Letters to the Editors

Only letters that are responsive to articles published in previous issues of the Journal will be accepted. Authors of these published articles are encouraged to respond to the comments of letter writers. The Editorial Board hopes that this section will enhance the educational mandate of the Journal.

Reply: Staring Down “The Dark Emptiness of Legal Jargon”

Editor:

Dr. Gordon* has honored us with a very stimulating commentary on our paper (P. G. Nestor and J. Haycock, Not guilty by reason of insanity: clinical and neuropsychological characteristics. 25:161–71, 1997). In the process, Gordon has advanced the provocative and (for the professional if not necessarily the popular mind) counter-intuitive maxim that “the iller the killer, the worse the purpose.” Because Gordon’s argument rests on some of the conceptual conflations we argued against, however, we find the catchy precept unconvincing.

The Mad and the Blameworthy

In our original paper, we were at some pains to set one aim of clinical science as maintaining boundaries “between moral and clinical judgments” and to define the work of clinicians as one of “providing information for the courts in matters of culpability and blameworthiness.” We referred to the “worst scenarios” as ones in which “distinctions between what may be ‘bad’ and what may be ‘mad’” are lost. Explicit in these distinctions, we thought, were the recognitions that the law and clinical science represent two different and incompatible realms of discourse and that when mental health professionals import concepts from one theoretical discourse into another, they do so at their peril.

Gordon’s reply illustrates that peril. Gordon thinks our paper said “forensic science rigorously distinguish[es] between moral and clinical judgments, between the bad and the mad.” But we did not say anything about clinical science itself distinguishing between the bad and the mad, or even that clinical science could alone distinguish between moral and clinical judgments. We simply said that clinical science provides “information for the courts in matters of culpability and blameworthiness.” Surely that phrase cannot be twisted to say that clinical science addresses the court on culpability and blameworthiness. Culpability and blameworthiness are socially agreed-upon, essentially moral categories that the law embodies. The best and worst scenarios to which we alluded in our original

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*This letter is in reply to the letter written by A. G. Gordon, MD, in the preceding issue of the Journal (The iller the killer, the worse the purpose (letter). 26:683–6, 1998).
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Paper concern the interaction of clinical science and law, in which each respects the limitations of its own discursive domain and in which the boundaries are "upheld."

Gordon then concludes that we have made the fundamental mistake of assuming that "evil and insanity have nothing to do with one another, can easily be separated and even that they don’t coexist." This is neither our assumption nor that of any other set of clinicians: this is, essentially, an assumption derived from most moral discourse, and it is an assumption that the law incorporates in the legal concept of "insanity." Clinical science can have no opinion about the relationship of "insanity" and "evil," because "insanity" is a legal concept and "evil" an ultimately religiously embedded one. Even the law cannot expatiate on the relationship between the two, except insofar as the law represents "evil" as criminal liability or criminal blameworthiness.

Nor can clinical science distinguish between, nor want to distinguish between, the "mad" and the "bad." "Mad" and "bad" are shorthand terms for moral, socially sanctioned, political and legal concepts. Clinical science doesn’t know the "bad" or the "good." and contrary to prevailing assumption, it wouldn’t know the "mad" either, because "mad" simply designates someone morally exempted from being labeled "bad," and clinicians have no special insight into the bad.

Gordon then provides a fascinating analysis of 764 persons indicted for murder in England and Wales. The problem is that Gordon does not supply a clinical analysis of those persons. Gordon instead proposes a reconfigured type of legal analysis of their acts, and on that basis, arrives at a proposition that succinctly jumbles a legal concept and a clinical one, namely that there is "a direct relation between intention to kill and mental illness." Gordon then follows that with the non sequitur "the iller the killer, the worse the purpose."

The difference between mad and bad is not that the two could never co-exist in a person, however prevailing social standards elect to define "madness" or "badness." Rather, the distinction is a legal one, incorporating into the law a philosophical differentiation of a particular type of exculpating excuse versus the absence of that or any other exculpating excuse or justification. It is this differentiation which, as we indicated in our paper, can be traced back into antiquity and is conventionally neatly pinned on Aristotle. However, even for ancient Greece it could just as easily be moved back another century to the more complicated treatments of madness in the great Greek tragedies of the fifth century B.C. on which Aristotle is commenting, or as Robinson1 reminds us in a recent bracing survey, to Homer in the eighth century B.C.

