

Clinical Assessment of the Voluntariness of Behavior

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There are a variety of therapeutic and forensic contexts in which the clinician is called upon to assess the voluntariness of behavior. Because the assessment has such complex moral and scientific dimensions, it has been difficult to conceptualize how it is done. By considering the behavior of clinicians and other relevant theoretical issues, the author has prepared a framework for thinking about the assessment of voluntariness. The relevance of diagnostic and philosophical issues is considered. Most of the factors which influence assessment are related to the nature of the patient's pathological experience, hypotheses of causation, and method of treatment. Dr. Diamond had a deep interest in questions of voluntariness and responsibility. I know that he would have disagreed with, at least, some of the material, but I believe that he would have thoroughly enjoyed discussing and arguing the issues. I know that I would have loved the dialogue.

Clinical assessment of whether conduct is voluntary (willful or chosen) or involuntary (outside of the control of the will) has moral as well as scientific dimensions. The moral dimensions arise out of certain social consequences that are regularly associated with labeling behavior as either voluntary or involuntary. People are held responsible for conduct viewed as voluntary. If that conduct is socially undesirable, they may be blamed and sometimes they are punished. In contrast, conduct viewed as involuntary, even if socially undesirable, is often excused.

Legal scholars, philosophers, and clinicians have disagreed as to the extent to which assessment of voluntariness (or volitional capacity) can be based on sci-

entific principles.¹⁻³ There is general agreement, however, that mental incapacity can compromise voluntariness.^{4,5} In practice, mental health professionals regularly assess voluntariness for both legal and therapeutic purposes. I will argue in the next section that such assessment is a necessary and inherent aspect of psychiatric practice.

Unfortunately, clinicians rarely have access to conceptual or practical guidelines for assessing voluntariness. This paper is an effort to identify issues that must be considered in developing a conceptual approach and to provide, at least, some practical assessment guidelines. Given the limited research in this area, many of my comments will be based on personal observations as to how clinicians go about the task of assessing involuntariness and how they rationalize their conclusions.

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When Is Assessing Voluntariness of Behavior a Clinical Issue? The question of whether conduct that is related to a mental disorder is voluntary arises more commonly than as generally assumed. Some of the situations in which such assessment is a necessary part of forensic or clinical practice, are listed below:

1. *Determining Criminal Responsibility* There is a close relationship between a clinical assessment that a given criminal act which is related to a mental illness is involuntary and a judicial determination that the individual who committed that act is not responsible for it. The volitional prong of the insanity defense, where it exists, deals directly with the question of voluntariness. But even when individuals are found not guilty by reason of insanity because of cognitive impairments, it is often argued that their lack of understanding or knowledge of their situation has compromised their will or capacity to choose.⁶

2. *Assessing Psychiatric Disability* Here society deals with the assessment of deficits or omissions of behavior such as failure to perform tasks. In determining psychiatric disability, a judgment must usually be made as to whether the patient fails to perform a task because it is beyond his or her capacities or if the patient is to some extent simply unwilling to do something that is within his or her capacities. An assessment of involuntariness is a predicate of disability, i.e., it must be determined that the patient could not choose to work before he or she is excused from this obligation.

3. *Determining Liability for Self-Destructive Acts* The psychiatrist's duty to prevent patients from harming themselves is in part derived from an assumption that mental illness compromises the voluntariness of suicidal acts. When the courts view suicide as a voluntary act, the physician may not be liable for failure to take steps to prevent it.⁷

4. *The Assessment of Dangerousness* While data as to the dangerousness of the mentally ill is inconclusive, there is general agreement that people whose acts are involuntary cannot control their behavior and are, therefore, more dangerous than others.⁸ In practice, clinicians impose external control upon those assumed to have deficient internal control. There are a number of situations in both the mental health and criminal justice system in which clinicians are asked to assess dangerousness.⁹ In all of these assessments the clinician may be concerned with the question of voluntariness.

5. *The Development of Strategies for Psychotherapy* In the process of almost any form of psychiatric treatment, therapists suggest to patients that they conduct themselves in a manner which maximizes their well-being. Therapists must, therefore, decide what therapeutically useful acts a particular patient is capable of performing and how the patient's symptomatology may compromise his or her capacity to perform these acts. Sensitive clinicians hold the patient responsible only for what he or she can will to do. They do not ask the patient to do what they believe the patient cannot will to do.¹⁰ Underlying these critical

and commonplace therapeutic maneuvers is an assessment as to the patient's capacity to voluntarily act on the clinician's suggestions.

