At a Loss for Words: Nosological Impotence in the Search for Justice

Kenneth J. Weiss, MD

The assessment and trial of Norwegian mass-murderer Anders Breivik, including disparate opinions about his sanity, raise questions about distinguishing "bad" from "mad." Although he was ultimately found criminally responsible, the tenacity and pervasiveness of his beliefs suggested delusional thinking. The author reflects on the difficulty psychiatrists have with nomenclature generally and on the application of imprecise classification to criminal justice. Ideally, a classification system should "carve nature at its joints." Barring that, psychiatry needs operational definitions to appreciate the differences between idiosyncratic, psychotic thinking, and shared subcultural beliefs or ideologies. The concept of extreme overvalued belief provides a basis for making this distinction, when applied in the criminal justice context.

J Am Acad Psychiatry Law 44:36–40, 2016

> The second principle is that of division into species according to the natural formation, where the joint is, not breaking any part as a bad carver might. Socrates, in Plato's *Phaedrus*[1]
>
> In baseball, you don't know nothing—Yogi Berra[2]

Understanding the natural world through Plato's anatomical analogy is an appealing idea made daunting when the carver's knife is dull. Like its predecessors, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[3] proves this point, despite its virtues. There is no pretense that psychiatric nosology "carves nature at its joints." It is instead a convenience, a placeholder impatiently awaiting robust science. In the two-plus millennia between Plato and Yogi, we see optimistic purpose yield to despair. Psychopathology, if it exists in nature, does not come to us in neat packages. And, as Yogi said, there are too many variables for us to understand human behavior, let alone predict it. Psychiatry's iterations of an atheoretical diagnostic scheme informed by field trials and consensus at least give us a vocabulary. Chaos can ensue, however, when the results get applied to the justice system.

Dr. Weiss is Clinical Professor of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA. Address correspondence to: Kenneth J. Weiss, MD, 2 Bala Plaza, Suite 300, 333 E. City Avenue, Bala Cynwyd, PA 19004-1512. E-mail: kenweiss@mail.med.upenn.edu

Disclosures of financial or other potential conflicts of interest: None.

Isaac Ray recognized the task at hand when he authored his medical school thesis in 1827.[4] In his "Remarks on Pathological Anatomy," Ray emphasized that anatomy would teach us to distinguish sickness from health. As the 20-year-old admonished: "[I]f it be once allowed that disease may proceed from any other cause than change of organic structure, then Pathological Anatomy is founded on the sand and its utility is a dream" (Ref. 4, p 122). Ultimately, he sighed, our microscopes may not be strong enough to tell the whole story. Insanity, being a multifarious condition, could not neatly be described. Thus, when constructing a taxonomy of insanity to be useful in court in 1838, Ray, following Pinel and others, allowed for a variety of diagnoses: dementia, moral mania (general and partial), and intellectual mania (general and partial (monomania)).[5] Insanity, a medical condition, could have several causes and manifestations. Ray's views were colored by phrenology,[6] which implied that any number of brain "organs" could be over- or underdeveloped enough to cause insanity. We know better than that now, don't we?

Modern Times

Nearly 200 years later, the bridge between structure and function is unfinished. Static anatomy is insufficient, and attempts at isolating it from other

dynamics (genetic, epigenetic, and environmental, for example) have not played well in legal settings. The meme that brains are responsible for crimes must be resisted.[7] Neuroimaging techniques themselves, such as magnetic resonance imaging, have now been called into question.[8] As Weinberger and Radulescu cautioned: "[W]e believe the evidence that these [MRI] 'findings' are reflections of changes in the brain related to pathogenesis is inconclusive at best and potentially represents artifacts or epiphenomena of dubious value" (Ref. 8, p 1). The clamor over what some have considered DSM-5's rush to publication was followed by an alternate scheme, Research Domain Criteria (RDoC).[9] According to RDoC's champion, Thomas Insel, the new schema would integrate brain and behavior without "invit[ing] continual recapitulation of the fruitless 'mind-body' and 'nature-nurture' debates that have impeded a deep understanding of psychopathology" (Ref. 9, p 499). This too may be premature, as RDoC's supporters[10] and detractors[11] have become vocal if not contentious.

