. Nevertheless, even with the above concerns, a careful assessment of all pertinent material should allow the expert to reach a conclusion that is congruous with reality.

Causation should be properly assessed by clearly differentiating consequence from subsequence (subsequence being something that follows something else, and consequence being something produced by a cause or necessarily following from a set of conditions). Psychological tests used by forensic experts, such as the MMPI-2 and the Rorschach, and, when necessary, neuropsychological assessments, as in the

[7] Axis I disorders include clinical disorders and other conditions that may be a focus of clinical attention. Axis II disorders include personality disorders and mental retardation.

case studies presented in this thesis, when correctly interpreted usually confirm, but occasionally contradict, the forensic evaluator's diagnostic impression.
There are frequently revelations in the test findings of psychological pathology that are kept consciously or unconsciously hidden by the testee. Often the tests rule out malingering. In the cases here presented, it was possible to rule out malingering, confirm the diagnostic impression and the conclusion that there was a direct cause-effect relationship between the serious personality-disordered offender's mental status at the time of the offense and the offense itself.

The forensic examination of an offender who pleads diminished criminal responsibility should assess whether that offender was or was not suffering from a clear mental illness or mental impairment (diminished capacity/diminished responsibility) at the time of the alleged offense, and did or did not have the mental ability to formulate one of the specific mental elements required for the crime charged. For example,

> 'An intoxicated individual accused of assault with intent to murder might reasonably claim that he was too drunk to formulate an intent to murder the victim of his assault; the result would be a guilty finding on the reduced charge of assault and battery' (Appelbaum & Gutheil, 2007, pp. 229).

The forensic diagnostic assessment in this type of case can be briefly summarized as follows:

- After introducing himself and asking the defendant to identify himself, the examiner should make clear the purpose of the interview, the limitations of confidentiality (e.g., a report of the findings of the examination will be sent to all the triers of facts or to the defense attorney only), and his objectivity. The examiner should be open to any questions by the defendant and he should make clear to the defendant that he can refuse to participate in the examination if he so wishes.
- The examiner should obtain informed consent for the examination. This is a critical moment for the examinee, because any disclosure could become self incriminating, and for the examiner, because it is the first time that he may detect whether the examinee is competent or not on the basis of the way he reacts.
- The examiner should observe the examinee's appearance, posture and ambulation, noting any difficulties in motor abilities. Any presence of tics, mannerisms, unusual facial mimicry or gross neurological deficits should also be noted. Orientation to time, place and situation should be elicited. The examiner should gather the examinee's personal, family and social history, as well as his medical and psychiatric history, including any history of mental illness within his family.

The psychiatric history should include questioning to ascertain the interviewee's cognition, affectivity, mood, proneness to impulsivity and anger, disturbances of perception (illusions, delusions, hallucinations), persecutory and/or grandiose delusions, command hallucinations, and other mental manifestations that may impair the examinee's understanding of the nature and quality (wrongfulness) of his actions and his ability to control his behaviour, such as any presence of moderate or severe mental retardation, psychomotor epilepsy, dissociative states, intoxication by drugs and alcohol.

- The defendant should be questioned about the alleged offense, including his recollection of events prior to, during and after the offense. He should be asked about his thoughts, feelings and behaviour during those periods and at the time of the examination. He should be asked about his relationship with the victim, his use of intoxicants prior to the offense, any use of prescribed and non-prescribed medications, sleep disturbances and fatigue.
- The examiner should be alert to any deliberate and conscious simulation of symptoms on the part of the examinee (secondary gains and malingering) through inconsistencies in the examinee's answers or replies to questions that are contradictory or that do not correspond to the criminal complaint, to statements given to the police by witnesses at the scene of the alleged crime, or with the narrative given at the time of apprehension. He should be aware of any exaggerated or bizarre symptoms.
- The examiner should never be confrontational unless he perceives deception in the examinee. He should maintain objectivity and avoid any emotional involvement.
- After capturing a longitudinal view of the examinee, embracing the totality of his clinical history, with special attention to his thinking and behaviour prior to, during and after the alleged offense, the examiner may reach a tentative diagnosis. To support the diagnosis he may request psychological testing and, at times, specialized neuroimaging studies, especially if the offense was committed by a person known to be free from irrational behaviour prior to the offense.

The final clinical forensic formulation will be made by the examiner based upon a comparison of the offender's behaviour at the time of the alleged offense as reported by witnesses and police investigators and the account of the offense by the offender himself; the offender's past social, medical and psychiatric history; the presence of

psychopathology at the time of the examination; the psychiatric diagnosis; whether the offense was committed impulsively or with premeditation; and finally the role that the offender played in the commission of the alleged crime. The examiner should assess whether delusions or hallucinations likely affected the offender's reasoning at the time of the alleged offense. As Gary Melton and colleagues (2007) stated, 'The most relevant (for the clinical formulation) are the accused person's characteristic thoughts, feelings and beliefs. Put in clinical terms, symptoms are more important than diagnoses to resolution of legal issues' (p. 259).

Slovenko, in *Psychiatry and Criminal Culpability* (1995), wrote that the assessment of criminal culpability hinges on the mental state of the accused at the time of the alleged offense and, therefore, a retrospective judgment is the basis of the assessment. The evidence regarding an accused person's mental state at the time of the offense, he stated, is circumstantial. Indeed, such an assessment is very challenging, because the defendant may have poor recollection of the events or he may attempt to malinger. However, the police investigative reports regarding the crime scene, the records of the interrogation of the accused after apprehension, and the interrogation of possible witnesses to the crime may be helpful in the assessment. Further, documentary evidence of previous illnesses, treatment and hospitalization may give more, or less, credence to the mental status assessment and help the forensic expert in the appraisal of the accused's state of mind at the time of the alleged crime. That assessment and eventual court testimony brings into a trial more 'flexibility and an element of humanity into the law' (Slovenko, 1995, p. 231).

7.2. Borderline Personality Disorder

Even though the Borderline Personality Disorder is an integral part of the personality disorder classification, it is questionable whether it is an autonomous entity. The characteristics of this personality disorder according to Gunderson and Singer in their seminal study (1975) were the following:

- Intense affectivity, depressive or hostile
- Impulsivity
- Mild to moderate social adaptation
- Brief psychotic episodes
- Tendency to disorganization in unstructured situations
- Superficial or very dependent relationships.
-

Persons with Borderline Personality Disorder have a weak ego. Their symptomatology is diverse. They may go through sudden mood changes, such as anger, depression, anhedonia, sense of futility, loneliness and isolation. Their behavior is marginal, transient and ego-dystonic, and their interpersonal

relationships appear to be good only on the surface. At times they suffer from transitory and fleeting hallucinations or delusions. Their personality disorder can be summarized as stably unstable (Gunderson, 1984). They seem unable to control their impulses because of sudden psychotic thinking due to internal and external stress.

The psychotic experiences of the borderline-personality disordered are ego-dystonic in that the person does not recognize them as part of the self. Their disorder is remindful of what Helena Deutsch stated regarding the 'as if' personality (in Kaplan et al., 1994). Indeed, they outwardly conduct their lives 'as if' they were essentially normal and in control of the self. Instead, their reality testing is quite faulty, they are highly vulnerable to stress, and emotionally unbalanced. The difficulty in making a correct diagnosis should be stressed, because they often have acceptable social behavior, and apparently function fairly well in social activities.Their occasional impulsive and destructive behavior, part of their personality, is difficult to predict. Their inability to test reality and to contain their impulsivity, which at times motivates their conduct, is due to the presence of depressive and delusional symptoms. Their psychotic breakdown may take the form of an acute schizoaffective disorder, a break with reality due to intense feelings of depression. Historically, Hermann Rorschach (1921) stated that some apparently normal individuals gave answers to his testing that were similar to those of schizophrenics. These people were later diagnosed as having a Borderline Personality Disorder.

Kernberg distinguished three stages in the Personality Borderline Organization. In the *first stage* the individual still possesses fairly discreet reality testing, with an absence of delusions or hallucinations, and the ability to differentiate the self from the non-self. The *second stage* involves the identity diffusion syndrome (feelings of emptiness, the inability to react well to others) and the *third stage* is that in which primitive defense mechanisms are resorted to. These include splitting—in which feelings of ambivalence divide people into good and bad—projective identification, feelings of omnipotence, denial, idealization and devaluation.

'In patients with borderline personality organization, projective identification weakens the ability to differentiate the self from external objects by producing an interchange of character with the object, so that something internally intolerable now appears to be coming from outside….(and) tends to diminish the reality testing' (Kernberg, 1992, p. 196).

Clinical Forensic Case : PF

Sources of Information

- **Criminal charges**: PF was charged with one count of Disorderly Conduct (Lewd and Lascivious Behavior) and one count of Fourth-Degree Sexual Assault.
- **Police record**: At the time of the charges PF was hospitalized for observation at a local county mental hospital. He became disorderly with two other patients, a male and a female.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary records; statements of hospital personnel; statements of victims/patients; statements of PF's relatives; statement of defendant; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to the forensic psychiatric examination the defendant was advised of his legal rights and the purpose and non-confidentiality of the examination. He freely gave his consent to the examination.

Social and Personal Data: White male; 49 years of age; middle-class family background; two years of college studying philosophy; divorced; homeless; unemployed.

Criminal History: Several brief incarcerations for drunkenness and minor misdemeanors.

Medical Psychiatric History: Several psychiatric hospitalizations because of alcohol abuse.

Pertinent Data: Poor relationship with parents; poor relationships with siblings; married at age 21; divorced by wife because of his drinking; minimal use of marijuana.

Mental Status Examination: Coherent; poorly relevant; at times tangential and slightly confused; blunted affect; oriented to time, place, person and situation; ideas of reference with paranoid coloring; some anxious suspiciousness and inappropriate interactions with others reported; claimed to have heard 'voices' at the time of the offenses.

Psychological and Other Tests: Multiphasic Personality Inventory-2 (MMPI-2).

Psychiatric Diagnosis: Borderline Personality Disorder, with Schizotypal features; Alcohol Addiction.

Defendant's Account of Offense: See psychiatric-forensic examination.

Criminogenesis:

- **Predisposing factors**: Weak ego defenses; ideas of reference; inability to cope with stressful situations.
- **Precipitating factors**: Anger because of hospital confinement; auditory hallucinations.

- **Risk factors**: Alcohol addiction; inability to properly relate to peers; tendency to misinterpret other people's behavior.
- **Obsessive-Compulsive Personality Disorder**
- **Victims**: 25-year-old, female fellow patient; 30-year-old, homosexual fellow patient.

Psychiatric Forensic Examination of Offender: PF entered the interview situation in a friendly fashion. His posture was erect and his ambulation normal. There were no tics or gross neurological deficits, but some grimacing was present on observation. He sat comfortably, although somewhat restlessly, in his chair. He was rather amiable and communicative. He was coherent, poorly relevant and at times dispersive and disorganized.

PF identified himself correctly and gave his age as forty-nine years. His account of his history revealed that he had a poor relationship with his mother and distrusted her. He said that he has seven brothers and three sisters, and that there are several lawyers in his family. He stated that he had a 'pretty secure youth' and never had any real mental problems until age nineteen. He had attended two years of college studying philosophy on the advice of his deceased father, a professor of Spanish language and literature. He married at age twenty-one and later divorced after his drinking caused his marriage to fall apart. He left his wife and traveled around the country, supporting himself by working as a bartender and in several restaurants.

Because of his tendency to be tangential, the questions asked of PF were of necessity direct. He denied any use of illicit drugs, except for minimal use of marijuana, and some use of alcohol although he used to drink large amounts years ago. He denied any major arrests while roaming around the country, but admitted to a few minor arrests for misdemeanors due to alcohol abuse. He admitted that he had been previously hospitalized at several regional mental hospitals since his late adolescence.

He spontaneously commented, attempting to explain the sudden onset of his illness: 'You know, walking in the street and all of a sudden things go wrong.' He said that the worst symptom of his mental disease was that at times he felt angry and violent. He claimed to detest violence but thought that he had a violent tendency. He recalled that he became rather angry and violent when the 'voices,' which were intermittent, told him to do so. He said they were very convincing. They wanted him to be violent and wouldn't let him alone until he was. He believed that people could read his mind and tell him what to do.

At the time of the offenses with which he was charged, PF was hospitalized for observation at the local county hospital on a court order. He said he was there because commitment procedures were going to be initiated by his family who said that they had had enough of his behavior. He said that he had been getting along well outside the hospital, even though he refused his medication. However, after several incidents of disorderly conduct his family called the sheriff. He appeared to

be somewhat confused when relating the events. He claimed that at times his mental disorder would become incapacitating. Regarding the disorderly conduct incidents, he said that striking out at people just seemed the way to do things because they were talking about him. He claimed that he 'was placed in seclusion, tied down and shut up with Haldol (an antipsychotic).' In a poorly integrated manner he stated: 'It just seemed they (the voices) wanted me to do it. They told me to do it. Everybody told me. The conversation goes from here to here to here.' The voices were those of both men and women telling him to behave the way he did. He said that although he thought it was a stupid thing to do the voices made it seem it was the right thing.

PF said that the victim in the offense at the county hospital for which he was charged with disorderly conduct and lewd and lascivious behavior was another patient,'a nice girl' in her twenties. I don't know what I did and I don't know why she reported me. Regarding the fourth-degree sexual assault charge, he stated in a confused manner that he touched a fellow patient sexually. He said it was all right because the man was suffering and the voices told him that he needed some help. He claimed he talked to the man who told him he was gay and didn't have anyone in his life. PF said that he wanted to get away and get some rest.

PF stated that the entire time he was at the county hospital he refused his medication because of the side effects. At the time of the examination he was taking a mood stabilizer twice daily and an antipsychotic intramuscularly, twice monthly.

Forensic Psychiatric Opinion: After reviewing pertinent records and the examination of PF, it was the author's forensic psychiatric opinion that at the time of the offenses with which he was charged, because he had lapsed into a confusional type of behavior, probably due to a psychotic disorganization with command hallucinations, he did not possess substantial mental capacity to appreciate the nature, quality and consequences of his actions and conform to the requirements of the law.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of PF's psychopathological state of mind at the time of the crimes: disorderly conduct and fourth-degree sexual assault. There was a direct nexus of causality between his psychopathological state of mind and the crimes committed. The MMPI-2 excluded any malingering.

At trial, regardless of two psychiatric reports supporting his non-responsibility plea, PF was found guilty of the offenses and sentenced to five years in prison as a sexual predator.

Commentary: This 49-year-old, single white male entered the interview situation in a friendly fashion. He tried to be cooperative during the interview. His speech was coherent but poorly relevant and at times tangential. He exhibited ideas of reference, paranoid ideation and recounted past auditory hallucinations during periods of stress. His affect was blunted. During the discussion, he became poorly integrated in

his thinking. He had vague recollections of his past history of mental illness and his vagabondage throughout the country, his past marijuana addiction and alcohol dependence.

PF's history revealed that he became irrational and odd in his behavior around age nineteen. He was suspicious, with ideas of reference, and unable to relate properly to others, distrusting even his own relatives, and he became increasingly paranoid. He felt that he never fit in and became tense and distrustful of gatherings of people. He was prone to vagabondage. Under stress he moved into a schizophrenic psychosis and during a period of irrationality he acted against people and the law.

People suffering from Borderline Personality Disorder with Schizotypal features feel different from others and have the feeling that they do not fit in. At times they believe that other people may read their mind and that makes them anxious and suspicious. Because of that, they have a decreased desire for intimate relationships and their behavior during interactions with others appears to be inappropriate and at times eccentric. Their communications show idiosyncratic speech and peculiar phrasing, at times with a tendency to be abstract. They exhibit ideas of reference and paranoid ideation. Under stress they may experience transient psychotic episodes, which may last from minutes to hours (Brief Psychotic Disorder). These persons are frequently underachievers in school, have difficulty in keeping a job, and may end of being homeless.

Clinical Forensic Case: LC

Sources of Information

- **Criminal charges**: The defendant was charged with two counts of First-Degree Intentional Homicide. The victims were a four-year-old boy and a 12-year-old boy.
- **Police record:** This record concerns the finding by townspeople of the victims' bodies, the four-year-old by a roadside outside of the town where both defendant and victims lived, and the 12-year old down the slope of a hill in back of the defendant's home
- **Records reviewed**:Criminal complaint; police investigative records; supplementary police narratives; autopsy reports; statements by townspeople; statements by relatives of victims; statements by defendant's adoptive parents; defendant's statements at time of interrogation; records of author's communications with attorneys

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of

the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.
Social and Personal Data: White male, 24 years old; university graduate; single; middle-class; lived with parents in small town in Italy
Criminal History: First-time offender
Medical/Psychiatric History: No previous contact with mental health experts; no past history of drug and alcohol abuse
Pertinent Data: History of immature behavior; difficulty in relating to peers; ambivalent towards adoptive parents; no heterosexual or homosexual experience; pedophilic fantasies; strong feelings of abandonment.
Mental Status Examination: Coherent and relevant but tangential; oriented to the usual spheres; hyperalert; hypertalkative; speech under pressure; shy; obsessive thinking; ambivalent; tendency to paranoid ideas—suspicious and fearful of others; lonely; feelings of inner emptiness; deep feelings of rejection; no friends; bizarre, unrealistic thinking, bordering on delusional.
Psychological and Other Tests: Minnesota Multiphasic Personality Inventory-2; Rorshach; Wechsler Adult Intelligence Scale (WAIS); Electroencephalogram (EEG); Computerized Axial Tomography (CAT) of the brain
Psychiatric Diagnoses: Borderline Personality Disorder, with strong narcissistic and paranoid traits
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Frustrated desire for acceptance; inability to relate to peers; feelings of abandonment by birth mother.
- **Precipitating factors**: Fear of rejection; extreme loneliness;
- **Risk factors**: Feelings of inadequacy; fear of abandonment; narcissism
- **Victims**: A four-year-old boy unknown to LC; a 12-year-old boy with whom LC was acquainted

Psychiatric Forensic Examination of Offender: LC was tried at age twenty-four for the murders of a four-year-old child, SA, and of a 13-year-old teen-ager, LP. At the time of the author's forensic examination, he was confined in a maximum security prison. He was hyperalert and hypertalkative, and his speech was under pressure and tangential. He was in good contact with his surroundings and extremely eager to relate to the examiner, to the point that it was difficult to take notes because of his rapid speech.

LC had been placed in an orphanage by his unmarried mother and adopted at age six by a middle-class family. His adoptive mother was a teacher and his adoptive father a medical doctor. LC had ambivalent feelings towards them both. He voiced feelings of loneliness and emptiness, and ruminative thoughts about guilt. Basically he had feelings of abandonment and rejection, and, as he stated, of being a bad boy: 'My mother left me and my adoptive parents often reprimanded me.' LC developed

into a shy, fearful, obsessive, somewhat suspicious person, and occasionally he withdrew into a world of fantasies. At times he entertained pedophilic fantasies, masturbating while having fantasies of sex with children. These fantasies, he said, were limited to touching. He viewed the sexual act as 'a dirty contact between two dirty body parts.'

LC was frustrated in his basic desire for attention and love. He was immature, deeply ambivalent, childish in his expressions, and unable to relate properly to people of his own age and he had no friends. He was unable to achieve bonding and intimacy with others and he felt rejected by his mother and not understood by his adoptive parents. He described his adoptive mother as strict and obsessive and his adoptive father as distant. Even though he had finished his studies, at the time of the crimes, he was not employed. He showed deep immaturity throughout the interviews.

Regarding his crimes, LC said that while cruising in his car during an absence of his parents he saw a young boy by the side of a county road and enticed him to go home with him where he bathed him and played with the child's genitals. He stated that if the boy had not come with him willingly he would not have taken him with him.

When, at LC's home, the boy began to cry for his mother, fearful that the neighbors would hear him, LC first covered the child's mouth to stop him from crying and then strangled him. Realizing that the boy was dead, he placed the body in a plastic container, drove out of town until he found an isolated spot where he stopped and removed the container. Then, not sure that the child was dead, without looking at him he stabbed him twice with a small knife and let the body roll down a hill.

Later, while at home and reflecting on what had happened, LC said that he interpreted the crying of the child when he attempted fellatio on him as a sign of rejection. He could not understand why the four-year-old boy was crying. In his immaturity, LC believed that he should not have cried because he (LC) would have explained everything to him. LC remembered that, taken by panic because of the boy's crying, like an automaton, he had strangled him. His dissociated state is evident from his own words: 'I only remember that I had my hands around the child's neck. I was thinking that it was wrong. I felt ashamed.'

LC was utterly unrealistic in his thinking, and obviously taken with childish fantasies when he expressed that his desire had been to run away from his parent's home, kidnap two children about two or three years old, and keep them with him in an isolated place away from the world. He said that he wanted to raise them to the age of seven and then return them to their parents. He had already purchased many items of clothing which he thought would be necessary for the children.

Before the police found the child's body LC had challenged them with written messages, mocking them, saying that they were incapable and unable to find the

killer. He even participated in a community group searching for the child's body. That shows his irrational, ludic and attention-seeking behavior. He recounted that he later stole the boy's photograph from his tombstone because he wanted to see him again. Whether that could be looked upon as a trophy is questionable. A killer at times enjoys a contemptuous delight when his deceptive act is perpetrated and he realizes that his deception has been successful. Indeed, as Reid Meloy (1996) wrote, 'The contemptuous delight...restores his pride...enhances his narcissism, and protects his vulnerability. It is necessarily repetitive because the threat of intrapsychic rupture within the grandiose self is always present' (p. 101).

Ten months after the first homicide, this depressed, narcissistic pedophile, basically hostile, even though apparently humble and servile, met a previous acquaintance, 12-year-old LP. He stated that he liked this young boy's independence because 'he looked like me.' When LC's parents were out of town, he invited LP to his home to play cards and they talked about school and about LC's timidity. LC remembered that the boy was winning the game and he began to perceive his behavior as bragging. 'Suddenly,' he recounted,

> 'I don't know what happened to me. When he turned around I hit him with a big We both fell to the floor, wrestling. He was resisting, trying to avoid my hitting him again. He looked at me but I didn't see him—I was so furious.'

At one point LC remembered, the boy said to him, 'Wait a minute. Why do you want to kill me? He said that he did not remember if he hit him another time but

> 'we started wrestling again and all of a sudden I put both my hands around his neck and suddenly I realized I had strangled him. I got a knife and I cut him in the neck, because it seemed as if he were still alive. Then I panicked. I didn't know what I had done, what to do. The floor was full of blood.'

About 60 meters from the house there was a dump and LC took the body outside and let it roll down the slope. Later, as he tried to clean the floor of the living room, wondering what he should do next, people from the town, led by LP's father, came to his home and when they realized that he had killed the boy they called the police and LC was arrested.

LC stated that there was no sexual play between himself and LP, but that LP had touched him on the shoulder and he had touched LP's leg while playing cards at the table. He blamed both of the young victims for what happened, claiming that it was their fault because they didn't help him and wanted to run away from him.

LC's recounting of the events which took place in both homicides was fair, with the presence of minimal confusion and subsequent correction of his statements. However, he spoke and acted in an uninvolved manner, as if he were talking about

something that he witnessed someone else doing. His speech was under pressure and high pitched. He claimed that he cared for the two boys and he was unable to explain the killings. It was evident from his description of the events that he perceived the behavior of the two boys as rejection and that had revived in him his ever-present disturbing feeling of having been abandoned. His affect at the time of the examination was shallow and his thinking was extremely childish, even though he spoke in a fluent and well-articulated manner.

Forensic psychiatric opinion: At the time of his crimes, LC was irrational because he had decompensated into psychotic thinking and behavior from his original Borderline Personality Disorder with narcissistic and paranoid features. Therefore, it was the author's legal opinion to a reasonable degree of medical certainty that he did not possess substantial mental capacity to appreciate the nature, quality and consequences of his wrongful actions and was unable to conform to the requirements of the law. A plea of partial insanity was supported. The repetition of his offense was due to the fact the he again found himself in the throes of a stressful situation during which his repressed psychopathology surfaced, creating the brief psychotic episode.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime, was useful in the reconstruction of LC's psychopathological state of mind at the time of the two homicides. There was a direct nexus of causality between his psychopathological state of mind and the crimes he committed. The MMPI-2 excluded any malingering.

The jury found him guilty and totally criminally responsible for both offenses and he was sentenced to life in prison. On appeal, the finding was changed to diminished criminal responsibility and the sentence was reduced to ten years in prison.

Commentary: The diagnosis in this case was Borderline Personality Disorder with Narcissistic and Paranoid Features. LC decompensated at the time of the crimes. At trial LC was found guilty of the two murders and legally sane. The author had supported his plea of diminished responsibility and on appeal the verdict was changed to diminished responsibility (partial insanity).

LC was very sensitive to rejection, unable to establish a human rapport with others of his age group, and had a tendency to paranoia. He felt grandiose with a sense of entitlement because of his early abandonment. He was selfish and easily angered when frustrated. He reported poor object relations with his biological mother, his adoptive mother and his adoptive father. Bad-good repressed imagoes inundated and partially disintegrated his ego when he was under severe stress, such as when facing rejection from his two young victims, at which time his ego instability reached the point of a pre-psychotic state. His desire to abduct and raise the two boys up to the age of seven was not only unrealistic but irrational and a clear

identification with the introjected good object. Rejected by the children, he killed them as if he were killing that introjected bad object.

When the author supported a plea of diminished capacity/responsibility he added that LC would continue to pose a threat to others and to himself if not treated, but also noted that treatment in such cases is rarely successful. Borderline Personality Disorder (BPD) interferes with an individual's ability to regulate emotions. The brain volume in persons with this disorder seems to differ somewhat from the normal. Their hippocampus and amygdala may be as much as 16% smaller. Hyper metabolism is also present. Neuroimaging research has focused on the amygdala and limbic system, centers that control the emotions of rage, fear and automatic reactions.

Persons with BPD are quite impulsive and that is probably due to the reduced blood flow in the right temporal cortex and the right prefrontal cortex. Research also strongly implicates low levels of serotonin in aggressive persons with Borderline Personality Disorder.

In this particular case, LC's behavior was typical of BPD. He was known to be an isolated young man, unable to relate properly to his peers due to his immaturity and self consciousness. His feelings of rejection and of being a bad boy ('My mother gave me away') made him feel bad and unusual. He had ideas of reference and extreme sensitivity to rejection. His impulsivity, part of the neuropathology at the basis of his BPD, became uncontrollable under stress. He then decompensated into a brief psychotic episode, commonly reported in BPD, and committed the two murders. His behavior in the interim period was narcissistic to the extreme. Indeed, even during the author's examinations of him he wanted to control the interviews and to be the center of attention, while exhibiting paranoid projection such as blaming the two children for his acting out in a murderous way.

Because legal responsibility should be viewed in a continuum, differentiated in 'degrees,' it was the author's professional psychiatric opinion to a reasonable degree of medical certainty that LC fitted the prerequisites for a finding of diminished responsibility while committing the crimes during micropsychotic episodes. He was unable to control his impulses, of which he was not totally aware at the time of the crimes, and he could not appreciate the nature and consequences of his actions. He had a distorted view of reality and loss of reality testing.

Clinical Forensic Case: LK

Sources of Information

- **Criminal charge**: LK was charged with one count of First-Degree Intentional Homicide.
- **Police record**: The police were called by the mother of the victim because her son had not answered the telephone for several days. The police entered the house of the victim and found him dead on the floor of his bedroom. He had been stabbed several times in his back and chest and also had a gunshot wound to the head. After an investigation of several weeks, LK was arrested.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary report; statements of police officers at crime scene; statement of arresting police officer; autopsy report; statements of relatives of victim; statement of friend of defendant who allegedly reported LK to the police; previous medical reports; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.
Social and Personal Data: White male; 18 years old; single; middle-class; high school student; occasional summer jobs; lived with parents in small rural town.
Criminal History: No prior police record.
Medical/Psychiatric History: Marijuana experimentation; alcohol abuse; occasional anxiety attacks to the point of panic.
Pertinent Data: Protective parents.
Mental Status Examination: Coherent; relevant; deep feelings of inadequacy; depressed; anxious; lonely; difficulty in relating to peers; tendency to brag about self; expressions of hostility; superficial understanding of charges; unable to explain behavior.
Psychological and Other Tests: Rorshach; Minnesota Multiphasic Personality Inventory-2 (MMPI-2); Wechsler Adult Intelligence Scale (WAIS-R); electroencephalogram (EEG); Computerized Axial Tomography (CAT) of the brain; neuropsychological testing.
Psychiatric Diagnosis: Borderline Personality Disorder, with dependent and narcissistic features; History of Alcohol Abuse; History of Panic Attacks.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Feelings of inadequacy; tendency to impulsivity; poor self esteem; difficulty in getting along with others;
- **Precipitating factors**: Feelings of humiliation and of having been taken advantage of; confusional panic.
- **Risk factors**: Abuse of alcohol.
- **Victim**: Young adult, male homosexual unknown to LK.

Psychiatric Forensic Examination of Offender: LK was examined upon the request of his attorney after he entered a plea of non-criminal responsibility when he was charged with First-Degree Intentional Homicide. On observation he appeared to be sad, friendly, and eager to communicate. His speech was coherent, relevant and logical. His mood was minimally depressed. He did not seem to fully realize the consequences of the charges against him; he did not even consider that he might have to spend the rest of his in prison. He had no insight into his actions. He stated that he was not a bad person and he thought that God would help him.

LK first stated that the homicide with which he was charged was the consequence of a botched burglary. He claimed that when the victim, a young man about 30 years old, awoke as LK cased the premises, he shot him with the hunting gun he had taken with him. Subsequently, he gave a different version of the crime, stating that he had been ashamed to tell the truth before.

In his second version he claimed that he had been drinking at home and feeling lonely. Later he drove to a park where he frequently went to drink and he continued drinking. While there, a man claiming to be a homosexual invited him to his home. Because of his drinking LK said, he was in an aroused state and he went with him. (Later in the examination he said that whenever he drank he was aroused and had homosexual urges.) When they arrived at the home they went to the bedroom and started to have sex but then the man wanted LK to perform fellatio on him, promising that he would do the same to him. LK did as he asked but the man refused to do the same to him. LK then left the house and went to his car where he fell asleep.

