Letters to the Editor

Only letters that are responsive to articles published in previous issues of the *Bulletin* 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 *Bulletin*.

Editor:

We read with much interest Professor Bradford's comprehensive review on the role of serotonin in forensic psychiatry (J. M. W. Bradford, 24:57–72, 1996). He reviewed the literature on the treatment of primary paraphilias with selective serotonin reuptake inhibitors and the role of serotonin in disorders of sexuality. We would like to add [a note on] our experience with clozapine (a serotonin antagonist) in the treatment of comorbid sexual exhibition in schizophrenia.

Most patients with sexual deviancy and schizophrenia have severe illnesses with prominent delusions and command hallucinations, which prove recalcitrant to conventional antipsychotic pharmacotherapy.[1] Consequently, these patients pose significant management problems and are often, in view of their real or perceived risk to the community, subject to protracted hospitalization and largely ineffective pharmacological interventions.

Clozapine has now emerged as the neuroleptic treatment of choice in severe forms of schizophrenia.[2] In addition to improvements in positive and negative symptoms of schizophrenia, clozapine therapy can result in substantial benefits in a broad range of cognitive and social functions. However, apart from isolated reports of clozapine-induced priapism,[3] little is known about the effect of clozapine upon sexual functioning and on sexual behavior in patients with schizophrenia.

We report here on clozapine therapy for two patients with severe schizophrenia who displayed prominent and treatment-refractory sexual deviancy.

Case 1 A 45-year-old man with a 20-year history of neuroleptic-refractory schizophrenia has been hospitalized in a state institution since 1975, due to persistent psychosis and recalcitrant sexual exhibitionism. His illness has been characterized by persecutory and religious delusions, prominent auditory hallucinations, impulsivity with verbal aggressive outbursts, self-injurious acts (repeated third-degree burns), and persistent exhibitionism with masturbation in public. These latter behaviors accounted for his prolonged hospitalization, as they were frequent, yet unpredictable, and took the form of running naked down corridors, exposing his genitals in front of windows, and masturbating without inhibition. He indicated that this behavior was the result of hearing the voice of Satan commanding him to either masturbate or harm himself.

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There was no history of paraphilia, sexual molestation, or any other sexual deviancy. The patient's medical history was unremarkable. There was no family history of psychiatric illness.

The patient was enrolled in the hospital's pilot clozapine program on the basis of his persistent psychosis and evident failure to respond to numerous adequate trials of antipsychotics and augmentation strategies. His pretreatment Brief Psychiatric Rating Scale (BPRS) score was 75. The patient was disheveled, with marked blunting of affect. He described systematized religious delusions and command hallucinations, believing that Satan had overpowered his spirit and was ordering him to engage in inappropriate sexual behavior. He exhibited prominent positive formal thought disorder. There was no cognitive impairment evident at interview. The patient lacked insight.

Clozapine was initiated without event and was titrated to a dosage of 450 mg by six weeks. The patient showed dramatic improvement in behavior with better self care, no aggressive outbursts and, most notably, a total cessation of masturbatory or exhibitionistic behavior. He reported that he was no longer driven by Satan to perform such acts, indicating that these command hallucinations had entirely abated. His BPRS score after three months had fallen to 31. He has since been discharged, is now six months in residence at a group home, and has recently begun cookery classes!

Case 2 A 50-year-old single male with a 25-year history of neuroleptic-refractory schizophrenia, continuously hospitalized since 1981, was selected for clozapine treatment because of his unremitting psychosis and associated, uncontrollable sexual behavior. In response to sexual delusions and command hallucinations, the patient engaged daily in exhibitionism and masturbation in public. These were often multiple episodes daily during which he would expose his genitalia and masturbate in front of doorways or windows, particularly in the presence of female patients or staff. Sexual gestures were occasionally expressed toward staff, but there had never been any sexual assault, any other deviant behavior, or childhood paedophilia. His medical and family illness history were unremarkable.

Despite a past and current history of adequate pharmacotherapy, the patient's BPRS score prior to clozapine was 56. His appearance was disheveled, and rapport was difficult to sustain because of his inattention and delusional preoccupation. The patient reported incessant second-person auditory hallucinations, most often of derogatory content. He described multiple, well-systematized religious and sexual delusions, believing that Satan had taken control of his body. He also exhibited prominent positive formal thought disorder. He had no insight into his illness or behavior. Although formal neurophysiological evaluation was unavailable, the patient showed clinical impairments in executive function and memory, and there was a clinical impression of below-normal intelligence. He was, however, fully oriented with no specific features to suggest any underlying organic brain disease.