What does today's folk psychology bring to the table? I detect a conflation of sick and bad when the act is heinous, seemingly random, or of large scale. When the news reports a mass killing, acquaintances often ask me, "Wouldn't such a person have to be insane to do something like that?" My response to the bad-versus-sick question is often a pusillanimous, "Not necessarily. That's what we have to sort out." My residency supervisor, plain-talking Nebraskan Dr. Elvin Semrad, taught a tripartite psychopathology: mad, sad, and scared; anything else was superficial.[12] It was useful for dynamic formulations and therapy but not forensic grade. When one adds a cross-cultural dimension, politics, and the enormity of a mass homicide, the microscope becomes a kaleidoscope. Perhaps Dr. Semrad could have added "bad" to the list, distinguishing it from mental disease.

How a society regards criminal responsibility is a function of its values, culture, and laws. Could insane behavior on one continent be culpable or even normative on another? In their discussion of Norway's *Breivik* case, Rahman *et al.*[13] refocus us on the importance of a vocabulary with clinical substance and real-world validity. Guardedly hopeful about DSM-5's efficacy, they draw a helpful distinction between delusions and extreme overvalued beliefs. Rahman and colleagues reach back over a century of international psychiatry to pull us forward, using a concept from Wernicke's lexicon reprised by McHugh.[14,15] In doing so, and by acknowledging the unrest within our fraught nomenclature, our colleagues have granted us a deep, cleansing breath.

Delusions: An Essential Ingredient?

Rahman and colleagues, following Dietz's advice,[16] aim for a "crisp" distinction between potential clinical bases of legal insanity, other forms of psychopathology and nonpathological behavior. Their sensible inclusion of extreme overvalued beliefs in the mix gives us a potential exit from Plato's Cave, provided that clinicians have a way to distinguish them from delusions. The simplest way to do it is to look for other evidence of a psychotic disorder. Playing the percentages, it would be rare for an individual to have an isolated symptom of delusions in the absence of other indicia of schizophrenia, mania, and others. The prevalence of delusional disorder, as defined in DSM-5, is 0.02 percent, versus 1.0 percent for schizophrenia.[3] We do not know the prevalence of extreme overvalued beliefs, but I suspect it outranks delusional disorder. Thus, political extremist views, provided there is cultural support, usually would not be considered bases for a claim of insanity or nonculpability.

Diagnosis Versus Jurisprudence

A psychiatric diagnosis is not dispositive of the legal question of criminal responsibility. There is no longer a medical definition of insanity. Some jurisdictions specifically exclude antisocial personality disorder or conditions that manifest as criminal behavior. Because most insanity statutes are *M'Naughten* variants or contain a cognitive element, it is safe to say that the cognitive test rests on the presence of delusions. The delusion test replaced the "wild beast" test in Britain no later than 1800, when James Hadfield was acquitted after firing a gun in the direction of King George III. This episode was an early example of a failed suicide-by-cop attempt; Mr. Hadfield expected judicial homicide but was excused as insane. When Edward Oxford was tried for attempting to shoot Queen Victoria in 1840, his attorney successfully argued irresistible impulse. The Queen was not disposed to abide another insanity acquittal when Daniel M'Naughten was found insane in 1843. The dynamics of Mr. M'Naughten's thinking and actions were based on his belief that the Tory Party and its leader were persecuting him.[17]

Whether the defendant was merely eccentric (with overvalued beliefs) or psychotic (with delusions) was tacitly at issue when the Queen commissioned the House of Lords to devise the correct insanity test. Under the *M'Naughten* test, a disease of the mind must animate the act and its underlying defect of reason. Someone like Mr. Hadfield would not have succeeded under the *M'Naughten* test, since calculating a wrongful act for a secondary purpose (one's own death) indicates knowledge of wrongfulness, regardless of the thought's origin.

What Was He Thinking?