6. *Environmental Aspects of Treatment* Family members, friends and others in the community may be concerned with the patient's degree of control of behavior. Their response to the patient's symptomatic behavior whether compassionate, firm, or punitive will have a powerful effect on reinforcing, diminishing, or extinguishing behavioral patterns. Generally, those in the patient's environment are more likely to respond compassionately to behavior that is considered involuntary, even if it is socially disturbing. They are firm or punitive in dealing with behavior considered voluntary, particularly if it is socially offensive. The clinician's assessment of the voluntariness of the patient's conduct once communicated to significant figures in the patient's environment will determine much of their response to that conduct.

7. *Economic Issues* In an era of cost containment, insurance companies increasingly try to distinguish between voluntary and involuntary disorders. They are reluctant to reimburse patients for treatment of disorders, characterized by symptoms that can be judged willful or voluntary. It is likely that clinicians will meet increasing pressure from both payers and patients to provide more definitive statements as to which behavioral symptoms and which disorders associated with behavioral symptoms are involuntary.

Problems of Conceptualization

Psychiatric Diagnosis and the Assessment of Voluntariness In Western society the idea that a patient has a disease is generally associated with an assumption that he or she does not will or choose to develop its symptoms.¹¹ The patient who is believed to have a disease may even be excused from obligation or blame for aspects of conduct directly related to a pathological process. A patient who has broken a limb for example, will not be obligated to perform physical labor, nor will he or she be blamed for lack of performance.

The assumption of involuntariness associated with the idea of a disease is not easily generalized to many psychiatric disorders. Most of the symptoms that define psychiatric disorders are either experiential or behavioral. Clinicians assume that patients have some, but limited, control of their experiences. They assume that patients have considerable control of their behavior. In fact, behavior is rarely viewed as involuntary in Western society, even if it is irrational. Behavioral symptoms of mental disorders, therefore, are rarely judged to have the same uncontrollable qualities ordinarily attributed to symptoms of other diseases.

The case for the involuntariness of behavioral symptoms would be strengthened if it were possible to demonstrate pathophysiological processes in mental disorders that fully explain why conduct associated with these disorders could not have been chosen. Most of the time in psychiatry this cannot be done. This means that it is problematic to assume

that any of the behaviors associated with diagnoses listed in the DSM III-R should be considered involuntary.

Moral Issues in Assessing Voluntariness Legal scholars have noted that acts may be intentional but at the same time involuntary.¹² Generally, it is useful for clinicians to be aware of this distinction, particularly when responsibility is assessed in the legal context. A man who kills because he hears God commanding him to do so in order to prevent a catastrophe acts intentionally but, perhaps, not voluntarily. He certainly intends to take another's life no matter how irrational his motives. But it can be argued that defective information and understanding obviates his capacity for choice and that his act is not voluntary.

Taking a different approach to the question of intentionality versus voluntariness, some philosophers point out that compulsive acts may be intentional but not voluntary. They argue that because the person who repetitively washes his or her hands cannot choose to abstain from doing so, it cannot be said that he or she chooses hand washing behavior.¹³ The compulsive act, therefore, is intentional but not voluntary. This approach still begs the question as to whether the compulsive hand washer is totally incapable of choosing not to wash his or her hands.

Another issue that has powerful moral implications is whether clinicians have any basis whatsoever for stating that the patient has absolutely no choice. While the clinician may be called upon to state definitively that an act is voluntary or involuntary, our science does not usu-

ally help in making this determination. In the absence of a demonstrable pathophysiological condition that completely obviates choice, the extent to which choices is compromised can only be conceptualized on a quantitative basis.

Consider a situation in which a group of individuals with a variety of physical and mental disorders are asked to run a race. One person is a paraplegic, another has a broken leg, another has an ankle sprain, another is extremely obese, another is very depressed and lethargic, and the last person has an unrealistic fear of competition. Understandably, none of these people would be eager to run the race, and the paraplegic person would be completely unable to do so. All the others, however, would have various degrees of choice. The degree of pain for the person with the broken leg might be excruciating, and he or she would have a hard or perhaps impossible choice. All the others would have various degrees of difficulties of choice but nevertheless could choose to participate. Patients with mental disorders have varying degrees of incapacity that may compromise, but rarely, obviate choice. In assessing the voluntariness of their acts, clinicians are actually assessing whether they have hard or easy choices.