When he woke up in the middle of the night LK realized that the man had taken advantage of him and he felt angry and disappointed. He was ashamed of what he been subjected to and what he had done. He felt deeply humiliated and his anger became a fury and, he said, 'I must have snapped.' He said that he found himself in the man's bedroom with a gun and knife that he always kept in the trunk of his car.The man partially woke up when LK irrupted into his room. Seeing the gun, he begged LK not to hurt him. The next thing LK remembered was seeing blood on the floor. It woke him from his trance-like situation, he said, and he was horrified by it. He ran to his car and drove around the town for several hours before going home, crying and trying to understand what had happened. Later, he felt increasingly guilty about the event and told a classmate what he had done. He informed the police.

LK felt that he was not accepted by his classmates. He claimed to have had feelings of loneliness and mood swings. He was unable to relate properly to his fears, suffered from anxiety and panic attacks, with paranoid and suicidal rumination. He occasionally used marijuana and frequently drank alcohol. He claimed that he was not aware of any homosexual feelings except when he was drinking.

Forensic Psychiatric Opinion: After reviewing the available records and my examinations of the defendant, it was my forensic psychiatric opinion that at the time of the crime LK underwent a Micropsychotic Episode during which he did not possess substantial mental capacity to appreciate the nature and quality of his actions and the consequences of wrongful behavior and was unable to conform to the requirements of the law. In other words, he was legally insane, even though temporarily.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime, was useful in the reconstruction of LK's psychopathological state of mind at the time of the homicide. There was a direct nexus of causality between his psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering.

Commentary: LK's history revealed that he was very immature and had unstable interpersonal relationships with his peers, identity disturbance, a tendency to impulsivity, suicidal rumination, marked reactivity of mood and dissocial behavior. His history revealed transient stress-related paranoid ideation with occasional dissociation. He had a psychotic-like break due to a sudden brief psychotic episode as a reaction to shame and emotional vulnerability to humiliation. He was possessed by fury and overkilled. Indeed, the autopsy revealed that in his psychotic acting out he stabbed the victim several times and shot him after death.

The jury rejected his plea of insanity or even diminished capacity/diminished responsibility at the time of the crime. The judge applied no mitigating factors and sentenced him to 25 years in prison.

The antisocial acting out of some adolescents at times is the forerunner of a pre-psychotic borderline state. Their acting out may be akin to a psychofunctional disorder of the mind, almost a necessary transitional period prior to achieving a stability of the personality. During this highly unstable period, as Silvano Arieti (1967) wrote, one can observe in the adolescent's behavior the intermingling of two worlds: the real and the psychotic.

7.3. Paranoid Personality Disorder

The main characteristics of persons with a Paranoid Personality Disorder are chronic suspiciousness and general mistrust. They displace onto others their own shortcomings and responsibilities. Often hostile, irritable and angry, they rarely seek treatment on their own, being convinced that there is nothing wrong with them. They are usually forced into treatment by family members or the courts, which they resent, and in situations in which such forced treatment is being sought they are bright enough and able enough to put on a normal façade. They show pathological jealousy, extreme litigiousness and, under stress, many become clearly delusional and

paranoiac. At those times they should be considered not responsible for any antisocial actions, since they are unable to conform to the requirements of the law and behave irrationally because of their misperceptions of the behaviors and intentions of others.

In essence, the basic problem of the thinking of persons with a Paranoid Personality Disorder is that they interpret the actions or demeanors of others as threatening, exploitative or harmful to themselves. They even mistrust family members, friends and associates. The mechanism of defense they use is projection: they project onto others feelings that they harbor about themselves or important persons in their lives, which they are unable or unwilling to accept—'It's not me. It's you!' Often, they suffer from ideas of reference and illusions. They are cautious and somewhat distant in their interpersonal relationships. In their professional endeavors they are efficient, but their expectations of themselves, and especially of others, create interpersonal difficulties.

Nevertheless, they claim to be rational and objective, and, as Shakespeare would say, they protest too much in their attempt to prove it. They have a tendency to be grandiose, to have superiority feelings, and to disdain the weak, the sickly, and passive individuals.

Persons with this type of personality disorder are rigid, tense and unable to relax. In their daily life they are so cautious and suspicious that they seem to search the environment for clues or criticism from others that they then misinterpret as being directed at undermining them. This behavior is remindful of the monomania of Etienne Esquirol, the persecutory delirium of Ernest Charles Lasegue, or the slow cognitive delusional disorder of Karl Kahlbaum and Emil Kraepelin (in DiTullio, 1971). The thinking of persons with this type of a personality disorder is seemingly logical. The conclusions they reach, however, are faulty because of incorrect initial premises. Their cognitive distortions are quite evident when they lose control. The prevalence of Paranoid Personality Disorder varies from 0.5 percent to 2.5 percent in the general population (Kaplan et al., 1994). Paranoid Personality Disorder may be the precursor of paranoia, a psychotic condition, or of a schizophrenic type of psychosis. It may occur because, having a fragile ego structure, these individuals often react to stress in a catastrophic manner.

Clinical Forensic Case: CS

Sources of Information

- **Criminal charge**: CS was charged with First-Degree Intentional Homicide.
- **Police record**: CS had gone to the office of his past manager to complain that he had not been hired for the job for which the company had trained him and

which had been promised to him. He was irrational in his thinking and behavior and shot to death a person unknown to him who was in the manager's office.

- **Records reviewed**: Criminal complaint; police investigative records; police supplementary records; statements by police officers; autopsy report; statement of CS to police; statement of past employer; statements of other employees of the company where the shooting took place; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: Black male; 22 years of age; poor student; high school dropout; single; one child; low social class; factory worker; resident of mid-size American city.

Criminal History: No previous charges.

Medical/Psychiatric History: Alcohol abuse; drug abuse (marijuana, LSD, cocaine); no history of psychiatric hospitalization.

Pertinent Data: Mother hospitalized for possible depression; resented mother's behavior towards him; father mostly absent from home; bad conduct with siblings.

Mental Status Examination: Coherent; relevant; logical in thinking; oriented to the usual spheres; minimal spontaneity; blunted affect; occasional puzzled facial expression; fair memory; tendency to suspiciousness and distrust; no evidence of delusions and hallucinations.

Psychological and Other Tests: Minnesota Multiphasic Personality Inventory-2 (MMPI-2).

Psychiatric Diagnosis: Paranoid Personality Disorder, with passive-aggressive traits; Chronic Drug Abuse.

Defendant's Account of Offense: See psychiatric-forensic examination.

Criminogenesis:

- **Predisposing factors**: Basic distrust of others; suspiciousness of other's behavior; immaturity; feelings of rejection; tendency to aggressivity.
- **Precipitating factors**: Feelings of rejection; persecutory paranoid ideation; anger; loss of self control due to paranoia.
- **Risk factors**: Drug and alcohol abuse; unstable personality.
- **Victim**: Middle-aged white male unknown to CS.

Psychiatric Forensic Examination of Offender: CS was a well-developed, 22-year-old black male, six-feet, one-inch tall. His posture was erect but his ambulation, although still within a normal range, was somewhat slow. He sat comfortably in his chair and his cooperation during the interview was good. There was minimal spontaneity but he answered the questions quite relevantly. His speech was coherent, relevant and logical, but his delivery was somewhat low toned. He

appeared to be minimally detached throughout the interview and his basic affect seemed to be blunted. There was a certain passivity in this young man's behavior. It seemed as if he was totally involved in his own thoughts and looked at other people as if they were unreal.

CS claimed that in junior high school he took courses in electronics, masonry and carpentry, but he dropped out of high school in his last year because his grades were poor. After leaving school he worked at various jobs and he was greatly disappointed when he lost the opportunity to be hired for a job for which he had been trained. He was a trained as a carpenter and he believed that he was the best worker, saying, 'It all came naturally to me. I am a qualified man. I have a good résumé.'

CS started using drugs when he was 20 years old, experimenting with several types, including marijuana, LSD, cocaine and various other substances. He said that he used acid once every two weeks and estimated that he had had 20 or 30 hits of acid in his lifetime. He stated that he drank alcohol on a regular basis and described consumption of relatively large quantities. When he drank it made him feel a little better and helped him forget things for a moment.

CS is single but has one child who was born the year of the offense. He claimed that the child was one reason why he acted so hastily in his decision, referring to his decision to go and talk to his previous manager at work the day of the offense. He claimed that his 43-year-old mother was not a good mother:

> 'I remember that when I was a child she tried to drown me. I was a baby but I remember it. She held my head under water because I was crying. Recently she said that she wished she had never had me. She used to call me the devil.'

He thought that at one time his mother had been in a mental hospital but did not know the reason. His father, who died from heart disease a few months prior to the examination, 'didn't spend much time at home. He never spent the night at the house. He lived out of town.' He said he fought all the time with his four siblings, three brothers older than he and one sister.

CS denied any police record but stated that as a teenager he was given a ticket while working at a small restaurant where he was accused of passing a counterfeit bill that a customer had given to him.

CS's intelligence appeared to be average. His vocabulary was very good. He was able to correctly multiply 11x11. His memory for past and recent events appeared to be good, even though interspersed with some quasi-delusional interpretations. His basic affect was blunted. Asked whether he had been suffering from depression he replied, 'I'm not depressed. I've been this way all my life.' He denied any hospitalization, either in general hospitals or mental hospitals, except for stating that

as a child he fell while he was playing and reported a laceration of his scalp which required four or five stitches.

In his account of the offense, CS stated that it took place after he was not hired after finishing training for a job. He did not know the real reason for the job loss but he felt that he was not wanted, even though he was 'a good worker.' His supervisor, an older white man for whom he had worked for a year and who was supposed to rehire him, was also fired. CS stated that he, CS, went to see the manager and told him to rehire his supervisor and that he himself would find another job. At that time he was staying with his mother and she had given him a few weeks to find a new job but he was unable to do so. He felt under intense pressure. He stated that he began to think that the manager had been spreading false rumors about him as a worker. 'I had my résumé typed up. I was dressed correctly. I spoke with a good vocabulary.' He added that at times he had seen the manager at places where he was going to be interviewed for work. He believed that he was persecuting him. He said that he saw the manager leave before he got there and he recognized his car.

During his period of unemployment CS drank, off and on, several 40-ounce bottles of beer daily, and took acetaminophen for headaches, sometimes four a day. He admitted to smoking marijuana joints but he denied using crack cocaine. At another time during the examinations, however, he contradicted himself and said that he had used 'everything—drugs and alcohol' prior to the shooting.

CS recounted the day of the offense as follows:

> 'A month after being fired I started hearing voices. I was drinking and sometimes I would smoke marijuana. I went back to see the manager to have him give me my job back. I had a knife with me—a 10- to 12-inch butcher knife. On the way there I met a friend on the bus, and he gave me a 25mm. automatic gun. I went to the place where I used to work. It was during the day. I hesitated about going into the manager's office when I saw another man in there with him, but the voices told me to do what I had come to do. I went in and, I don't know why, I told the other guy to lie down. The manager was at his desk. They told me in court that I said that I was the son of God. But actually I remember asking the manager whether he believed in God? I was confronting the man who had destroyed my life but I shot the man on the floor. I don't why I did it.'

Asked whether he realized that he had killed the man on the floor he replied, 'I don't remember, but they say I did.' He said that he only tried to hit the manager when he ran away and had no intention to kill him. He only wanted to talk to him and tell him what he had done to him. The manager ran out into the street and CS went back inside and sat down. He heard voices telling me to get out because they were going to kill him. Previously, he had asked the manager for the keys to his car.

He went outside and got into the car, but since it would not start he walked back to his girlfriend's house.

CS' speech became poorly organized during the examination and he exhibited bizarre delusions. He said that around the time of the offense he thought that he was Jesus because he was raised by a baby-sitter named Mary and because he was a carpenter. This was interspersed with some recounting of historical events regarding the Messianic age and the fact that Jesus and the Egyptians were black people and he talked about the zealots killing people. He spontaneously stated that he spent a lot of time in the library reading religious books. Asked at the time of the examination whether he still believed himself to be Jesus, CS replied, 'I don't even think about it. When I felt that way it gave me a sense of worth. I understood the meaning of life.' He appeared to have a certain amount of resignation about his legal situation and its outcome.

Forensic Psychiatric Opinion: In reassessing this case, it is the author's opinion to a reasonable degree of medical certainty that CS did not possess substantial mental capacity to possess the nature, quality and consequences of his actions and conform to the requirements of the law, because of a decompensation under stress of his previous paranoid personality with passive-aggressive traits into a full-blown paranoid delusional disorder.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime, was useful in the reconstruction of the CS's psychopathological state of mind at the time of the homicide. There was a direct nexus of causality between the psychopathological state of mind of the offender and the crime committed. The MMPI-2 excluded any malingering.

Commentary: CS was basically suffering from a Paranoid Personality Disorder with paranoid features and Chronic Alcohol and Drug Abuse (marijuana, cocaine, LSD). He decompensated under severe stress (loss of promised job) into a full-blown Paranoid Delusional Disorder. This 22-year-old black male seemed to be detached during the interview. He had no history of previous mental illness or hospitalization prior to the instant offense, which was the first offense in his life. He had an unremarkable childhood and adolescent development except for a rather absent father figure and some difficulty with his mother whom he described as 'not too good to me.' He claimed that she thought of him as a 'devil.' He did not have a good relationship with his siblings with whom he fought frequently. He did not graduate from high school and left school during the 12th grade. He was trained in carpentry and electronics and eventually, after a year of restaurant work, he secured a trainee job doing carpentry and he claimed to have been a diligent worker. He admitted that prior to being fired from the job he had been using drugs in the form of marijuana and cocaine and had a heavy alcohol intake. That increased after he was fired. He intensively read the Bible.

CS, even though coherent, expressed paranoid ideation. He was angry and resentful of others. He believed that his former manager had not only fired him from his job but persecuted him afterwards, and was trying to make it difficult for him to find another job.

Rather than in a forensic mental institution, CS was incarcerated in a maximum security institution. During a recurrent psychotic break, he killed the serial killer JD and another inmate. He was found dazed, confused and completely delusional and when asked why he had killed the two men he claimed that God had ordered him to do so. Had the legal codes for criminal responsibility been different, he may have been found not guilty by reason of insanity at trial and the two victims may not have been killed.

Clinical Forensic Case: LM

Sources of Information

- **Criminal charge:** LM was charged with one count of First-Degree Intentional Homicide. The victim was a 23-year-old female, his estranged girlfriend.
- **Police record**: The police record states that LM erupted into the city-center building where his estranged girlfriend worked, threatening those present with a shotgun and forcing the girl into a room where he had her perform fellatio on him before shooting her in the mouth. He was apprehended by the police after a minor shootout.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary records; autopsy report; statements of victim's co-workers; statements of victim's relatives; statements of defendant's relatives; medical and psychological records; social service reports; communications with brain imaging experts at the university clinic and with the defense attorneys.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: Black male; 25-years old; single; low social class; 10^{th} grade education; factory worker but unemployed at time of offense; lived in medium-sized Midwestern American city.

Criminal History: No previous arrests.

Medical/Psychiatric History: A CAT scan of the brain, done after the forensic psychiatric examination, revealed numerous plaques of Multiple Sclerosis disseminated throughout the brain, but mostly in the region of the amygdala and the prefrontal cortex; history of drug and alcohol use; no psychiatric hospitalization.

Pertinent Data: LM reported, and this was confirmed by relatives, that he had been unable to find work during the six months prior to the offense. He quarreled with his girlfriend, who left him. Unable to get back together with her, he became depressed.
Mental Status Examination: In good contact with surroundings; coherent; relevant; logical in thinking; oriented to the usual spheres; feelings of rejection; remorseful; suspicious with a tendency to projection; no clear-cut delusions or hallucinations; hazy memory for the offense; unable to explain why he committed offense: 'I didn't want to kill her. I just wanted to scare her.'
Psychological and Other Tests: Minnesota Multiphasic Personality Inventory-2 (MMPI-2); Wechsler Adult Intelligence Scale (WAIS-R); Electroencephalogram (EEG); Computerized Axial Tomography (CAT) of the brain; neuropsychological testing. The neuropsychological testing revealed a mild degree of cognitive impairment and a tendency to impulsivity, without reflection prior to acting.
Psychiatric Diagnosis: Paranoid Personality Disorder; Organic Brain Disease due to Multiple Sclerosis plaques; Drug and Alcohol Use.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Unemployed; feelings of rejection; despondent; feelings of helplessness; tendency to suspiciousness and projection.
- **Precipitating factors**: Intense ruminations about being abandoned; intense anger at girlfriend.
- **Risk factors**: Emotionally unstable.

Psychiatric Forensic Examination of Offender: LM was of average body build, of average intelligence, slightly confused, and emotionally distraught at the time of the examination. He expressed deep feelings of rejection. There was no evidence of delusions or hallucinations. He was in fairly good contact with his surroundings. He was coherent and relevant. His affect was minimally flat and his mood was depressed. His memory for the events preceding, during and following the offense was hazy. He claimed to be surprised by his extreme irrational behavior, which he said was completely out of character for him. He said that he had loved his girlfriend and he expressed deep remorse for his actions.

LM admitted to being suspicious by nature and he described his behavior as a bit borderline and erratic. He recounted that just a few hours prior to the offense he was at home drinking beer and watching television. He remembered that suddenly he left his home armed with a sawed-off shotgun and he drove to the municipal building in the center of the town in which he lived and where his former girlfriend worked. He was distraught, depressed, and angry because she had ended their relationship. He entered the building and took the elevator to the floor where he had often visited her before. There, entering her office, he frantically looked for her, holding people at bay with his shotgun. The testimony of the victim's co-workers confirmed what he

said and they portrayed him as a man ‘out of his mind’ and in a fury, especially when he was unable to locate his girlfriend.

Even though LM’s girlfriend attempted to hide from him by running from room to room, he finally caught up with her and took her to an isolated room. Wanting to be reassured that she still loved him, he confronted her with that question and the girl, frightened and screaming, reassured him of her love. He was not satisfied by her feeble and tremulous assurances, however, and, disregarding the intense police search for him already under way in the building, he forced her to perform fellatio on him. He then inserted the barrel of his gun in her mouth and shot her twice, killing her instantaneously. Frightened by what he had done, in a bewildered and irrational state he fled from floor to floor in the building in an attempt to escape from the police. Eventually, engaged by the police, he made a feeble defense, hoping, he said, that they would kill him. But after being wounded he was taken into custody. On apprehension he was confused and suicidal.

Because of the haziness of his memory, the unusual type of crime, and claims by LM, his relatives and those of the victim that the criminal act was completely out of character for him, a computerized axial tomography (CAT scan) of the brain and other tests were ordered. The CAT scan revealed numerous plaques of multiple sclerosis, especially involving the prefrontal lobes and the amygdala.

Forensic Psychiatric Opinion: It was the author’s forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offense, because of his underlying brain pathology and his deep psychotic depression LM was prey to a Brief Paranoid Psychotic Episode and because of that did not possess substantial mental capacity to appreciate the nature, quality, wrongfulness and consequences of his actions and to refrain from his antisocial acting out. In other words, he was legally insane.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime, was useful in the reconstruction of LM’s psychopathological state of mind at the time of the homicide. There was a direct nexus of causality between his psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering.

In spite of these findings and the author’s report that the young man was cognitively and emotionally impaired by damage to those particular brain areas, which, more likely than not, had disinhibited his behavior and led to a concomitant acute depressive reaction and a brief psychotic episode, at trial he was found legally sane.

Commentary: No consideration was given by either the judge or the district attorney to the report of the brain lesions that had been found on the CAT scan. Also not taken into consideration were social service reports that prior to the offense he was described as irritable, depressed and insomniac, and unable to work because of his mental condition, all of which supported the diagnosis of a depressive reaction,

psychotic in type (on the basis of his irrational behavior prior to and after the crime), complicated by an organic dysfunction of the brain. At the time of the offense LM was paranoid, vindictive, and basically homicidal and suicidal. Indeed, he voiced the hope that he had at the time that the police would kill him. It was learned from the relatives that his sudden break with reality followed a period of depression with brooding and feelings of deep rejection. His impulsive acting out was due to an organically-based disinhibition.

Could the behavior of LM been the product of a psychopathic individual? He did not have a history of antisocial behavior; he had never been jailed or imprisoned for any crime prior to the offense. He was essentially remorseful for his act and unable to explain what he had done. LM was wounded by police at the time of his arrest and faced the possibility of being killed. His actions were those of an irrational and disinhibited depressed young man.

7.4. Schizoid and Schizotypal Personality Disorder

The Schizoid Personality Disorder shows a lifelong pattern of social withdrawal. Individuals suffering from it are usually introverted and lonely. Their affect is constricted and they isolate themselves, because of the discomfort felt in social interactions. They appear to be cold, aloof, distant, unsociable, unemotional and uninvolved. They frequently hold non-competitive lonely jobs and lack an intimate life. They have difficulty in expressing anger. They often involve themselves with astronomy, philosophy, mathematics and dietary health fads. They are in touch with reality but do a great deal of daydreaming and entertain fantasies of omnipotence. This type of personality disorder is not uncommon, reportedly affecting 7.5 percent of the general population, with a male-female ratio of two to one (Kaplan et al., 1994).

Even though the Schizoid Personality Disorder is fairly stable, at times those who suffer from it move into a schizophrenic breakdown, from which, however, they usually go into remission. Some scholars believe that this personality disorder is a prodromal phase of schizophrenia. Other personality disorders may have schizoid traits.

Clinical Forensic Case: EL

Sources of Information:

- **Criminal charges**: EL was charged with one count of First-Degree Intentional Homicide and one count of Attempted First-Degree Intentional Homicide. The

victims were her eight-year-old son (in the homicide case) and her nine-year-old son (in the attempted homicide case).

- **Police record**: The police, called by EL's husband, found the cadaver of the eight-year-old son with his bleeding skull shattered, and the nine-year-old son with severe hematomas to the head and a possible fracture of the skull. EL, extremely agitated and restless, was speaking irrationally and was restrained by her husband.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary records; various police officer statements; county jail records; medical record; autopsy report; statement by husband; defendant's statement; communications with attorneys.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of her legal rights and of the purpose and non-confidentiality of the examination. She freely gave her consent to the examinations.

Social and Personal Data: White female; 35 years old; married; two children; middle-class; teacher; occasional part-time jobs; lived in small Midwestern American city with husband children; dependent relationship with relatives.

Criminal History: No past legal record.

Medical/Psychiatric History: Two brief psychiatric hospitalizations after attempted suicide, with diagnosis of non-psychotic depression and Schizoid Personality Disorder; under doctor's care for several months because of neurotic depression; no history of drug or alcohol abuse.

Pertinent Data: Difficulty in relating to others; marital disharmony; exaggerated concern about children's welfare.

Mental Status Examination: Good contact; coherent; relevant; logical but rigid thinking; obsessive thinking; minimal eye contact; well oriented to the four spheres; depressed, anxious mood; shy, with deep feelings of insecurity and inadequacy; feelings of guilt; projection of guilt onto husband.

Psychological and Other Tests: Rorshach; Minnesota Multiphasic Personality Inventory-2 (MMPI-2); Wechsler Adult Intelligence Scale (WAIS-R); neuropsychological testing; Beck Depression Inventory (BDI); Electroencephalogram (EEG). Her MMPI-2 profile showed depression, anxiety, nervousness, feelings of inadequacy, lack of self confidence, irritability, hostility and suspiciousness. The BDI indicated significant depression with self hatred, feelings of being punished, indecisiveness, self blame, feelings of guilt, and EL's belief that she and her life were a failure. The EEG was normal.

Psychiatric Diagnosis: Schizoid Personality Disorder with Obsessive-Compulsive and Borderline Features; Dysthymia; Suicidal Risk. Under severe inner and interpersonal stress, EL decompensated into a brief psychotic Episode (depression with paranoid ideation) just prior to the offense. This decompensation lasted for

several months and eventually, under treatment in a forensic psychiatric hospital, she reintegrated.

Defendant's Account of Offense: See psychiatric-forensic examination.

Criminogenesis:

- **Predisposing factors**: Self-consciousness; feelings of inadequacy; suspiciousness; fear of rejection.
- **Precipitating factors**: Marital discord; obsessive thinking; retaliatory thoughts; loneliness.
- **Risk factors**: Inability to properly relate to husband, family members, and peers; denial of mental problems.
- **Victims**: EL's two sons, eight years old and nine years old.

Psychiatric Forensic Examination of Offender: At the time of each examination, EL entered the examining room in a matter-of-fact manner. Observation showed normal ambulation, a sad facial expression and tense posture. Throughout the examinations her speech was coherent and relevant but was interspersed at times with long pauses. She appeared to be somewhat detached.

EL's personal history showed good academic achievements and a good, but somewhat dependent, relationship with her parents and siblings. At age 22, she graduated from college with a Bachelor of Arts degree.

She worked as a bank teller and as a middle-school teacher. At age 23 she married, but she felt frustrated and unable to relate well to her husband, towards whom she had angry feelings, and brief periods of separation ensued. She felt helpless, had few friends, and went through periods of existential depression. Her obsessive personality clashed with her husband's more easy-going one. She became self-blaming and she perceived her husband's remarks as condemnatory. He wanted her to be busy, get a job and not worry excessively about their children. She had ruminative thoughts that the social and family atmosphere was not conducive to the healthy growth of her children. She occasionally had fleeting ideas of doing away with them, in order 'to save them.'

Discussing the offenses, EL said that that morning she had prepared her sons for school as usual. After they left, she did some shopping and then talked a bit with her husband about taking the children for a bike ride on the weekend. They were undecided, because it was her husband's father's birthday and he wanted his parents to come over to celebrate. Her husband left for work without kissing her good-bye. EL drove to work and stayed there until evening when she went to pick up the children at their daycare center. Her sons smiled when they saw her and got into the car, seemingly happy.

When they got home her sons went downstairs to watch television, EL began to prepare dinner, and her husband returned home shortly afterwards. She only had a hazy memory of what happened next but remembered that they talked about school with the children and that her younger son said that his friends at school had told

him that his mother was ‘crazy and dumb.’ She did not remember her conversation with her husband, even though they were at the table for 30 minutes, but remembered that she had thoughts of doing away with the children while were at the dinner table.

EL’s husband told her that both children should stay in after supper because of school the next morning. She did not remember that he had said anything to upset her and said that she was not angry about anything but she felt frustrated. ‘Frustration, frustration, frustration,’ she said. She began to think that if she had not gone to work she could have bought a gun to kill the children. It was an obsessive and disturbing thought. During the examination, she began to cry as she recalled her obsessive ideas that her children would be better off if she would kill them. She recognized that the thoughts had been of a delusional nature but said that she could not stop them at the time. Her compelling thought was that she wanted her children to have a normal decent home life and she was afraid that it was lacking. She feared that if they couldn’t have a normal life, job, wife, and family, they would grow up and end up in jail if they had to continue to endure this world, and that they would be ‘better off with God.’

After dinner EL’s husband and her older son went to the toy room. They talked for a while and then her son began to read a book. Her younger son got his schoolwork and showed her that he could write his name. He asked her if she could order a book from the school, which she agreed to do. He then went downstairs to watch television and she did some laundry.

EL’s husband had gone out but he came back home much earlier than she expected and went to the garage to fix the older child’s bike. She felt that her children were closer to her husband than to her, and that they were close to each other, but sometimes she felt that they were not close to her.

EL told her sons to take a bath. Her younger son suffered from allergic asthma and needed a breathing apparatus on a daily basis for five or ten minutes. After his bath, she went downstairs and gave him his asthma medicine because he appeared to be a bit tight in his chest. Then she went to make lunch for the next school day. At the same time she had fleeting, ambivalent obsessive thoughts about killing and not killing her children; but at some point, after she gave her youngest son his medicine, she suddenly felt she had to do it. She went to the utility room, got a baseball bat and went to her son as he was lying on the couch. He was not sleeping but he had not seen her. She vaguely remembered that at first she froze but then impulsively hit him on the head with the baseball bat four or five times. EL’s narrative of the episode was mechanical and she recounted it as if it had been done by someone else. Her affect was rather flat and she was distant.

EL’s husband had come in from the garage and tried to hold her back, shouting at her. She remembered being completely out of touch with reality. Her husband later testified that he called their son by name and then he called their older son upstairs

but he did not come down because he was still reading. EL recalled that, in a frenzy, she freed herself from her husband, ran upstairs with the bat, and hit her older son in the back of the head. Her husband ran after her and tried to hold her down. Her husband reported that EL told him that the child would be better off dead, otherwise he would go through life knowing that his brother had been killed by his mother. Her husband then called the emergency squad and continued to restrain her until it arrived.

Forensic Psychiatric Opinion: After reading the numerous reports available to me, and the examinations of her, it was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offenses EL was deeply depressed, with psychotic ideation and, because of her mental status, she did not possess substantial mental capacity to appreciate the nature, quality and consequences of her actions and was unable to refrain from them. She decompensated from her schizoid depressed personality into a severe delusional depression, with insistent, obsessive homicidal thoughts that she was unable to control.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime, was useful in the reconstruction of EL's psychopathological state of mind at the time of the homicide and the attempted homicide. There was a direct nexus of causality between her psychopathological state of mind and the crimes she committed. The MMPI-2 excluded any malingering.

Commentary: This case is presented because at trial the experts for the prosecution agreed with the author's findings. EL was found legally insane and sent to a forensic psychiatric hospital. After three months of treatment she had fully reintegrated from her brief psychotic break. The case supports the author's argument that severe personality disordered persons at times undergo a brief psychotic decompensation during which they may commit serious offenses and from which they reintegrate within a relatively brief period of time. During her psychotic decompensation, EL was taken by irrational, ambivalent obsessive thoughts at the basis of which there were feelings of inadequacy, frustration and anger. The type of filicide she committed was altruistic, since she believed that her actions would be beneficial to her children: 'I thought of him. I thought I should be thinking of him and I did what I did for him.' The strong delusional nature of the above statement by EL reflects the psychotic quality of her thinking at the time of the offense.

