

Exoneration of the mentally ill

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Author's abstract

Mental illness may be manifested in the impairment of understanding or of volitional control. Impairment of understanding may be manifested in delusions. Impairment of volitional control is shown when a person is unable to act in accordance with good reasons that he himself accepts. In order for an impairment of understanding or of self-control to exculpate, the offence must be causally connected with the impairment in question. The rationale of exculpation in general, which applies also to the case of mental illness, is that the offence does not indicate a morally bad attitude in the offender. A consequence of this rationale is that Kenny is wrong to hold that no injustice would result from the elimination of the legal defence of diminished responsibility (8,10).

Mental illness may be manifested in the impairment of one or more psychological capacities. These include the capacity to obtain correct information from one's environment and to reason on the basis of it, and the capacity to act in accordance with what oneself accepts as good reasons for acting in a certain way. I shall consider how impairment of these capacities is shown, when such impairment exculpates or reduces moral responsibility, and why it does so. I shall conclude with a brief discussion of the relevance of this topic to issues concerning the defences of insanity and of diminished responsibility in English criminal law.

Impairment of cognition

Impairment of the capacity to obtain correct information from one's environment and to reason on the basis of it may be shown by the occurrence of delusions. A delusion is a false belief. But not all false beliefs are delusions. If a person has a belief that turns out to be false even though he had good evidence for it, or if he holds a false belief that is unsupported by evidence because of his membership of a group that shares that belief or because of his childhood training, then we should not normally regard the false belief as a

delusion. According to Jonathan Glover, 'where I hold a false belief despite being presented with overwhelming evidence against it, and my doing so cannot be explained in terms of the beliefs common in my group or society, the only explanation that seems to be left is that my reasoning abilities are impaired to an abnormal extent' (1). Delusions are false beliefs that can be explained only in terms of abnormally impaired reasoning abilities.

I agree with the substance of Glover's account of the concept of a delusion, but I believe that this account requires modification. For if one considers a particular delusion in isolation from the patient's other beliefs, one may find either that he has no overwhelming evidence against it or that it seems explainable in terms of a widespread ideology in his society. An example that illustrates both these possibilities is provided by an extract from an American psychiatrist's interview with a person suffering from paranoid schizophrenia; the extract is reprinted in R S Lazarus's *Patterns of Adjustment* (2). One of his beliefs that the patient discloses in the interview is that he is being spied upon by 'Russians', that is, Soviet agents. We are able to judge that the patient's belief that he is being spied upon is a delusion, even though he is not confronted with overwhelming evidence against it or even though such a belief may possibly be explainable in terms of an ideology that is shared by many people in the patient's society. We are able to judge that the patient's belief is a delusion when we take into account some of his other beliefs. We realise that the belief in question does not exist in isolation, but forms part of a set of interrelated beliefs in which the other beliefs of the set are clearly counter-evidential and idiosyncratic. For the extract from the interview reveals that not only does the patient believe that he is being spied upon by 'the Russians', he also believes that he has an atomic device to blow them up, that he is Franklin D Roosevelt, that the Russians tried to drop a bomb on him from his fire escape, and that he can tell whether a person is a Russian agent by the colour and shape of his eyes. Thus, we discern that the patient's belief that he is being spied upon hangs together with a number of other beliefs and that the interrelated set of beliefs form a paranoid outlook, constitutive of much of his experience, according to which the patient is a rather

Key words

Mentally abnormal offenders; moral responsibility; McNaughton Rules; diminished responsibility.

grand and important personage who is being persecuted by an organised group of individuals. Even though the patient is not confronted with overwhelming evidence against his belief that he is being spied upon by Russians, we discern that his belief is a delusion because it is interrelated with other beliefs of his which *are* clearly delusions according to Glover's criteria. In our view, the belief that he is being spied upon by the Russians takes on the delusional colouring of these other beliefs.