Given the fact that most patients with psychiatric disorders do not have impairments that completely obviate choice, decisions as to when to consider their behavior involuntary cannot be made solely on a scientific basis. Unless there is absolutely no choice (as in the case of the paraplegic) the evaluator has

Clinical Assessment of the Voluntariness of Behavior

the task of deciding how much incapacity should be present before involuntariness is ascribed. This is a "line drawing" function that must take into account the nature of the behavior in question as well as the patient's impairments. One consideration that governs the "line drawing" function is the degree of difficulty of the patient's choice. The harder the choice, the more likely is it to be considered involuntary. Moral considerations, however, may also influence the "line drawing" function.

When the patient's acts are particularly objectionable, the clinician's moral perspective can influence his or her assessment of the patient's capacities. Judgments as to whether to hold a particular patient responsible for a particular act may lead the clinician to see more or less impairment than is actually present. When we say an individual cannot control him or herself, we may not be describing impairments that make control possible. Rather, we may be assuming an exaggerated degree of impairment because we believe it is morally wrong to find that person blameworthy. Or, if we are already willing to ascribe responsibility, we may minimize the degree of impairment.

The power of social and moral considerations to influence assessment of voluntariness is illustrated by considering the various thresholds society utilizes to ascribe responsibility for behavior related to alcohol addiction. From the standpoint of criminal justice, alcoholism is not an excusing factor, and "voluntary" intoxication rarely reduces culpability or liability for criminal acts.¹⁴

From the standpoint of tolling a statute on the basis of incapacity, the Supreme Court has ruled that alcohol abuse is not an aspect of a disease but rather, willful conduct.¹⁵ In terms of treatment, however, the alcoholic is increasingly viewed by clinicians as a diseased person who has very hard choices in seeking abstinence.¹⁶ Even here, however, clinicians are ambivalent as to the patient's capacity to abstain. In treating the disease the alcoholic is urged to abstain. This assumes that he or she can make this choice. Society's ambivalence regarding the voluntariness of substance abuse is especially apparent when there are high economic costs to accepting a disease model. Third-party payers put strict limits on benefits for substance abusers, limits that are not ordinarily invoked in dealing with "physical" diseases. To at least some extent, this may reflect a moralistic belief that substance abusers could control drug-seeking behavior if they wished to.

A Basic Principle in Conceptualizing Evaluation: Experiential Symptoms Are More Readily Viewed as Involuntary than Behavioral Symptoms There is both experimental and clinical evidence that patients have less control over experiential than behavioral symptoms. Many psychological studies demonstrate that people can control most aspects of behavior when presented with the proper contingencies.¹⁷ This at least suggests that they have the power to control the same behaviors when the contingencies are not present. At the same time, experiential symptoms such as deficits of cognition or distressing

emotions are more difficult to change by altering contingencies.

In actual practice, clinicians put demands on patients to control behavior and are reluctant to urge similar control of experience. Clinicians would not urge a patient to stop feeling angry but are very likely to be urge him or her to stop expressing that anger. Clinicians would not blame a patient for feeling depressed but might hold him or her responsible for sitting in his or her room all day and refusing to take meals with other patients. Nor do clinicians ordinarily view cognitive deficits as voluntary. Patients obviously do not choose the cognitive deficits associated with delirium or dementia. Ordinarily, hallucinations are not assumed to be under control of the will. Whether patients can control delusional thoughts is more debatable, but clinicians ordinarily assume that they cannot.

The actual practice of psychiatry or psychology also teaches clinicians that patients are more likely to respond to demands for behavioral than experiential change. Patients are unlikely to respond to admonitions to feel less confused, less depressed, or less anxious. They often do, however, respond to urgings to be more assertive, more cooperative, or less manipulative. None of this should mean experiences such as thinking and feeling are incapable of being influenced by the environment or even by behavior. To some extent, they certainly are. It is just that in the triadic interaction of experience, environment, and behavior, experience is less influ-

enced by the other two factors than behavior.¹⁸

While it is obvious that experience influences behavior, it is never clear that a specific behavior should be viewed as being as involuntary as the experience that helped to generate it. No two patients are likely to respond to the same experiential symptoms with the same behavioral pattern. There are many variables that influence the manner in which a patient responds to any painful experience including the patient's earlier learning, the current environment and the patient's character. Each of these variables plays a sufficient role in determining behavior so that it is almost always simplistic and incorrect to assert that the same degree of involuntariness should be attributed to the behavior as to the experience that has only, in part, caused it.