Further reflection on the M'Naghten rule and the American Law Institute Model Penal Code rule in United States courts may be made about filicide. Andrea Yates was convicted of capital murder charges for the bathtub drowning of her five children, even though examining psychiatric and psychological experts testified that she had become psychotic at the time of the crimes and did not possess substantial mental capacity to appreciate the nature, quality and consequences of her actions.

During her 17-day trial, the experts chronicled Yates' history of mental disorder—Personality Disorder NOS with intermittent bouts of depression—which, as in the case of EL, included several suicidal attempts and brief hospitalizations in mental hospitals. The filicides she committed were due to delusional obsessive thinking and severe homicidal depression at the time of the offenses. Prior to the filicidal episode, Yates was not delusional and, even though fatigued and depressed, she was able to work and care for her children. On appeal she was found legally insane at the time of the crime.

The ALI test for insanity reads as follows: 'A person is not responsible for criminal conduct if, at the time of such conduct, as a result of mental disease or defect, he/she lacks substantial capacity either to appreciate the criminality (wrongfulness) of his/her conduct or to conform his conduct to the requirements of the law.' It is important to point out that the impairment should be substantial and not total, and that the term 'appreciate' is more comprehensive than 'knowing.' Not present in the M'Naghten rule, it is designed to allow testimony about a defendant's emotional and affective attitude about and at the time of a crime.

Clinical Forensic Case: NG

Sources of Information

- **Criminal charge**: NG was charged with one count of Bank Robbery of a small bank at the periphery of the town in which he lived.
- **Police record**: The police were called to the bank by a bank teller stating that a young man, rather confused and peculiar in his demeanor, had come in the bank holding a shotgun and asked for money. He was given $5,000 and he left the bank. About 30 minutes later he was apprehended by the police. At that time, even prior to the search of his car, he spontaneously stated to them, 'I am the man you are looking for.'
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary report; statement of arresting police officers; statements of bank tellers; statement of defendant; previous medical reports; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: White male, 25 years old; single, middle class; university dropout; unemployed; recently moved out of parents' home; frequent arguments with father; recent split up with girlfriend.

Criminal History: No prior police record

Medical/Psychiatric History: Some use of marijuana and experimentation with cocaine; hospitalized in local psychiatric hospital for a minor anxious depressive episode; non-compliant with prescribed medication.
Pertinent Data: Protective mother; rigid authoritarian father.
Mental Status Examination: Oriented to the usual spheres; blank facial expression; detached and shy; coherent and relevant, but somewhat tangential and circuitous speech; some statements poorly organized; flat tone of voice; blunted affect; depressed mood; hazy memory for crime episode; ideas of reference; no presence of delusions or hallucinations; suspiciousness; ideas of reference; childish reason given for bank robbery.
Psychological and Other Tests: Rorshach; Minnesota Multiphasic Personality Inventory-2 (MMPI-2); Wechsler Adult Intelligence Scale (WAIS-R).
Psychiatric Diagnosis: Schizotypal Personality Disorder, with depressive features; Dysthymia.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Feelings of inadequacy; feelings of rejection (by father and girlfriend); self-consciousness; difficulty in getting along with others; unable to concentrate in school.
- **Precipitating factors**: Quarrel with father; humiliation by father; unemployed and supported by mother.
- **Risk factors**: Use of drugs and alcohol; deep feelings of rejection.
- **Victim**: None

Psychiatric Forensic Examination of Offender: NG, charged with bank robbery, was seen at the request of his representing attorney for a forensic psychiatric evaluation prior to trial. This 25-year-old white male entered the interviewing room in a matter-of-fact manner. He appeared to be depressed and his ambulation was slowed down. He showed some peculiar facial mimicry and a shifting gaze and occasionally he stared fixedly at the walls. He was detached in his behavior and his speech, though understandable, tending to be tangential and circuitous; the tone of his voice was flat and devoid of feeling.

NG had enrolled in the university at age twenty-one. He began smoking marijuana and experimented with cocaine sporadically two years later. He was ambivalent about school, where he had some problems. His mother was very protective of him but he had problems with his father, whom he described as authoritarian. He voiced ideas of reference, stating 'My friends believe there is something wrong with me.' He broke up with his girlfriend even though she did not want to do so. After their breakup he had episodes of mental confusion and was hospitalized at a local psychiatric hospital for a mild depressive episode. He was non-compliant with medication.

NG was a bit confused about the events leading to the offense. He did not seem to remember the exact date it took place. He had gone to a motel the night before because he did not want to meet people at his apartment house, believing that they could realize his intentions from looking at him. He decided to rob the bank because he was bored and because his mother was not giving him enough money. His thinking was very immature and irrational. He bought a hunting rifle, but said that he had some transactional difficulties. He was ambivalent about the purchase and at one point wanted to return the rifle to the store. He had no plans for getting away after the robbery, thinking that he would worry about that once he got the money.

The morning of the robbery, NG drove around the city for one hour. He did not stop anywhere, afraid that somebody would see him. He left the highway, parked in a bus parking lot, and loaded the rifle with a single shot. He said that he had probably loaded the gun because he could not think straight since he had not slept the night before and was very tired. He said that the night before he was unable to sleep because he was obsessively ruminating for hours about whether or not to commit the robbery.

NG went to the bank and drove by it many times. He thought it would be an easy target because he knew its layout and it was far from traffic. He parked far away, afraid that people would notice the rifle through the car window because it was so big, and he walked to the bank to commit the robbery.

Once he was inside, he said, it felt like going there to withdraw money from his account. He remembered that the bank teller looked angry. After he got the money, he walked out, went to his car and drove away, intending to go back to his apartment. He was very tired and all he wanted to do was to go home and sleep. But while he was driving he was pulled over by the police who had received a call about a suspicious car similar to his; he told them spontaneously and immediately that he was the person they were looking for. NG stated that only after he was caught did he understand that what he had done was real. He claimed that it had happened so fast that he really didn't realize it was happening.

NG's reasons for the robbery were rather childish. He was envious of people he saw going into stores and coming out with a lot of packages and he wanted to do the same for one day. He planned to fill up his car with merchandise from an electronics store—videogames, DVDs, and CDs. He said that he was sick of sitting around watching television and wanted some more action in his life. He claimed that even though he had not been sold on the idea of carrying out the robbery he went ahead with it anyway.

On inquiry, NG claimed that he suffered from depression and when he was depressed he became angry with people. He had stopped going to the university and he was very happy to be out of it, but at the same time he thought that people were upset with him because he was living a sort of dream life rather than being

productive. Without mentioning him, he was probably referring to his father. He was somewhat confused and poorly organized in his speech.

Forensic Psychiatric Opinion: After reviewing the various documents available and the forensic psychiatric examinations of him, it was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offense NG was in the throes of a brief psychotic depressive episode and because of that he did not possess substantial mental capacity to appreciate the nature, quality (wrongfulness), and consequences of his actions and was unable to conform to the requirements of the law.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of NG's psychopathological state of mind at the time of the bank robbery. There was a direct nexus of causality between his psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering.

Commentary: Schizotypal Personality Disorder is a premorbid, prepsychotic condition that, in a small number of individuals, at times of severe stress moves into a brief psychotic episode. This was the case with NG. Many of the diagnostic criteria of Schizotypal Personality Disorder were evident prior to his psychotic break, such as ideas of reference, bizarre preoccupations, vague suspiciousness, constricted affect, peculiar behavior, and excessive social anxiety.

In these cases, it is easy for the individual to become psychotic and unable to conform to the requirements of the law. There was no feature of pyschopathy in this young man, except that the act he perpetrated was antisocial. There was none of callous, remorseless behavior seen in the psychopath, but what was present was a cognitive deficit, which was also evidenced by the neuropsychological testing and the Rorshach.

Regardless of the author's psychiatric report, NG was adjudicated by the court as guilty of the offense and responsible for his crime. He was sentenced to five years in prison.

7.5. Antisocial Personality Disorder/Psychopathy

Even though the *Diagnostic and Statistical Manual-IV-TR* (American Psychiatric Association, 2000) includes under the heading Antisocial Personality Disorder some of the basic characteristics of the psychopathic personality, the consensus is that a distinction should be made between the two. The majority of persons with an Antisocial Personality Disorder can be viewed as reactors to social stresses, while the psychopaths are 'real' actors, planning and initiating an antisocial action. The characteristics of the latter, as reported by Robert Hare (1993), who seems to retrace Hervey Cleckleys (1955) definitions of the psychopath, are that a psychopath is a

self-centered, callous and remorseless person, profoundly lacking in empathy, and with an inability to form warm relationships with others, a person who functions without the restraint of a conscience. The untreatability and the recidivism of the psychopath are well known.

The concept of psychopathy dates back to the time of Cesare Lombroso (1889) and Philippe Pinel (1801/1962); to Pinel with his emphasis on the lack of morals in offenders, and Lombroso with his characterization of the so-called 'born criminal.' Many authors have stressed the etiology of psychopathy, presenting it, for example as congenital, biological, personal or environmental. Pinel considered the psychopath to be mentally ill, in need of moral treatment, suffering from a *manie sans delire*; Benjamin Rush (1812) proposed organic causes for psychopathy, which he considered a disease; and James Cowles Prichard (1835) described it as a disorder of a persons feelings and attitudes, without involvement of higher mental faculties, but with a predisposition to behave as a morally insane person. Julius Koch (1891) coined the term psychopathic inferior, and he considered it to be an hereditary disease with emotional and moral aberrations and abnormal behaviors. Henry Maudsley (1896), as well, considered the psychopath to be suffering from moral imbecility due to cerebral dysfunctions. Richard von Krafft-Ebing (1922) referred to these persons as 'savages,' and believed that they should be kept isolated in mental asylums for their own sake and that of society. Emil Kraepelin (1915) described them as liars and manipulators, who employed charm and glibness, but were impulsive and remorseless (Arrigo & Shipley, 2001).

It was Cleckley, however, who, in 1955, made a distinction between the psychopath who ends up in jail and the one who does not. In his seminal work, *The Mask of Sanity*, he described them as grandiose, arrogant, callous, superficial and manipulative. The latter, he believed, keeps a far better and more consistent appearance of being normal. He stated that psychopathic conduct 'varies in severity from a mild or borderline degree up through a great degree of disability' (p. 279). He pointed out the recidivistic tendencies of psychopaths in the commission of their crimes.

Cleckley postulated that persons diagnosed with an Antisocial Personality Disorder or a psychopathic disorder have 'a genuine and often a very serious disability' (p. 422). He added that 'to say that this is merely queer or perverse or in some borderline state between health and illness does little or nothing to account for the sort of behavior (they) demonstrate objectively and obviously' (p. 422). In the psychopaths, we are confronted, as Cleckley says, with a *mask of sanity*, and 'all the outward features of this mask are intact….The thought processes retain their normal aspect under psychiatric investigation and also in technical testing…(an example of) *la folie lucid*,' while their expressions, tone of voice, and general demeanor seem normal, but they fail 'altogether when (they are) put into the practice of actual living' (pp. 423, 424). And, as Cleckley further wrote, their

> ‘failure is so complete and so dramatic that it is difficult to see how such a failure could be achieved by anything less than a downright *madman* (emphasis in original), or by one who is totally or almost totally unable to grasp emotionally the major components of meanings or feelings implicit in the thoughts which he expresses or the experiences (they appear) to go through’ (p. 424).

Their distorted affectivity, their tragic persistence in their antisocial behavior, their inability to learn from their mistakes bespeaks a profound childish immaturity which causes them to move, without reflection, from thought to action, without appraising and discerning what type of decision they should make and act upon. ‘Our concept of the psychopath’s functioning,’ said Cleckley,

> ‘postulates a selective defect…which prevents important components of normal experience from being integrated into the whole human reaction, particularly an elimination or attenuation of those strong affective components that ordinarily arise in major personal and social issues’ (pp. 427, 428).

The emotions of psychopaths are pseudo-emotions. They use a pantomime of feelings. They are full of rationalizations, their judgment is poor, and their sense of value is almost inexistent. Their outward behavior seems to be the outcome of a deeply distorted inner personality, akin to a schizophrenic process, at times largely concealed by good reasoning and their ability to go through life in a quasi-sane manner. After years of socially restricted but apparently not psychotic lives, a few psychopaths carry out other tragic misdeeds, even committing murder, for which they show little evidence of remorse.

John Macdonald (1961) described the psychopath as lacking ‘the capacity to “feel” with others and devoid of affection, callous and cynical…egocentric and immature…’ (p. 247), adding that ‘their impulsivity and intolerance of frustration may lead to repeated antisocial acts’ (p. 248). However, they may be ‘quite successful in whatever is their chosen professional activity. They may have paradoxically reached their position of success, power, and wealth by ruthless exploitation of others...’ (Stoudemire, 1994, p.186). They are usually of average or above average intelligence, have an apparent lack of guilt and do not learn from experience. They show a great deal of ‘impulsivity as manifested by frequent physical fights and abusive behavior...(and) encounters with the law and other authorities are frequent,...in repetitive criminal behavior’ (Stoudemire, 1994, p.186).

Franz Alexander and Helen Ross (1952) believed that the presence of unconscious neurotic conflicts could be at the basis of the symptomatic behavior of the psychopath’s irrationality, stereotyped repetitive behavior and self-destructive

tendencies. They posited that an 'actual crime,...is often a substitute for incestuous or patricidal impulses' (p.133).

Seymour Halleck (1967) thought that '(t)he psychopath is an activist, who in his efforts to suit the world to his own needs often finds that it is necessary to violate the law' (p. 109). One can see the same type of behavior, cunning and goal directed, in the paranoid, with variations in the clinical manifestations along the paranoid spectrum. Suzanne Reichard and Carl Tillman (in Macdonald, 1961) suggested that, when lacking an understandable motive, a murder committed by a psychopath represents 'an attempted defense against the outbreak of a schizophrenic psychosis, in which the ego seeks to protect itself from disintegration by discharging unassuageable anger through an act of violence' (p. 115). Often, these persons are sentenced to repeated terms in prison or even life terms.

In attempting to understand the motives behind destructive behavior, one must take into consideration the fact that at times an individual projects his unacceptable aggressive feelings outwardly and for him the world suddenly becomes a hostile place in which to live. '…(M)any criminals utilize projective devices to justify and sustain antisocial tendencies....a degree of distortion of reality which is poorly rationalized and which is totally inconsistent with readily observable fact' (Halleck, 1967, p. 171).

Arieti (1967) subdivided the psychopathic states into the pseudo-psychopath and the idiopathic psychopath. He attributed the psychopath's impulsivity and his desire for immediate gratification to his attempt to overcome unbearable inner tension due to short-circuited anxiety. He 'is unable to change, repress, postpone or neutralize his need for hostility,' he stated (p. 248), and his acting out may be in the form of murder, rape, seduction in men, or promiscuity and prostitution in women. More important and relevant to this discussion, however, is Arieti's reflection on the paranoid psychopath. While pointing out that psychopathic traits or behavior 'generally preceded a definite paranoiac symptomatology, or, in some cases, periods of acting out with no freely expressed delusions alternating with obvious delusional periods,' he suggested that, most probably, 'when the paranoid psychopath is prevented from acting out, for instance, by imprisonment or hospitalization, he becomes more paranoid' (p. 248).

In summary, as Richard Schneider and David Nussbaum (2007) wrote, psychopaths have difficulty in 'processing and responding appropriately to the emotional and moral dimensions of a situation' (p. 167). They show deficits in the cognitive, emotional and linguistic spheres. They have reduced sensitivity or no response to displays of distress in others, are distractible, and have a desire for immediate gratification, without a balance between immediate and long term gratification. Linguistically, their speech is syntactically and semantically disordered, with disconnected components which are, nevertheless, masked by a superficial grammatical orderly structure (Hare, 1993). Their transgressions of

societal rules bring harm to others and disclose their inability to process moral issues in a mature way. They seem to be fixed at a pre-conventional level of moral development (Kohlberg, 1984; Piaget, (1932/1965).

Clinical Forensic Case: JD

Sources of Information

- **Criminal charges:** The district attorney's office charged JD with 15 counts of First-Degree Intentional Homicide. His victims were 15 young males, 16-23 years of age.
- **Police records:** In JD's home, the police found two male cadavers, five human skulls, various human skeleton parts, and one human head and pieces of human flesh in the refrigerator; pictures of the dead victims in special sexual positions; material used to deflesh the bodies.
- **Records reviewed**: Criminal complaint, police investigative records; police supplementary records; autopsy reports; statements made by various police officers; statements made by victims' relatives; statement by defendant; author's files regarding communications with attorneys.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights, the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: White male; 31 years of age; single; high school education; middle-class; factory worker; lived in Midwestern American city

Criminal History: Previously on five-year probation for sexual assault of a child; several past brief incarcerations for drunkenness.

Medical/Psychiatric History: no previous psychiatric in-patient history; past history of drug and alcohol abuse; early discharge from United States army because of frequent fighting with comrades while stationed in Germany

Pertinent Data (Sexual): struggled with homosexual tendencies since adolescence; desire for male contact mixed with homicidal tendencies; active homosexual behavior as a young adult; driven by lust-power; sodomist; serial killing of sexual partners; dismembered victims' bodies

Mental Status Examination: no spontaneity but cooperative; tense; coherent, relevant; well oriented to the four spheres; no clear-cut delusions or hallucinations; withdrawn and sad; lonely and distant; deep feelings of rejection; bizarre fantasy life; ideas of omnipotence and control; fear of retaliation for homosexual behavior; fear of being sodomized

Psychological and Other Tests: Rorshach; Minnesota Multiphasic Personality Inventory-2 (MMPI-2); Wechsler Adult Intelligence Scale (WAIS-R);

Electroencephalogram (EEG); Computerized Axial Tomography (CAT) of the brain; chromosomal map (XYY search). The MMPI-2 showed a tendency to malingering and a mixed personality disorder.
Psychiatric Diagnosis: Personality Disorder Not Otherwise Specified, with multiple features: Psychopathic, Sadistic, Schizoid.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: strong desire to be accepted; deep fear of rejection; hateful and homicidal destructive thoughts.
- **Precipitating factors**: fear of rejection; fear of being sodomized by partner; extreme loneliness.
- **Risk factors**: inability to properly relate to peers; fear of abandonment; lack of introspection and self control.

Victims: young, well-built, minority males with passive-aggressive personalities, homosexual tendencies and economic difficulties.
Psychiatric Forensic Examination of Offender: The homicides of JD occurred between 1988 and 1990 and were discovered during the summer of 1991. Following his arrest, he was charged with fifteen counts of First-Degree Homicide; he confessed to but was not charged with a previous murder he committed in 1978, and he was not charged with an additional homicide to which he had confessed because of lack of evidence. His trial was a bifurcated trial: he pleaded guilty to all the offenses in the first trial and then entered a plea of not guilty by reason of mental illness in a second trial.

In accordance with the law in the state of Wisconsin, where the murders took place, the psychiatric and forensic examination of JD was to determine whether or not at the time of each and every offense he had possessed substantial mental capacity to distinguish right from wrong, refrain from doing wrong, appreciate the nature and quality of his actions, and conform to the requirements of the law.

JD was examined on several different occasions for a total of thirteen hours. He was a 31-one year-old white male with a light complexion, tall, well developed, and well nourished. His hair was brownish-blond and his face was unshaven during most of the interviews. His posture was erect, his ambulation normal and, on observation, he evidenced no presence of neurological deficits, unusual facial mimicry, tics, or mannerisms. He sat straight in his chair, a bit tense but unemotional only during the first part of the first interview and even though he was shy and withdrawn his attitude was one of cooperation. His speech was clear and understandable. His answers were direct but short, and his statements coherent, relevant, and logical. No circumstantial, tangential, or disorganized thinking, or delusions or hallucinations were present. From a clinical point of view, his intelligence level seemed to slightly above average. His thinking was apparently unimpaired. He did not expound on his answers to questions. He accepted full responsibility for all of the murders. His

affect was flat and in a detached manner he unburdened himself of many memories pertinent to his offenses.

JD's family moved a great deal as he was growing up and he claimed to have had difficult relationships in his various schools. He described his father as strict and his mother as unpredictable and he said that they frequently argued and he felt angry with both of them. He denied sibling rivalry with his younger brother.

He had violent fits of anger and rage, and was prone to lying and deceit. He became angry when he was found to be lying, but eventually would admit to his wrongdoing. When he was not sulking he would often express his resentment by destructive activity in his backyard.

During his adolescence, JD became interested in taxonomy and collected insects. He showed a compulsive interest in anatomy by dissecting small animals, mostly dogs and foxes found dead on the road, often preserving them in formaldehyde. He said that he wanted to keep their bones and make a statue out of them like a taxidermist but that he never got to it.

He remembered taking home from his biology class at school the head of a pig and keeping the skull. He graduated from high school at age 18 with a C grade average.

JD was involved in homosexual experimentation on a few occasions in adolescence and in streaking (running naked in public). He began to drink alcohol at age 13, alone and with friends. However, most of his heavy drinking and marijuana smoking (three or four joints daily) started at age seventeen. He experienced some drunkenness and hangovers and several times he passed out.

His self-concept during childhood and adolescence was poor. He described himself as a loner and said that he felt picked on by other boys but was unable to express his anger openly for fear of retaliation and he claimed that he never got into fights. He had never enjoyed sports, always thinking that the other guys were better than he. He was envious of them and stated that at times he felt so angry that he had thoughts of killing them.

JD said that he masturbated daily while looking at pictures of 'good-looking guys' in magazines—trim with good muscle tone, youngish, not older than thirty. He stated that he admired their physical appearance and when he imagined himself in bed with them it was always as a male, never a female. He stated that he had no racial preferences in his fantasies. Later, he enjoyed sodomizing people but abhorred the idea of being sodomized. He had never had any heterosexual experiences. He was shy and somewhat uncomfortable when having to start new relationships, basically withdrawn and sad.

JD resumed his heavy drinking and as his weekend drinking increased he felt directionless and without clear ideas. He felt that he did not fit into any particular group at college. After a semester, at his father's suggestion, he joined the army, and he seemed to be proud of having gone through basic training. He became a medic and after two weeks he was transferred overseas. He was taught basic

cardiopulmonary resuscitation, how to set bones and stop bleeding, medication dispensing, and so on.

While in the army, JD drank heavily—a six- or twelve-pack of beer a night—as well as brandy, wine, or liqueurs. He was involved in a few fights and shouting matches with other soldiers. His sexual activity was limited to looking at pornographic magazines and masturbation; he disclaimed any romantic or non-romantic homosexual relations at that time, stating that he was afraid of engaging in any such relations while in the army.

Back in the United States and honorably discharged from the army, after a brief period with his father JD moved to Milwaukee to live with his grandmother, hoping that by living with her his heavy drinking and his homosexual behavior might diminish. He claimed that he didn't drink for two years until one day, while in a public library quietly reading a book, one of the other library patrons handed him a note inviting him to have sex with him downstairs in the library bathroom. Even though he had dismissed the offer, he claimed that the episode changed his life for the worse.

He would go to local taverns, often getting drunk and returning home at 2 or 3 am., or occasionally staying out all night. On three occasions he was arrested for drunkenness and jailed overnight. He again began going to porno book stores, gay bars, and bathhouses. At the bathhouses he started his homosexual behavior again and, wanting to be in control of the relationship, he began to give his occasional sexual partners drinks containing dissolved sleeping pills prior to sodomizing them, thus avoiding being sodomized himself.

JD was fired from his job at the city's blood plasma bank because of poor performance. He expressed ambivalent feelings about the job and, ironically, he stated that he did not like to stick people with needles. He did temporary odd jobs until he was hired by a local chocolate factory where he worked for seven years until his arrest.

In 1989, JD was charged with and convicted of second degree sexual assault for enticing a child for immoral purposes and was placed on probation for five years, during which period he had to report to the state correctional service. Also in 1989, wanting to be free of his grandmother's supervision, he moved to the inner city because, he stated, he wanted a place of his own that was close to work and had low rent. By that time he had been turned out of the bathhouses because some of the patrons reported their suspicions of having been put to sleep with an intoxicating substance and taken advantage of by him sexually.

Questioned about the offenses with which he was charged, JD explained in a flat and detached manner that the fifteen charges of first-degree intentional homicide did not include a white male victim he had killed after a rendezvous in a Milwaukee hotel, nor that of a young man, his own age, whom he had killed at age eighteen in

another state. He claimed that earlier, when he was fifteen years old, he had entertained homicidal thoughts about another young boy.

In a flat, monotonous way he discussed each murder, as if he were at a recital. He went into the specific details about the enticement and sexual seduction of his victims, love-making, use of drugged drinks, his killing them by knifing or strangling, his photographing the dead persons or parts of the dead bodies, and his disposal of the dead bodies, whether by crushing bones, by cutting, dismembering, disemboweling them or by boiling the flesh, and his attempts to preserve some of them.

It was evident that on each and every occasion his murderous actions were part of a sexual orgy. He described how he obtained all the necessary items for such heinous crimes and how he decided to secure his apartment with a high-quality security system.

Intense repressed hostility and deep fear of rejection by his peers were freely voiced by JD in reply to specific questioning. His feelings of loneliness were exemplified by his possibly delusional remarks that he did not want to lose his victims, that he would like to have kept their bodies with him, and that he wanted to keep some memorials of them. He stated that at times he had continued to lie next to the dead body of a victim, kissing it. He described his bizarre, irrational maneuvers to keep some of the victims in a zombie-like state and to eventually make fetishes out of their body parts. Symbolic memorabilia, such as parts of the victims' bodies, isolated bones, or entire skeletons and skulls found in his apartment, testify to his fetishism. Sexual *sadism* seemed to be at the basis of his unrealistic desire to keep his victims half-alive by drilling holes into their skulls and injecting muriatic acid, hoping to obtain a perfect skull by liquefying the brain. Anthropophagy, as claimed by him, may have climaxed some of the murderous scenes.

JD disclosed a strong need to control people and events. His irrational fantasies were linked to power, sex, and money and he admitted to getting a thrill from the killing. He drank while performing his criminal acts and it can be questioned whether he was always aware of what he was doing. He showed no remorse for what he had done.

JD was a sexual sadist as evidenced by his cruelty and by his motivating drives for lust and power. His sexual sadistic involvement with his victims was often paraphilic in nature. He was obsessive-compulsive in his behavior. His behavior did not seem clearly psychotic but a programmed manifestation of a meticulous erotomanic individual, with an appearance of planning to avoid risk. The media interpretation that his behavior was racially oriented concerned and frightened him because he was in a jail/prison environment surrounded by many black inmates and most of his victims had been black.

The destructive hostility of this serial killer needs no comment. It was heinous, irrational repetitive behavior, apparently programmed and methodically carried out

by a person who was suffering from a profound disorder of the mind, without gross overt manifestations of a psychotic mind. He was, nevertheless, found to be legally sane at the time of his offenses. One explanation for JD's abhorrent conduct is that he was driven by irrational, compulsive hostile aggressivity. He shared with other serial killers not only deep violent destructive hostility, but also boredom, loneliness, fear of rejection and an ambivalent craving for human closeness.
Forensic Psychiatric Opinion: Because of the quality of his crime and strict adherence to the M'Naghten Rule, the author's diagnosis of JD was Personality Disorder Not Otherwise Specified, formerly called Mixed Personality Disorder, with narcissistic, grandiose, sadistic, obsessive, fetishistic, antisocial, and necrophilic features, an organized non-social lust murderer. Others suggested a diagnosis of Schizophrenia and of Anthropophagy.
Commentary: Due to the strict legal parameters of the M'Naghten rule, JD was found guilty of the offenses with which he was charged because, in spite of his mental disorder, he was found to have substantial mental capacity to know the nature and quality of his acts at the time of the crimes and to appreciate their wrongfulness. The American Law Institute Model Penal Code, which includes a prong for volitional capacity, was not taken into consideration by the Court.

JD's violence was so profound that he killed, cut, dismembered and dissected in an obsessive, sadistic way, the body that attracted and repelled him at the same time—a body that he wanted to torture and destroy because he felt that by doing so he would be able to get rid of his inner torture and unwanted attraction; a body that he really did not love, contrary to what he wanted to believe or, once apprehended, wanted to make others believe, since it would have been easy for him to continue a living relationship with his victims. He claimed to have eaten body parts, possibly as an expression of his biting hostility or his desire to incorporate and make his own their attractive qualities, and perhaps part of a superstitious, atavistic belief remindful of tribal anthropophagy. His hostility-out was the counterpart of his hostility-in. His actions may have, in some way, saved him from committing suicide. Even his sadism was the exercising of power and violence upon another for the assertion and preservation of his self.

The verdict of the jury found him legally sane on all fifteen murder counts and the court sentenced him to fifteen consecutive terms of life in prison—one for each count of murder with which he had been charged—without the possibility for parole. In 1994, he was killed by another inmate in the correctional institution in which he was confined. (See the case of CS.)

According to the current legal code and because he was suffering not from a mental illness but from a Mixed Personality Disorder JD was found responsible for his crimes. Society sees serial killers as evil and through the legal system condemns them primarily on an assessment of their behavior. It could be, however, that these serial killers suffer from a deeply buried psychotic disorder, a disorder that cannot

be detected with present testing, one that cannot be detected, also, because there are no witnesses to their crimes. But the psychotic behavior could be inferred by the findings at the crime scene. Indeed, contrary to the author's previously-held belief, it is possible that, at the time of his crimes, when he compulsively killed, dismembered and reified the bodies of his victims, JD was irrational and unable to control his pathological complexes, which resurfaced and made him commit his opprobrious acts. And then, he reintegrated from his brief psychotic-like episodes.

At the beginning of his court testimony in the JD case the author, court-appointed forensic expert, said to the judge, 'Your Honor, from the various media accounts of JD's alleged crimes, and after reading the charges against him, but before examining him, I thought he was a madman.' However, by the legal standards in use, although he could be seen as a 'madman' he was legally sane. The case of JD belongs not only to the Psychopathic Personality Disorder, but also to the Narcissistic, Schizoid and Sadistic Personality Disorders, like most serial killers.