Impairment of volition

In another chapter of his book *Responsibility*, entitled 'Conscience and Capacities', Glover states that 'where a man has some mental illness . . . his condition may be such that his actions cannot be altered by persuasion. This may be because he is unable to alter his intentions in response to argument, or because, if he does alter his intentions, he will be unable to act upon them . . .' (3). The type of volitional disability which Glover describes may be illustrated by reference to obsessive-compulsive neurosis. The patient who suffers from this disorder seems to be forced against his or her will to think about something or to engage in certain actions. A standard example is the behaviour of a person who feels compelled to wash his hands repeatedly, even though he believes that his hands are perfectly clean and accepts that he has good reason to abandon this ritual behaviour.

Glover's account of the type of volitional disability under discussion considers such a disability only from the third-person or second-person point of view, that is, from the point of view of a person who observes that the subject, in conversation, accepts reasons for altering his intention or his course of action but claims that he is unable to act accordingly. There seems to be no reason why Glover's account should not be supplemented by one that focuses on the point of view of the subject who suffers from the type of volitional disability in question.

A basis for such an account is provided by Harry Frankfurt in his article, 'Freedom of the Will and the Concept of a Person' (4). Frankfurt makes two useful and intersecting distinctions with regard to human wants: a distinction between first-order and second-order wants, and a distinction between motivating and non-motivating wants. (Frankfurt uses the terms 'want' and 'desire' interchangeably, but it seems stylistically preferable to speak of a desire.) A first-order desire is a desire to perform a certain action. A second-order desire is a desire that is directed towards an actual or possible first-order desire. For example, I may have a second-order desire that a first-order desire of mine should persist.

Frankfurt's second distinction, as I said, is that between motivating and non-motivating wants or desires. First, with regard to first-order desires, although one desires to perform a certain action, X, this may be only one among several desires, not all of which can be fulfilled. Further, the desire to do X may

not be paramount amongst the desires that one has. One may strongly prefer to do something else instead. Alternatively, a person may want or desire to do X in the sense 'that it is this desire that is motivating or moving [him] to do what he is actually doing or that [he] will in fact be moved by this desire (unless he changes his mind) when he acts' (5). In the latter case, but not in the former, the desire to do X is a motivating or effective desire.

Frankfurt's two distinctions intersect. For example, a person may have a second-order desire that one among a number of competing first-order desires should be effective or motivating. Let us consider now how Frankfurt's two distinctions with regard to desires enable us to understand further the kind of volitional disability that Glover discusses. We should note that this kind of disability is present not only in obsessive-compulsive neurosis, but also in certain sexual anomalies, some of which are likely to get the subject into trouble with the law. One such sexual anomaly is exhibitionism. The exhibitionist usually exposes himself to female strangers, but he seeks no further relationship with them. According to Henderson and Gillespie's *Textbook of Psychiatry*, 'there is a compulsive quality often about the act; the perpetrator experiences an overwhelming urge to do it and commonly feels dejected and guilty after it' (6).

The condition of the compulsive exhibitionist may be described in terms of Frankfurt's distinctions as follows: the exhibitionist has two conflicting first-order desires, a desire to expose himself in public and a desire not to do so because of moral scruples. Further, he does not view this conflict with impartiality. He has a strong second-order desire that his first-order desire to refrain from exposing himself in public should be effective. But contrary to this second-order desire his first-order desire to exhibit himself is the one that is effective. Since its effectiveness is contrary to his second-order desire, the first-order desire to exhibit himself seems to have a force of its own, and he feels with regard to its operation like a helpless bystander.

This Frankfurtian account of acting knowingly from inner compulsion requires supplementation in turn. In cases where a first-order desire is effective or motivating, it may not be effective or motivating of its own accord. It may be effective because the person who has the desire *decides* to act on it. For example, suppose that when the alarm clock rings in the morning, I awake and experience a conflict between two first-order desires. On the one hand, I desire to get up right away; on the other hand, I desire to remain in bed. It may be that my strongest felt desire is to remain in bed. But, further, I have a second-order desire that my first-order desire to get up right away should be effective or motivating. But the mere fact that I have such a second-order desire doesn't necessarily mean that my desire to get up right away *will be* effective or motivating. What may be required in this case is that I should *decide* to get up and that, consequently, I should

make an *effort of will* to overcome my inclination to remain in bed. This example illustrates the point that there are cases in which I experience a conflict of first-order desires, where I am conscious that it is *up to me* to decide which of these desires to act upon. If I have a second-order desire that one rather than another of these conflicting first-order desires should be the one that is effective or motivating, then, presumably, I shall decide to act in accordance with this second-order desire.