Factors Considered in Assessing Voluntariness

The factors that generally influence clinicians' assessments of voluntariness are the nature of the patient's experiential symptoms, the hypothesized causes of those symptoms, and the manner in which they are treated.

The Nature of Pathological Experience: Cognitive Impairment

Cognitive Impairment Impairments in thinking have a clear and direct influence on behavioral choice. The patient who is deficient in any of the processes involved in obtaining, retaining, and utilizing knowledge may have diminished capacity to behave rationally. In cases of severe mental illness, the manner in

Clinical Assessment of the Voluntariness of Behavior

which cognitive impairment compromise rational behavioral choices is obvious. The patient who is demented, for example, may not have access to information needed to make rational judgments. The patient who is delusional and motivated to act on the basis of false knowledge is likely to make irrational choices. Irrational behavior while often intentional is also likely to be viewed as involuntary. It is assumed that patients who cannot understand their situation cannot exert will.

In dealing with omissions of behavior such as failure to work, the role of cognitive impairment as an indicator of involuntariness is usually evident. If a patient simply lacks the capacity for perceiving, conceptualizing, and remembering information that is required for performing a particular job and fails to perform, most clinicians will consider the lack of performance as involuntary.

While cognitive impairments are readily viewed as dysfunctions that compromise voluntariness, it should be emphasized that it is rarely clear how impaired cognition actually leads to a specific behavior. Our lack of certainty becomes a particularly difficult problem in evaluating socially noxious behavior. Because patients with apparently equal levels of cognitive impairment behave quite differently, cognitive impairment can be only a partial determinant of behavior. Personality and environmental variables must also be causative factors.

Distress or Painful Emotions The phenomenon of suffering where there is no apparent environmental cause for it

is a classical criterion of disease. If we believe patients who complain that they are experiencing overwhelming anxiety or depression, we may view some of their behavioral omissions or troubling behaviors as involuntary. Clinicians do not consider the diminished activity of depressed patients nor the motor agitation of manic patients to be willful. On the other hand, antisocial conduct on the part of a patient who shows little sign of emotional distress is usually assessed as willful.

As is the case with cognitive impairment, there is a problem in determining the extent to which an emotional experience causes specific behavior. The relationship is easiest to conceptualize in terms of deficits of behavior. Patients who because of emotional suffering lack capacity to perform tasks or who fear taking certain actions clearly have a hard choice. The failure of a depressed person to go to work or the failure of a phobic patient to enter an elevator might be viewed as involuntary behavioral omissions.

The issue of voluntariness is more complicated when a troubling or a disruptive behavior appears to be an effort to deal with an unpleasant emotional state (such as a situation in which a frightened patient becomes violent). Patients who are experiencing severe psychological pain may act inappropriately by striking out against themselves or some aspect of the environment in an effort to alleviate that pain. Indeed, there is evidence that the experience of suffering may be diminished by activity and even by actions that are socially inappro-

priate.¹⁹ Depending on the clinician's assessment of the degree of the patient's pain, these actions might be viewed as involuntarily. Emotional, like cognitive impairment, however, can be only a partial cause of noxious behavior. We know very little about how a painful emotional state helps to create a specific behavior. Many patients who experience excruciating suffering never behave inappropriately.

Emotional States of Craving A number of mental disorders are defined on the basis of a socially maladaptive behavior plus some motivation or craving that is associated with that behavior. These include paraphilias, impulse disorders, and addictive disorders. Arguments can be made that the behaviors associated with these disorders reflect diminished choice. Conceivably, these patients experience a form of emotional suffering. If they abstain from antisocial conduct, the pain of abstinence might be greater than the pain associated with the possible social consequences of the behavior. To the extent that this is true, the behavioral symptoms are sometimes viewed as involuntary.