On the basis of object relations theories, one could opine that serial killers are unable to tame their archaic, grandiose, exhibitionistic self, as Kohut (1971) and Mahler (1972) asserted. Or, as Klein (1935) stated, their repressed bad imagoes are projected onto the outside world and their desire to destroy them ensues. Or even that, as in a narcissistic crisis, the repressed pathological complexes come to the fore and in aggressive acting out they destroy the frustrating object instead of committing suicide. It could be postulated that in those moments, at the time of the killings, these killers are victims of their pathological, irrational unconscious, in which case they could qualify for an NGRI plea. Due to the strictness of the M'Naghten Rule of criminal responsibility, JD was found legally sane. However, the possibility that he was suffering from a schizophreniform illness or necrophilia was raised by the expert for the defense. The prosecutor claimed that the defendant was free from any major recognizable illness and was simply a psychopathic, narcissistic evil individual who knew what he was doing at the time of each of his crimes, who showed no real remorse and who, by the common standard of testing, was able to determine right from wrong. *A posteriori*, one should comment on the present view of psychopathy. JD was basically a psychopath and the epitome of sexual sadism.

At present, psychopathy is intended as a malignant form of Antisocial Personality Disorder. It is not part of the many classifications of the *DSM-IV* (American Psychiatric Association, 2000). The *DSM-IV* is limited in its usefulness and should not be looked upon as a textbook of medicine, psychiatry or law. It has been found by scholars that many psychopaths have neurobiological irregularities, which are manifested by learning and processing deficits involving neurotransmitter abnormalities. These abnormalities involve the frontal lobe (11% reduction in gray matter) and include regional cortical thinning in subjects with violent antisocial personality or schizophrenic disorders. This is intimately involved with the response to fear and stress (due to unchecked amygdala firing), and planning and cognitive

response to criticism. Also, there may be faulty wiring in the hippocampus, which is responsible for regulating aggression and memory and in the corpus callosum.

The areas of the brain principally identified as dysfunctional in the psychopath include the prefrontal cortex, temporal cortex, the amygdale, the hippocampal complex, the corpus callosum, and the angular gyrus. In addition, the neurotransmitters dopamine and serotonin are involved in the uninhibited (impulsive) behavior of the psychopath. The frontal inhibitory system is under the effect of serotonin. If serotonin is deficient, dopamine takes over and increases the tendency to immediate reward, with a lack of encoding or moral appreciation. As Schneider and Nussbaum (2007) wrote: 'The psychopath is oblivious and insensitive to affective moral valences and therefore the prospect of being governed by those aspects of life is not even a possibility' (p. 180).

The psychopathic offender, then, even though not overtly delusional, suffers from a disorder of the mind that deprives him of the ability to rationally evaluate his actions. The legal question should be not whether he knows right from wrong but whether he can appreciate right and wrong from a legal and moral point of view. The psychopath was actually described by earlier psychiatrists, such as Esquirol (1865) and Prichard (1835), as morally insane. These past scholars argued that they were people who were truly insane and not responsible for their actions but who were not so intellectually disordered that they could be recognized as insane by the traditional criteria. They were seen with characteristics including a complete lack self control and an inordinate propensity to unrestrained behavior.

In the case of JD, and other similar cases, the mental disorder, which includes a personality disorder, most probably deprived the offender of the ability to know that the action or omission of action was both legally and morally wrong in the eyes of society. He applied the above in an irrational but consequential way to the alleged criminal act. After giving them sleeping potions in their beer and sodomizing them, JD tortured his victims with slow trephining of the skull and, finally, he placed many of the bodies of his victims in sexually explicit positions (signature). Because of that he certainly can be classified as a sadist and sexual sadist. As a sexual sadist, he was a chronic liar and an isolated, lonely man. In a sense he was also, by Brittain's (1970) description, a typical sexual sadist—weird, emotionally detached, isolated and lonely person, with schizoid features—as also pointed out by Michael Stone (2001). Isolation in childhood, sadistic personality traits, repetetive sexual aggression as part of the sadistic sexual murderer have also been reported by other scholars (e.g., Hill, Habermann, Berner & Birken, 2006).

7.6. Narcissistic Personality Disorder

People who suffer from a Narcissistic Personality Disorder show a heightened sense of self-importance and grandiose feelings, considering themselves to be special and deserving of special treatment. (See the cases of LC and JD.) They have a sense of entitlement and handle criticism poorly. They are ambitious and wish to be famous, and are strongly exhibitionistic, almost demanding admiration. At the same time, they are selfish and exploitative. Their relationships are superficial and they do not show empathy for others. They refuse to obey conventional rules. They are vulnerable to mid-life crises. Their judgment is not objective. They seem to exhibit the so-called *mirror hunger* of Kohut (1971; Kohut & Wolf, 1978). When they are frustrated their manipulative personalities may explode in a narcissistic rage. They are egocentric like a child and when they do not achieve their expectations they fall into a state of inner emptiness.

Various theories of behavior can be considered in the attempt to understand narcissism. Klein (1935) and Mahler (1975) contributed to the its understanding as did Kohut (1971) who hypothesized that a narcissistic trauma suffered by the child during the process of individuation does not enable him to tame the archaic, grandiose and exhibitionistic self as is necessary for wholesome development. Originally described by Freud, narcissism was later subdivided by Kohut into primary and secondary narcissism. Primary narcissism is seen as the investment of libidinal energy in the achievement of object love, empathy and possible creativity, while secondary narcissism is the withdrawing of the original psychic libidinal energy from objects back to the ego.This latter mechanism seems to be present in the psychodynamics of serial killers. They are, indeed, not only pathologically narcissistic but unrealistically grandiose, and their exaggerated self-importance is very fragile and sensitive to shame.

7.7. Sadistic Personality Disorder

People suffering with a Sadistic Personality Disorder show a pervasive pattern of cruel, demeaning and aggressive behavior. (See the case of JD.) They have a tendency to inflict pain on others or to humiliate others. They are fascinated by violence, by weapons, by injury and torture. When sexually aroused, they become paraphilic and sexually sadistic.

During the eighteenth century, the erotic and licentious writings of the libertine Marquis de Sade (Pauvert, 1965) shocked the world with their descriptions of cruel sadistic violence and unbound perverted lust. De Sade believed that instincts are the motivating force in life, and that pleasure is the most important goal for which one should aim. (His books about debauchery and acts of sexual violence were written while he was in jail for crimes of poisoning and sodomy, and his life ended in a lunatic asylum.) Years later, in 1869, Richard von Krafft-Ebing ([1869] 1965)

coined the term sadism and the term acquired the meaning of a sexual perversion in which the pervert forced upon the subject of his sexual attraction physical or moral suffering, deriving sexual pleasure from his actions. The infliction of pain seems to be part of the complete mastery of another person. The most radical aim of a sadistic act is to make the person suffer, since there is no greater power over another person than inflicting pain.

Nevertheless, it has been hypothesized that rather than to express cruelty in and of itself, the object of sadism is to procure strong emotions (MacCulloch et al., 1983).

Robert Brittains seminal work in 1970 laid the foundation for a possible typology of a sexual sadist and his description is basically that which fits some present-day sadistic murderers. He described the sadist as a secretive male individual, who is generally non-violent in everyday life, but obsessive, insecure and narcissistic, a loner with a rich fantasy life. He believed that the sexual sadist creates sadistic scenes in his fantasies that he later acts out in his killings. This type of killer is single, his perversion starts early in life, he exhibits an interest in pornography and is excited by cruelty. Brittain's description of the sexual sadistic murderer is remindful of the serial killer JD, who, a typical charming psychopath, behaved well even on apprehension, but hid behind his calm and socialized appearance destructive sexual fantasies (Palermo, 2004).

Frequent sexual fantasies, at times violent in type, may degenerate into sadistic sexual fantasies. In such cases they may be the forerunner of homicidal acting out. According to Malcolm MacCulloch and colleagues (1983), sadistic sexual fantasies have their origins at the time of traumatic episodes, such as sexual or physical abuse during early childhood. Fantasies of rape or murder were found in 86 percent of the cases of adults in one study of serial sexual homicide conducted by Robert Prentky and colleagues (1989). Similarly, Janet Warren and colleagues (1996) found evidence of violent fantasies in 80 percent of their cases. The important role of sadistic fantasies, especially repetitive masturbatory fantasies, in these killers was emphasized by MacCulloch and colleagues, and that of daydreaming and compulsive masturbation was reported by Prentky and colleagues.

It has been hypothesized that the sadist may suffer from an arrest of psycho-sexual development, possibly at the anal stage (the anal-sadistic stage), or from a neurotic regression to that level. The majority of these offenders are eventually diagnosed with severe personality disorders. It can be theorized that the behavior of the sadistic, power and control-driven serial killer reflects the conduct of a curious child in the demolition of its toys.

Although Freud (1960) first viewed sadistic drives as primary instincts camouflaged by the drive to dominate, he later came to believe that sadism is the excessive outward manifestation of the death instinct. The gratuitous cruelty of sadism is possible because of insufficient control by the basic mechanism of

defense. JD, whose case is reported under Psychopathy, also belongs to this type of personality disorder.

7.8. Dependent Personality Disorder

The dependent-personality-disordered person is characterized by a pervasive and excessive need to be cared for that leads to submissive and clinging behavior and fear of separation. This disorder begins in early adulthood and is present in a variety of contexts. The stability of this type of personality depends on environmental circumstances. It moves into a semi-psychotic breakdown when factors supporting the dependency needs suddenly and unexpectedly disappear and a new existential adaptation must be made. Such people have difficulty in making decisions; require advice and reassurance; wish that responsibility for most major areas of their lives would be taken by others; fear that expressing disagreement will make them lose the supporting person; lack self-confidence when making judgments and plans; feel helpless and are fearful of not having someone to depend on. They may suddenly become depressed if they lose the person they depend on. In such instances, they feel rejected and panicky and they may act out against the person they feel has abandoned them.

Clinical Forensic Case: PH

Sources of Information

- **Criminal charge**: PH was charged with First-Degree Intentional Homicide by Firearm.
- **Police record**: At the crime scene the police found a female cadaver with evident signs of a struggle. PH was standing by the victim, motionless and in tears. A gun was next to the body.
- **Records reviewed**: Criminal complaint, police investigative record; police supplementary report; statements of police officers; statement of PH to police; autopsy report; PH's previous medical reports; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of her legal rights and of the purpose and non-confidentiality of the examination. She freely gave her consent to the examinations.

Social and Personal Data: Black female; 48 years old; sexually abused by father in early adolescence; high school graduate; low social class; divorced; two children,

one illegitimate; sporadic employment; resident of mid-size Midwestern American city.
Criminal History: No previous criminal history.
Medical/Psychiatric History: Hospitalization for depression with insomnia and fear of being hurt by others; hospitalization for alcohol abuse;
Pertinent Data: Dysfunctional family; numerous unstable relationships with men.
Mental Status Examination: Coherent; relevant; oriented to the usual spheres; logical thinking; blunted affect; depressed mood; emotionally labile; frequent crying; taking antidepressant medication.
Psychological and Other Tests: Minnesota Multiphasic Personality Inventory-2 (MMPI-2).
Psychiatric Diagnosis: Dependent Personality Disorder, with dependent and depressive features; Alcohol Addiction.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Dysfunctional family; poor judgment; inability to properly relate to peers, especially men; feelings of inadequacy and rejection.
- **Precipitating factors**: Fear of abandonment; suspiciousness; extreme anger.
- **Risk factors**: Alcohol addiction; previous rejection by various men.
- **Victim**: Middle-aged black female; wife of PH's boyfriend.

Psychiatric Forensic Examination of Offender: PH was examined at the request of her representing attorney. She entered the interviewing room in a friendly fashion. Her posture, ambulation and facial mimicry were normal. There was no presence of neurological deficits. Throughout the interview she appeared to be in good contact. She was coherent and relevant and her ideas progressed logically. She had no cognitive deficits. There was no presence of circumstantiality, hallucinatory experiences or clear-cut delusional ideas. Her affect was blunted. She was obviously depressed and almost throughout the interview she appeared to be emotionally distressed, weeping and sobbing most of the time when recounting the events that took place at the time of the offense. At the time of the examination, she was taking Zoloft (an antidepressant) and Trazodone at bedtime for sleep.

PH's personal and family history revealed that from age 11 to age 13 her father had taken advantage of her sexually. Later, she had several boyfriends but she was unable to establish a lasting relationship with any of them. She drank alcoholic beverages during her late adolescence and experimented with marijuana. She did not complete high school until age 21 because of life events. Prior to graduation she had a baby from a 'white guy' whom she had met at a party and by whom she felt jilted. She later married a man with whom she had had another child but after three years she separated from him because he was not a good provider. She held various factory jobs and worked as a bank teller. She then moved to another state where she

worked in a factory until she was laid off. Subsequently, she was on welfare for one year.

PH met a new boyfriend and moved with him to another state but she left him after one year because of maltreatment. Then, at age 28, she returned to her hometown where she lived with her mother until age thirty-one. During that period she briefly reconciled with her husband and although it did not work out they remained good friends. She worked briefly in an office until it closed down. She cared for her grandmother until she (PH) had a 'nervous breakdown' consisting of insomnia and severe depression. She was worried about her life and had paranoid fears of being hurt by others. Unable to find a job and drinking, she was hospitalized in the psychiatric unit of a local hospital for several weeks. While in the hospital she was given a tranquilizer, which she continued for a period after her discharge.

After leaving the hospital, PH held various jobs and also did some kind of charity work with older people. She first lived with her mother and then moved to another city where she lived with yet another man whom she also left because of maltreatment. Again her poor choice of a partner reflects her poor judgment (borderline features). She finally managed to find a steady job and eventually she married a man with whom she had been living for several years, but the marriage lasted only two and a half years. Shortly after the divorce, she again met the man who had jilted her many years earlier and although he was married to another woman she moved to be near him in the hope that he would leave his wife. She worked briefly at several jobs.

As recounted by PH, the victim—PH's boyfriend's wife—had been harassing her, telephoning her and swearing at her almost on a daily basis and saying offensive things about her to her (PH's) son. She also wrote letters to PH and at one point left a brick on her patio table with an insulting note under it. Apparently the victim was also harassing her own husband, stalking both him and PH. PH attempted to get a restraining order but reached the office too late to get the order and because of employment commitments was unable to return. When PH's boyfriend was with his wife she did not harass PH. PH claimed that she tried to leave her boyfriend but he would not let her go. She said that the gun that she eventually used in the offense was one that her boyfriend claimed to have bought to kill her if she left him, threatening to come after her if she did so.

The day of the offense PH awoke after a bad night's sleep, rented a car and spent the day shopping in various stores. At her last stop she bought two bottles of wine, a large bottle of gin, and a carton of cigarettes. She came home in the late afternoon, depressed, and started drinking, trying unsuccessfully to reach her boyfriend on his cell phone. She became confused and suspicious that he was with his wife and decided that if she found that it was true she would end their relationship. She went to her boyfriend's wife's home to see if he was there and when she saw his truck parked outside she got out of the car and began calling him to come out. When her

boyfriend did not respond to her calls she rang the doorbell and his wife came to the door. PH asked to see her boyfriend but his wife replied that they were upstairs having sex and he did not want to talk to her. Angry and humiliated, PH left, but before leaving she broke a window.

Shortly afterwards, extremely upset and in a confused state, having gotten the gun from her home, PH returned to the house, shaking and 'seeing everything red.' She wanted to get her boyfriend, not his wife.

She found the door of the house unlocked and walked inside where she found her boyfriend's wife in front of her. In her confused and dazed state, PH managed to blurt out her anger regarding the woman's harassment. She called her offensive names and told her that her husband (PH's boyfriend) had been coming to see her the entire time that he had been living with PH. She claimed that he was sick and an alcoholic. PH said that she did not remember what happened next. She vaguely remembered fighting with the victim, throwing the gun on the floor and pushing her off of her. At that point she suddenly realized that she had shot her. She looked in vain for her boyfriend but he was nowhere to be found. She called her mother and an ambulance and then asked a man who had come into the house at the sound of the gunshot to call the police.

Forensic Psychiatric Opinion: It was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that around and at the time of the offense, PH, suffering from a Severe Dependent Personality Disorder with borderline traits, decompensated into a brief psychotic episode, during which she did not possess substantial mental capacity to appreciate the nature, quality and wrongfulness of her actions and could not conform to the requirements of the law.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of PH's psychopathological state of mind at the time of the homicide. There was a direct nexus of causality between her psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering.

Commentary: PH had struggled with feelings of abandonment and felt harassed and humiliated. She stated that she did not intend to commit murder and had only taken the gun to intimidate her boyfriends' wife. She was depressed and confused and felt provoked by the woman at the time of the crime. She admitted that she had been drinking. Her history showed intense affectivity, hostility, fluctuating moods, impulsiveness, and poor social adaptation. She had an inability to establish a lasting relationship with any of the men she dated or those she married, and she frequently felt rejected and frustrated by them. She had extremely dependent relationships in general and had difficulty in properly relating to others, showing poor judgment. This symptomatology is typical of a Borderline Personality Disorder. Under extreme feelings of humiliation, her dependent and borderline personality broke down in an acute depressive and confusional episode, during which she committed the crime.

PH entered a plea of non-criminal responsibility. She was found to be legally sane and guilty of the offense. She was sentenced to twenty years in prison.

7.9. Obsessive-Compulsive Personality Disorder

Persons with an Obsessive-Compulsive Personality Disorder are characterized by emotional constriction, orderliness, perseverance, stubbornness, and indecisiveness. Beginning in early adulthood they show a pervasive pattern of perfectionism and mental and interpersonal control at the expense of flexibility, openness and efficiency. They are over-conscientious, scrupulous, and inflexible about matters of morality, ethics or values. They are excessively devoted to work. At times they are unable to bring a project to completion because of their strict standards and if unable to live up to their standards they become depressed. They lack a sense of humor. They alienate others because they are unable to compromise and they become ruminative. If their routine is upset, they may become anxious. The disorder may impair the social and occupational functioning of these persons. At times they become delusional and these delusions may be the reason for their acting out against others in a paranoid manner.

Clinical Forensic Case: PQ

Sources of Information

- **Criminal charges**: The defendant was charged with two counts of Arson to Building.
- **Police record**: The record reports that the police were called by passersby who had seen flames coming from a window of a Planned Parenthood office in a Midwestern American city. The damage to the building was insignificant. Investigation led to the arrest of the offender.
- **Records reviewed**: Police investigative records; police supplementary records; police officer statement; statements of employees of Planned Parenthood; defendant's statement; communications with attorney; consultations with parents.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: White male, 18 years old; high school student; single; upper middle-class background; lived with parents; employed part-time at jobs below educational level.

Criminal History: First-time offender.
Medical/Psychiatric History: No past history of drug or alcohol use or abuse; history of outpatient psychiatric visits for past suicidal ruminations and threats; hospitalization at a local mental-health hospital for suicidal ideation and attempts; placed on antipsychotic and antidepressant medication; previous diagnosis of Asperger's Syndrome.
Pertinent Data: 'Odd' interpersonal behavior with peers in adolescence reported by parents; shy; withdrawn; intelligent; non-competitive.
Mental Status Examination: Bewildered facial expression; rigid posture; minimally dystonic body movements; good contact; brief eye contact; coherent; relevant; logical thinking; oriented to the usual spheres; precise, staccato speech under pressure, at times blocking or halting; affect minimally blunted; minimally depressed; answers to questions to the point; no evidence of delusions or hallucinations; puzzled by his behavior at the time of the offense: 'That was not me.'
Psychological and Other Tests: Rorshach; Minnesota Multiphasic Personality Inventory-2 (MMPI-2); Wechsler Adult Intelligence Scale (WAIS-R).
Psychiatric Diagnosis: Severe Obsessive-Compulsive Personality Disorder, with borderline features; Asperger's Syndrome.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Feelings of inadequacy; sensitive to rejection; inability to properly relate to peers.
- **Precipitating factors**: Rejection and humiliation by girlfriend.
- **Risk factors**: Tendency to suicidal rumination and impulsive behavior.
- **Victim**: None

Psychiatric Forensic Examination of Offender: PQ, a young, white, male high school student, was charged with two counts of arson and was examined at the request of his representing attorney. He entered the interview situation in a matter-of-fact fashion but with a somewhat bewildered facial expression. His posture was erect and somewhat rigid and his ambulation was minimally hyperactive. There was no presence of tics, mannerisms or gross neurological deficits on observation. However, when he sat in his chair he seemed to be slightly rigid. His rigid posture was congruous with his speech during the examination, which was precise, meticulous and staccato in type.

PQ's history revealed that he is one of three siblings. As a child he suffered from hyperactivity, for which he took no medication. As a young adolescent, he began to lift weights in an attempt to become 'one of the strongest boys in school,' but he basically was afraid of others and felt picked on. He was involved in fights at school, but he felt weak and unable to cope. He also felt hopeless, angry, and depressed at times. Because of his behavior he had been suspended from school several times. Throughout his years of school, he recalled, he was suspicious of

people and the suspiciousness increased a few months prior to the offense. At times he thought people were lying to him.

During his second year in high school PQ steadily dated a girl. She had been molested twice by another boy and during the examination he recalled that he wanted to beat him up. He described the memory in a detached manner. His friendship with his girlfriend degenerated and they began to argue because PQ thought she had been flirting with another boy, which made him angry. He felt demeaned because at a party she frequently danced with the other boy and he thought that she was talking about him (PQ) with her girlfriends. Eventually his girlfriend left him because she could no longer take his suspiciousness.

After breaking up with his girlfriend PQ was depressed, cried a lot, and had thoughts of hurting himself. In anger he put his forearm almost through a plaster wall at home. At times he thought of deliberately having an automobile accident and at other times he thought of shooting himself. His mother, concerned about him, started to drive him to school. Because of his mental condition, his grades began to fall, and for the ensuing several months he was intermittently depressed and anxious, at times not even wanting to get up in the morning. He tried to make up with his girlfriend, or at least to be friends with her, but he was unsuccessful. He made suicide threats and was taken to the family doctor who reassured the family that there was nothing serious.

PQ recalled that one day, as he was sitting in class, his mind began to wander. He started having weird obsessive concerning his former girlfriend. He described hearing 'voices' coming from inside his head. They were telling him to go an office of Planned Parenthood and set it on fire. At first he dismissed the idea because he did not feel up to it, but when he went home from school his obsessive ideas began to bother him again and, like an automaton, he went to a nearby store and bought charcoal lighter fluid, rubber cement, and wood to start a fire. He was surprised when he paid for the items because nobody asked why he was buying them. He then went home, took the things he had purchased to his bedroom and locked the door. For the rest of the day he was unable to get rid of his obsessive ideas about setting the fire.

PQ continued to be anxiously depressed. Nevertheless, that afternoon he went to his usual part-time job at a local grocery store. He recalled that during the night he woke up feeling extremely upset and he suddenly found himself sitting up straight in bed, feeling compelled to 'do that thing.' He vaguely remembered that about midnight, like a robot, he took the material out of his closet and put it in his gym bag. He felt not only very upset but almost as if he was in a videogame (autoscopic feelings). He drove to the Planned Parenthood office building, parked his car, took the bag and ran across the street, excited and agitated. When he reached the back of the building he broke a glass window with his fist, hitting it hard enough to set off the burglar alarm. He then broke a second pane of glass, again with his fist. He

dumped the things he had brought with him inside, took a match and threw it in the window, and quickly moved out of the way. He stated that at the sight of the flames he became very excited and frightened and felt that the whole thing was unreal. He found himself in his car, going home. His plan had been to create a small nuisance fire outside the building and he realized that he had 'screwed up again.'

The next morning PQ went to school, exhausted, and found that no one knew about what had happened. Later, at a school party, he felt weird. He continued to think that his former girlfriend was trying to make him miserable, and he felt lonely and depressed. After he tried to talk to her, unsuccessfully, he got in his car, began to cry and his obsessive thoughts of setting the fire started again. The thoughts were so strong, he said, that he felt forced to go back to the Planned Parenthood office to 'finish the job.' He recalled being very confused and agitated as he broke a window at the office with a baseball bat, causing the alarm to go off. Even though he was frightened, he quickly started the fire, after which he ran to his car and, without knowing what he was doing, raced back and forth on the expressway, reaching the point that he was stopped by a police officer who gave him a speeding ticket. He almost hoped that he would be arrested, because he could no longer argue with his 'stupid' thoughts. The next morning he was arrested at school by two police officers and an agent of the Federal Bureau of Investigation. Asked the purpose of setting the second fire, PQ replied, 'I was terribly confused and my obsessive thoughts were insistent.'

Forensic Psychiatric Opinion: It was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that, at the time of the offense, PQ was suffering from a major depressive episode, with obsessive-compulsive features. Under social interpersonal stress he had decompensated from his Obsessive-Compulsive Personality Disorder. During the period surrounding the offense, and especially during the offense, he behaved like an automaton in a confused way. His cognitive and volitional capacities were impaired and his attempt to set a fire was almost abortive.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of PQ's psychopathological state of mind at the time of the arson. There was a direct nexus of causality between his psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering.

Commentary: This young man suffered from a rather severe obsessive-compulsive illness and Asperger's Syndrome. At the time of the offense he decompensated into a major depressive psychotic episode. He was despondent and because of social/interpersonal stress he acted in a manner that was not congruous with his usual self. Because of his cognitive and volitional impairment, his auditory hallucinatory experiences (voices), and his bizarre impulsive behavior at the time of the crime, it was the author's forensic psychiatric opinion to a reasonable degree of

medical certainty that at the time of the offense PQ did not possess substantial mental capacity to fully appreciate the wrongfulness of his actions and their consequences and he was unable to refrain from carrying them out.

In a differential psychiatric diagnosis one should also consider that the concomitant Asperger's Disorder from which he suffered shows deficits in communication with others, an inability to respond appropriately in a social discourse, and impairment of executive functions. PQ exhibited minimal dystonic movements, which are also typical of the disorder. But most of all, it is interesting to note that person's who suffer from Autism Spectrum Disorders, in this case Asperger's Disorder, are primarily male and are thought to be at an increased risk of criminal behavior, and are especially fixated on fire and fire-related themes (*DSM-IV, 2000*; Haskins & Silva, 2006). Arson is, indeed, a crime they frequently commit. As in the case of PQ, they are unable to appreciate that their actions have no impact on those whom they want to punish (in the case of PQ, his girlfriend). From a psychopathological point of view, brain imaging studies suggest that several brain areas involved in cognition, such as the prefrontal cortex, the amygdale, involved in emotional reactions, and the fusiform gyrus are affect by Autism Spectrum Disorders.

At trial PJ was found guilty of the offense and sentenced to five years of probation.

Clinical Forensic Case: JEC

Sources of Information

- **Criminal charges**: The district attorney's office charged JEC with Attempted Intentional First-Degree Homicide while Armed and Use of a Dangerous Weapon. The victim was a middle-aged white male, unknown to him.
- **Police record**: The record states that a young male, agitated, confused and speaking in an irrational fashion, turned himself in to the police department, stating that a few minutes earlier he had attacked an unknown man with a knife.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary records; statement of police officer; statement of victim; statement of defendant; previous medical reports; author's files regarding communications with attorneys.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: White male; 18 years old; single; middle-class; unemployed; high school dropout (10^{th} grade); resident of Midwest American city.
Criminal History: On probation for misdemeanor theft at time of examination; charged at age 17 as Party to a Crime and Operating a Motor Vehicle without Owner's Consent.
Medical/Psychiatric History: Use of prescribed amphetamines for past ten years for Attention-Deficit/Hyperactivity Disorder (ADHD); abuse of lysergic acid diethylamide (LSD) for previous two years; no history of hospitalization for mental illness.
Pertinent Data (Family): Dysfunctional family; alcoholic and abusive mother; father gambler, often absent.
Mental Status Examination: Coherent; relevant; logical progression of ideas; oriented to the usual spheres; obsessive-compulsive; overly conscientious; critical; hyperactive, cautious; shy; no eye contact at times; impulsive; difficulty in interpersonal relationships; no evidence of delusions or hallucinations at time of examination; claimed mood changes.
Psychological and Other Tests: Multiphasic Personality Inventory-2 (MMPI-2).
Psychiatric Diagnosis: Obsessive-Compulsive Personality Disorder, with mood changes; Attention-Deficit/Hyperactivity Disorder; Polysubstance Dependence.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Chronic feelings of rejection; anger; feelings of inadequacy.
- **Precipitating factors**: Sudden onset of delusions of grandiosity, omnipotence; and command hallucinatory experiences.
- **Risk factors**: Abuse of prescribed and no-prescribed drugs.
- **Victim**: Middle-aged white male; unknown to victim.

Psychiatric Examination of Offender: As JEC entered the examinin room his posture was erect and his ambulation normal. There was no presence of unusual facial mimicry, tics, mannerisms or gross neurological deficits on observation. He sat comfortably in his assigned chair and appeared to be friendly but shy. He had an aura of cautiousness when answering the questions posed to him. He made occasional eye contact and at times he smiled appropriately during the conversations. Intellectually, he appeared to be average. He was aware of his offense and of its implications and was willing to proceed with the examination for legal responsibility.

JEC's parents separated before he was born and he moved from his mother, to his father, to his grandparents. He described his father as emotionally distant, a gambler, a person who put no effort into his relationship with his family or with him. His mother was portrayed as a full-blown alcoholic, a person difficult to be with, who abused him physically. He attended high school up to the 10th grade at

age sixteen, but then became bored with it. He was involved in the use of drugs early on, including the use of LSD for a two-year period until just before his 18th birthday. The other drugs consisted of marijuana and sporadic use of cocaine.

At age eight, JEC was diagnosed with ADHD and since that time and up to the day prior to his incarceration he had been taking Dexedrine (an amphetamine) prescribed by a medical doctor in the amount of 15 mg. more than once a day. He talked about his relationship with his uncle, a person addicted to amphetamines. He disclaimed any hospitalization for mental illness or any suicidal attempt, stating that he had been completely sane all his life. He showed no insight into his personal problems. Previous medical reports had classified JEC as a personality disorder not otherwise specified and as a marijuana abuser, and described him as immature and subject to mood changes.