Clozapine therapy proceeded uneventfully, and the patient is currently receiv-

ing 600 mg daily with no noticeable side effects. Improvements in mood (diminished irritability), disorganized speech, and overall grooming have accompanied a reduction in his delusional ideas and hallucinations, although the latter two symptoms are still evident. His present BPRS score after 8 months of clozapine therapy is 49. His aberrant sexual behavior has shown a dramatic and disproportionate improvement. The public exhibitionism has virtually ceased, and any masturbatory behavior (also infrequent now) is confined to his bedroom.

Sexual deviancy in patients with schizophrenia may occur as a consequence of either positive symptoms or behavioral disturbances which are intrinsic to the psychosis, or it may be the expression of a co-morbid sexual disorder. Presently, the etiology and management of aberrant sexual behavior among schizophrenic patients is poorly understood and is seldom the topic of scientific enquiry. In contrast to a voluminous literature on the use of behavioral therapy in the treatment of "primary" paraphilia and exhibitionism, this systematic approach has been infrequently used in schizophrenia patients with sexual deviancy, and available anecdotal reports suggest only limited treatment success.[1] Such was the case for both patients [whose case histories are given] here. Also, while conventional antipsychotic medications may ameliorate psychosis in patients, these agents do not appear to exert a primary or specific therapeutic effect upon sexual disturbance. Rather, any decrement in sexual behavior observed with neuroleptic therapy is more likely to be attributable to adverse effects such as reduced libido, retrograde ejaculation, orgasmic dysfunction, or painful priapism.

Given this background, the dramatic improvement (and total cessation in one patient) of aberrant sexual behavior which occurred with clozapine therapy is noteworthy. For each patient, this improvement appeared disproportionately in excess of the reduction in psychotic symptomatology. The dramatic response is intriguing and poses the question as to whether clozapine may also have exerted some specific effect on sexual behavior/function in a manner that might relate to this agent's unique pharmacologic profile for the serotonin system. Clozapine possesses strong affinity and antagonism at multiple serotonergic receptors.[2] It may be of some relevance, as Professor Bradford reviewed, that recent reports have shown that patients with paraphilia and related sexual disorders may achieve cessation of sexual disturbance when treated with serotonin reuptake inhibitors. However, the pharmacodynamics (i.e., enhancement of serotonergic tone) of this observation are inconsistent with clozapine's serotonergic antagonism. This proposed explanation for the amelioration of sexual disturbance in both patients receiving clozapine may imply a serotonergic component also to sexual deviancy in these patients with schizophrenia, a disorder for which a prominent serotonergic unbalance is postulated. We contend that the conspicuous response in our patients' sexual behavior is suggestive of a specific (possibly serotonergic-mediated) effect of clozapine. We have previously highlighted a similar incongruity between

clozapine's specific antiaggressive effect in violent schizophrenic patients and the deficits in central serotonergic metabolism which are associated with violent behavior.[4]

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Editor:

I write in response to Dr. Kroll's letter (Letters, 24:144–5, 1996) about Dr. Herman's article (23:5–17, 1995).

I agree with Dr. Kroll that the tone of our discourse is critical to the quality of our problem-solving and indeed to the quality of all internal and external psychic life. Some of the data collected to test hypotheses about psychological trauma indicate that intense emotion, especially for vulnerable individuals, essentially turns off parts of the cortex. I would submit that Dr. Kroll's sense of clarity about Dr. Herman's article results from her success in sublimating strong emotions and thus in achieving simultaneously intact cortical function in her audience and clear discourse in herself. I would challenge Dr. Kroll to do the same. I count many insults and epithets in Dr. Kroll's letter but few facts of any kind. We need facts and we need to process those facts complexly.

Some questions: Is it a social evil for practitioners to specialize in posttraumatic disorders? In my experience these cases are fully as difficult as other anxiety disorders, as mood disorders, as adolescent disorders—areas in which we feel some comfort calling in a specialist to help resolve difficult situations. What is the frequency of what Dr. Kroll calls "flim-flam therapy"? And how does this differ from bad therapy of other sorts? Is Dr. Kroll excoriating a straw man? My experience with malpractice cases in this area is that the bad therapy—boundary problems, intrusive overprotectiveness, inadequate technique for dealing with multiply co-morbid, suicidal, and at times psychotic people—never becomes part of the tort case, because these memory controversy cases rest on the fantasy that the lifelong natural history of symptoms did not exist until enquiry about the person's tragic life story was initiated at some late stage in the treatment course. If one alleges that symptoms do not exist, it is difficult to insist on adequate treatment. Does Dr. Kroll have strategies for treating