The fact that there are cases of conflicting desires that call upon the subject to make a decision does not imply that *whenever* one acts from a desire in non-compulsive cases, one decides to do so. I can be said to decide to do something only if I consider the question of whether or not to do it, or of whether to do *it* or something else. But even in non-compulsive cases, one may act on impulse, without considering any such question.

Now, as F H Bradley points out (7), a person who knows what he is doing but who is compelled to do it, is unable to collect himself so as to decide one way or another. That is to say, such a person acts upon a certain desire without deciding to do so, but he differs from a person who simply acts impulsively, without inner compulsion. For the strength of the desire or the emotion in the former person is such that it is impossible for him to collect himself sufficiently to decide either to do or not to do something. Whereas the person who acts impulsively but not compulsively could have made a decision, a decision either to do what he did in fact do, or to do something else. Since a person who is in the grip of an inner compulsion is not capable of making any decision, he is not capable of deciding to act in accordance with a second-order desire that one of two or more conflicting desires should be effective or motivating.

Further, when this Bradleian description holds true of someone, the description also holds true of him that he cannot be persuaded by reasons to alter his intention or his course of action. For a person can be persuaded by reasons to alter his intention or his course of action only if he is capable of making a decision; for it is only if he is capable of making a decision that he can decide to do one thing or another on the basis of reasons that are offered to him. So the foregoing Bradleian description of compulsion and Glover's description of a certain kind of volitional disability, are descriptions of the same condition from two different points of view. Glover's description represents the point of view of another person who observes the subject in question; the Bradleian description represents the point of view of the subject himself.

Circumstances in which impaired capacity excuses

But in what circumstances do the kinds of disabilities that I have discussed excuse a person from responsibility, and what is the justification for regarding such disabilities as excusing conditions?

With regard to the first question, one should note that the mere fact that a person is mentally ill does not necessarily excuse him from responsibility for any wrong that he may commit. For example, in cases of paranoia, the cognitive capacities of the patient may be unimpaired in matters that have nothing to do with the subject of the patient's delusion. A woman who believes that her husband has men in the attic who are trying to influence her by x-rays may be able to remember general information and events from her past life, to speak clearly and connectedly, and to appreciate where she is and whom she is with. Suppose that such a woman sees an expensive silk scarf displayed on the counter of a boutique. She fancies it, but she cannot afford to purchase it. She decides to shoplift the scarf. Her motive is that she would enjoy wearing the scarf, despite that she cannot afford to purchase it. Unless her shoplifting is in some way causally connected with her paranoia, her mental illness does not excuse her from moral responsibility for the theft.

The rationale of excuses

I have raised the question of what justifies excusing people on the basis of their having such disabilities as I discussed. In order to answer this question, first, I will state what I believe to be the relation between moral responsibility and moral blame, and, secondly, I will consider under what conditions moral blame is justified.

First, to say that someone is morally responsible for a morally wrong action is to say that he is morally blameworthy. And to say that he is blameworthy is to say that it is right or correct or justified to blame him. But what do we mean by 'blaming' someone? In order to explain the meaning of 'blaming' it is necessary to distinguish between blaming someone and expressing blame. One can express blame by words, as when one says that it was deplorable or reprehensible that a certain person should have done a certain thing; one can express blame by gestures or facial expressions; and one can express blame by other sorts of action, as when one deliberately snubs a person whom one blames. Blaming should not be confused with expressing blame by words, gestures, facial expressions or actions of other sorts. For one can blame a person 'in one's heart', without ever expressing this blame either to the person blamed or to a third party.

To blame someone (morally) is to have towards him an attitude of moral disapproval on account of something that he has done or has failed to do. It is a necessary condition for blaming someone (morally) that one should believe that he has done something that (morally) one ought not to do or that he has omitted to do something that (morally) one ought to do. But though this condition is necessary, it is not sufficient. The attitude of blame is directed primarily to the person whose action or omission is a moral offence or misdeed. The reason why our attitude of moral disapproval is directed primarily to a person rather

than to his action or omission is that, in blaming, we regard a person's action or omission as a sign, indication or manifestation of an attitude which he has, and which we judge to be a morally bad attitude.