The colloquial and oft-repeated distinction between mad and bad therefore has nothing to do with whether some more or less mentally disordered offenders are also more or less nasty folk. Clinical experience already says yes, and if doctors tried to argue otherwise, the force of everyone else’s life experiences would laugh us out of court. Some of our most trying patients may not be nice people. The distinction has to do with whom a
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society will hold criminally blameworthy and whom it will hold criminally blameless. In that moral and legal sense, “mad” and “bad” do have nothing to do with one another because they are mutually exclusive logical categories, not characteristics of individuals or of acts. From a philosophical, moral, social, or legal point of view, Gordon’s idea, “the madder the badder,” is therefore an oxymoronic proposition.

*The “Truly Wicked,” the Middling Wicked, and the Hanged*  The fallacy of any attempt to mix and match clinical and legal concepts can be seen in Gordon’s analysis of the 764 murder indictments returned in England and Wales in the period 1957–1962 and in his attempt to transpose legal terms and legal outcomes into some clinically relevant spectrum.

Dr. Gordon begins by rating case vignettes for the *mens rea* of the offender, “or the inferred intention to kill,” in an attempt to determine which homicides represented “true murder” “i.e., where there was *intention* to kill” [emphasis in original]. Criminal law being concerned with the identification of the bad, it is interested in the mad only as one exclusionary criterion for isolating the bad. Since law presupposes a fanciful universe of rational decision-makers, it takes a lot of law and legal commentary to explain why anyone would escape blame for criminal offenses, and if so, who those persons might be. Among the concepts legal discourse deploys to this end are admittedly those of “premeditation” and “intent.”

But contrary to Gordon’s argument, the law is not concerned simply with the existence of “intention,” understood as “decided to do something other people (or the legal actor) think is bad.” Rather, the law is concerned with blameworthy intention and with degrees of culpability among intents. Intending to do something is not the same as forming a legally blameworthy, criminal or bad intent; “mad” (blameless) intentions may also be said to exist. “Premeditation” is a particular blameworthy design and in the United States is one of the elements of first degree murder, the most blameworthy of U.S. law’s homicides.

In place of U.S. legal definitions of the most blameworthy homicides, and in place of existing English legal definitions of the most blameworthy homicides, Gordon substitutes a new *legal* definition of the most blameworthy homicides, the “true murders.” Gordon found “true murders” in those brief case vignettes where “there was evidence from the perpetrator’s actions or statements of a plan to kill formulated at a different time or place to the homicide site. Someone who picked up a nearby weapon in a rage would be classed as impulsive, whereas someone who went to fetch a knife from the kitchen would not be given the benefit of the doubt. . . .” Unlike premeditation in current criminal law, which famously (or infamously) “need not exist for any particular period before it is carried into effect,” (Ref. 2, p. 1180) the intent to kill of Gordon’s most criminally liable murderers must simmer for a good half hour, during which they have all the opportunity “Gordon’s Law” will allow them to contemplate the gallows or other unpleasant consequences. “The minimum time
for which intent had to be shown was set at half an hour, so as to exclude impulsive homicide and to allow enough thinking time for any deterrent effect of hanging to operate.” The qualities of intents no longer matter; the durations of intents are alone relevant. Yet intent judged irrational and an outgrowth of a mentally disordered mind may very well characterize a successful insanity defense. Whereas level of intention represents a central characteristic of the legal concept of diminished capacity, it has no necessary relationship to the legal concept of insanity.3 A defendant judged insane need not demonstrate a substantial lack of intent, and Dr. Gordon is nowhere warranted in identifying intent and evil.

This new legal definition of the “truly wicked” in hand, Dr. Gordon proceeds to re-analyze the brief facts selected by Terence Morris and Louis Blom-Cooper4 for their book concerning 764 different English homicide indictments. The Morris and Blom-Cooper book totals 413 pages, considerably less than the transcripts of many single murder trials. Gordon then constructs a table relating legal outcomes to murderous intent, as now redefined.