JEC showed good contact with reality and calmly described the events preceeding, during, and after the offense. He had been living with his grandmother at the time. He said that he felt like his usual self but was unable to explain what he meant by that. He recalled having the obsessive irrational thought that he should kill somebody and that that somebody would be the devil. When he was at work at the grocery store he saw a girl who had the exact face of a character in the movie *Stargate*, which he had recently seen. He was shocked by it and he began to think that he had seen the devil. His recollections show that at the time he was delusional.

After work JEC said, he went home and slept for about ten hours. The next morning, after getting up, he again was taken by the thought that he had seen the devil and that the devil had contaminated him and he had to decontaminate himself. 'Contamination' was like a dare from the devil for him. He recalled hearing a voice in his head telling him to kill somebody; the voice was challenging him, telling him that he wouldn't be able to do it. Urged on by the auditory hallucinations, he got a knife, went to the basement to sharpen it, and put it in his coat pocket. After his usual breakfast, around 10 a.m. he went to a quarry looking for someone to kill.

JEC was looking for somebody alone, so that he would not be caught. At the quarry he found such a person, a man who was alone and who was taking pictures. He approached the man and asked him what he was doing and then he walked past him up to the end of the trail. He then turned around, asking himself if he should kill the man or not. He knew that he wanted to stab the man and he also knew the reason why: basically, he wanted to save the world from chaos. He thought that he was the one to save the world because he believed himself to be God. Obviously, his obsessive-compulsive ideas had become more delusional and he recalled how he felt at the time: 'There was mental telepathy going on in my mind. It was not that I thought I was God. I knew I was God. There was no doubt in my mind about it.'

JEC continued to narrate his account of the offense, stating that he walked back toward the man. He walked back and forth several times in the throes of a dilemma about 'doing it or not doing it'. Then he walked past the man but did not stab him.

He took his bike and went back to the end of the trail; the victim was going in that direction, too. JEC followed him to the end of the trail and decided that it was the perfect situation for him and he stabbed the man in the back left shoulder. The victim turned around with a startled look on his face and with his arms outstretched, and he cried out, 'Oh, my God, he attacked me.' JEC had stabbed the man in the back because he felt safer that way, because he did not want to be caught or get into a fight with him. This shows that he had moments of lucidity. He spontaneously said, 'I did not want to do it, but I did it. It took a lot of energy. It was my intention to kill him, and that is what I was trying to do.' He was utterly contradictory.

JEC left the knife in the victim's shoulder and ran away. The victim ran after him but was unable to catch up with him. JEC, exhausted, hid in a swamp, feeling weak and afraid that he would pass out. (Told that it did not make any sense to run away or to be afraid of being caught if he was on a mission to save the world or if he were God himself, he smiled and said that that was a good point.) He kept walking until he found a policeman, turned himself in, and was taken to jail.

At the time of the examination, JEC recognized that he knew what he did was wrong and said spontaneously, 'That was the likely ending of the story: The root of all evil—killing the devil.' He made partial mention of a passage from Matthew 5:28 (sic)—'cast out'—in support of what he had done. He made a reference to 1999 and the number 999 which he equated with the apocalypse. He mentioned that the universe comes together from chaos and that there is not enough space in the world.

Asked what he would have obtained by killing the man, JEC said that would have freed the world from the devil. From the time he saw the movie *Stargate* he had been thinking about the devil, whose eyes were glowing and whom, he believed, was actually talking to him in the movie. At the time of the crime, JEC thought he was God, who was going to kill the devil. He became somewhat excited when discussing this topic and said that although he couldn't explain the logic of his actions, they might have originated from stories his uncle had told him.

Forensic Psychiatric Opinion: It was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offense JEC had decompensated from his personality disorder into psychotic behavior with delusions and command hallucinations. Because of that, he did not possess substantial mental capacity to fully appreciate the nature, quality and consequences of his actions and conform to the requirements of the law. In other words, he was legally insane and not responsible for the offense.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of JEC's psychopathological state of mind at the time of the attempted homicide.

There was a direct nexus of causality between his psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering. However, at trial he was found guilty of the offense, legally responsible and was sentenced to a five-year prison term.

Commentary: This 18-year-old, white male of average intelligence had been a troubled child, coming from a dysfunctional family. He harbored feelings of anger throughout his life. He appeared to be concerned with minutiae and was highly opinionated. He was over-conscientious, a perfectionist, at times critical of himself and others. He was given to a bit of irony, at times was spiteful, and generally vindictive. His history revealed that he had difficulty in maintaining a good relationship with people and in keeping jobs. His personal life was unstable and his behavior was impulsive and self-destructive.

JEC used marijuana and LSD for several years during his adolescence and he had used amphetamines for ADHD for almost ten years prior to the offense, including the immediate days prior to it. He claimed to have a very ambivalent relationship with an uncle whom he blamed, to some degree, for his antisocial behavior, seeing him as a poor role model. The sudden appearance of his bizarre thinking and behavior and the delusional ideas and command hallucinations about the devil had followed a quarrel with his grandfather and possibly the use of illicit substances.

The effects of LSD, which JEC had been using, are unpredictable. He did not report the physiological signs of LSD use (dilated pupils, higher body temperature, increased heart rate, sweating, dry mouth or tremors). Although the emotional mood swings that are often reported and the delusional ideas that are frequently observed in LSD users were noted in this case, there was no presence of visual hallucinations, real panic, or the feeling of hearing colors and seeing sounds that are usually reported. Amphetamine abusers also undergo mood swings and occasional paranoid ideas, but again there was no evidence of reports of any physiological body signs experienced by JEC at the time of the crime. Therefore, the author's diagnosis of an Obsessive-Compulsive PersonalityDisorder that decompensated into a delusional disorder, as stated in the psychiatric diagnosis, is justified. JEC's reality testing, his poor insight into his condition, his extreme delusional preoccupation with contamination by the devil, and command hallucinations bespeak a brief psychotic episode following the intense stress that he underwent after a quarrel with his grandfather, the only person to whom he was deeply attached. It should also be pointed out that shortly after the offense his personality reintegrated and he turned himself in to the police. (See *DSM-IV* description of brief psychotic episodes.)

Because of his irrational behavior at the time of the crime due to a psychotic decompensation, it was the author's professional forensic psychiatric opinion to a reasonable degree of medical certainty that JEC did not have substantial mental capacity to appreciate the nature, quality and consequences of his actions and was

legally not responsible for the crime. Nevertheless, his plea of insanity was rejected and he was found guilty of the offense and sentenced to five years in prison.

Clinical Forensic Case: GP

Sources of Information

- **Criminal charge**: GP was charged with the First-Degree Intentional Homicide of his divorced wife. The weapon used was a knife.
- **Police record**: The police were called by a friend of the victim who partially saw the incident taking place. She recognized the estranged husband of her friend and was afraid that something terrible was going to happen.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary report; statement by police officers at crime scene; autopsy report; various statements by persons who knew the couple, in particular that of the witness who called the police; records of GP's previous hospitalizations; GP's physical health report; GP's professional work record; present jail records; reports of GP's previous brief incarcerations; report of psychiatrist for prosecution; report of previous psychological testing; reports by psychologist who attempted to conduct neuropsychological tests; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.

Social and Personal Data: White male; 70 years of age; divorced; upper middle class; professional, presently unemployed at time of offense; resident of large Midwestern American city.

Criminal History: Brief incarcerations in recent past for breaking no-contact order with divorced wife.

Medical/Psychiatric History: Double coronary bypass; angioplasty; massive heart attack; heart failure; ventricular tachycardia two years prior to offense; previous psychiatric hospitalization four and five year prior to offense, with discharge diagnoses of Obsessive-Compulsive Personality Disorder and Adjustment Disorder with Mixed Disturbance of Emotions and Conduct. Neuropsychological testing several years prior to offense revealed mild cognitive deficits.

Pertinant Data: Rigid, authoritarian family; met wife while stationed in Europe as medical officer with United States Air Force; poor relationship with adult children; wife denied sexual contact for decades; divorced by wife because of his obsessive-compulsive behavior; difficulty with superiors at last place of work resulting in his losing his job.

Mental Status Examination: In contact with surroundings; speech coherent, but relevancy minimized; rapid compulsive speech; often tangential; incessant narrative lacking insight; mood depressed; emotional at times; capacity for reflection impaired because of self-centeredness and projection; animated affect; narcissistic grandiosity; felt rejected by wife and three children; ambivalent about wife; humiliated and tortured by wife's divorce; felt persecuted by people at work; narcissistic and grandiose with paranoid features; immature; tendency to become impulsive; basic inferiority complex; voiced suicidal ideation in past; no hallucinations or well-systematized paranoid persecutory ideas.
P**sychological and Other Tests**: Refused electroencephalogram and psychological and neuropsychological tests.
Psychiatric Diagnosis: Obsessive-Compulsive Personality Disorder with strong narcissistic and grandiose features; Tendency to bipolarity with hypomanic episodes and paranoid tendencies.
Defendants's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Obsessive-compulsive personality; ruminative tendencies; suspiciousness; basic inferiority complex; fear of rejection.
- **Precipitating factors**: Rejection by divorced wife, highly traumatic with breaking of ego defenses.
- **Risk factors**: Tendency to rumination; feelings of humiliation.
- **Victim**: Divorced wife.

Psychiatric Forensic Examination of Offender: GP's attorney requested that a forensic psychiatric examination be done in order to ascertain his criminal responsibility at the time of the offense. Two years prior to the offense his wife had filed for divorce claiming incompatibility and harassment. During the preceding years GP had had difficulties with a supervisor at the institution where he worked. Because his professional reputation was very good, that had upset him to the point that he became increasingly irritable, somewhat depressed, and legally litigious. During this period, even though standing by him, his wife slowly had withdrawn her affection and her sexual self from him. This behavior made him increasingly upset, because he felt rejected by his wife with whom he claimed, during the examination, to have been deeply in love. In spite of his insistence in wanting to reestablish a normal rapport with her, she went through with the divorce which, from what he said, deprived him of his house and most of his financial estate.

At the time of the examination, GP was in good contact. His speech was under pressure and he often lost his train of thought becoming tangential, and had to be redirected. He was obsessive, self centered and paranoid, but without a well-systematized delirium. He said that at the time of the offense he was taken by a confusional/delusional raptus during which he repeatedly stabbed his wife. He explained that the night of the offense, aware that his ex-wife was out to dinner with

friends, he had waited for her near her car, carrying with him a bouquet of flowers, because it would have been their wedding anniversary (had they not divorced). But he also had a knife hidden in his coat, a knife which he claimed he usually carried for self defense. He claimed that he had no intention to hurt his wife but was just attempting to give her the flowers in the hope of restarting a good relationship with her. He claimed that when he approached her she became very frightened. In order to emphasize to her that he was a man of personal integrity and that he had no intention to hurt her, he showed her the knife, saying, 'You see, I have a knife. But I would never hurt you, because I am an honorable man.' His wife was terrified and non-responsive at first but when she noticed some people coming towards them she screamed for help. GR claimed that he didn't know what happened after that. He found himself self stabbing her—various times in different parts of her body. Soon afterwards, other people arrived and found him crying and embracing his dead wife who was on the ground next to the car.

Forensic Psychiatric Opinion: The author's forensic psychiatric opinion to a reasonable degree of medical certainty was that at the time of the crime GP underwent a brief psychotic episode and in a raptus he stabbed to death his ex-wife. By that time, his Obsessive-Compulsive Personality Disorder had evolved into a Major Depressive Episode with strong paranoid features. The author also suggested that a Frontal Lobe Syndrome should be ruled out. Further, it was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offense, because of his brief psychotic episode, GP did not possess substantial mental capacity to appreciate the nature, quality and consequences of his actions and was unable to conform to the requirements of the law.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of GP's psychopathological state of mind at the time of the homicide. There was a direct nexus of causality between his psychopathological state of mind and the crime he committed.

At trial GP was found guilty and legally responsible for the offense. As of this writing, he was awaiting sentencing.

Commentary: It would be quite simple to look at the case of GP from a behavioral point of view in order to reach a forensic psychiatric diagnosis. Indeed, on the basis of his past behavior and the documentation perused it would be possible to limit the diagnosis *only* to his behavior, without delving into any possible causes of an organic nature that might have impaired his capacity to appreciate what he was doing and the consequences of his actions when he committed the brutal overkilling of his wife, even though he strongly claimed that he was in love with her and described himself as a devout Christian. His behavior could be interpreted as uncontrollable anger due to his feelings of humiliation and abandonment, a state of mind described by him as if he were a split observer. Also, it could be argued that

there was a larval form of premeditation. However, it behooves the triers of court to exclude that his behavior at the time of the offense was not due to a frontal lobe disinhibition caused by fronto-temporal brain pathology (dementia), as already suggested by previous neuropsychological testing, and to the acute firing of the amygadala under severe stress.

Indeed, impulsive acting out, which often originates in the amygdaloid nucleus at the base of the brain, is kept under control by the discriminatory function of the frontal cortex. If the frontal cortex, for whatever reason (fronto-temporal dementia or vascular repercussions due to GP's poor cardiovascular state and medication), does not exercise its controlling influence on the amygdala, it is possible that impulsive destructive behavior takes place.

In addition to the above, it should be pointed out that deep ambivalence towards the victim, his wife, is also at the basis of GP's inconsistent statements found throughout the records reviewed and present during the forensic examinations of him. For instance, in a letter to his children, he stated that he never had the intention to harm his wife. In a statement to the author he said that he might have lost control when she called out for help and he was taken by an intense fear of going back to jail. The inconsistency here is that GP committed an act that may send him to prison for life. Because of that, one may opine that at that particular time, due to his underlying pathology, he did not possess full appreciation of the situation he was in nor full control of his actions. Also, his refusal to have a functional MRI and to have neuropsychological testing, as suggested by the author, was self defeating in that the tests could rule out his criminal responsibility at the time of the offense.

The fact that GP's general cognitive mental state seemed to be fairly good does not exclude a mental impairment, especially of his volitional capacity. Intellectually he scored within normal limits when tested. However, one should be reminded of his high IQ at the time of earlier testing. One may opine, but this is difficult to prove, that GP felt so guilty about what he did that he wanted to be punished for it. However, that contradicts what he sustained throughout the examinations–that he was victimized by his wife and the justice system, as he also stated to his children.

Basically, GP's personality was paranoid, with strong obsessive features, and sensitive to rejection and abandonment. His wife's screaming sounded to him like total rejection and led him into a brief psychotic episode. The uxoricide was characterized by extreme violence and ambivalent irrational behavior. Indeed, he was found embracing his dead wife and crying. From the point of view of object relations theory he might have been in the throes of a projective identification. He projected his bad introject onto his wife, the primary cause of his aggression, aggression that was at the basis of his murder of her. It is possible that early traumatic experiences of rejection by his mother, as he suggested during the examination, were an unconscious connection to his recent spousal abandonment and led to his catastrophic murderous act. From the testimony of those who knew

him, GP had become very depressed, suicidal and paranoid during the two or three weeks preceding the offense.

7.10. Passive-Aggressive Personality Disorder

People who are diagnosed with a Passive-Aggressive Personality Disorder are characterized by overt obstructionism, procrastination, stubbornness and inefficiency. The *DSM-IV-TR* (American Psychiatric Association, 2000) describes this disorder as a pervasive pattern of negativistic attitudes and passive resistance to demands that their duties be fulfilled. They become sullen, argumentative and unreasonably critical. They are hostile in their defiance and unpredictable in their behavior. They easily become depressed and assaultive. A good percent of them may be diagnosed as suffering with schizophrenia.

Clinical Forensic Case: LH

Sources of Information

- **Criminal charge**: LH was charged with First-Degree Intentional Homicide. The victim was his estranged second wife.
- **Police records**: The police were called to a local tavern because of a reported shooting. On arrival they found the body of a dead woman who had been shot in the head. A man (the defendant) was being restrained by two other men.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary reports; statements by police officers; autopsy report; jail medical records; statements by witnesses at the scene of the crime; statement by the defendant; author's files regarding communications with attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to the forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examination.

Social and Personal Data: White male; 57 years old; technical school graduate; middle-low class; divorced from first wife; separated from second wife; bad conduct discharge from the United States Marine Corp after three years service, possibly due to alcohol addiction; tavern manager; previously worked as plumber; resident of Midwestern city.

Criminal History: First-time offender; single homicide of estranged wife.

Medical/Psychiatric History: Stabbed in chest by first wife while sleeping; suffered heart attack necessitating angioplasty after separation from second wife; suicidal threats after separation from second wife; depression; paranoid ideation.
Pertinent Data: Passive-aggressive with deep feelings of rejection; difficulty in relationships with women; past traumatic experiences; questionable Posttraumatic Stress Disorder (PTSD); history of alcohol abuse.
Mental Status Examination: Coherent; relevant; well oriented as to the four spheres; tense; labile; suspicious, bordering on paranoia; feelings of rejection and anger; mostly amnesic for offense.
Psychological and Other Tests: Minnesota Multiphasic Personality Inventory-2
Psychiatric Diagnosis: Passive-Aggressive Personality Disorder, with strong dependent and immature and paranoid features; Confusional state due to decompensation under stress, with concomitant alcohol imbibition.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Feelings of abandonment; frustrated desire for acceptance; deep chronic fear of rejection; distrust of women in general.
- **Precipitating factors**: Belief in wife's unfaithfulness; anger at wife; alcohol use.
- **Risk factors**: Fear of abandonment; mental confusion; lack of self control; tendency to alcohol abuse.
- **Victim**: Second wife; bartender; ambivalent towards husband; separated from husband.

Psychiatric Forensic Examination of Offender: This 57-year-old, obese white male was charged with the first-degree intentional homicide of his second wife. On observation at the time of the forensic examination he showed normal posture and ambulation, no presence of tics, unusual mannerisms, or gross neurological deficits. During the examination he was tense and emotionally labile. He was talkative and his speech was coherent and relevant and his affect appropriate. He spoke fluently and without hesitation throughout the examination and showed no evidence of delusions or hallucinations. Occasionally, he became minimally emotional but composed himself again quickly.

LH has eight sisters and two brothers. As a child he had been placed in a boys' home and he believed that it was because there were too many children at home. He remembered the event as being very traumatic. He said that his father was good to him but was an alcoholic who was physically abusive of his wife, LH's mother, who divorced him. After graduation from a boys' technical school LH joined the Marine Corp and served for three years but received a bad-conduct discharge.

LH was married to his first wife for 20 years and worked for various companies during that time. He said that he divorced her after she stabbed him in the chest while he was asleep, claiming that he had been physically abusive. After the

divorce, he became a plumber and developed his own business. He married his second wife eight years prior to the offense and they worked together in a tavern. She had had previous drug problems but they had stopped at the time of their marriage. She had had surgery on her nose because of cocaine use and he said that she needed help when they met. LH had no history of drug use but used alcohol in moderation. He was aware of the dangers of addiction.

Regarding the offense with which he had been charged, LH stated that it took place on an afternoon of early December and that he and his wife had had a fight the day before Thanksgiving (late November). He said he really didn't know what happened at the time but that he had been going to invite her out and as he was going to work at the tavern he looked through the window and saw that she was kissing another man. He entered the tavern and yelled at her about kissing the man, thinking that she was drunk. He said that he pushed her and told her to go home and she fell. He kicked the bar stool and the man she had been kissing pushed him and there was a scuffle between the two of them. Then his wife and the man left and the police came, called by a man who lived above the tavern. LH said he told the police that nothing serious had happened and claimed to be sober. That night his wife slept in the spare bedroom, but during the night she came to their bedroom and told him that she had done nothing and was sorry. He pushed her away and told her to leave him alone. The next morning she again told him she had done nothing and was sorry, but he pushed her away and told her that he wanted a divorce.

LH and his wife separated. During the separation he had a heart attack and needed an angioplasty. He said that even though the nurse called his wife's mother and told her that he was in the hospital, his wife did not come to see him. On the day of the offense, he went to his daughter's house and after that, he said, he was unable to remember what he did. He only remembered talking to his wife on the phone. He was depressed at the time.

LH had used a gun at the time of the offense and when questioned about it he stated that he had taken it from his house the week before when he and his wife had the first argument. At the time he was staying at a motel and was not working. He claimed that he wanted to kill himself because he was tired of the whole thing. He took his daughter's car and drove around, lonely and very depressed, somewhat confused.

LH said he went and talked to a friend who owned a tavern, played the poker machine, and had a few drinks, staying for about one hour. His friend wanted him to stay longer, but he was too worked up, tense, and under pressure. He wanted to go home to sleep because he was exhausted. Nothing seemed to be going right and it reminded him of the first day he was in the boys' home. He didn't know what to do and didn't know why his wife would do that. He began to think that everybody was against him and that she had told everybody stories about him. So he went and bought some bullets to kill himself. But first he went to the tavern where his wife

was working. While he was going there he had had the feeling that someone was following him, perhaps to stop him. The next thing he remembered, he said, was being at their tavern. It was dark outside and he was going to ask his wife if he could go home and get some rest and to sleep, because he was so tense inside. He was unable to breathe. He vaguely remembered that he had the .38 caliber handgun in his belt.

When he went inside the tavern he still could not figure out if, and why, his wife was mad at him. He dimly remembered that he asked her for a beer and she refused to give it to him, and that she would not even talk to him. He did not remember exactly what happened from that point on; his memory was blank. He said he was told that he shot his wife in the back but he claimed that he would never shoot anyone, especially his wife, in the back, particularly because, as the police complaint reported, his in-laws were present. He was told that he fired two shots at the ceiling of the tavern, for which he had only a vague memory. He did not remember, as reported in the police complaint, shouting anything at the people in the tavern. He remembered struggling with some people and seeing his wife on the floor but didn't remember much after that. He thought that somebody hit him with something. The police picked him up at the tavern but he did not remember leaving. He was confused about exactly what took place there and continued to state that he did not know why he had not killed himself as he had wanted to do at the time. He claimed that he had no intention to kill his wife. He continued to feel extremely rejected and despondent.

Forensic Psychiatric Opinion: It was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offense, because of his decompensated personality disorder into psychotic behavior, LH did not possess substantial mental capacity to appreciate the nature, quality and wrongfulness of his actions and could not conform to the requirements of the law. He was in a confused paranoid state, with possible alcohol intoxication and because of that he was not criminally responsible for the offense. The possibility that he was also suffering from PTSD with a psychotic overlay could be entertained.

LH was found legally sane. The police records reported that according to testimony by persons who had been present at the crime scene he had attempted to kill himself. This was probably a case of abortive homicide-suicide.

Because of the intense emotional feelings with which he suffered, LH decompensated into a brief psychotic episode, manifested by confusion, paranoia and uncontrolled behavior, during which he shot his wife in the back. His poor recollection of events and the testimony of witnesses to the offense supported the legal impression of insanity.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of LH's psychopathological state of mind at the time of the homicide.There was a

direct nexus of causality between his psychopathological state of mind and the crime committed. The MMPI-2 excluded any malingering.

The verdict of the jury, supported by witnesses for the prosecution, did not accept the above forensic psychiatric opinion. LH was found guilty of the offense and sentenced to 15 years in prison.

Commentary: LH underwent several traumatic episodes in his life. The first took place at age 11 when he was placed in a boys' home. At that time, it is highly possible that he felt extremely rejected by his family. The second traumatic episode he recalled was that in which a fellow marine was killed in his presence by a civilian during some kind of argument. At that time LH was not only exposed to a traumatic situation but he lived through it because he felt that he might have been killed himself. A third episode of extreme trauma happened when, while he was sleeping, he was stabbed in the chest by his first wife, a stabbing that required hospitalization and surgery. A fourth episode was when he witnessed his wife kissing another man in what he saw as a loving fashion. It can be argued that he underwent serious psychological trauma and rejection throughout his life.

Feelings of rejection and an attempt to ward them off are often followed by the defense mechanism of aggression. LH's aggression throughout the years had been fairly well-channeled through active work and with the help of alcohol, possibly used as a sedative, and he was able to establish some workable, quasi-normal relationships with women. A tinge of paranoid feeling was, however, present, becoming more acute during stress, and was especially evident in his statement, 'Women cannot be trusted. You never know what they are up to'; and, 'It felt like when I was in the boys' home. I was lost.' He projected some of his problems onto his mother and the female partners in his life.

The homicide of LH's wife may have been an abortive homicide-suicide, with all the motivational characteristics of such a syndrome: abandonment by a partner who is viewed as a part of one's self and the loss felt as rejection, which reawakened the early childhood rejection by his mother, by his first wife, and by his girlfriend in between. He was in a clouded psychotic state at the time of the shooting. Nevertheless, he was found guilty of the homicide, with no attenuating circumstances.

He grew up with feelings of rejection and deep suspiciousness, bordering on paranoia. He was deeply disappointed by his second wife, who was unfaithful and untrustworthy, as well as uncaring of him during a hospitalization for a heart ailment. He became very depressed, paranoid and suicidal, and his deeply buried feelings of childhood rejection resurfaced with great intensity. Despondency, hostility and ambivalence, fueled by alcohol, led to a confusional, defensive, paranoid state, during which he did not realize what he was doing and was unable to appreciate the wrongfulness of his actions. Such brief psychotic episodes may take place under stressful situations in paranoid personalities.

Clinical Forensic Case: DL

Sources of Information

- **Criminal charges**: DL was charged with one count of Attempted First-Degree Intentional Homicide of a Fetus; one count of Kidnapping; two counts of Interfering with Child Custody.
- **Police record**: DL was arrested at his place of work after the boyfriend of his divorced wife was able to contact the police. She had called her boyfriend via cellular phone from the storage place where DL had left her tied up.
- **Records reviewed**: Criminal complaint; police investigative records; police supplementary reports; statement of victim to the police; statement of DL to police; statement of arresting police officer; previous medical records; communications with defense attorney.

Purpose of Examination and Statement of Non-Confidentiality: Prior to each forensic psychiatric examination the defendant was advised of his legal rights and of the purpose and non-confidentiality of the examination. He freely gave his consent to the examinations.
Social and Personal Data: White male; 42 years old; one year college; divorced; middle class; employed full time as air-traffic controller; part-time builder.
Criminal History: No prior criminal history.
Medical/Psychiatric History: Mild mood swings; family history of unspecified emotional disorders, possibly bipolar; no history of psychiatric or other hospitalization.
Pertinent Data: Good family background; fairly good relationship with parents; loving attitude towards children.
Mental Status Examination: Coherent; relevant; oriented to the usual spheres; speech logical; affect even; at times a bit puzzled; mood depressed; minimal suspiciousness; voiced feelings of humiliation; spotty, unclear memory regarding events leading to charges; no indication of delusions or hallucinations.
Psychological and Other Tests: Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Electroencephalogram.
Psychiatric Diagnosis: Passive-Aggressive Personality Disorder, with depressive features.
Defendant's Account of Offense: See psychiatric-forensic examination.
Criminogenesis:

- **Predisposing factors**: Feelings of despondency and inadequacy; intense anxiety; ambivalence about and interpersonal difficulties with women; recurrent humiliation by wife.

- **Precipitating factors**: Anger; scheduled court appearance for child custody hearing; fear of losing children.
- **Risk factors**: Depression
- **Victim**: Divorced wife who miscarried following DL's abusive behavior.

Psychiatric Forensic Examination of Offender: DL was examined at the request of his representing attorney. He entered the interviewing room in a matter-of-fact fashion, appearing to be in good contact with his surroundings. During the examination, he was quiet but tense, at times puzzled and somewhat detached. He was aware of the charges against him and the possible consequences if found guilty. He was coherent and relevant and when he spoke his ideas progressed logically. His mood was depressed and anxious. His memory for the events surrounding the offense was hazy. There was no presence of delusions or hallucinations.

DL's past history revealed a dysfunctional family with some unspecified emotional disorders, possibly bipolar illness. He graduated from high school and after a brief period in college he joined the United States Marine Corp. He had a Federal Aviation Administration license and worked as an air-traffic controller. He also had a license as a real estate broker and worked as a builder. He described himself as a hardworking and successful man, possibly with some interpersonal difficulties with women.

DL's wife, a former night club dancer, had left him several years prior to the offense and there were occasional quarrels regarding their children after that. He claimed that their divorce was shattering to him, to the point that he became anxious and very depressed. He felt humiliated and began to feel that she had married him only for his money. The day after the offense he was to have appeared in court for a custody hearing for their children who occasionally lived with him. He was obviously under intense stress. On the day of the offense his wife had come to his house to take the children to spend one week with her.

DL had a spotty, unclear memory of what took place on the day of the offense at his home and thereafter. In his difficult recollection of the events, he claimed that his wife entered the house and when he turned to look at her she was standing with her gym-suit pants pulled down to her knees and brandishing a hammer. After that bizarre recollection, he vaguely recalled that he found himself swinging a baseball bat in self-defense and hitting the hammer that she was directing at him. He didn't remember anything else about the offense except for driving towards Chicago with his children and being somewhat confused about directions, even though it was a trip he took every day to go to work.

He did not remember eating with the children, as stated in the police report, but he vaguely remembered that they had asked him for food. He did not remember having placed his wife in a garbage can, putting her in his truck, and taking her to his storage place where she was later found.

DL's loss of memory was consistent throughout the author's examinations of him, as was reported by another examiner in her extensive report of her interview of him, and was also noted in the police reports. The police documentation stated that two hours into questioning he seemingly remembered that his wife had come to his house and that she was holding a hammer and he was swinging a baseball bat. The police investigation revealed that after struggling with his wife in the living room of his house he probably hit her with a baseball bat, tied and gagged her and placed her in the trunk of his small truck. Then, as he stated to the author, he put his two children in the truck and drove to Chicago to his place of work. From the report it seems that his memory had numerous lacunae but on his way to Chicago he stopped to have lunch with his children, stopped by a girlfriend's house, where he left the children, and then at the storage place, where he placed his wife in some type of garbage container and left. Fortunately, his wife was able to untie herself and use her cell phone to call a boyfriend who called the police who rescued her. DL was arrested while entering his place of work.

Throughout the examinations DL was amnesic for the events that took place in the household except for repeating the unclear statements reported above. He was otherwise well oriented as to time, place and person. He stated that he had never been mentally ill with the exception of a depression after the divorce that required antidepressants and in the month preceding the crime. There was no indication of psychotic thinking or behavior during the examination. He claimed that the whole event must have been the result of a raptus.