Moral blame, then, is an attitude of moral disapproval towards a person for doing what one oughtn't, in general, to do or for omitting to do what one ought, in general, to do; but this moral disapproval is based on the assumption that the person's action or omission or, more vaguely, 'behaviour', is a sign, indication or manifestation of an attitude, which, in the view of the blamer, is morally bad. But, as I have said, to be morally responsible for a morally wrong action is to be blameworthy, and to say that a person is blameworthy is to say that to blame him is right, correct or justified. It follows that if a person's behaviour is contrary to what one ought not, or ought, to do, but his behaviour does *not* truly signify or indicate, or does *not* actually manifest, a morally bad attitude, then to blame him is *not* right or correct or justified. In such a case he is not blameworthy, and so he is not morally responsible for what he has done or failed to do. Here we have the basis, or rationale, of a variety of recognised types of excuse.

Let us consider examples of some different types of excuse. 1) A driver is stung by a swarm of bees and as a result his car swerves into a pedestrian. The rationale of excusing the driver is that his behaviour, consisting in involuntary reflex movements, did not indicate a morally bad attitude towards the pedestrian, such as callousness or malice. 2) An anaesthetist who has every reason to believe that her equipment is in working order induces a coma in a patient because of a fault in the equipment. As the anaesthetist made a non-negligent mistake about the condition of her equipment, her behaviour indicated no morally bad attitude towards the patient, such as malevolence or a careless disregard of his welfare. 3) At the point of a gun a passing motorist drives away a man who has just robbed a shopkeeper. Acting under coercion, the driver did not manifest a morally bad attitude, such as approving of the robbery or condoning it.

Application of the rationale to impaired capacities

The rationale I have proposed of the foregoing types of excuses applies also to excuses based on mental illness. Specifically, it applies to cases where we excuse a mentally ill person because his reasoning or volitional capacities are impaired. For example, a man suffering from paranoia may have the delusion that his next-door neighbour is an enemy agent who has been injecting measured amounts of poison into the patient's water supply with the intention of murdering the patient. Feeling that he is being poisoned, the paranoid assaults his next-door neighbour. In doing so, he evidently believes that he has been sorely provoked or even that he is acting in self-defence. Consequently, his attitude towards his neighbour is quite different from that, say, of an adolescent hoodlum who assaults a passer-by. We

may suppose that the hoodlum assaults the passer-by because it flatters his vanity to beat up someone. That is, the hoodlum regards the passer-by as merely a means to the end of demonstrating to himself his physical prowess. Whereas the paranoid in our example assaults his neighbour in the belief that he is an enemy agent who is bent on murdering him. His attitude is not a morally vicious one, like that of the hoodlum. So even if the paranoid's assault and that of the hoodlum cause equal physical injury, we do not regard the paranoid and the hoodlum as equally blameworthy.

My discussion of this type of excuse should not be taken to imply that a person's action is excusable whenever he *believes* that he has been provoked or is under attack. A standing moral requirement in relations between individuals is that no one should impute wrong-doing to another without reasonable evidence for the imputation. If, finding that a pot of paint has been flung into my garden, I regard my neighbour as the culprit, simply because of his proximity, then I am failing to fulfil the above moral requirement and to respect him as a fellow human being who is as entitled as I am to be presumed innocent until proved guilty. So in assaulting him I should be manifesting an attitude that is morally defective.

Now, the attitude of the paranoid in my example is not morally defective in this way. One cannot say that he fails to respect his neighbour as a person because he has not tried to establish whether or not his neighbour is guilty. For the paranoid's reasoning capacities are impaired, and so this question could not arise for him. He doesn't show a negligent disregard about the matter of evidence, for the private world of his paranoia is incompatible with the framework of thought in which matters of evidence, of verification, of testing and proving, play a part. So his attitude towards his neighbour is not morally defective in the way that mine would be if I believed that my neighbour spilled the paint I find in my garden simply because he lives next door.