such cases more successfully? With a combination of medication, psychotherapy aimed at emotional containment, systematic crisis intervention, multimodal treatment planning, and trauma therapy techniques (all recommended both in Dr. Herman's 1992 book and Dr. Kroll's 1993 book), I can halt emergency room visits and psychiatric hospitalizations in most such cases by the end of the first year, but there are a few patients who continue to self-harm clandestinely and experience crises. If Dr. Kroll has data about the efficacy of quelching visualization in such patients (and an effective technique for ensuring that habitual visualizers abandon this thinking mode and take up others), this needs to be published. My experience is that highly hypnotizable individuals benefit from knowledge about hypnosis and guided practice with self-hypnosis. The premise is to assist the gifted visualizer in gaining mastery over this capacity rather than to ignore or try to extinguish this mental activity.

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Editor:

Professor Michael Perlin's article, "Myths, Realities, and the Political World: The Anthropology of Insanity Defense Attitudes" (24:5–26, 1996), is a brilliantly crafted adaptation of his book, *The Jurisprudence of the Insanity Defense*,[1] which deservedly won the 1995 Guttmacher Award. In my review[2] of the book, I lauded Perlin for his scholarly presentation of all the arguments for preserving the insanity defense and recommended the book as must reading for anyone interested in the insanity defense and especially for forensic psychiatrists, whom I felt would benefit greatly by becoming familiar with the exhaustive analyses and formulations developed by the author.

I pointed out, and wish to do so again in this letter in response to Perlin's article, that although he forcefully and effectively "deconstructs" a number of myths about the insanity defense, he mistakenly advances the argument that all those who support the abolition of the "not guilty by reason of insanity" (NGRI) verdict base their position on a number of mythical assumptions. Regrettably, Professor Perlin avoids the truths that cry out for abolition of the NGRI verdict in the interests of a more rational and humane criminal justice system. It is no myth that the insanity defense fails to identify fairly and clearly those mentally disabled persons who deserve to be spared what is assumed to be the moral condemnation inherent in a criminal conviction. It is no myth that more than 20 percent of NGRI acquittees are not mentally ill and drain the usually sparse resources of maximum security hospitals, while individuals with clear-cut psychiatric illnesses, including treatable schizophrenia and bipolar disorder, having been found guilty of crime, are often left to deteriorate in prison without a modicum of appropriate therapy. It is no myth that mental health professionals are misused at every point in the administration of the insanity defense, especially in

the period following "acquittal." It is no myth that, as Professor Perlin himself points out, there is an "inherent irrationality in legal insanity defense decisionmaking." The continuing "incoherence of our insanity defense jurisprudence" and the ineradicable "pretextuality" that pervasively "riddles the entire insanity defense decisionmaking process," so forcefully decried by Perlin, should be enough to persuade the few remaining retentionists to support the elimination of the insanity defense.

Shorn of its well-intentioned but impractical theoretical formulations, the article compels the conclusion that the insanity defense be condemned by the medical profession and by psychiatrists in particular. That is because misuse of psychiatry follows the insanity defense like a shadow. It is inevitably so, and Professor Perlin, notwithstanding his call for education of "judges and legislators and other policy-makers," the creation of a "new scholarship agenda," and the application of "therapeutic jurisprudence principles to each aspect of the insanity defense," offers no workable solution. Thus, what may be convenient for judges, law professors, philosophers, and certainly defense attorneys, should, if anything, be anathema to mental health professionals. The erroneous and misguided notion that the insanity defense is essential to the moral integrity of the criminal law imposes a terrible burden on psychiatry. Although this understandably may not be an important concern to a law professor, it should elicit the vigorous opposition of thinking psychiatrists everywhere. However useful it may seem to be in practical and philosophical terms, the insanity defense would at once be discarded by our justice system if it were not possible to misuse psychiatry in the post-acquittal phase. The *Hinckley* case epitomizes the problem. John Hinckley's release from St. Elizabeths Hospital is not a matter to be decided by the treatment staff or even by a medical review committee, but by other entities accepted as the decisionmakers—the Secret Service, FBI, U.S. Attorney's office, and the trial judge. The psychiatrist who is involved in the care and treatment of the insanity acquittee is required, sadly, in many cases to violate the following ethical canon adopted by the World Medical Association: "A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental rule is to alleviate the distress of his or her fellow men, and no motive—whether personal, collective or political—shall prevail against this higher purpose."[3]

Contrary to Professor Perlin's view that mainly ignorant laity and vote-seeking politicians call for abolition of the insanity defense, at least two polls conducted by responsible surveyors[4, 5] have shown that a majority of physicians, including psychiatrists, are in favor of eradicating the insanity defense and enabling the criminal justice system to deal rationally with the problem of the mentally disordered offender.