There may also be reason to assume that paraphiliac patients have fewer or harder choices than others because society punishes them for satisfying their cravings. Patients with paraphiliac disorders may be unable to obtain sexual gratification through legally or socially acceptable activity. Their only choices are to abstain from sexual gratification or to break a law. On the other hand, the choices for those who have socially condoned sexual proclivities are much

easier; they can either abstain or gratify their urges without fear of punishment.

When diagnoses are made on the basis of behaviors associated with cravings, there are a wide variety of ways to think about the voluntariness of the behavioral component. Here both clinical and social judgments seem to merge. Pleasure seeking acts involving sex, social drinking, and perhaps gambling are likely to be viewed as voluntary. It does not appear that the paraphiliac who abstains experiences much suffering other than the frustration associated with the loss of pleasurable activity. Similar arguments could be made about pathological gamblers, though it is unclear how much they actually enjoy gambling. Society expects its citizens to be able to endure the frustration of abstaining from pleasure seeking. If it is not endured, the pleasurable act, whether socially acceptable or not, is usually viewed as voluntary.

The cravings of addictive disorders may be viewed differently because they are often associated with emotional pain rather than pleasure.²⁰ Many patients use drugs not for pleasure but to mute the pain of mental illness. The patient tempted to drink to drown out frightening voices faces a hard choice. Once addicted, the patient may experience withdrawal symptoms that create a new burden of physical and emotional pain that can be relieved by drug-using behavior. Clinicians generally acknowledge that the choice of abstention is difficult for the addicted patient. They may make this choice easier for him or

Clinical Assessment of the Voluntariness of Behavior

her by providing hospitalization or chemical detoxification.

Another issue that arises primarily in criminal law is how to assess behaviors that do not directly satisfy a craving, but that are motivated by a desire to facilitate satisfaction. Addicted persons may steal to obtain money for drugs or gambling. The general tendency is for society to hold these individuals responsible for their acts. Clinicians usually consider these acts voluntary, although some have argued that the pathological gambler's stealing might be involuntary.²¹

How Does the Patient Think About the Voluntariness of His or Her Behavior? The patient's own perception of the voluntariness of his or her behavior may influence the likelihood of it occurring. Often patients experience their behavior as uncontrollable or involuntary even when it appears that this assessment is based on exaggeration or false belief. Patients with borderline or multiple personality disorders, for example, may believe that they cannot help behaving in certain ways, when they seem to have the capacity to do otherwise. Their perceptions can be considered as a cognitive impairment, in this case, a deficiency in accurately assessing or knowing their true capacity. To what extent does the patient's belief in lack of choice actually constrict his or her range of choices? This question may become very important in the assessment of dangerousness. Empirically, it appears that a belief in lack of choice or lack of responsibility is more likely to be associated with antisocial conduct.²² There is also evidence from social learning the-

ory dealing with perceptions of self-efficacy, which indicates that those that believe they can control their behavior are more likely to do so.²³

To what extent should the presence of a false concept of one's capabilities influence clinical assessment of the voluntariness of that person's actions? Here the physician's view of causation is important. (This issue will be discussed in the next section.) Much depends on whether the clinician views the patient's false perception as a defect based on biologic abnormality or poor learning experiences or as a rationalization for efforts to manipulate the environment. In practice, clinicians tend to be ambivalent in assessing patients who claim lack of control. Some clinicians treat patients who perceive the less desirable aspects of their behavior as uncontrollable, such as patients with borderline or multiple personality disorders, with a firm, limit-setting approach. This tells those patients that they are capable of control and implies voluntariness. Other clinicians adopt a more indulgent or excusing approach, which implies involuntariness.²⁴)

Issues of Causation

The major causative dimensions of mental illness are altered pathophysiology, deficient or distorted past learning, and current environmental contingencies. While these factors are interactive, it will be convenient to consider them separately.

Biologic Causation The factor most likely to lead to behavioral manifestations of psychiatric disorders being

viewed as involuntary is altered pathophysiology. This reflects classical medical thinking in which the idea of a disease, including access to the sick role and an assumption of involuntariness of symptomatology, is largely based on evidence of biologic causation. If there is sufficient biological impairment, behavioral symptoms may be viewed as being as uncontrollable as other symptoms such as pain, nausea, or fatigue.