Mr. Breivik, ostensibly for ideological reasons, killed many countrymen in the summer of 2011 to call attention to communism-inspired trends and Islamization centuries in the making. His written work, with contributions from others, took years of research and is freely distributed,[18] along with a 12-minute companion video.[19] The book, cobbled together to suit Mr. Breivik's rhetorical purpose, can generously be described as an eclectic political philosophy, but its main trajectory is xenophobia. Norwegian journalist Åsne Seierstad has synthesized Mr. Breivik's life history with a cultural context.[20] Her complex biography traces the development of Mr. Breivik's character and thought. Looking at his many developmental problems could lead a clinical psychiatrist to presume that some type of serious psychopathology was unavoidable.

After the incident, two teams of psychiatrists studied him extensively: one within weeks of the incident and the other in 2012. Artifact may have been present during the first round, given that the suspect was ordered to solitary confinement.[21] The second team's opinion (that Mr. Breivik was not psychotic) prevailed, and the findings were later presented at the 2013 meeting of the American Academy of Psychiatry and the Law.[22] After reviewing Mr. Breivik's language and interrogation data, the evaluators distinguished "extreme political fanaticism" from psychosis. It was this distinction, in essence, that governed the court's guilty verdict in 2012, as Syse summarized:

> Explaining why the court found Breivik to be sane, the court stated that many people share "Breivik's conspiracy theory, including the Eurabia theory." However, "The court finds that very few people, however, share Breivik's idea that the alleged 'Islamization' should be fought with terror" (Ref. 21, p 391).

In this sense, Mr. Breivik's underlying ideology was not delusional, and his consequent actions, however radical, could not be considered psychotic.

Speaking of Spectra

Norway's insanity standard is clear cut and categorical: "A person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty" (Ref. 21, p 397). There is no reference to wrongfulness or to thought content, placing the standard in the contexts of *Hadfield* or the New Hampshire "product" test.[17] Whatever we may think of the *M'Naughten* rule, at least it operationalizes the cognitive dimension: knowing whether the act was wrong. DSM-5 supplies cold comfort in this regard. Norway's sentencing guidelines also differ from America's, in that the maximum penalty is capped at 21 years.[23]

It is not yet apparent how a dimensional approach to diagnosis will play out in criminal justice. But how psychotic does a person have to be to be insane under Norwegian law? Rahman and colleagues take heart in DSM-5's dimensional leaning; wise considering psychiatry's chronic state of disappointment over our serial joint-carving efforts. In DSM-5, we see dimensional categories or groups of associated disorders (e.g., schizophrenia spectrum, trauma- and stressor-related disorders, and OCD-related disorders). If Norwegian jurisprudence were to stretch the schizophrenia spectrum to include overvalued ideas as even temporary forms of psychosis, Mr. Breivik could have prevailed with an insanity defense; it was never his intent. As it was, cooler heads prevailed, and the second team of experts saw through the defendant's behavior and enormous narcissism to reach the conclusion that he represented an extreme adherent to a widely held belief.[21] Mr. Breivik's legal position was one of self-defense,[24] by which he meant the defense of his country against Islamic immigration.

There is another spectrum, autism, that has been discussed in connection with DSM-5's retirement of Asperger's disorder and in relation to Mr. Breivik. Consider these observations by his child psychiatrist when Mr. Brievik was age 6:

> Marked inability to enter into the spirit of games. Takes no pleasure in the toys. When the other children are playing, he operates alongside them. He is wholly unfamiliar with "Let's pretend" games. He is always wary during play. Anders lacks spontaneity, appetite for activity, imagination or ability to empathise. Nor does he have the mood swings seen in most children of his age. He has no language for expressing emotions [Ref. 20, p 26].

During the trial, Oslo University psychiatrist Ulrik Malt suggested concurrent diagnoses of Asperger's, Tourette's, and narcissistic personality disorder. Stakeholders representing Asperger's support groups had resisted such a formulation, citing no association between the condition and violent criminality.[25] In any event, under Norwegian law, persons within the autism spectrum (except when associated with intellectual disability) would not be construed as psychotic. Norway's simplified standard, like many worldwide, is categorical, leading to a short algorithm that was followed in the *Breivik* trial to a guilty verdict.