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Reply

Editor:

I deeply appreciate Dr. Halpern's kind words about both my book (*The Jurisprudence of the Insanity Defense*) and my recent *Bulletin* article (Perlin ML, 24:5–26, 1996; based on my Guttmacher acceptance paper), but do want to address a few points in his letter.

First, he implies that I argue that "all" who support insanity defense abolition base their positions on myths. I made it clear both in my article (p 8, footnote †) and in my book (p 137, n 291) that I exempted Dr. Halpern from this criticism. I did so because I have found—after more than 20 years of thinking about this subject—Dr. Halpern to be the only important proponent of abolition to base his arguments on principles and on a vision of a coherent criminal justice system. I expect I should have added a few words to my article about intellectualist abolitionists on what I can awkwardly characterize as "the academic left," who argue that the existence of any insanity defense perpetuates the excesses of the "therapeutic state" (*Jurisprudence*, pp 134–35, n 275), but I was speaking here of the "political world" and this position has, at this point in time, very little political capital.

Second, I agree completely with Dr. Halpern that many "individuals with clear-cut [major] psychiatric illnesses . . . are often left to deteriorate in prison without a modicum of appropriate therapy." This is a scandal, and I join hands with him in decrying it (and deal with this specifically in my book (*Jurisprudence*, p 428, discussing ways that mentally ill prisoners "are often institutionalized in facilities bereft of even minimal mental health services, and are often treated more harshly than other inmates")). But: abolition of the insanity defense will have one major and inevitable result—it will significantly increase the number of mentally ill prisoners. And it will make prisons even more hellish places—for mentally ill inmates, for non-mentally ill inmates, and for staff.

Third, I'm concerned that Dr. Halpern sees my recommendations as merely offering a "convenien[ce]" for judges and lawyers, and that he characterized the burden created by an incoherent insanity defense system as "understandably [perhaps] not an important concern to a law professor."

My recommendations—educating factfinders as to the mythic bases of our assumptions about the insanity defense system; exposing sanism and pretextuality in insanity defense decisionmaking; incorporating therapeutic jurisprudence insights into all insanity defense scholar-

ship—are not simply for the benefit of lawyers. They, rather, were crafted to illuminate the underlying problems for all decisionmakers in the insanity defense system (a universe that clearly includes forensic psychiatrists).

More importantly, I *am* concerned—deeply concerned—about the burden that an incoherent jurisprudential system places on all participants in that system. Ironically, the example that Dr. Halpern cites—the fact that John Hinckley's potential release has become a political football (and a decision which will be made, in significant part, by law enforcement agencies, as opposed to clinical staff)—is *precisely* the same example that I cite as an example of the pernicious nature of pretextual insanity defense decisionmaking (article, p 19).

The irony here, of course, is that Dr. Halpern and I agree on so much about what is fundamentally wrong with our insanity defense system. We part ways—sharply—on the remedy. I call for education and reconstruction; he calls for abolition. I fear that, in the end, his solution would only make a bad situation worse.

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Editor:

I read with great interest Michael L. Perlin's article on "Myths, Realities, and the Political World: The Anthropology of Insanity Defense Attitudes" (24:5–26, 1996).

I have also had the opportunity to read the author's book, *The Jurisprudence of the Insanity Defense*. He certainly makes thoughtful and salient points and I must say I agree with all of them. However, as a practicing forensic psychiatrist who must deal with many of these issues in a practical way, on an almost daily basis, I feel he has, perhaps, overlooked one significant ongoing myth that may deserve further amplification. He discusses the "obsessive fear of feigned mental states," but I would submit that this arises not necessarily from a general concern, but from each individual's own private experience. I would suggest that almost "everyone" has called in to work to say that they can't come to work because they are ill and that they have noted this excuse to have been readily accepted. Thus, the fact is that everyone has experienced success by saying one is sick when one is not. This is by analogy then associated to the mentally ill with the assumption that with the same facility, they will easily be successful as well. I feel that this error of mistaken projection contributes the most significantly to the insanity defense being so impervious to any kind of reasonable review.

While I would agree that all the features Mr. Perlin lists play a role, I would suggest, again, that it is this particular underlying "myth" that drives us all to distraction. I feel that it is this particular preconceived notion that must be attacked, in and of itself, with vigor, through education, so that people can understand the difference between a "mental

illness and a common cold," so that they can differentiate between their own common experience and the day-to-day life of someone who is actually mentally ill.

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