As biological dysfunctions associated with mental disorders are discovered, clinicians have been tempted to expand category of symptoms labeled involuntary. There are inherent problems, however, in relating biological causality to voluntariness. The most critical issue is that the precise pathophysiologic mechanisms that lead to experiential symptoms and eventually, perhaps, to behavioral symptoms are often unknown. Even when biological deficits are readily demonstrable, psychological and social variables will still influence behavioral outcomes. Thus, patients with equal levels of biological impairment will behave differently, some in a socially acceptable and some in a socially harmful manner. The mere fact that a behavior has biological determinants does not mean that it was fully caused by these factors and does not justify an assessment of involuntariness.

Biologic causation is most relevant to assessment of involuntariness when the biologic impairment is readily discernible and mechanisms by which it influences behavior can be described. If it can be shown how biologic impairment increases the likelihood of a behavioral

aberration (acknowledging that other factors are contributory), the case for involuntariness is strengthened. Currently such mechanisms can be described with relative precision only in certain disorders such as dementia or delirium. The mechanisms are less clearly apparent in severe psychotic disorders such as schizophrenia or bipolar illness. The influence of these mechanisms can only be hypothesized in personality or impulse disorders.

Knowledge of the precise cause of a biologic impairment may also influence assessment of voluntariness. Biological impairments associated with mental disorders may be caused by genetic factors, by a large variety of physical diseases, and even by psychological stressors.²⁵ Impairments believed to be congenital or caused by other illnesses such as infection or traumatic injury may be given more weight in assessing involuntariness than impairments caused by past learning or stress (such as those associated with post-traumatic stress disorder). This may reflect the relative ease of documenting the pathophysiologic mechanism associated with physical illness. The mechanisms by which psychosocial stressors cause biological impairment are more obscure. It is also true that apparently voluntary conduct such as drug abuse may produce biological impairment. Unless such impairment is severe and fits into a recognized organic syndrome, however, the actions associated with it are likely to be viewed as voluntary.

There is reason for special caution in evaluating the influence of biological

Clinical Assessment of the Voluntariness of Behavior

variations associated with disorders that are defined primarily on the basis of descriptions of behavior. Patients with antisocial personality disorder who often engage in criminal acts are likely to show consistent patterns of biological variations. They may have different autonomic response curves than most other people, and some researchers believe they have a harder choice in refraining from noxious behavior than others.²⁶ Does this mean that their antisocial acts should be judged to be involuntary? Most of the time clinicians are reluctant to make such a judgment. There are many reasons for this reluctance, one of which is that biological variation is probably associated with many behavioral patterns, some of which have high social value. All societies tend to view socially condoned behavior as voluntary even when those who behave well may have biological advantages. When noxious behavior is associated with only moderate biological handicaps, the case for ascribing involuntariness is not strong.

Learning and Causation The influence of past learning is a critical aspect of behavioral and psychoanalytic theories of causation. Learning theories are frequently invoked to explain the symptomatology of personality disorders, dissociative disorders, sexual disorders, and somatiform disorders. (Although they may be partial etiologic factors in all disorders.) Ordinarily, an understanding of why or how an individual learned to behave in a socially deviant manner does not compromise society's view of that conduct as voluntary. Even the fact that a person has been raised in an environ-

ment where antisociality is learned through modeling and operant conditioning does not seem to influence society's assumptions.²⁷

The possibility that past learning might compromise the patient's current capacity for choice has been more seriously addressed by psychoanalysts. Psychoanalytic theory postulates that behavior is often based on learning experiences that are no longer part of the individual's current consciousness or awareness, i.e., they are unconscious. There is, at least, some logic in assuming that people cannot control conduct based on motivations of which they are unaware. Psychoanalytic theory also provides an elaborate explanation of irrational behavior. There is a tendency for clinicians and others to excuse conduct that appears to be explained, particularly when the explanation makes the irrational comprehensible.²⁷

There are differences in the manner in which the issue of voluntariness is dealt with in psychoanalytic practice as opposed to theory. Although psychoanalytic therapists do not punish patients (other than by communicating disapproval), they do tend to hold patients responsible not only for acts based on unconscious motivation, but also for the motivation itself. In the utilitarian context of treatment, experiences as well as acts may be viewed as controllable. Freud²⁸ argued that patients should be held responsible for their dreams. All psychoanalysts hold patients responsible even for negligent omissions, such as forgetting or "slips of the tongue."²⁹ This rigid demand for responsibility in the

treatment context (based on the utilitarian principle of expediting treatment) contrasts with some psychoanalytic views of how unconscious motivation might compromise voluntariness outside of the treatment situation, including situations where criminal sanctions are an issue.