Conclusions: Joint-Carving 2.0

Platonic Forms and permutations of human behavior may not be on the same metaphysical page. This is not to imply we should stop trying. As Slater and Borghini put it, "taxonomies are *discoveries*, not mere *inventions*" (Ref. 26, p 2). Although aspirational when considering psychiatric nosology, there is no consensus that DSM-5 is a discovery. McNally framed the situation this way:

> The boundary between mental distress and mental illness will never be neat and clean. What counts as a mental disorder depends on shifting cultural, political, and economic values as well as on scientific facts about how our psychology and biology can go wrong, producing suffering and functional impairment in everyday life. We'll never have a clear-cut list of criteria that will enable us to identify all instances of mental disorder and exclude everything else [Ref. 27, p 212].

What's more, McNally cautions, there are stakeholders with potentially competing interests, such as insurance and pharmaceutical companies. Let me add criminal justice and the prison industry to the list.

In a weird turn of events, at the end of Mr. Breivik's trial his defense attorneys argued that he was sane and should be sent to prison, whereas the prosecutors argued that he was insane and should be hospitalized.[28] Prosecutor Svein Holden, taking the high-road position of a moral stakeholder, explained it this way: "In our opinion, it is worse that a psychotic person is sentenced to preventative detention than a nonpsychotic person is sentenced to compulsory mental health care" (Ref. 29). Defense lawyer Geir Lippestad took the position, advocated by the client, that it was the defendant's right to take responsibility for his actions.[30] The *New York Times* reporter covering Mr. Lippestad made an interesting speculation that portrayed the country of Norway as a stakeholder: "As Norway as a whole seeks to regain its soul intact, a verdict of insanity might offer some comfort to a nation traumatized by the events of last July and wanting to avoid the conclusion that Mr. Breivik reflected a political trend in society" (Ref. 30).

The *Breivik* trial has prompted a reassessment of our values, procedures, and theory of knowledge. The defendant was prosecuted and defended in a system different from America's. I was especially impressed by the persistence of the evaluation process, whereby a second look at the defendant, after the dust had settled from the mass murder, produced a result consistent with contemporary values and clinical psychiatry. Thus, beyond the din of outrageous acts by an unrepentant defendant, national mourning, and positions by various stakeholders, the forensic team coolly distinguished political extremist views from mental illness. Overvalued beliefs, whereas containing psychodynamic nuggets, have always had a home within freedom of speech. Let us not conflate them with exculpatory mental illness or permit defendants to exploit untidy areas of our system of classification.

References

1. Plato: Phaedrus. In The Dialogues of Plato, Vol. 1. New York, Random House, 1937 p 269
2. Berra quote Berra Y: Available online at http://www.baseball-almanac.com/quotes/quoberra.shtml. Accessed January 19, 2016
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5]. Arlington, VA, American Psychiatric Association, 2013
4. Quen JM: Isaac Ray and his "Remarks on Pathological Anatomy." Bull Hist Med 38:113–26, 1964
5. Ray I: A Treatise on the Medical Jurisprudence of Insanity. Boston: Little, Brown & Co., 1838
6. Weiss KJ: Isaac Ray's affair with phrenology. J Psychiatry Law 34:455–494, 2006
7. Morse SJ: Brain overclaim syndrome and criminal responsibility: a diagnostic note. Ohio St J Crim L 3:397–412, 2006
8. Weinberger DR, Radulescu E: Finding the elusive psychiatric "lesion" with 21st-century neuroanatomy: a note of caution. Am J Psychiatry 173:27–33, 2016
9. Insel TR, Cuthbert BN: Brain disorders? Precisely. Science 348: 499–500, 2015
10. Yee CM, Javitt DC, Miller GA: Replacing DSM categorical analyses with dimensional analyses in psychiatry research. The Research Domain Criteria Initiative. JAMA Psychiatry, published online November 11, 2015. doi:10.1001/jamapsychiatry.2015.1900
11. Weinberger DR, Glick ID, Klein DF: Whither Research Domain Criteria (RDoC)? The good, the bad, and the ugly. JAMA Psychiatry, published online November 11, 2015. doi:10.1001/jamapsychiatry.2015.1743
12. Rako S, Mazer H (eds): Semrad: The Heart of a Therapist. New York, Jason Aronson, 1980