Finally, let us consider a case in which we are prepared to excuse a mentally ill person because of his impaired volitional capacity. The behaviour of a voyeur or 'Peeping Tom' may have a compulsive character. A man who seeks out opportunities to spy on loving couples may feel unable to control his scopophilic desires. He may despise his own behaviour, and the conflict between his behaviour and his moral scruples may even give rise in him to nausea and vomiting, symbolic of moral disgust. If a person's voyeurism is truly compulsive, we are prepared to excuse him, for in such a case the agent's behaviour does not manifest a blatant disregard of, or contempt for, the tender feelings of loving couples and their wish not to be spied upon.

Insanity and diminished responsibility

I should now like to show how the foregoing discussion

is relevant to a claim that has been made by Anthony Kenny. Kenny asserts: 'In my view there is no injustice in attaching a stigma to mentally disordered offenders, provided they do not come within the McNaughton Rules' (8). The McNaughton Rules serve to define the defence of insanity in English criminal law. They require for such a defence that it be shown that because a defendant was suffering from a mental illness in which his understanding was impaired he did not know, at the time he committed the offence, what he was doing or that it was wrong. Kenny holds that this should be the only legal defence available on the grounds of mental illness and that the diminished responsibility defence, provided by section 2 of the Homicide Act 1957, should be abolished (9). Kenny's argument for his claim is as follows: The moral justification of legal punishment is that the threat of punishment deters from the commission of offences. It does so by affecting the practical reasoning of citizens. A mentally ill person may be capable of practical reasoning. To the extent that he is, he can be influenced by the threat of punishment. In so far as this practical reasoning is vitiated by delusions that disguise from him what he is doing or the moral and legal consequences of his act, the McNaughton Rules apply to him. So a mentally ill offender may be justly punished except where the McNaughton Rules apply to him (10).

Kenny's argument appears not to allow for the possibility that a mentally ill offender may be incapacitated from practical reasoning and yet know what he (or she) is doing when committing an offence, or that it is wrong. Let us consider, for example, the character of offences associated with the premenstrual syndrome (PMS). Dr K Dalton defines PMS as 'the recurrence of symptoms in the premenstruum with the absence of symptoms in the postmenstruum' (11). It is the timing of the symptoms rather than their type that is most relevant to the medical diagnosis of PMS. The symptoms of PMS include both somatic and psychological symptoms. The symptoms may start at any time during the luteal phase, but they increase in severity during the premenstruum and are relieved by the full menstrual flow. The most common psychological symptom of PMS is tension, which has three components, *depression*, *irritability* and *lethargy*. Irritability can range from 'the cross word or sarcastic remark' to 'violence which knows no bounds and ends in actual bodily harm and even murder. A feature of premenstrual tension is the loss of control in those who normally would not raise their voices or assert themselves' (12). Irritability may be intensified by lack of food intake resulting in relative hypoglycaemia countered by adrenalin upsurge.

Criminal offences committed by sufferers of PMS have certain characteristic features. The woman acts alone; her offence is unpremeditated and without apparent motive; she may make no attempt to escape detection; her action may be a *cri de coeur* (13). Further, '... PMS does not seem to affect an individual's

ability to appreciate the "nature and quality" of criminal conduct, or to understand whether it is right or wrong. Rather, the ability to control one's behaviour is affected. Therefore, under the McNaughton rules premenstrual tension would not constitute grounds for an insanity defence' (14). So a sufferer from PMS who kills someone may realise what she is doing but be unable to control herself, or to engage in practical reasoning. In such a case, the woman's behaviour would not necessarily be a sign, indication or manifestation of a callous attitude towards the life of the victim. If it were not, then from the rationale of excuses that I have presented it would follow that the woman is not morally responsible, or not fully so, for the killing. So, contrary to Kenny's claim, this would be a case in which a mentally disordered offender did not come within the McNaughton Rules, but in which it would be unjust to convict the offender of murder (15).

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- (13) See reference (11): 236; see also: Spencer S. Homicide, mental abnormality and offence. In: Craft M, Craft A. *Mentally abnormal offenders*. London: Baillière Tindall, 1984: 101-102.
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- (15) Even if one were to argue that the occurrence of PMS in its 'pure' form is relatively rare, it is sufficient for my argument that such a case as I have described could occur.