The fairness of the English criminal justice system has come under increased attack in recent years, but nothing prepared us for Dr. Gordon’s finding that 84 percent of those executed during the years in question did not even intend to kill their victims. That English jurists once systematically put on the black hat for those least culpable would be a shocking indictment of the workings of the English criminal justice system.

We are as dismissive of the deterrent effects of hanging as the next social scientist, and we appreciate the fine irony of Gordon’s schema, which shows Great Britain executing members of a group least deserving of it and exculpating or otherwise declining criminal prosecution of the members of groups most morally deserving of punishment. All capital punishment admits of fantastically capricious application, and the former English legal mechanism which allowed the Home Secretary to decide, in secret, to which murderers sentenced to death should be extended the Royal Prerogative of reprieve, and for which the law should be allowed “to take its course,” was as ghastly as many a U.S. capital case. Gordon’s indictment of the already notorious Homicide Act of 1957 joins a large literature.5 That the Crown and the Home Secretary allowed to be executed at least some of the less culpable during the time period in question is not in dispute (cf. the many books, including one of Blom-Cooper’s,6 on the A-6 murders and the subsequent hanging of James Hanratty7). Whether the English actually went about systematically exculpating the truly evil and executing the less culpable is a matter for the English public, or the Home office, to decide. Gordon’s tabular schema will not convince them.

Mental Disorder and the “Intention to Kill” More relevantly for the purposes of a psychiatric journal, Gordon’s table provides no data from which to conclude that “there is a direct relation between intention to kill and mental illness.” [emphasis in original] that “madness causes badness,” or “the iller the killer, the worse the purpose.” Count us among the “un-
lucky, careless, confused or deluded,” but we do not understand the reasoning that allows different legal outcomes or verdicts to be arranged in an ascending order of clinical pathology. Gordon’s categories are not even all legal outcomes: leaving aside the already vexed question of whether homicides who attempt suicide afterwards represent a valid methodological substitute for the homicide/suicide group (given the differences in gender that obtained between the homicide/suicide group and other homicides in England for the period in consideration, this seems to us an invalid substitution.8 “Murder and failed suicide” is not a legal outcome, much less the legal disposition held in law to be least criminally blameworthy of those listed.

Nor can we endorse Gordon’s assumption that the murder followed by completed suicide group would represent on balance the greatest degree of mental disorder (the “iller”). In the United States, at least, potentially medically lethal suicide attempts following a homicide occur more often among non-psychotic than psychotic homicides.9 A serious suicide attempt following murder is unlikely to exculpate the homicide perpetrator, and the existence of suicidal intent preceding, accompanying or following a homicide rarely exculpates either, absent the disabling presence of causally linked signs and symptoms of psychosis at the time of the killing. Most research on homicide/suicide regards it as having more in common with suicides than with homicides; given this “extended suicide” feature, we don’t see how this group can be placed at a more ill end of the spectrum compared to, say, persons that fact-finders have found Not Guilty by Reason of Insanity (NGRI) or Guilty but Mentally Ill, who in the main display psychotic disorders. We are equally perplexed by the assumption that those unfit to plead represent on balance a more fundamentally psychiatrically impaired group than the adjudicated “insane,” especially since at different stages of the legal process they are often the same persons.

Dr. Gordon is certainly correct that many NGRI acquittees would not pass the Gordon test (e.g., lacking the intention to kill). As a matter of fact, it is difficult to think of a landmark insanity case in which the defendant would have met it, from Hadfield and M’Naughton onward. After all, Hadfield had thought of going into that theatre and firing a shot for more than half an hour, as had M’Naughton of killing Prime Minister Peel. Indeed, the history of the insanity defense in the 19th century can be read as an attempt by the law to grapple precisely with the existence of capacities such as planning or an intent to kill in certain persons whose mental disorders did not deprive them of all reasoning, yet who were obviously severely mentally impaired. Our original paper attempted to show that the clinical characteristics of the very few persons likely to be held blameless of murder in Massachusetts included related capacities. For a set of reasons, those are some of the persons most likely to be acquitted of murder by reason of insanity; perhaps because their prior disordered brooding reassures fact-finders that the illness is neither “temporary” nor situationally convenient; perhaps because the existence of
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such prior disordered brooding provides clinicians with material with which to fashion clinical narratives that will lead fact-finders in turn to construct their own legally exculpatory narratives; and for a host of other reasons, perhaps including the fact that a small number of other murder defendants receive “unlucky, careless [and] confused” legal representation.