13. Rahman T, Resnick PJ, Harry B: Anders Breivik: Extreme beliefs mistaken for psychosis. J Am Acad Psychiatry Law 28–35:44, 2016
14. Wernicke C: Grundriss der Psychiatrie in Klinischen Vorlesungen. Leipzig, Germany: Fischer and Wittig, 1900
15. McHugh PR: The Mind Has Mountains: Reflections on Society and Psychiatry. Baltimore: Johns Hopkins University Press, 2006
16. Keiger D: The dark world of Park Dietz. Johns Hopkins Magazine (Electronic Edition), November 1994. Available at http://pages.jh.edu/~jhumag/1194web/dietz.html. Accessed December 1, 2015
17. AAPL Task Force to Revise the Guideline on Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense: Practice Guideline: Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense. J Am Acad Psychiatry Law 42(4) suppl.:S3–S76, 2013, Table 1, pp S37–S45
18. Berwick A (pseudonym of Anders Breivik): 2083: A European Declaration of Independence. Available at https://info.publicintelligence.net/AndersBehringBreivikManifesto.pdf. Accessed November 3, 2015
19. Anders Breivik: Gunman Anders Behring Breivik's Video Manifesto. Published 11/14/14 by Homeland Security Management Institute at Monroe Community College (SUNY). Available at https://www.youtube.com/watch?v=Mhh1qYJPfUs. Accessed November 3, 2015
20. Seierstaf Å: One of Us. The Story of Anders Breivik and the Massacre in Norway. New York: Farrar, Straus and Giroux, 2013
21. Syse A: Breivik: the Norwegian terrorist case. Behav Sci & L 32:389–407, 2014
22. Leonard CH, Annas GD, Knoll JL, *et al*: The case of Anders Behring Breivik: language of a lone terrorist. Behav Sci & L 32: 408–422, 2014
23. Lappi-Seppälä T, Tonry M: Crime, criminal justice, and criminology in the Nordic countries. Crime & Just 40:1–32, 2011
24. Lewis M, Cowell A: Norwegian man claims self-defense in killings. New York Times, April 17, 2012, p A6
25. Daily Mail Reporter: Mass killer Breivik may have rare forms of Aspergers and Tourette's syndromes, says Norway's leading psychiatrist. Daily Mail.com. Available at http://www.dailymail.co.uk/news/article-2156530/Anders-Behring-Breivik-rare-forms-Aspergers-Tourette-s-syndromes-says-Norways-leading-psychiatrist.html#ixzz3sSmkAU3O/. Accessed November 24, 2015
26. Slater MH, Borghini A: Introduction: Lessons from the scientific butchery. In Campbell JK, O'Rourke M, Slater MH (eds.): Carving Nature at Its Joints. Cambridge, MA, MIT Press, 2011, pp 1–31
27. McNally RJ: What Is Mental Illness? Cambridge, MA: Belknap Press of Harvard University, 2011
28. Lewis M: At trial's end, lawyers say Norway killer is not insane. New York Times, June 23, 2012, p A6
29. Lewis M: Prosecutors in Norway seek hospital for gunman. New York Times, June 22, 2012, p A6
30. Morris H: Devil's advocate: Breivik lawyer defends rule of law. New York Times, June 22, 2012. Available at http://rendezvous.blogs.nytimes.com/2012/06/22/devils-advocate-breivik-lawyer-defends-the-rule-of-law/?rref=collection%2Ftimestopic%2FBreivik%2C%20Anders%20Behring. Accessed November 24, 2015