It is useful to try to think about how psychoanalytic theory provides a rationale for ascribing involuntariness. There are three ways in which unconscious motivation could play a role in determining undesirable behavior. First, acts might be symbolic and represent displacement of feelings toward an inappropriate object. Thus, a child angry at her mother may inappropriately lash out at a benign teacher. Second, conflicts based on out of awareness impulses might increase levels of emotional tension or suffering and increase the likelihood that an individual will act in some inappropriate manner to deal with that anxiety. Third, it is conceivable as Freud³⁰ described, that some individuals might have an unconscious wish to be punished and behave in a noxious manner in order to fulfill that wish. None of these hypothetical dimensions of causality in themselves provide sufficient reason for ascribing involuntariness or nonresponsibility.

While the child who attacks her teacher rather than her mother may have a form of cognitive impairment, she still has motivation to do harm. If the physical act were to be taken against the actual parent whom she saw as oppressive, it would be viewed as both intentional and voluntary. The apparent ir-

rationality of an attack on an innocent subject does not necessarily obviate the reality of the child wanting to do harm. It should be no harder to control anger against symbolic as opposed to actual objects.

The issue of noxious behavior being fueled by emotional suffering has already been discussed in the previous section under experiential issues. Here, there is some rationale for assessing involuntariness. An explanation that emotional suffering is caused by unconscious conflict, however, would appear to have no more and probably less relevance to the issue of voluntariness than one based on emotional suffering caused by biological deficits.

The person who seeks punishment because of severe guilt and, perhaps, depression distorts the risks of noxious behavior and may find that conforming behavior is a harder choice. This person may be viewed as having a cognitive disorder that leads to irrational behavior. Still, it is not entirely clear why he or she did not simply elect to harm him or herself rather than to invite retaliation by doing harm to others. It is reasonable to assume that such a person also has, at least, some wish or motivation to impose harm on others. Absent other experiential defects, the rationale for viewing his or her acts as involuntary is not strong.

The Influence of Victimization

Psychoanalytic theory is also concerned with the long-term influence or traumatic events or experience and behavior. Severe trauma in early life, particularly physical or sexual abuse by

Clinical Assessment of the Voluntariness of Behavior

adults, is a factor in many victims developing a high reliance on disassociative and other pathological defense mechanisms in adulthood.³¹ The use of these mechanisms is often associated with painful emotional states of anxiety and depression and troubling behavior. If victimization is a factor in the patient developing experiential symptoms and if these symptoms are a factor in the patient developing troubling patterns of behavior, it follows that there is a relationship between the victimization and the behavior. Some clinicians view this relationship as so powerful that they consider behavior related to victimization as involuntary. Patients diagnosed as having multiple personality disorder, for example, are often assumed to have little capacity to influence either the appearance or conduct of alters.³²

It is certainly true that many patients diagnosed as multiple personality disorder perceive themselves as lacking control of much of their conduct. Perhaps, it is this factor plus a natural sympathy for the victim plus a wish to gain rapport with the patient that leads clinicians to accept the patient's view of involuntariness. There are certain practical and social risks, however, in making this assumption.

One practical issue is that the traumatic events patients report are often remote in time and the relationship between past trauma and current behavior is likely to be obscure. Both the history of trauma and the symptoms of emotional suffering attributed to the victimization are likely to be based on self-reporting. There is a likelihood that the

clinician may be deceived. Another practical consideration is that the clinician by accepting the patient's view of involuntariness may reinforce what is possibly a distorted perception and thereby make the patient worse.

At the same time the social consequences of excusing conduct based on victimization could be troubling. Many people are exposed to severe trauma, including victimization. Among some social groups such as convicted criminals, the rate of victimization is relatively high.³³ Society may not wish to make it too easy for people to rationalize current behavioral inadequacies by claiming that early trauma is an excusing condition. Too much expansion of victimization as an excusing factor carries with it the threat of radically altering the nature of our societal assumptions about responsibility.