At least in the United States, the criminal justice system’s own practical differentiation of more and less blameworthy homicides does not inspire great confidence. As a definition of the most legally culpable or blameworthy (“bad”) types of homicides, Dr. Gordon has simply substituted a different arbitrary schema for what is, admittedly, the law’s often phantasmagorical distinctions among degrees of criminal homicide. Gordon tosses off the qualifier that murder in the Gordon definition will not include “intent to harm but not kill,” as if this distinction is one that can be quickly ascertained. We doubt it. Or consider that 15 minutes of prior thought would earn one the label impulsive and less criminal liability while 35 minutes prior thought earns maximum criminal liability. Dr. Gordon’s distinction between “picking up a nearby weapon in a rage” and “someone who went to fetch a knife from the kitchen” (whether enraged or not) is certainly not one on which we would want our own defense case to rest.

We see no evidence anywhere that mental health professionals have any special divining powers into those homicides society should consider the “truly wicked” and those the “somewhat less wicked.” Dr. Gordon has obviously mined an important data base; any description of homicides that permits the divination of mens rea at this distance is a rich source for study. We look forward to more extended use of the material. But in the meantime we see no constructive purpose in further muddying the waters by talking about “diagnosing murder.” Mental health clinicians cannot “diagnose” the legal category of murder, independently or otherwise, as Gordon purports to do. It likewise seems to us terribly doubtful that any doctor’s readings of brief summaries of the facts could ever permit the breathtaking conclusion that “clearly [English] juries took no notice of legal definitions of murder or manslaughter when reaching their verdicts.” U.S. Justice Frankfurter, in his dissenting opinion in Fisher v. United States, referred to the judge’s charge in a murder case as the “dark emptiness of legal jargon.” Our own profession’s concepts are sometimes obscure enough. We see no benefit in sprinkling them about in selected other disciplines.

Reflecting on the distinction between first and second degree murder, Justice Benjamin Cardozo wrote, “The present distinction is so obscure that no jury hearing it for the first time can fairly be expected to assimilate and understand it. I am not at all sure that I understand it myself after trying to apply it for many years and after diligent study of what has been written in the books. Upon the basis of this fine distinction with its mystifying psychology, scores of men have gone to their deaths”1 (Ref. 11, p. 161). Gordon’s reply to our paper reminds us that clinical reality does not duplicate these already

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mystifying distinctions of the law. We agree. This is why legal fact-finders are and should be free to ignore even the best grounded opinions of clinicians.

**Learning Disorders** Having examined the neuropsychological data presented in the original paper, Dr. Gordon believes that we omitted the most sensitive analysis on our “IQ data. Their non-insane murderers would be expected to disproportionately comprise former recidivist juvenile delinquents, where learning disability is a frequent finding and in whom the most striking and long-established neuropsychological finding is specific depression of verbal IQ, but not non-verbal IQ.” Dr. Gordon then noted that the non-insane homicide group had on average a nonverbal IQ of 1.2 scaled points lower than their verbal IQ in comparison to the NGRI group who showed an opposite pattern, with verbal IQ of 10 scaled points higher than their nonverbal IQ. Dr. Gordon now asks us to confirm this is a statistically significant difference.