Forensic Psychiatric Opinion: It was the author's forensic psychiatric opinion to a reasonable degree of medical certainty that at the time of the offense with which he was charged, because his Passive-Aggressive Personality Disorder with depressive traits had decompensated under stress into a Dissociative Confusional Reaction (partial dissociative amnesia), DL did not possess substantial mental capacity to appreciate the nature, quality and consequences of his actions and conform to the requirements of the law. In other words, he was legally insane.

From a forensic point of view, the analysis of the crime dynamics, the crime genesis, and the psychodynamics of the crime was useful in the reconstruction of the offender's psychopathological state of mind at the time of the crimes (attempted homicide, kidnapping, interfering with child custody). There was a direct nexus of causality between the psychopathological state of mind of the offender and the crime committed. The MMPI-2 excluded any malingering.

Commentary: This case seems to be a typical psychotic decompensation of a passive-aggressive personality-disordered individual under severe stress.
Fear of losing his children, humiliation, and anger were probably the decompensating factors. DL himself conjectured that his behavior at the time was automatic and due to his inability to use good judgment because of the intense stress

of fear of losing his children. He was not using drugs or alcohol. His psychogenic amnesia for the events continued during his incarceration.

Psychogenic amnesia, total or partial, refers to memory failure secondary to stressful emotional experiences that cause a person to remember only certain events. In other words, because of intense stress the individual is unable to register permanently some events that take place. In a dissociative state, (in DL's case perhaps also on the basis of a PTSD situation with his estranged wife) the individual is capable of complex sequences of purposeful and goal-directed behavior. It is more common in persons who are emotionally immature, self centered and dependent. The diagnosis of psychogenic amnesia is looked upon at times, especially in legal settings, with a certain amount of skepticism.

DL was sentenced to ten years in prison after the court refused his defense of diminished criminal responsibility on the basis of a brief psychotic episode with amnesia. As of this writing, he is appealing the court decision and attempting to undergo hypnosis and narcoanalysis to see if he can recover his memory of the event.

7.11. Depressive Personality Disorder

Persons with a Depressive Personality Disorder show life-long traits along the depressive spectrum. They are pessimistic, anhedonic, self-doubting and chronically unhappy (Kaplan et al., 1994). Nevertheless, they are duty-bound. They fear disapproval, tend to suffer in silence and to cry easily. Among the other traits of those with a Depressive Personality Disorder are conscientiousness, a tendency to brood and to be preoccupied with negative events. They are self-critical and derogatory. Under stress they become dysthymic and may move into a major depressive disorder. At times they may be involved in serious felonies, including family mass murder.

7.12. Histrionic Personality Disorder

Those who suffer from a Histrionic Personality Disorder exhibit colorful, extroverted and dramatic behavior and are emotional and excitable. They seek attention and tend to exaggerate their thoughts and their feelings. They show mood changes, temper tantrums and persist in wanting to be at the center of attention. Their behavior is flirtatious and seductive. Sexually, they may act on impulse to reassure themselves that they are attractive. They are mostly unaware of their

feelings and unable to explain their motivations. Under stress their reality testing easily becomes impaired and they may have problems with the law.

7.13. Case Study Reflections Based on Object Relations Theory

Persons suffering from severe personality disorders share among themselves some of their symptomatology as well as some of the unconscious factors at the basis of their occasional destructive psychotic behaviors. They are demanding and grandiose, and they have a diminished capacity for empathy. They are manipulative, emotionally unstable, often ambivalent, depressed, fearful of being annihilated, feel imaginary threats for which at times they tend to blame the entire world. This array of symptoms is part of an underlying chaotic inner world, caused by traumatic experiences, abuse or neglect, to which they often tend to react aggressively and even with psychotic violence.

Many theories have attempted to explain the reasons behind human aggression and violence and the factors are multiple: biological, sociological, and psychological. Psychoanalytic theories, especially Freudian theories, have explained aggression as instinctive and as a reaction to lowered self-esteem, humiliation, or displacement or psychotic rage. Aggression can be reactive or predatory.

More specifically, in Freud's theoretical perspective, aggression is first viewed as a reaction to the blocking or thwarting of libidinal impulses. Later, Freud (1961), in addition to the life instinct (*eros*) proposed the existence of a second major instinct, the death instinct (*thanatos*). He proposed that human behavior derives from the interplay and constant tension between the two instincts; and that aggression against others redirected the destructive death instincts outwardly (Kaplan et al., 1994). Albert Bandura (1973) viewed aggression as a learned behavior that was instigated by specific social or environmental circumstances. Closer to the argument of this thesis, aggression may be the outcome of neuroanatomical and dysfunctional brain structures as will be explained elsewhere.

Object relations theory, a further development of ego psychology, views aggression as having deep roots in the early psychological development of the child, in his early relationship with his primary objects, especially during the first three year of life. During the first year of life, the child sees himself as the center of the world and his primary objects are indistinguishable from himself. As he proceeds in his developmental maturation, the objects become more defined. They become holding, cuddling, and nourishing figures, and the child will perceive them (especially the mother) as good objects or bad objects. Later, fearing the reaction of the bad object and her retaliation for the child's anger and dissatisfaction with her, the child keeps the good and bad objects separate from one another. This splitting is a defensive maneuver that will not permit the bad object to destroy the good one. It

is at this time that feelings of fear, guilt, anger and aggressiveness develop in the child.

Within the first two years of life, if the child is unable to progress in his developmental maturation due to neglect or abuse by parental objects, he will be unable to join the good and bad qualities of a single object, for example the mother, viewing her as a good person but with some bad qualities, and will continue to live in a temporary fantasy world, trying to avoid the world of reality where traumatic situations exist, situations that stunt his normal inner growth and create a structurally-abnormal, psychotic personality organization.

Winnicott's (1953) belief was that the child does not need a perfect mother but a 'good enough' mother in order to make a successful transition from internal objects to external ones. Horney (1945) believed that the infant/child needs to feel secure, loved, protected and emotionally nourished. She also thought that the personality is shaped primarily by the environment and that childhood relationships strongly contribute to its development and functioning.

Eduardo Weiss (1960), an ego psychologist, asserted that the child slowly learns how to renounce immediate gratification of destructive aggressive drives and antisocial impulses because this renunciation is constantly rewarded by 'approval and love from his parents and from persons who rear him and because he anticipates punishment and rejection if he yields to wishes that are forbidden' (pp. 76-77). It is then that the child gradually substitutes the reality principle for the pleasure principle.

An analysis of some of the case studies presented in this thesis in accordance with object relations theory could show, for example in the case of JD, the serial killer, that with the absolute control he exerted over his victims he obtained object permanence, since he killed them, and thus the objects—his victims—could not run from him as he perceived his primary objects having done (mother and father). One could also opine that he objectified his victims, killing and dismembering them, because he was terrified of being humiliated or abandoned by them, as his primary objects had done. His aggressivity, in addition to having a cathartic component, was certainly destructive of the primary objects that he remembered as 'bad objects.' He experienced external objects as omnipotent and he feared being attacked by these once potent cruel objects. At the same time, identification with the cruel objects gave him a sense of power, freedom from fear, and the belief that aggression was the only way he could deal with a potentially cruel world. Seeing the good object (mother) as weak, his identification with what he felt or experienced as parental aggression reinforced his identification with bad objects and his belief that, as Kernberg stated (1984), 'only his own power (was) reliable, and that the pleasure of sadistic control (was) the only alternative to the suffering and destruction of the weak' (p. 83). Thus, as a malignant narcissist, JD gratified himself while ignoring others as persons.

In the case of LC, one can see a basic immature and dysfunctional young man, with a mixture of narcissistic and paranoid schizoid features, who avoided contact with others and lived in an unrealistic fantasy world. He had irrational plans to abduct and rear children from age two to age six. He certainly was projecting, without realizing it, the abandonment by his mother and his neglected needs during that period, which he synthesized when he stated, 'My (adoptive) mother was demanding and unloving, and my (adoptive) father was distant and quasi-absent.' By avoiding contact with the world of his peers he did not upset the fragile organization of his pre-psychotic self. He taunted and challenged authority figures and he would have liked to challenge and taunt his own primary objects. He internalized the good object to support his grandiose self-concept and externalized, projected and displaced the bad, rejecting object on the two children he killed. His murders were also murders of revenge against his primary objects and an expression of the anger against them that he had kept inside of himself for so many years.

Parents are generally the primary objects, especially the mother. She is the first agent of socialization for the child. It is generally through the mother that the infant/child obtains the answers to his inquisitive questions—answers that will help to shape his life. It is through his contact with her that he begins to appreciate what love is and how loveable he himself is, how independent he can be, or even what abuse and neglect feel like. Both JD and LC showed an obsession with the self, a relentless pursuit of gratification and dominance typical of the narcissistic personalities.

EL showed a long history of poor personal adjustment to society and family and a schizoid-depressive solution to her basic psychopathology. In her psychotic personality organization, which eventually led her to the abrupt killing of her eight-year-old son and the attempt to kill her nine-year-old son immediately afterwards, she was certainly in the throes of a profound identity disturbance, ambivalence, affective instability, uncontained rage and transient paranoia, typical of the borderline-depressed psychotic individual. In her, violence displacement and magical thinking were contributory: 'They will be better off with God than in this world where they will never be able to have a good and satisfactory life.' Murdering her children made EL feel omnipotent and, at the same time, allowed her to make a statement towards the bad object (mother), displaced onto her husband and then killing her children in a further displacement of her anger. She rationalized and intellectualized the murders by stating that she intended to liberate her sons/victims from a future worse than death.

In the case of GR one sees a person with a narcissistic personality organization who develops the conviction that someone with whom he is in contact is 'cheating him, betraying him in some way, artificially attempting to provoke him or make him suffer, or obtaining sadistic pleasure from manipulating him in various ways' (Kernberg, 1984, p. 199).

In this case, this narcissistic paranoid struggled with feelings of dishonesty in himself. The conviction of being sadistically provoked by the other person's 'badness' gradually increased through their contacts, which eventually led to violent acting out.

Meissner (1988) believed that the paranoid patient assumes the stance of a victim, 'while the aggressive, destructive and sadistic elements are projected to the outside '(p. 384). He thought that the constant complaint of the paranoid is that he is a helpless victim and that he may reinterpret reality, events, and circumstances to prove his point. His environment is felt to be hostile; he feels excluded. At times, the feeling of victimization is strongly visible in the Rorshach test. As stated by Meissner, the paranoid shows a narcissistic superiority, a compensation for his long-standing sense of inferiority and victimization—a victimization by his father and his mother—parents whose attention he longs for but whose behavior was often sadistic and cruel, and certainly not supportive.

Meissner (1984) argued that 'introjects…form the core elements of the self' (p. 446) and that they are organized 'along two primary dimensions, the narcissistic and the aggressive' (p. 446). He termed the two variables 'aggressor-introject' and 'victim-introject.' The narcissistic-introject can lead to feelings of superiority or inferiority, while the aggressive-introject is 'hateful, evil, powerful and yet weaker and helpless' (p. 446). (See the case of GP.)

From a neurobiological point of view, aggression could be explained as a top-down lack of control: amygdaloid aggressive impulses had lost the control of a possibly dysfunctional orbito-frontal cortex (OFC). Recent neuroimaging studies show anatomical and functional similarities of some brain areas between patients suffering from psychosis (Schizophrenia, Paranoid Psychosis and Bipolar Illness) and patients with severe personality disorders. These areas include the frontal lobes, temporal lobes, the limbic system, and the amygdala formation. The findings are supportive of the pre-psychotic and psychotic personality organization that has been well pointed out not only by clinical observation but also by numerous research studies.

Often aggression against the other is due to primitive hatred. A common defense against the awareness of such hatred is the destruction of the other. The acting out is facilitated by projective identification and at times the aggressor may be in a fragmented cognitive state. As Kernberg wrote, the person's mind can no longer 'contain the awareness of a dominant emotion' (1992, p. 212). The object (the victim) is seen as a persecutor and the aggressor becomes intolerant and paranoid. At this time, the aggressor fears losing his love object by his own destructiveness and he is also afraid that the bad object (the bad mother) will annihilate him. Further, his fear of the other—the frustrating and hated object—is transformed into a powerful dangerous enemy which has to be destroyed.

7.14. Summary

In this chapter, impulsivity and aggression, with their characteristics of antisocial and disruptive behavior are discussed. In furthering an analytical inquiry into the aggressive antisocial behaviors of individuals suffering from personality disorders, psychoanalytical thoughts pertinent to the topic of discussion are presented, including those of Sigmund Freud, Carl Jung, Carl Menninger, Russell Monroe, and others.

In discussing the personality disorders, it is pointed out that the *DSM-IV* classification of personality disorders under Axis I is at present controversial and problematic for diagnostic reliability. Indeed, the most severe personality disorders (Borderline, Paranoid, Schizoid, Schizotypal and Antisocial) could easily qualify for Axis I classification as precursors of full-blown psychotic entities. For instance, Schizotypal or Schizoid Personality Disorders, if included in Axis I, could be classified as an early stage of schizophrenia or dysthymias.

The various personality disorders are summarized, with their chronic maladaptive behavior, and illustrative case studies of some of the disorders were presented. The case studies, taken from the author's forensic psychiatric experience, support the argument of this thesis: that, under severe stress, persons suffering from personality disorders may move into brief psychotic thinking and behaviors, during which they may commit a criminal act, following which, over a period of hours, days or weeks, they may reintegrate into their previous non-psychotic personality disorder. An interpretive analysis of some of the case studies presented is based on object relations theory.

In this chapter, diminished capacity and diminished responsibility are also discussed. The reader is reminded that mental capacity to commit a crime is not an all-or-none, black-and-white, phenomenon. There is an infinite and graduated spectrum of legal responsibility that goes from complete irresponsibility to various grades of diminished responsibility, to full responsibility. Diminished responsibility means that the mental state of an offender, because of a mental disorder, does not reach the level of an insanity defense but that there is substantial evidence that at the time of an alleged crime an offender was *laboring under a severe impairment of the mind* that diminished both his cognitive and decisional capacity. Case law decisions are presented throughout this thesis in support of the above. A plea of diminished responsibility should be allowed in those criminal cases perpetrated by offenders suffering from severe personality disorders who, under internal or external stress, were irrational at the time of an alleged crime and who are able to support their plea with pertinent evidence in that regard.

The description of the criminal forensic assessment briefly illustrated the way in which an insanity defense examination is carried out. Special attention was paid to

the possibility of malingering and of the offender's thinking and behavior that could support diminished responsibility.

The cases presented were adjudicated during the post-Hinckley period. Whereas prior to that period the prosecution had to prove that a defendant who pleaded not guilty by reason of insanity was legally sane at the time of a crime, the post-Hinckley reform legislation shifted the burden of proof to the defendant, who must prove with clear and convincing evidence that he was legally insane.The volitional prong was excluded. Because of the adversarial system in the United States judicial system, however, the prosecutor is still allowed to present his case that the offender was legally sane.

The Hinckley trial aftermath suggests that the insanity defense construct was primarily based on political decisions. The defense is a set of legal-psychiatric procedures used to establish the culpability of offenders who, when found not criminally responsible for their action at the time of an offense, rather than being directed to the criminal justice system, are mandated to a forensic mental health system for an indeterminate period of observation and treatment. The insanity construct may change due to the political perception of the degree of retributive justice and its shortcomings, societal concerns and fears about crime, and even, at times, public outrage. The case of M'Naghten (1843) in England and that of John Hinckley (1982) in the United States testify to that. The first led to the strictness of the M'Naghten Rule (right/wrong test) and the second to the rigid Federal Insanity Defense Reform Act of 1984.

In response to crime, the moral climate of society fluctuates throughout the years from complete blameworthiness to a more humane approach towards offenders. The legal standards of society regarding insanity also vary, depending on scientific and psychological/psychiatric progress, and on its view of the type of punishment that should be meted out to an offender, which may range from almost total isolation in prison to humanistic methods of rehabilitation. Prior to the Federal Insanity Defense Reform Act of 1984, during a period of revision and liberalization of criminal responsibility assessments, in addition to the well-known M'Naghten Rule, various legal codes made their appearance on the United States judicial panorama. The M'Naghten Rule asserts that an offender is not criminally responsible if, at the time of an offense, he did not know the nature of the act or its wrongfulness.

In 1954, a broader, medically-based determination of insanity, the Durham rule, was adopted by the Federal Court of Appeals for the District of Columbia (Durham v. U.S., 1954). In the decision, Presiding Judge David Bazelon basically stated that a defendant is not responsible for his criminal act if the act was the product of a mental disease or defect, without any requirement to assess the mental state of an offender at the time of an offense. This was a change from the previous moral considerations and was considered a more neutral determination of responsibility,

giving importance to advances in psychiatric and psychological research and breaking away from the 'right/wrong' test of the M'Naghten Rule.

Later it was found that the new rule was difficult to apply, and people feared that it would lead to the exoneration of more offenders than previously. There was confusion over the term mental disease or defect and whether it referred only to psychosis or also to other less serious disorders found in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), such as general antisocial behaviors. It was feared that psychiatrists and psychologists were wielding too much influence in the courtroom. Eventually, 22 states rejected the Durham test.

In 1962, the American Law Institute Model Penal Code Test (ALI test) was adopted. The ALI test is a broader test than the M'Naghten Rule. It states out that the individual offender should have substantial (not total) mental capacity to distinguish right from wrong and, in a second prong includes the volitional capacity, meaning that the individual could not resist the impulse to offend and, therefore, could not conform to the requirements of the law.

Following the adoption of the Durham Test, there had been a liberalization of decisions regarding criminal responsibility pleas, as well as increasing rulings against an indefinite commitment of insanity acquitees to a forensic psychiatric hospital. Various sentences, such as Bolton v. Harris (1968), Wilson v. State (1972), People v. McQuillan (1974), and State v. Krol (1975), militated in favor of equal protection of insanity acquittees and found the policy of automatic indefinite commitment of such acquittees unconstitutional. They called for periodic reviews of defendant's mental condition with particular emphasis on dangerousness.

The 1960s and the 1970s were a period of unrest for the United States Civil Rights Movement, and it extended to mentally ill offenders. At the time of the mental health advocacy movement, during which all three insanity tests were used depending on the jurisdiction, all classes of mentally ill defendants benefited from procedural protection and very frequently their mental condition was seen as exculpatory or mitigating at sentencing. By the end of the 1970s, most states had incorporated new procedures and courts were functioning in a more lenient and understanding way towards mentally ill offenders. Cases including People v. Wells (1949), People v. Gorshen (1959), and People v. Wolff (1977), involving specific intent, considered an offender's defense based on reported psychopathology, at times without recurring to a not guilty by reason of insanity plea. Regarding the axiom that there cannot be a criminal offense without the act being voluntary, cases such as Bass v. Aetna Insurance Company (1979) and Bizup v. People (1962) supported the test of irresistible impulse.

In addition to the above, the jurisprudence system and the courts attempted to recognize as appropriate for a defense of insanity automatism, homosexual panic, hypnotic suggestion, and inconsistent personality. (See e.g., People v. Jones, 1954; State v. Cavallo; U.S. v. MacDonald (Slovenko, 1997).

Following the Federal Insanity Defense Reform Act of 1984, more than 30 states changed their insanity defense statutes, returning to the more restrictive M'Naghten Rule. The burden of proof of insanity from that time on rested with the offender and the volitional prong of the ALI test was abolished. In addition, some states enacted laws that called for more restrictive confinement for persons found to be not guilty by reason of insanity, and three states, Idaho, Montana, and Utah, abolished the insanity defense. Some states introduced a 'guilty but mentally ill' verdict. Although the offender is considered to be legally guilty, the fact that he has been found to be mentally ill means that he is entitled to receive treatment for his illness while institutionalized. If his condition improves, however, he must serve the rest of his sentence in a correctional institution. This differs from the case of an offender who has been found to be not guilty by reason of insanity who must be released once found to be no longer dangerous to self or others.

In the period post-Hinckley, a successful insanity plea became much more difficult, especially for persons who are not diagnosed as mentally ill (suffering from Schizophrenia, Bipolar Disorder, Delusional Disorder, Schizotypal Disorder). These individuals, as stated elsewhere in this thesis, mostly classified as suffering with severe personality disorders, when under severe inner or outer stress, may decompensate and undergo a brief psychotic episode lasting from a few minutes to a month or more followed by total mental reintegration. During that brief period of irrational behavior, they may commit crimes for which they are not responsible. Unfortunately, once they reintegrate they are not looked upon as having been *bona fide* mentally ill offenders at the time of the crime. This is so even when there is supporting evidence from police, witnesses, psychiatrists and psychologists, and even from the victims themselves. Neuroimaging studies of the brain which could provide additional exculpatory evidence in these cases are frequently not admitted. The purpose of this thesis is to support changes in the insanity plea, especially for these people suffering form severe personality disorders. It argues for several changes that should be made in the way the United States judicial system approaches the problem of insanity.These changes, listed below, would accord with those in other countries.

First, the prerequisite of strict mental illness should be changed to a *state of mind* during which the individual did not possess substantial mental capacity to appreciate the nature, quality and consequences of his actions and to conform to the requirements of the law. Second, it should accept the premise that any individual under extreme stress may break down and become irrational and not responsible for his acting-out conduct. The *DSM-IV* (2000) includes an entity that describes exactly such sudden psychotic behavior. Third, any change should include personality-disordered offenders, persons more predisposed to such psychotic breakdowns, as candidates for a non-responsibility plea, without prejudice. These changes not only would be a sensible recognition of current scientific knowledge but a humane

approach to the mentally disordered offender. They would also be in accordance with justice and due process of law.

Once these offenders are found not guilty by reason of mental illness, they should be mandated to a forensic psychiatric hospital for treatment. As their treatment progresses and they are found by mental health professionals not to be a risk for dangerousness and recidivism they can be tried on extended periods of probation in the community or with the family. It was previously noted that this type of program is present in the Netherlands and the results have been quite positive.

The American public is less receptive to a not guilty by reason of insanity verdict because they fear that the length of confinement may be very short and when the offender is released from the institution he can expect to regain all his rights as a citizen. That is because, technically, he has not committed a crime. This has not been the experience of the author, however, since, with rare exceptions, the offenders with whom he has had contact spend more time in forensic psychiatric hospital than they would have spent in a correctional institution had they been directed to the general prison system.

Chapter 8. Conclusion

Persons diagnosed with a severe personality disorder may, under severe stress due to external or internal stimuli, become irrational or psychotic. During these relatively brief psychotic episodes, at times they commit crimes, even serious ones. In the United States, following the John Hinckley trial and the Federal Insanity Defense Reform Act of 1984, individuals suffering from severe personality disorders who went through such a psychotic decompensation are strongly discouraged from, or even flatly precluded from, the possibility of, entering a plea of legal non-responsibility or diminished responsibility, and, in those rare cases where such a plea is entered, the courts do not recognize a diagnosis of a brief psychotic episode as evidence of justification of legal insanity at the time of the crime. The argument this thesis has made, articulated in various sections supporting it, is that those severe personality-disordered offenders who were suffering from a mental decompensation at the time of an alleged crime should be allowed in all cases to enter a plea of non-responsibility and to present exculpatory evidence, as was possible prior to the Federal Insanity Defense Reform Act of 1984. Any exculpatory evidence presented should be assessed without prejudice and in the light of present-day scientific knowledge and the due process of law.

Following the introduction, in Chapter One, the purpose of the thesis is clearly set forth and a description of the methodology used, a brief note on the cases studies presented, and a concise prospectus of the argumentation employed were given. A discussion of pre-and post-Hinckley case law in the United States was made and several cases pertinent to the argument of this thesis were presented. The reader was able to appreciate the difference in case law decisions in the two periods. The case of John Hinckley, Jr., the man who attempted to assassinate President Ronald Reagan in 1981, is reminiscent of the case of Daniel M'Naghten who, in 1843, attempted to assassinate British Prime Minister Howard Peel, in that both attempts failed and both brought about changes in criminal law, specifically that regarding mental disease and crime.

In the years prior to the Hinckley case, the United States legal system was more open to, and gave more credence to, the idea that offenders suffering from personality disorders may have been acting antisocially due to psychopathological factors. That often led to a verdict of diminished responsibility or non-responsibility. Following the Hinckley case, the American legal system became stricter in regard to mental illness as a justification for criminal acts, significantly modifying the

standards for insanity previously applied in the Federal courts, standards that were upheld by the State courts.

The Federal Insanity Defense Reform Act of 1984 limited the insanity defense to people suffering from mental illness (Schizophrenia, Bipolar Disorder, Delusional Disorder) who lacked the mental capacity to distinguish right from wrong and to be aware of the wrongfulness of their actions at the time of a crime. The volitional prong was dropped and persons suffering from personality disorder were excluded from pleading the insanity defense. A similar thing had occurred at the time of the M'Naghten case from which the M'Naghten Rule derived.[8]

Following the Federal Insanity Defense Reform Act of 1984 many attorneys for the defense did not even attempt to enter a legal insanity plea for severe personality-disordered offenders, certain that such a plea would be rejected a priori by the court. This is not what due process of law should be. Due process affirms that, on the basis of the collected evidence, *anyone* who at the time of a crime was insane or whose mental capacity was greatly impaired has the right to present evidence to that effect in a court of law, and the case should be decided on the facts and without prejudice. Such a possibility is, at present, ignored or not accepted for personality-disordered offenders.

Chapter Two included a meticulous excursus describing the normal personality and aggression. Particular regard was given to the role that character, instincts, drives, emotions, and impulsive aggressivity play in forming normal and abnormal behavior. Biological, psychodynamic, and object-relations theories of aggression were amply reported. The psychotic personality organization from the time of Kraeplin to Kernberg was presented.

A discussion was introduced in Chapter Three of recent neuropsychological testing and of neuroimaging studies (CAT, MRI, fMRI, SPECT, PET) in severe personality disorders. These studies offered support to the argument that brain changes in personality-disordered persons are similar to those found in the major psychoses (Schizophrenia, Major Depression and Delusional Disorder). Because of these reported similarities between the major psychoses and the severe personality disorders, it seems logical to assume that the shared similar cerebral changes (neuropathological and neurophysiological) could account for the proneness to psychotic decompensation at times observed in these persons when under particular stress. That possibility is being taken into consideration, indeed, by the redactors of the next version of the *Diagnostic and Statistical Manual (DSM-V)* and it is possible that the category of personality disorders, Axis II, may be reclassified under Axis I,

[8] In addition to the M'Naghten Rule, other legal codes used in the United States are the Durham rule and the American Law Institute Penal Code. The Durham rule is quite liberal regarding the insanity defense, perhaps too much so, and the ALI re-instituted the volitional and affective role in the defense.

thus viewing the personality disorders as an early onset of Axis I psychosis. For instance, the Paranoid Personality Disorder would be considered an early onset, chronic and milder variant, of a Delusional Disorder (Widiger, 2007). This is strong supporting evidence for the argument of this thesis.

Neuropsychological testing and neuroimaging studies seem to corroborate the author's professional experiences in the clinical forensic assessment of offenders diagnosed with severe personality disorders. In such cases, when scientific evidence exists supporting abnormal brain changes in these miscreants, their crimes should not be looked upon only as the product of free will (decisional capacity) but also as the possible outward manifestations of an underlying neuropsychopathological malfunction of the brain at the time of the crime.

Any individual who commits a crime acts on the basis of his cognitive intent, which remains an intent until he decides to put it into action. There are people, however, who are unable to form intent, as there are people who act without reflecting, like the psychopath. Many of these people are not volitionally free to decide, often due to a dysfunctional frontal lobe and a hyperactive amygdala. This is well pointed out by neuropsychological testing and neuroimaging studies. *Mens rea* exists only when the individual is cognitively intact and *actus reus* only when the will of the individual is free to decide. What is also important in a criminological assessment is 'the determination of the moment when aspects of the disorder became manifest in the situation (the scene of the crime) that eventually led to the perpetration' (van Marle, 2008).

As Raine (2002) aptly stated, 'Brain imaging research on violence and personality disorder, including psychopathy, is troubling to some because it challenges the way we conceptualize crime at present' (p. 73). But philosophers and scientists, from Plato to Kant, from Esquirol to Lombroso, opined that the underlying factors in crime eventually might be found in brain pathology. These scholars seem to have envisioned that which is taking place today in the biological and neuropathological fields.

Chapter Four discussed the various approaches to the insanity defense in the United States. The section on the diminished capacity defense and the relative case law showed that the present-day legal system has no intention to admit such a defense—a defense excluded in 1984 by *vox populi*—a socio-political decision—and not based on scientific findings. The discussion of will and decisional capacity reminded the reader of the fact that any human action is the outcome of the cognitive and decisional capacity of an individual. This also extends to the behavior, by omission or commission, of offenders who are mentally disordered. Therefore, the author strongly supports the reinstatement of the volitional prong, excluded by the Federal Insanity Defense Reform Act 1984, as part of the assessment for legal non-responsibility or diminished responsibility.

Chapter Five, the section on international law, acquainted the reader with the legal changes regarding total or diminished legal responsibility which have taken place in the legal codes of several countries, substituting the strict M'Naghten rule with a new concept for responsibility: mental abnormality, mental impairment, or a psychopathological condition of the mind. A brief comparative analysis between the Dutch and the United States criminal courts' structure and functioning preceded the section on the Netherlands and personality-disordered offenders. The new concept of responsibility empowers those who suffer from a mental disorder or a state of mind that greatly diminishes their capacity to understand and decide (to form intent) to be assessed by the courts in a more objective, thorough and fair manner. This concept could be applied to severe personality-disordered offenders and it would demonstrate real progress in the law, supporting what Raine (2001) aptly stated: 'The history of civilization has shown that as time progresses society becomes more ennobled, wiser, and humane' (p. 52).