Environmental Variables Environmental variables, including stressors, reinforcements, and patterns of communication within the patient's family and society may have a powerful impact upon the patient's behavior. These determinants, however, are not usually given very much weight in assessing voluntariness unless they are extreme. Even a "rotten life" does not excuse.³⁴ Unusual environmental stress, however, may sometimes change clinical and societal perspectives. The woman who physically attacks her husband after having endured years of violent abuse from him may be excused when she is viewed as having attacked him out of fear. Even if the act is viewed as voluntary, the

patient may be seen as having acted in self-defense.³⁵

Issues Related to Treatment

There are three major issues to be considered in understanding how the manner in which a disorder is treated may influence clinical assessment of voluntariness. First, the extent to which the symptom can be treated by changing the environment; second, the extent to which the disorder can be treated with medication; and third, the extent to which the disorder can be treated by appeals to the will.

Environmental Treatment Many symptoms of mental disorders are highly influenced by environmental change. Thus, patients with personality disorders characterized by troubling behavior may behave quite appropriately when sufficient external controls are present. Even patients with severe schizophrenia can be taught to behave in a relatively normal manner in closely structured environments.³⁶ There is some inherent logic in assuming that behavior that can be environmentally controlled can also be internally controlled. Indeed, much evidence from social learning theory tells us that this is true.³⁷

An important guide in assessing voluntariness is estimation of how drastically environmental variables would have to be changed in order to have some effect upon a given behavior. There are certain common sense considerations here. If a particular form of antisocial conduct is unlikely to occur as long as there is an immediate threat of apprehension and punishment in the

environment the case for excusing the person for antisocial conduct that occurs in the absence of those constraints is not very strong. On the other hand, antisocial behavior that occurs even in environments where punishment is likely might suggest a kind of irrationality or compulsion, which favors an assessment of involuntariness.

Biological Treatment When a mental disorder is treated with medication, there is an assumption that the drug is modifying some altered physiological mechanism. Drug treatment supports biological hypothesis of causation and its effective use may influence assessments of voluntariness of behavioral symptoms. Such reasoning, however, must be accepted with caution. The mere fact that a drug influences behavior, does not mean that the behavior is entirely or even partially determined by biologic abnormalities. Some medications have an impact on many aspects of physiologic functioning and may alter adaptive as well as pathophysiologic processes. The behavior that is changed might not necessarily to one that was caused by a biologic defect. Anti-anxiety drugs, for example, may change behavior associated with even normal or adaptive levels of anxiety.

In general, the use of medication is most likely to support biological hypotheses when drug treatment is specific, i.e., when a distressing behavioral system believed to be caused by pathophysiologic processes is removed, without grossly altering any other aspect of the individual's symptomology. Here, the strengthening of the evidence for

Clinical Assessment of the Voluntariness of Behavior

biological causation may strengthen the case for involuntariness.

Appeals to the Will The extent to which clinician appeals to the will in treating a specific disorder gives a kind of common sense clue as to whether its behavioral manifestations ought to be viewed as voluntary or involuntary. If we tell a patient in the context of treatment that he or she must try harder at some task, we assume that the person has the capacity to accomplish that task. If we do not believe the patient has sufficient capacity to follow clinical directives, no demands are made and current behavioral patterns are accepted as involuntary. It would seem that when mental disorders are treated by appealing to the will, assumptions of involuntariness should routinely be questioned.

Conclusion

Both clinicians and society must ultimately consider where to draw the line that reflects a judgment that a person's incapacities are so great that his or her actions can no longer be considered voluntary. Where the social consequences of this decision are powerful, as is the case in assessing criminal responsibility, disability, or dangerousness, judicial agencies may assume the line drawing function. Here, the clinician may have the option of merely describing the patient's incapacities to the court and allowing the court to assess whether they are severe enough to allow for an ascription of involuntariness and nonresponsibility. There are many clinical situations, however, in which this option is not present. Clinicians must on their

own, assess voluntariness in determining what behavioral demands to put on patients, in helping patients develop an appropriate sense of their self-efficacy, in helping relatives relate to patients, and, sometimes, in assuring the safety of themselves and their staffs. Thus, however convoluted the scientific and moral dimensions of the task may be, clinicians must assess voluntariness. It is better that they do this on a conceptual rather than an intuitive basis.

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