Unfortunately we cannot oblige him. First, to demonstrate statistically a verbal-nonverbal IQ asymmetry, one would need to submit a Full Scale IQ, Verbal IQ, and Performance IQ to a profile analysis. This is essentially a repeated measures MANOVA with the interaction group (e.g., group × intellectual scale) serving as the statistical test as to whether the nonpsychotic homicide group shows statistical evidence of elevated Performance IQ in relation to Verbal IQ. In the paper under discussion, we did not find statistical evidence of elevated Performance IQ in relation to Verbal IQ. Second, differences between Verbal and Performance IQ occur frequently, even discrepancies of considerable magnitude that would be considered statistically significant. Third, a mean difference of 1.2 scaled points in favor of Performance IQ would hardly be considered statistically significant or clinically relevant. Fourth, to diagnose a verbal learning disorder, the best evidence lies in comparisons between scores on academic tests of reading and spelling with those on psychometric tests. Finally, we conceptualized and designed the paper to examine clinical and neuropsychological characteristics of persons acquitted as not guilty by reason of insanity of murder. Our findings demonstrated that some clinically distinguishing characteristics of these persons may be related to generally preserved intellectual abilities in the presence of acute psychosis. As cited in the paper, we have previously reported neuropsychological evidence of verbal learning disorders in young adults without psychotic disorders charged with murder and can only refer Dr. Gordon to it.

Finally, to return to Dr. Gordon’s incendiary maxim: just as there is no basis to assume reliably distinct degrees of criminal blameworthiness, there is no basis to posit reliably distinct degrees of that particular form of blamelessness, “madness.” Mental health professionals are the last people who should coin slogans like “the madder the badder” or “the iller the killer, the worse the purpose.” Whatever evil is—and like art, we suppose we know it when we see it—there is no reason to think that more of it resides in the hearts of the mentally ill than in others.
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and good moral reason to think that less of it does.

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References


Editor:

I doubt whether any medical journal, including your journal, would publish a peer-reviewed article which included the statements “Not all physicians become corrupt or unable to function . . .” and “A doctor, retired from a hospital with a staff of 75 doctors, estimated that 1 to 3 percent of doctors in his hospital would be categorized as antisocial personalities; 60 to 65 percent, the passive-dependent or inadequate personality, 30 percent, the treatable; and 1 to 3 percent would be high quality doctors.”

In a recent issue of your journal, the authors of “The Corruption Process of a Law Enforcement Officer” (F. L. McCafferty, S. Souryal, and M. A. McCafferty, 26:433–58, 1998) in their second paragraph state that “The majority of law enforcement officers are competent, honest, professional and psychologically stable. . . .” but then they go on to trash law enforcement officers by stating that “Not all law enforcement officers become corrupt or unable to function” (para. 2, p. 451).

[Later] the authors quote, but do not give the officer’s name: “A veteran law enforcement officer, retired from a 75-man suburban department, estimated that 1 to 3 percent of law enforcement officers in his department would be categorized as antisocial personalities; 60 to 65 percent, the passive-dependent or inadequate personality; 30 percent the treatable; and 1 to 3 percent would be high quality officers.” (para. 3, p. 452).

I cannot believe that this is a valid assessment of the officers in this unnamed police department, and I cannot understand why the authors included this uncharitable, absurd assessment in their article. Nor do I think that if you were a “peer-reviewer” of this article that you
would have approved publication of the above statements. In my opinion the authors have shown a bias against police officers (despite their opening statement that the majority of law enforcement officers are competent, honest, professional and psychologically stable) and the peer-reviewers either share this bias or did not carefully review the article.

In the next issue of your journal, would it be appropriate to include something to counteract the disrespect for law enforcement officers shown in the above statements by the authors of “Law Enforcement Corruption”?

John M. MacDonald, MD
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Reply

Editor:

Dr. MacDonald’s point is well taken that the statistics cited from the retired police officer are subjective. However, the particular officer was in a command position; was intelligent, insightful and observant. I respect his opinion, which he arrived at using the criteria for personality types listed on pages 451 and 452 of this article (26:433–58, 1998) to evaluate officers that he had observed in his 25 years of police work. It is extremely difficult to get information from police departments about their individual police officers because of the department’s concern that their information would be used against the department in any accusations against a particular police department. There are few statistics in the literature on personality types in police work, and it is my opinion that statistics such as this will be helpful in the long run to help understand police work and its effects on personality.

I do not believe that these percentages that this retired police officer noted are invalid. I would suggest that Dr. MacDonald show this article to a local Police Chief and get his opinion about the article’s statistics.

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