To this effect, history is replete with humane progress: society did away with keeping the mentally ill in shackles, and Pinel initiated a more humane approach to their care. In the second half of the twentieth century, society began the process of deinstitutionalization of the mentally ill with great strides in the therapeutic arena. It is just and timely that the laws be changed concerning those offenders who may not have been totally legally responsible for their criminal acts because of their mental condition or their mental impairment while under stress. This would rectify the present legal attitude towards them and would result in more equitable, less retributive punishment, rehabilitative practices, and a better resocialization with less recidivism.

Chapter Six briefly discussed due process of law and juror attitudes toward the insanity defense. It also presented an ample discussion of the *Diagnostic and Statistical Manual*, pointing out its limitation as a textbook of psychiatry as well as various cautionary statements in the manual itself to the effect it would be risky to employ it in the determination of criminal responsibility, because the clinical information it contains, especially regarding the determination of mental impairment, may be misleading and misunderstood by attorneys and judges. In other words, it is insufficient to support a forensic plea of non-responsibility or diminished responsibility in and of itself.

Chapter Seven introduced the various personality disorders and presented a sample of 14 case studies of persons examined by the author as a forensic psychiatric expert. These persons carried a primary diagnosis of severe personality disorder. They underwent a psychotic decompensation prior to and/or during the commission of a crime (murder or other major felonies) from which, after days or weeks, they reintegrated into their previous personalities. With the exception of a few cases, the court did not accept an insanity plea or a plea of diminished capacity on the basis of a malfunctioning or decompensated personality disorder, and even in

those cases in which the offender was allowed to enter such a plea the author's forensic report was rejected and the offender was found guilty of the offense. It should be noted that at trial the offenders had completely reintegrated from their psychotic decompensation.

It has been posited that in the future punishment will be looked upon differently, reconceptualized as the outcome of biological genetic forces, beyond the control of the individual. Raine (2001) and Slobogin (2005) argued that rehabilitation, consistent with present-day scientific knowledge of human behavior should replace the retributive system. This would be a continuation of the psychiatric and legal reforms begun so many years ago: As Esquirol wrote in 1805, persons suffering from a mental disorder are not led to actions by reasoning but by feelings that their conscience abhors and that their will is incapable of repressing (in Marchetti, 1990).

In this thesis it has been put forth that the forensic assessment of offenders needs cautiousness and thoroughness, and that court sentencing should be merciful and just. In the United States courts, the strict concept of legal insanity due to mental illness should be abolished and the concept of *mental abnormality* should replace it, as has been done in other nations. Although being allowed to present evidence of a mental abnormality at trial does not bring about an automatic finding of non-responsibility, offenders have a legal and human right to attempt to prove, by presenting in their defense *all* exculpatory evidence available, including evidence that they may have acted irrationally at the time of the commission of an antisocial act due to a brief psychotic episode. They must have an unprejudicial and objective hearing.

Such changes might positively impact the attitude of jurors toward personality-disordered offenders, which at present is generally negative. The jurors often do not give credence to psychiatric and psychological reports, due to lack of knowledge and understanding of them. In addition, they have a prejudicial attitude towards what they term 'psychobabble.'

Allowing offenders to present possible exculpatory clinical, neuropsychological and neuroimaging findings in their defense occasionally may be perceived as a burden on the legal system, especially at present when plea bargaining has been constitutionally adopted by the courts. But due process and justice for all are not words that should easily be disregarded. They are there to safeguard the legal rights of *all* individuals, and especially the weakest members of society. If those are individuals suffering from a decompensated personality disorder who committed a crime for which they are found not responsible at trial, they should be directed to a forensic psychiatric hospital for proper psychiatric/psychological treatment. Such treatment should be mandatory and aimed at lessening the possibility of recidivism. Incarceration has not proved to be the only answer for these individuals (see the Netherlands experience).

At present, a diagnosis of psychosis is used in the assessment of insanity; but psychosis is a definition that cannot reflect the nuances of psychopathological impairment in the etiology of a disorder of the mind.

Persons suffering from mental disorders should be looked upon as suffering from a dynamic condition, subject to change depending on inner and outer stressful factors. A symptomatological approach to the mental disorder of criminal offenders would better render the assessment of their *mens rea* and *actus reus*. This approach would be more comprehensive and ethical, and more respectful of their human rights. Michael Perlin lamented the 'persistent ambivalence' of the legal system toward developments in dynamic psychiatry and neurodiagnostics. He traced some of the ambivalence to what he calls 'a culture of punishment flowing from the medievalist conception of sin and evil' and located the source of the 'procedural shrinkage of the insanity defense' ' in nothing less than a societal fear of and ambivalence toward dynamic psychiatry' (Robinson, 1996, p. 244, quoting Perlin, 1989-1990).

What really counts in reaching a verdict in the court trial of a mentally-disordered individual, and what should basically be taken into consideration, is the individual's mental capacity to appreciate or to not appreciate his behavior, and his capacity or incapacity to make a choice and to conform to the requirements of the law at the time of a crime. It is hoped that therapeutic jurisprudence will continue to influence policies and procedures in the legal system, making it more knowledgeable and just, and, in so doing, promoting the psychological and physical well-being of all those persons who are the center of its concern.

From a deductive reasoned judgment of the material incorporated in this thesis there appears to be no psychological, psychiatric, or legal reason why severe personality disordered-offenders should be precluded from entering a plea of not guilty by reason of insanity or a plea of non-responsibility to a criminal offense committed during a brief psychotic break. On the basis of the author's psychiatric forensic experience and the review of national and international literature, he strongly suggests that the United States judicial system reassess and amend its present approach, which is basically due to socio-political factors, to individual offenders who are suffering from a severe personality disorder. The best approach for non-responsibility pleas, as stated before, would be to adopt a more inclusive and flexible formulation with less specific terminology, such as *disease of the mind, abnormality of the mind, or impairment of the mind*, an approach similar to that found in the Dutch system, which reportedly is highly successful. In a trial of law fairness and justice, not just the application of sometimes questionable, outdated rules of law should be central. This is of the utmost importance in the honest determination of legal responsibility.

It is important to conclude by reiterating that the limitations to the insanity plea for personality-disordered offenders of the Federal Insanity Reform Act of 1984

were based on socio-political reasons as a direct consequence of the attempted assassination of then-President Ronald in 1981, just as the M'Naghten Rule followed the attempted assassination of the English prime mister Robert Peel and the killing of his private secretary. This should be rectified.

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Summary

A small percentage of those who break the law suffer from a severe mental disorder, which, if present at the time of a crime, may annul or greatly diminish their mental capacity to appreciate the nature, quality and consequences of their criminal behavior or their capacity to conform to the requirements of the law.These persons are allowed by the law to enter an exculpatory plea and to attempt to prove at trial that they were legally insane at the time of an alleged offense.

In *chapter one* the basic proposition is that there is a substantial cohort of persons who suffer from a severe personality disorder for whom entering a plea of not guilty by reason of insanity in United States courts at present is typically a futile exercise, even though their behavior at the time of their alleged crime was bizarre, confused and irrational. The futility of their plea stems from the practical reality that their disorder is not recognized as a mental illness. They cannot take advantage of the insanity plea because of the prevailing legal view that they cannot meet its threshold criterion. Even if they were in a court of law that would allow them to surmount that hurdle, they would still be subjected to exceptionally strict scrutiny. It is the argument of this thesis that in regard to individuals suffering from a severe personality disorder in the United States the criminal law operates if not from unfounded prejudice certainly from a foundation that disregards current scientific knowledge.

In the United States, prior to the John Hinckley case and the subsequent Federal Insanity Reform Act of 1984 (which excluded personality disorders and the volitional capacity prong from the insanity test) offenders suffering from severe personality disorders were not restricted in their presentation in a court of law of an insanity plea if supported by irrational behavior at the time of a crime. Case law studies are presented to corroborate the above as well as to place into evidence the deliberations of pertinent courts decisions since 1984. The restriction of the insanity defense for severely mentally-disordered persons since 1984 is contrary to Due Process of Law as pointed out in a subsequent discussion.

The premise underlying this argument is that persons with a severe personality disorder (many of whom are capable of only marginal functioning in daily life),

under severe stress may, at times, undergo a personality disintegration that is tantamount to a frank psychotic episode, which should make them eligible for an insanity plea. However, United States courts, including the United States Supreme Court, have held explicitly that criminal defendants have no due process right to how the insanity defense is framed or worded, what sorts of conditions it may cover or exclude, or even whether they may have the benefit of an insanity defense at all—or any number of other exculpatory concepts. Elementary fairness suggests they ought to be allowed to assert their non-accountability in the context of an insanity defense or any other defense. Of course, it is well known that offenders at times attempt to malinger mental disorders, or to greatly exaggerate any existing mental pathology. That is a risk that is run with any offender. However, it is better to free ten guilty people than to convict one innocent one. It serves as the justification for requiring, that is, an extraordinarily high standard of proof (beyond a reasonable doubt) in criminal prosecutions.

In *chapter two,*personality and aggression, a descriptive analysis of basic instincts and emotions and their interplay in the development of both a mature, stable personality and a disordered personality is offered. Instincts are the natural propensity of an individual to behave in a certain way in order to achieve anticipated aims. Emotions, viewed as the *primum movens* of all human interactions, are defined as a psychic and physical reaction (e.g., anger and fear) experienced as strong feelings and a physiological preparation to immediate reaction, such as in the expression of love or the fight or flight reactions. They can be positive or negative, and they can be intense, as for example in hatred or violence. Character, the composite of distinctive qualities, both mental and emotional, expresses a person's dynamism in his interpersonal relationships.

Reference is made to the many scholars who studied the interplay of emotions, affect, mood and impulsive aggression. They include René Descartes, Henri Bergson, William James, Sigmund Freud. Anger, hostility and aggressive violence are described as progressive manifestations of negative feelings, as well described in the dyscontrol syndrome of Karl Menniger and in the limbic syndrome of Russell Monroe. Further, the object-relation theory of aggression is briefly presented. The theories of the psychological development of the infant of Heinz Kohut, Margaret Mahler, Melanie Klein, Edith Jacobson, Otto Kernberg and Donald Winnicott are viewed as shedding light on adult aggressive behavior. Indeed, through the process of individuation and the tendency of the child to achieve self-esteem and intrapsychic autonomy, because of a poor relationship with his mother he may develop early paranoid anxiety and cognitive distortions. This is of paramount importance in the child's future relationships as an adult and it may play into his later experience of feelings of rejection, hatred, love, aggression and violence.

Object relations theory emphasizes the gradual differentiation of the self through the reflective experiences that the infant/child has with his primary objects (mother and mother substitutes). This is done because the proper resolution of the child's inner feelings towards his introjected bad and good imagoes is pivotal to his proper development and its improper resolution could have negative consequences in his adult relationships. Subsequently, the five stages of Otto Kernberg's model of Self and Object development are reported and the stages of undifferentiation, differentiation, understanding of self and other, and the formation of Ego, Superego and Id structures are briefly discussed. The neurotic, borderline and psychotic personality organizations and the defensive mechanism of splitting are briefly touched upon. Special mention is made of reality testing.

Kernberg (1992) postulated that the infant's affective memories of earlier experiences are stored in the limbic system of the brain.These memories may be reactivated in specific relationships. At times, when under stress, the dynamic unconscious and primitive pathological complexes erupt into consciousness in persons with severe personality disorders, as well as in those with a psychosis. Kernberg's idea of pathological narcissism is frequent among psychopaths and serial killers. It derives from the chronic pursuit of personal gratification present in infants.

The section on philosophical notes briefly acquaints the reader with the ideas of Plato regarding the importance of an individual's character formation in his moral life and his deliberative capacity. A reference to Plato is important because already in the 4th century BCE, he believed that no one wishes to be bad, but becomes so because of an unwanted physical and mental predisposition. This idea supports the argument of this thesis. A reference to Immanuel Kant's description of the various dementias is introduced because Kant believed that the state of mind of the demented person who lacks understanding and judgment is probably due to hereditary or endogenic factors. Mention is made of Arthur Schopenhauer, who believed that if a person's cognitive functions are sufficiently disturbed the will is not free in its choices.An offender with such a dysfunction, he thought, should not be punished and he upheld partial criminal responsibility in such cases.This is the basic argument of this thesis.

In discussing the personality disorders, it is pointed out that the *DSM-IV* classification of personality disorders under Axis I is, at present, controversial and problematic for diagnostic reliability. Indeed, the most severe personality disorders (borderline, paranoid, schizoid, schizotypal and antisocial) could easily qualify for Axis I classification as precursors of full-blown psychotic entities. For instance, Schizotypal or Schizoid Personality Disorders, if included in Axis I, could be classified as an early stage of schizophrenia or dysthymias. It is possible that the category of personality disorders, Axis II, may be reclassified under Axis I, thus viewing the personality disorders as an early onset of Axis I psychosis.

The various personality disorders are summarized, with their chronic maladaptive behavior, and illustrative case studies of some of the disorders were presented. The case studies, taken from the author's forensic psychiatric experience, support the argument of this thesis: that, under severe stress, persons suffering from personality disorders may move into brief psychotic thinking and behaviors, during which they may commit a criminal act, following which, over a period of hours, days or weeks, they may reintegrate into their previous non-psychotic personality disorder. An interpretive analysis of some of the case studies presented is made based on object relations theory.

Chapter three shows that neuroimaging techniques have given further supporting objective evidence that pathological brain structures and their dysfunction in the various mental disorders may contribute to mental impairment leading to abnormal behavior and even crime. These fast-evolving techniques (CAT, fMRI, sMRI, PET, SPECT) are continuously improving our understanding of the neurobiology of psychiatric disorders. This chapter discusses the above.

At present, scientists have found that disturbances of thinking and conduct have specific brain structural and functional correlates. Obviously, that does not imply that brain physiopathological correlates, evidence supported by neuroimaging, are the only determining factors of human behavior. It is, indeed, the interaction between the underlying cerebral dysfunctions and the biopsychosocial factors that determine the abnormalities of mind and those behaviors that constitute what are called mental disorders. Functional neuroimaging, by pointing out specific abnormalities in regions of the human brain has led to better diagnoses and more appropriate treatment in psychiatry. It is one piece of good evidence the expert should rely on in determining the extent of neuropathology.

Emerging neuroimaging data (fMRI), for example, can identify specific neural biomarkers that may help distinguish patients with bipolar disorders from those with unipolar disorders as well as determine which treatment is best suited to a patient. Such neuroimaging may also have the potential to 'identify correlates of illness which are subclinical, perhaps preceding the onset of clinical symptoms or persisting after an apparent remission' (Fu & McGuire, 1999, p. 1366).

In this thesis, the author proposes that the underlying structural and functional brain similarities in psychotics and in severe personality-disordered persons evidenced by neuroimaging techniques should add credence to the fact that the latter are suffering from a latent prepsychotic condition that under severe stress decompensates temporarily into clear psychotic behavior. Those severe personality-disordered people are frequently the offenders in felonies and serious misdemeanors on whom the courts have to pass judgment on responsibility. As Raine (1999) wrote,

'Responsibility and self-reflection are not disembodied, ethereal processes but are firmly rooted in the brain' (p. 8).

Functional neuroimaging has clearly pointed out that irrational aggressive behavior is often the outcome of a top-down dysfunction of the brain in which, for example, the frontal cortex loses its control on lower structures, such as the amygdala. These techniques, fairly well established in psychiatry, will eventually have to pass a reliability standard, such as in Frey and Daubert, before they become exculpatory or mitigating evidence at trial.[9] It is assumed that, because of that, modern neuroscience will change the way in which the law views and assesses criminal offenders. It would be unfair, indeed, to persist in blaming and punishing individuals who lack substantial capacity for rational behavior or substantial control over their behavior at the time of an offense. The possibility that a neuropsychopathological dysfunction may be at the basis of disinhibited behaviors may add to the claims concerning impairment in the capacity for rational conduct at the time of a crime, an impairment of the mind that this type of offender should have the opportunity to present and attempt to prove in a court of law.

Chapter four, The Will and Decisional Capacity, points out that in the assessment of an insanity plea, in addition to the cognitive capacity of an offender, it is important to consider his decisional capacity. In the United States, the Insanity Reform Act of 1984 excluded the assessment of whether an individual charged with a crime did not have the capacity, because of mental disturbance, to make a free and conscious deliberation to carry out the alleged criminal act. While cognitive capacity is the capacity to assess one's own actions, decisional capacity is the ability to reach a free and voluntary decision (will-intent), after reflection, to carry out any action. Indeed, any form of behavior should be looked upon as the resultant of cognitive and decisional capacity. This is often not the case in offenders suffering from a severe personality disorder, such as the psychopath, the person with a Borderline Personality Disorder, or a person in the manic phase of a bipolar illness, who often act out without reflecting. A case study regarding the decisional capacity is presented and some pertinent case laws are given.

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[9] The Frey rule (Frey vs. United States, 1925) states that the admissibility of scientific evidence should be based on its being 'sufficiently established to have gained general acceptance in the particular field to which it belongs' (Melton et al., 2007, p. 20). The Daubert rule (Daubert vs. Merrill-Dow Pharmaceutical, 1993) states that a scientific opinion must be based on an inference or assertion derived by the scientific method; the court should decide "whether the reasoning or methodology underlying the testimony is scientifically valid and whether that reasoning or methodology properly can be applied to the facts in issue" (Melton et al., 2007, p. 20). It revolves around testability, error rate, approval by peer review, validity, relevance and reliability.

In *chapter five* a brief excursus is presented of various international penal code models. It is interesting to note that the majority of the codes reported have a more flexible legal assessment of mentally ill offenders than those used in the United States at present. Specifically, several nations allow persons suffering from severe personality disorders to enter a plea of non-responsibility if, at the time of an alleged crime, they were under such severe stress that they decompensated into a mental state during which they were unable to appreciate the nature, quality and consequences of their behavior. It seems that the international judicial tendency is to do away with the rigidity of a mental illness definition as a prerequisite for a justification for criminal responsibility and veer towards a psychopathological approach that would support the rationality or irrationality of an offender at the time of an alleged offense under the umbrella definition of mental impairment, total or partial, at the time of an alleged crime.

Diminished rationality of various degrees should be at the basis of a possible finding of non-responsibility. At present, three judicial verdicts are possible: guilty, not guilty and not guilty by reason of insanity. In cases in which there is inadequate proof of an offender's complete irrationality at the time of an alleged crime, but there is supporting neuropsychological, clinical and neuroimaging evidence of mental impairment that would support a plea of diminished responsibility, such a plea should be allowed to be presented and should be taken into due consideration by the court in the legal assessment of the case.

In *chapter six*, diminished capacity and diminished responsibility are discussed. The reader is reminded that mental capacity to commit a crime is not an all-or-none, black-and-white, phenomenon in every case. There is an infinite and graduated spectrum of legal responsibility that goes from complete irresponsibility to various grades of diminished responsibility, to full responsibility. Diminished responsibility means that the mental state of an offender, because of a mental disorder, does not reach the level of an insanity defense but that there is substantial evidence that at the time of an alleged crime an offender was laboring under a severe impairment of the mind that diminished both his cognitive and decisional capacity. Case law decisions are presented in support of the above. A plea of diminished responsibility should be allowed in those criminal cases perpetrated by offenders suffering from severe personality disorders who, under internal or external stress, were irrational at the time of an alleged crime and who are able to support their plea with pertinent evidence in that regard.

In *chapter seven* case studies of persons with a primary diagnosis of severe personality disorder, examined by the author as a forensic psychiatric expert, are given. The description of the criminal forensic assessment briefly illustrates the way in which an insanity defense examination is carried out. Special attention is paid to the possibility of malingering and of the offender's thinking and behavior that could support diminished responsibility. They underwent a psychotic decompensation prior to and/or during the commission of a crime (murder or other major felonies) from which, after days or months, they reintegrated into their previous personalities. With the exception of a few cases, the court did not justify their behaviors on the basis of a malfunctioning or decompensated personality disorder and in most cases did not allow them to enter a plea of not guilty by reason of insanity or even of diminished capacity. Neuropsychological testing and neuroimaging studies seem to corroborate the author's professional experiences in the clinical forensic assessment of offenders diagnosed with severe personality disorders. In such cases, when scientific evidence exists supporting abnormal brain changes in these miscreants, their crimes should not be looked upon primarily as the product of free will (decisional capacity) but, rather, as the outward manifestations of an underlying neuropsychopathological malfunction at the time of the crime.

Persons diagnosed with a severe personality disorder may, under severe stress due to external or internal stimuli, become irrational or psychotic. During these relatively brief psychotic episodes, at times they commit crimes, even serious ones. As noted throughout this thesis, in the United States, following the John Hinckley trial and the Insanity Defense Reform Act of 1984, individuals suffering from severe personality disorders who went through such a psychotic decompensation are strongly discouraged from, or even flatly denied the possibility of, entering a plea of legal non-responsibility and, in those rare cases where such a plea is entered, the courts do not recognize the brief psychotic episode as evidence of justification of legal insanity at the time of the crime.

In *chapter eight*, Conclusion, the argument stands this thesis makes, articulated in various sections supporting it. Those severe personality-disordered offenders, suffering from a mental decompensation at the time of an alleged crime should be allowed in all cases to enter a plea of non-responsibility and to present exculpatory evidence, as was possible prior to the Insanity Defense Reform Act of 1984. Any exculpatory evidence presented should be assessed without prejudice and in the light of present-day scientific knowledge and the due process of law.

Following the Insanity Defense Reform Act of 1984 many attorneys for the defense did not even attempt to enter a legal insanity plea for severe personality-disordered offenders, sure that such a plea would be rejected a priori by the court. This is not what due process of law should be. Due process affirms that, on the basis

of the collected evidence, *anyone* who at the time of a crime was insane or whose mental capacity was greatly impaired has the right to present that evidence in a court of law, and the case should be decided on the facts and without prejudice. Such a possibility has so far been ignored or not yet accepted. If this is not done, the process is unfair and contrary to the law.

Indeed, in the past, society did away with keeping the mentally ill in shackles, and Pinel initiated a more humane approach to their care. In the second half of the twentieth century, society began the process of deinstitutionalization of the mentally ill and other objective and therapeutic changes were made. Today, it seems just that this type of progressive thinking should be extended to those offenders who may not have been totally legally responsible for their criminal acts because of their mental condition or their mental impairment while under stress. This would rectify the present legal attitude towards these offenders and would result in more equitable, less retributive punishment when indicated and better rehabilitative practices that would lead to better resocialization and less recidivism.

It has been posited that in the future punishment will be looked upon differently, reconceptualized as the outcome of biological genetic forces, beyond the control of the individual. Raine (2001) and Slobogin (2005) argued that rehabilitation, consistent with present-day scientific knowledge of human behavior should replace the retributive system. This would be a continuation of the psychiatric and legal reforms begun so many years ago.

The forensic assessment of offenders needs cautiousness and thoroughness, and any court sentence should be merciful and just. In the United States courts, the strict concept of legal insanity due to mental illness should be abolished and the concept of mental abnormality should replace it, as has been done in other nations. Although being allowed to present evidence of a mental abnormality at trial does not bring about an automatic finding of non-responsibility, offenders have a legal and human right to attempt to prove, by presenting for consideration all evidence available, evidence that they may have decompensated into a psychotic state and acted irrationally at the time of the commission of an antisocial act. They must have an unprejudicial and objective hearing.

Allowing offenders to present possible exculpatory clinical, neuropsychological and neuroimaging findings in their defense occasionally may be perceived as a burden on the legal system, especially at present when plea bargaining has been constitutionally adopted by the courts. But due process and justice for all are not words that should easily be disregarded. They are there to safeguard the legal rights of all individuals, and especially the weakest members of society. If those are individuals suffering from a decompensated personality disorder who committed a crime for which they are found not responsible at trial, they should be directed to a forensic psychiatric hospital for proper psychiatric/psychological treatment. Such

treatment should be mandatory and certainly would lessen the possibility for recidivism. Incarceration has not proved to be the only answer for these individuals.

In conclusion, on the basis of the author's psychiatric forensic experience and the review of national and international literature, he strongly suggests that the United States judicial system reassess and amend its approach to individual offenders who are suffering from a severe personality disorder. They should be allowed to enter a plea of total or partial insanity (non-responsibility) based on evidence of a decompensation into irrational behavior at the time of the alleged crime, and should be allowed to present all exculpatory evidence available to them in order to prove their claim. The best approach for non-responsibility pleas would be to adopt a more inclusive formulation with less specific terminology, such as disease of the mind, abnormality of the mind, or impairment of the mind. The interest in a trial of law should be fairness and justice, not just the application of sometimes questionable, outdated rules of law. This is of the utmost importance in the honest determination of legal responsibility.

Samenvatting

Van die delinquenten die op grond van een ernstige psychische stoornis de wet overtreden, is er een kleine groep bij wie de psychische stoornis dusdanig is dat die hun vermogen om de aard en ernst van hun delict te beoordelen, teniet doet dan wel bijna teniet doet. Ook kan bij deze groep het vermogen om de wetten na te leven afwezig of gedeeltelijk verdwenen zijn. Deze delinquenten kunnen wettelijk verzoeken om schulduitsluitingsgronden en niet-strafbaarheid, waarbij zij in een rechtszaak moeten aantonen dat zij ernstig psychisch gestoord waren in de zin der wet ten tijde van het delict dat ten laste wordt gelegd.

Hoofdstuk een heeft als uitgangspunt dat een aanzienlijk aantal personen die lijden aan een ernstige persoonlijkheidsstoornis niet in staat zijn een verzoek tot ‘not guilty by reason of insanity’ in te dienen in de Verenigde Staten, ook al is hun gedrag ten tijde van het ten laste gelegde feit bizar, verward en irrationeel. Dat ze zo’n verzoek tevergeefs indienen, komt door de wettelijke realiteit dat hun stoornis niet wettelijk wordt erkend als een ernstige psychische stoornis. Zij kunnen geen gebruik maken van het verzoek om schulduitsluiting en straffeloosheid, omdat in de Verenigde Staten de huidige juridische visie is dat zij niet voor het criterium van een ernstige psychische stoornis in aanmerking komen. Zelfs wanneer zij wel een rechtszaak zouden kunnen beginnen, zullen zij nog intensiever worden onderzocht dan anderen die wel voldoen aan het juridisch criterium van een ernstige psychische stoornis (‘mental illness’). In dit proefschrift wordt betoogd dat in de Verenigde Staten het strafrecht met betrekking tot delinquenten met een ernstige persoonlijkheidsstoornis, wellicht niet beslist op grond van een ongefundeerd vooroordeel, maar in ieder geval wel de huidige wetenschappelijke ontwikkelingen over het hoofd ziet.

Deze beperking bestaat al sinds 1984 toen er vanwege de ‘John Hinckley case’ een ‘Insanity Reform Act’ werd aangenomen, waardoor personen met een persoonlijkheidsstoornis of beperkte wilsvrijheid van de ‘insanity test’ werden uitgesloten. De ‘insanity test’ wil in de Verenigde Staten zeggen dat de verdachte bij het toerekenen van het misdrijf wordt beoordeeld op het hebben van een ernstige psychiatrische ziekte waarbij het contact met de werkelijkheid verloren is gegaan. Voor 1984 werden delinquenten die leden aan een ernstige persoonlijkheidsstoornis,

niet beperkt in hun mogelijkheid bij de rechtbank een pleidooi voor ontoerekeningsvatbaarheid te houden wanneer zij irrationeel gedrag ten tijde van het delict hadden vertoond. In dit hoofdstuk worden beschrijvingen van de Amerikaanse Case Law gegeven om de bovenstaande verschuiving te onderbouwen en om ook de motivatie van de vonnissen sinds 1984 te laten zien. De beperking van de 'insanity defense' bij ernstige psychische gestoorde patiënten sinds 1984 is in tegenspraak met het beginsel van 'due process of law', zoals in een volgend hoofdstuk zal worden betoogd.

Het betoog in het proefschrift bestaat er uit dat personen met een ernstige persoonlijkheidsstoornis, van wie velen alleen maar in staat zijn marginaal in de maatschappij te leven, onder grote stress een desintegratie van hun persoonlijkheid meemaken, die dusdanig ernstig is dat er op dat moment sprake is van een psychotische episode. Wanneer dat idee geaccepteerd is, kunnen zij ook in aanmerking komen voor hun beroep op straffeloosheid. De rechtbanken in de Verenigde Staten, inclusief de Hoge Raad, houden er echter expliciet aan vast dat delinquente verdachten niet het recht hebben een beroep te doen op de strafuitsluitingsgrond, hoe die dan ook wordt verwoord, onder welke omstandigheden het delict ook is begaan, en zelfs niet wanneer zij op grond van dit beroep op ontoerekeningsvatbaarheid een voordeel kunnen hebben bij een behandeling. De eerlijkheid en de gerechtigheid van de justitiële procedures houden in dat zij toch een beroep moeten kunnen doen op de mogelijkheid van ontoerekeningsvatbaarheid wanneer zij worden aangeklaagd voor een bepaald delict. Natuurlijk weten wij allemaal dat delinquenten er soms toe neigen geestelijke stoornissen te simuleren, dan wel bepaalde psychische symptomen te overdrijven. Maar dat is een risico dat bij de berechting van elke delinquent kan optreden. Men kan hier aan toevoegen dat het beter is tien schuldigen vrij te laten dan één onschuldige te veroordelen. Juist daarom heeft een strafrechtzaak een grote behoefte aan een sterke bewijsvoering en een sluitend bewijs wanneer het komt tot een strafrechtelijke vervolging.

Hoofdstuk twee, persoonlijkheid en agressie, geeft een beschrijvende analyse van de basale drijfveren en emoties van de mens, en het samenspel ervan bij de ontwikkeling van een stabiele dan wel een gestoorde persoonlijkheid. 'Instincten' zijn van nature in een individu aanwezig om zich op een bepaalde manier te gedragen zodanig dat verlangde doelen kunnen worden gerealiseerd. Emoties, gezien als de primaire kracht achter alle menselijke interacties, worden gedefinieerd als een psychische en lichamelijke reactie, zoals boosheid en angst, die indringend ervaren wordt, en hierop volgende voorbereiding en instelling tot een reactie daarop, zoals een 'fight or flight' reactie. Deze reacties kunnen zowel positief als negatief

zijn, en wel of niet leiden tot een misdrijf. Het karakter, samengesteld uit al die verschillende geestelijke en emotionele aspecten, drukt iemands dynamiek uit die hij weet te handhaven in zijn interpersoonlijke relaties.

In dit hoofdstuk wordt verder aandacht besteed aan de vele wetenschappers die het samenspel van emoties, affect, stemming en impulsieve woede hebben bestudeerd, te beginnen bij René Descartes, Henry Bergson, William James, Sigmund Freud. Boosheid, vijandigheid en fysiek geweld worden beschreven als telkens sterker wordende manifestaties van negatieve gevoelens, zoals die destijds beschreven zijn in het 'discontrolesyndroom' van Karl Menniger en in het 'limbisch syndroom' van Russell Monroe. Verder wordt in dit hoofdstuk ook de object-relatietheorie met betrekking tot agressief gedrag behandeld. De theorieën van Heinz Kohut, Margaret Mahler, Melanie Klein, Edith Jacobson, Otto Kernberg en Donald Winnicott over de psychologische ontwikkeling van het kleine kind worden bestudeerd vanuit hun visie op volwassen agressief gedrag. De geleidelijke differentiatie tussen zelf en de persoon van de vaste verzorger is noodzakelijk om een goede oplossing te krijgen voor de gevoelens van het kind in relatie met de door hem geïnternaliseerde slechte en goede ervaringen. Die moeten de ontwikkeling niet belemmeren maar geïntegreerd worden in de verdere psychische ontwikkeling en vervolgens in de persoonlijkheid. Wanneer dat niet lukt, blijven deze slechte ervaringen een negatieve rol spelen tot en met de relaties op volwassen leeftijd. In dit hoofdstuk worden ook de vijf stadia van Kernberg's model van Zelf en Object ontwikkeling beschreven, en de verschillende stadia van de Ik-ontwikkeling, zoals de ongedifferentieerde fase, de differentiatiefase, het begrijpen van het onderscheid tussen ik en de ander, en de formatie van het Ego als mediator tussen enerzijds de innerlijke driften en impulsen en anderzijds de eisen en verwachtingen van de samenleving. De afweermechanismen die met deze persoonlijkheidsorganisaties te maken hebben wanneer het gaat om neurotische, borderline of psychotische persoonlijkheidsorganisaties, worden kort besproken. De realiteitstoetsing ('reality testing') is hierbij speciaal van belang omdat die geheel of gedeeltelijk kan disfunctioneren.

Via het proces van individuatieseparatie en het natuurlijk streven van het kind om een gevoel van zelfwaarde en zelfcontrole te krijgen, bestaat echter het gevaar vanwege een problematische relatie met met name zijn moeder, dat het al vroeg angstige achterdocht en cognitieve overwaardige ideeën gaat ontwikkelen. Zo'n ontwikkeling heeft met name grote consequenties wanneer het kind later volwassen is geworden; dan kan die een belangrijke rol spelen bij gevoelens van afwijzing, haat, liefde en geweld.

Kernberg (1992) postuleerde dat herinneringen aan bepaalde emotionele gebeurtenissen en vroege ervaringen opgeslagen worden in het limbisch systeem van onze hersenen. Deze herinneringen kunnen in specifieke relaties weer worden gereactiveerd wanneer die er erg op lijken. Soms kunnen onbewuste en primitieve

pathologische complexen terugkeren in het bewustzijn van personen met een ernstige psychische stoornis, zoals dat ook gebeurt met patiënten met een psychose. Kernbergs idee van pathologisch narcisme komt heel veel voor onder psychopaten en seriemoordenaars. Hij baseert dat op het gegeven dat het streven naar persoonlijke beloningen bij kinderen vanzelfsprekend is, maar vervolgens middels de socialisatie wordt gesublimeerd en in goede banen wordt geleid.

Het filosofisch gedeelte in dit hoofdstuk brengt nog de ideeën naar voren met betrekking tot het belang van de ontwikkeling van iemands karakter voor de rest van zijn morele leven en vermogen tot interactie. Hierbij dient Plato genoemd te worden die al in de vierde eeuw voor Christus geloofde dat niemand graag slecht wil zijn, maar zo wordt vanwege een niet gewilde lichamelijke of geestelijke predispositie. Op dit idee berust ook het betoog van dit proefschrift. Tevens wordt er verwezen naar Immanuel Kants beschrijving van verschillende geestesziekten, omdat Kant van mening was dat de geestestoestand van een psychisch zieke waarschijnlijk te wijten was aan erfelijke of endogene factoren, wanneer die tekortschoot in zijn verstandelijke vermogens- en oordeelsvorming. Verder wordt nog kort ingegaan op het werk van Arthur Schopenhauer, die van mening was dat wanneer iemands cognitieve functies maar voldoende gestoord waren, de wil niet vrij was in zijn keuzemogelijkheden. Een delinquent met zo'n gebrek, zo dacht hij, moest niet gestraft worden; Schopenhauer oordeelde in die gevallen tot een gedeeltelijke toerekeningsvatbaarheid. Bovenstaande uitspraken vormen het fundamentele argument voor deze dissertatie.

Bij de bespreking van de persoonlijkheidsstoornissen wordt de nadruk gelegd op het feit dat de DSM-IV-indeling van de persoonlijkheidsstoornissen onder As II op dit moment ter discussie staat en een probleem vormt voor de diagnostische betrouwbaarheid ervan. Even zo goed kan naar voren gebracht worden dat de meest ernstige persoonlijkheidsstoornissen zoals de borderline, paranoïde, schizoïde, schizotypische en de antisociale stoornissen, als klinische symptomen onder As I kunnen worden ondergebracht als voorlopers van ernstige psychotische stoornissen. Bijvoorbeeld wanneer schizotypische of schizoïde persoonlijkheidsstoornissen worden geïncludeerd in As I zouden die geclassificeerd kunnen worden als een vroeg stadium van schizofrenie. Het is niet onmogelijk dat bij het tot stand komen van de DSM-V de categorie persoonlijkheidsstoornissen (dus de As II) opnieuw geclassificeerd wordt onder de As I. Dat is dan de bevestiging dat de persoonlijkheidsstoornissen inderdaad worden opgevat als een vroeg ontstaan van een As I-psychose.

De verschillende persoonlijkheidsstoornissen worden vervolgens samengevat, inclusief hun chronisch slecht aangepast gedrag. Illustratieve gevalsbeschrijvingen van sommige patiënten die lijden aan deze stoornissen, worden beschreven. De gevalsbeschrijvingen zijn gebaseerd op de forensisch psychiatrische ervaringen van de auteur van dit proefschrift en zij ondersteunen het discussiepunt: onder ernstige

stress kunnen patiënten die lijden aan een persoonlijkheidsstoornis, vervallen in een korte psychotische episode met denk- en gedragstoornissen. Gedurende zo'n episode kunnen ze een delict plegen, waarna zij na enige uren, dagen of weken kunnen reïntegreren en weer hun eerdere niet-psychotische persoonlijkheidsstoornis manifesteren. De interpretatie van de psychodynamiek van sommige gevalsbeschrijvingen is gebaseerd op de object-relatie-theorie.

Hoofdstuk drie laat zien dat beeldvormende technieken van het centrale zenuwstelsel disfuncties en pathologische afwijkingen in de hersenen bij verschillende stoornissen kunnen aantonen, die een verslechtering van het psychisch functioneren opleveren. Die kan op zijn beurt weer tot abnormaal gedrag en zelfs misdaden leiden. De zich snel onwikkelende technieken (CAT, fMRI, sMRI, PET, SPECT) vermeerderen nog steeds ons begrip van de neurobiologie van de psychische stoornissen. In dit hoofdstuk wordt hier verder op ingegaan.Tegenwoordig weten wetenschappers dat denkstoornissen en gedragsstoornissen voortkomen uit specifieke structurele en functionele stoornissen in de hersenen. Dit wil natuurlijk niet zeggen dat stoornissen in de psychopathologie van het brein zoals die bij de beeldvormende technieken worden aangetoond, de enige bepalende factoren zijn voor menselijk gedrag. Het is natuurlijk de interactie tussen de onderliggende cerebrale disfuncties en de biopsychosociale factoren die leidt tot de psychische afwijkingen en gedragsstoornissen zoals wij die kennen bij de psychische stoornissen. Functionele beeldvormende technieken hebben tot betere diagnostiek geleid en tot een meer geschikte behandeling omdat ze specifieke afwijkingen in bepaalde delen van de menselijke hersenen hebben laten zien. Het behoort tot het professioneel handelen van de gedragsdeskundige dat hij mede zijn oordeel daarvan moet laten afhangen, wanneer hij de mate van ernst van de neuropathologie vastlegt in zijn rapport. Nieuwe gegevens van de fMRI beeldvormende technieken kunnen bijvoorbeeld specifieke neurale biomarkers opsporen die psychiatrische patiënten met bipolaire stoornissen onderscheiden van die met unipolaire stoornissen, en kunnen ook vaststellen welke behandeling het beste voor zo'n patiënt is. Deze beeldvormende technieken kunnen ook de mogelijkheid hebben om bepaalde kenmerken van stoornissen die nog niet klinisch zichtbaar zijn, al aan te tonen, ook wanneer er nog helemaal geen sprake is van psychiatrische symptomatologie. Dit is ook het geval wanneer die afwijkende kenmerken zijn blijven bestaan terwijl het klinisch toestandsbeeld geen afwijkingen meer laat zien.

De onderliggende structurele en functionele overeenkomsten in het functioneren van de hersenen bij psychotici en bij patiënten met een ernstige persoonlijkheidsstoornis, zoals die blijken uit de eerder genoemde beeldvormende technieken, moeten ook door juristen serieus worden genomen. Zij wijzen erop dat

die patiënten met een ernstige persoonlijkheidsstoornis inderdaad aan een latente prepsychotische toestand lijden. Deze prepsychotische toestand leidt dan onder ernstige stress tot duidelijk psychotisch gedrag wanneer de persoonlijkheidsstructuur onder invloed ervan tijdelijk decompenseert. Deze patiënten met een ernstige persoonlijkheidsstoornis zijn vaak delinquenten van ernstige en minder ernstige delicten bij wie de rechtbank een oordeel moet vormen over de mate van toerekeningsvatbaarheid daarvoor.

De beeldvormende technieken van de functionerende hersenen hebben duidelijk laten zien dat irrationeel agressief gedrag vaak het resultaat is van een disfunctioneren in de hersenfuncties waarbij bijvoorbeeld de frontale cortex de controle verliest over de meer basale structuren zoals de amandelkernen. Deze beeldvormende technieken, die in de psychiatrie zijn geaccepteerd, zullen ook bij de rechtbank voor de forensisch psychiatrische rapportage aan de standaard van betrouwbaarheid moeten voldoen, zoals die van Frey en Daubart (beide Amerikaanse standaards voor de wetenschappelijkheid van een deskundigenrapport). Deze betrouwbaarheid dient onomstreden te zijn voordat deze technieken er mede voor gebruikt kunnen worden een verminderde verantwoordelijkheid of zelfs ontoerekeningsvatbaarheid voor een bepaald delict aan te tonen.

Het valt te verwachten dat de huidige mogelijkheden in de ‘neuroscience’ de manier waarop het recht naar misdaad kijkt en die beoordeelt, zullen veranderen. Het zou immers niet eerlijk zijn om delinquenten verantwoordelijk te stellen en hen te straffen terwijl uit neuropsychiatrisch onderzoek blijkt dat zij een beperkt vermogen hebben om rationeel gedrag te vertonen, en dan met name ten tijde van het delict. De mogelijkheid dat een neuropsychopathologische disfunctie de basis is van ontremd gedrag, kan leiden tot het pleidooi dat de vermogens voor rationeel gedrag ten tijde van het misdrijf waren verminderd. Deze vermindering van de cognitieve vermogens bij de delinquent zou moeten leiden tot de mogelijkheid om die ook tijdens een terechtzitting aan te voeren als argumenten voor een verminderde toerekeningsvatbaarheid.

In *hoofdstuk 4*, de vrije en wil en het vermogen een besluit te nemen, wordt betoogd dat bij het onderzoek naar de verstandelijke vermogens van de delinquent in de rapportage Pro Justitia, het standaard is om, wanneer er een pleidooi wordt gehouden voor schulduitsluiting, ook het vermogen tot het nemen van beslissingen te beschouwen. In de Verenigde Staten heeft de Insanity Reform Act of 1984 in afwezigheid van een psychotische stoornis zelfs het psychiatrisch en psychologisch onderzoek buiten de wet gehouden wanneer het gaat om een onderzoek naar de geestvermogens met als vraag of de verdachte in staat was om een vrije en bewuste afweging te maken om de ten laste gelegde daad uit te voeren. De definitie van

verstandelijke vermogens is hierbij het vermogen om zijn eigen daden te beoordelen. Het vermogen een beslissing te nemen vervolgens houdt in dat men in staat is een vrije en vrijwillige beslissing te nemen, en dus de intentie te hebben, en na nagedacht te hebben, een bepaalde daad te volvoeren. Daarom is het ook zo dat elk gedrag moet worden opgevat als een resultante van de cognitieve vermogens en besluitvorming. Dat laatste is vaak niet het geval bij delinquenten die lijden aan een ernstige persoonlijkheidsstoornis, zoals de psychopaat, iemand met een borderline persoonlijkheidsstoornis of tijdens de manische fase van een bipolaire stoornis. Deze patiënten denken vaak niet na wanneer zij gewelddadig zijn. Een gevalsbeschrijving met betrekking tot het vermogen om een besluit te nemen wordt hier beschreven samen met enkele gerechtelijke uitspraken.

In *hoofdstuk vijf* wordt een beknopt overzicht gegeven van de verschillende internationale strafrechtsmodellen. Het is interessant om te constateren dat de meerderheid van deze strafwetgeving een meer flexibele forensisch psychiatrische rapportage van psychisch gestoorde delinquenten laat zien dan die zoals die op dit moment gebruikt worden in de Verenigde Staten. Specifiek laten verschillende landen het toe dat verdachten die aan een ernstige persoonlijkheidsstoornis lijden, via hun advocaat het verzoek doen om niet toerekeningsvatbaar te worden geacht voor een delict wanneer zij ten tijde van het delict onder zo'n ernstige stress verkeerden dat zij psychisch decompenseerden. Dat wil zeggen, zij verkeerden in een toestand waarin zij niet in staat waren de aard, ernst en de consequenties van hun gedrag te overzien. Uit deze internationale wetgeving komt de tendens naar voren om zich verre te houden van een rigide definitie van het begrip psychische stoornis bij de beoordeling van de toerekeningsvatbaarheid. Veeleer wordt er een meer psychopathologische benadering betracht bij de uiteindelijke beoordeling van het psychische toestandsbeeld van de daden ten tijde van het delict. De rationaliteit of de irrationaliteit van de dader ten tijde van het delict kan dan worden uitgedrukt in een geheel of gedeeltelijke beperking in de geestvermogens ten tijde van het delict.

De verschillende graden van ernst van de stoornis van de geestvermogens moeten overeenkomen met dezelfde oorzaken die ook ten grondslag liggen aan ontoerekeningsvatbaarheid. Tegenwoordig zijn er in de Verenigde Staten drie verschillende juridische uitspraken mogelijk, namelijk schuldig, niet schuldig en niet schuldig vanwege een psychose ('reason of insanity').

Wanneer er onvoldoende bewijs is voor een onvolledig disfunctioneren van de geestvermogens ten tijde van het delict, maar er bestaat wel neuropsychologische, klinische en beeldvormende evidentie van een verslechtering van de geestvermogens, dat een pleidooi voor een verminderde toerekeningsvatbaarheid zou schragen, dan zou zo'n pleidooi toegestaan moeten worden voor de rechtbank.

Dit pleidooi zou ook in de besluitvorming van de rechtbank moeten worden meegewogen.

In *hoofdstuk zes* worden de verminderde toerekeningsvatbaarheid (‘diminished responsibility’) en de beperkte geestvermogens (‘diminished capacity’) besproken. De lezer van dit proefschrift wordt er aan herinnerd dat in de meeste gevallen het psychisch vermogen om een misdaad te plegen niet een alles-of-niets-, of een zwart-wit-fenomeen is. Er bestaat een oneindig aantal gradaties van wettelijke verantwoordelijkheid die variëren van volledige ontoerekeningsvatbaarheid tot verschillende gradaties van verminderde toerekeningsvatbaarheid, tot een volledige toerekeningsvatbaarheid. Verminderde toerekeningsvatbaarheid houdt in dat het toestandsbeeld van een delinquent vanwege een psychische stoornis niet het niveau bereikt van een pleidooi voor ontoerekeningsvatbaarheid via de ‘insanity defense’. Wel kunnen er in dat geval voldoende aanwijzingen (‘substantial evidence’) zijn om te concluderen dat ten tijde van het delict de delinquent zijn handelingen verrichtte terwijl er sprake was van een ernstige verslechtering van zijn psychisch functioneren. Dit moet mogelijk zijn wanneer zowel zijn cognitieve vermogens als zijn vermogen tot het nemen van een beslissing waren verminderd.

In dit hoofdstuk worden opnieuw uitspraken van rechtbanken als ‘case law decisions’ beschreven die de stelling onderbouwen. Een pleidooi voor een verminderde toerekeningsvatbaarheid zou bij deze gevallen toegestaan moeten worden wanneer deze delinquenten lijden aan een ernstige persoonlijkheidsstoornis, en als gevolg van interne of externe stress irrationeel handelden ten tijde van het delict. Zij moeten dan wel in staat zijn gesteld hun verzoek om ontoerekeningsvatbaarheid te onderbouwen via een gedragsdeskundigenrapportage.

In *hoofdstuk zeven* worden verschillende gevalsbeschrijvingen van personen met een primaire diagnose met een ernstige persoonlijkheidsstoornis zijn door de auteur weergegeven. Allen maken deel uit van het aantal personen dat hij in de loop der tijd als forensisch psychiatrisch gedragsdeskundige heeft onderzocht. Een beschrijving van de forensische psychiatrische gedragsdeskundigenrapportage geeft in het kort weer hoe het psychiatrisch onderzoek bij de ‘insanity defense’ wordt uitgevoerd. Speciale aandacht wordt besteed aan de mogelijkheid dat de onderzochte simuleert (‘malingering’) en aan die facetten van het denken en handelen van de delinquent die de verminderde toerekeningsvatbaarheid kunnen aantonen.

Deze patiënten decompenseerden op een psychotische manier eerder dan of tijdens het begaan van een ernstig delict, zoals doodslag of andere gewelddaden. Na dagen of maanden reïntegreerden zij weer tot het psychisch functioneren van voorheen en manifesteerde zich weer bij hen de eerder bestaande persoonlijkheidsstoornis. Met uitzondering van een paar gevallen beoordeelde de

rechtbank hun gedrag niet als disfunctioneren of een decompensatie op grond van een persoonlijkheidsstoornis. In de meeste gevallen stond de rechtbank hen niet toe een pleidooi te voeren voor niet schuldig door een psychotisch toestandsbeeld (‘not guilty by reason of insanity’), of zelfs voor gebrekkig functionerende geestvermogens. Neuropsychologische tests en beeldvormende technieken schijnen de ervaringen van de auteur als professional in de klinische psychiatrische gedragskunde te bevestigen bij die delinquenten die zijn gediagnosticeerd met een ernstige persoonlijkheidsstoornis. Wanneer er wetenschappelijke evidentie bestaat die bij hen afwijkingen in het functioneren van de hersenen bevestigt, en wanneer die ook tijdens het gedragsdeskundig onderzoek naar voren zijn gekomen, dan zouden de misdrijven door deze delinquenten niet in de eerste plaats beschouwd moeten worden als een product van de vrije wil, alsof het vermogen om beslissingen te nemen intact is geweest. Eerder zou het misdrijf moeten worden opgevat als een manifestatie van een onderliggend neuropsychopathologisch disfunctioneren ten tijde van het delict.

Patiënten met ernstige persoonlijkheidsstoornissen kunnen onder ernstige stress vanwege externe of interne prikkels, irrationeel of psychotisch worden. Gedurende deze relatief korte episodes kunnen zij misdaden plegen, en zelfs zeer ernstige. In de Verenigde Staten, als een gevolg op het proces tegen John Hinckley, die de toenmalige president van de Verenigde Staten Ronald Reagan neerschoot en op grond van de Insanity Defense Reform Act of 1984, worden patiënten die lijden aan een ernstige persoonlijkheidsstoornis en die vervolgens een psychotische decompensatie hebben meegemaakt, met klem afgeraden om een pleidooi te houden voor een wettelijke ontoerekeningsvatbaarheid, of hen wordt zelfs de mogelijkheid daartoe ontnomen. In de zeldzame gevallen waarin zo’n pleidooi wel is toegestaan, herkent de rechter vaak niet de korte psychotische episodes als blijk van de aanwezigheid, en ook de juridische aanwezigheid, van een psychose ten tijde van het delict.

In *hoofdstuk acht*, conclusie, staan de conclusie en aanbevelingen van dit proefschrift, gebaseerd op de verschillende argumenten in de verschillende hoofdstukken. Patiënten die lijden aan een ernstige persoonlijkheidsstoornis en die psychisch zijn gedecompenseerd op het tijdstip van hun misdrijf, moeten in staat worden gesteld om in alle gevallen een pleidooi voor ontoerekeningsvatbaarheid bij de rechtbank te voeren. Daarbij moeten zij in staat worden gesteld ontlastende onderzoeksbevindingen aan het oordeel van de rechtbank te laten onderwerpen, zoals al mogelijk was voordat de Insanity Defense Reform Act of 1984 werd ingevoerd. Het zou mogelijk moeten zijn om alle ontlastende onderzoeksgegevens en conclusies zonder vooroordeel en in het licht van het niveau van het hedendaagse wetenschappelijk denken, aan een beschouwing van de rechtbank te laten

onderwerpen waardoor een eerlijke rechtsgang ontstaat (‘due process of law’). Een eerlijk proces (‘due process’) houdt in en bevestigt dat iedereen die tijdens een delict psychotisch was of wiens geestelijke vermogens aanzienlijk waren verslechterd, het recht heeft om die onderzoeksgegevens die op grond van de forensische gedragskundige rapportage daarover zijn verzameld, tijdens de rechtszitting naar voren te brengen. Vervolgens moeten deze onderzoeksgegevens ook meegenomen worden in de besluitvorming rond het vonnis, en dat zonder vooroordeel. Die mogelijkheid is tot nu toe over het hoofd gezien dan wel niet geaccepteerd. Dan is er echter sprake van een oneerlijke procesvoering en dat is tegen de wet.

Het huidige juridische denken in de Verenigde Staten moet worden uitgebreid tot die delinquenten die niet helemaal verantwoordelijk kunnen worden gesteld voor hun daden. Dan kan blijken dat zij die daden hebben begaan onder invloed van een verslechterde conditie of een tekort schieten van de psychische vermogens terwijl ze onder stress verkeerden. Deze mentaliteitsverandering zou met zich meebrengen dat de huidige wettelijke instelling in de Verenigde Staten jegens deze delinquenten zal resulteren in meer redelijke en minder repressieve straffen als vergelding wanneer dat mogelijk is.

Ook zou dat met zich meebrengen dat er een betere resocialisatie kan worden georganiseerd op grond van een nazorgpraktijk die berust op rehabilitatie. Op zo’n manier valt er ook vermindering van recidive te verwachten. Het kan gesteld worden dat er in de toekomst zeker anders naar straffen zal worden gekeken en dat ze opnieuw zullen worden geconceptualiseerd als het resultaat van biologische en genetische krachten die buiten de controle van het individu liggen. Zo houden bijvoorbeeld vooraanstaande onderzoekers als Raine en Slobogin een pleidooi dat in overeenstemming met de huidige wetenschappelijke kennis, rehabilitatie en resocialisatie het repressieve gevangenissysteem zouden moeten vervangen.

De psychiatrische en psychologische gedragskundige rapportage moet natuurlijk zorgvuldig, doorwrocht en voorzichtig zijn, en elk vonnis door de rechtbank rechtvaardig en genadig. In de Verenigde Staten zou van de beperkte opvatting van psychose in de zin der wet afstand moeten worden gedaan, en het concept van de geestelijke abnormaliteit zou die moeten vervangen, zoals dat ook al is gedaan in andere landen. Alle informatie over de verdachte zou in een rechtszitting moeten worden beoordeeld, alhoewel dat natuurlijk niet direct hoeft te leiden tot een automatische ontoerekeningsvatbaarheid. Centraal in dit proefschrift staat dat delinquenten het recht moeten hebben, zowel wettelijk als ethisch, om alle mogelijke gegevens naar voren te brengen waaruit kan blijken dat zij zijn gedecompenseerd in een psychotisch toestandsbeeld, en dat zij irrationeel op de tijd van hun antisociale daad hebben gehandeld. Zij moeten een onbevooroordeelde en objectieve mogelijkheid hebben om gehoord worden.

De mogelijkheid dat dit gebeurt, zou opgevat kunnen worden als een verdere belasting van het wettelijk systeem, speciaal nu overleg over de aanstaande

aanklacht (‘plea bargaining’) is aanvaard in de Grondwet. Maar een eerlijk proces en rechtvaardigheid voor allen mogen ook in dat geval niet uit het oog worden verloren. Deze rechtsbeginselen bestaan immers om de rechten van alle personen te beschermen en speciaal die van de zwakste leden van onze maatschappij. Psychiatrische patiënten die ten tijde van het delict zijn gedecompenseerd in een psychotisch toestandsbeeld en die tijdens de terechtzitting als ontoerekeningsvatbaar worden beoordeeld, moeten direct in een forensisch psychiatrisch ziekenhuis kunnen worden geplaatst, waar dan een geëigende psychiatrische en psychologische behandeling kan plaatsvinden. Zo’n behandeling zou verplicht moeten zijn en zou zeker als doel moeten hebben de kans op recidive te verminderen. Alleen maar detentie heeft nooit bewezen het enige antwoord te zijn voor psychische gestoorde delinquenten.

Ten slotte brengt de auteur van dit proefschrift met kracht naar voren dat het juridische systeem in de Verenigde Staten opnieuw zal moeten stilstaan bij zijn benadering van individuele delinquenten met een ernstige persoonlijkheidsstoornis, en die benadering vervolgens moeten aanpassen. Zijn eigen forensisch psychiatrische ervaringen als professional gedragsdeskundige, en het overzicht van de nationale en internationale literatuur geven dit argument nog eens te meer kracht. Patiënten met een ernstige persoonlijkheidsstoornis zou het moeten worden toegestaan een pleidooi te voeren voor ofwel een totale ontoerekeningsvatbaarheid dan wel een verminderde toerekeningsvatbaarheid. Alle gegevens die daaraan ten grondslag kunnen liggen, zouden ter terechtzitting moeten kunnen worden behandeld zodat zij ook in staat zijn dit pleidooi te onderbouwen. De wettekst zou in dezen zodanig aangepast moeten worden dat de wettelijke formulering van een geestelijke stoornis minder beperkt is. Hierbij valt dan te denken aan ‘disease of the mind’, ‘abnormality of the mind’ of ‘impairment of the mind’ in plaats van de huidige term ‘insanity’.

(Vertaling: H.J.C. van Marle)

Acknowledgements

I wish to thank the many people who have supported me throughout the writing of this thesis with their knowledge and their expertise, among whom Prof. Bruce Arrigo, Dr. Richard Kocsis, Prof. Jan Brakel, Prof. Ralph Slovenko, Prof. David Weisstub, The Hon. Richard D. Schneider. Special thanks go to Prof. Hjalmar van Marle, my promoter, for his attentive guidance and help. My deepest gratitude goes to my wife, Adrienne, who has helped me during the entire period of my work with her challenging thoughts, her constructive criticism and, above all, her loving presence.

Curriculum Vitae

Prof. Dr. George Palermo was born in Tarquinia, Italy. He graduated from the University of Bologna Medical School, Bologna, Italy, and was trained in general medicine and psychiatry in the United States. He is a Diplomate of the American Board of Psychiatry and Neurology in Psychiatry, a Fellow of the American College of Forensic Examiners, and a Diplomate of Forensic Medicine. In 2004 he received a Master of Science Degree in Criminology from the University of Rome, La Sapienza. He is presently Clinical Professor of Psychiatry at the University of Nevada School of Medicine and at the Medical College of Wisconsin, and Professor Adjunct of Criminology and Law Studies at Marquette University in Milwaukee, Wisconsin. He is Director of the Center for Forensic Psychiatry and Risk Assessment in Milwaukee, Wisconsin, and in Henderson, Nevada. In 1996 he was awarded the Citizen of the Year by the Greater Milwaukee Legal Auxiliary, and in 1997, the Person of the Year by the Justinian Society of Milwaukee. In 2002, he was honored with the *Lex et Justitia* award from the Department of Criminology and Law Studies, Marquette University. He has also received several awards in Italy. He is a *Grande Ufficiale* of the Italian Republic.

Dr. Palermo is Editor-in-Chief of *International Journal of Offender Therapy and Comparative Criminology.* In addition he is on the editorial and review boards of various national and international psychiatric and criminological journals. He is a member of the Executive Board of the International Academy of Law and Mental Health.

He has published numerous articles on forensic psychiatry and criminology, and is the author of book chapters and of the following books:
- *The Faces of Violence* (1st and 2nd editions),
- *Aggressivita e violenza, oggi: Teorie e manifestazioni*
- *Il fenomeno della paranoia*

He is co-author of:
- *The Paranoid: In and Out of Prison* (with Edward M. Scott, Ph.D.)
- *Letters from Prison: A Cry for Justice* (with The Hon. Maxine Aldridge White)
- *Satanism: Psychiatric and Legal View* (with Michele C. Del Re, J.D)
- *The Dilemma of the Sexual Offender* (with Mary Ann Farkas, Ph.D.)
- *Psichiatria di Emergenza* (with Mark T. Palermo, M.D.)

- *L 'abuso e la molestia sessuali: Aspetti storico-culturali, psicologici, psichiatrici e legali* (with Mary Ann Farkas, Ph.D., and Domenico Carponi-Schittar, J.D.)
- *Affari di famiglia: Dall'abuso all'omicidio* (with Mark T. Palermo, M.D.)
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