Mania, Crime and the Insanity Defense: A Case Report

RICHARD A. RATNER, MD*

The successful introduction of lithium carbonate as both therapy and prevention for manic illness has sparked a new interest in distinguishing the boundaries and manifestations of the illness from both schizophrenia and the character disorders. Simultaneously, the need for a valid and reliable new classification for mental illness, which DSM-III aspires to be, has led to a set of criteria for all the major psychoses that may well expand the numbers of patients diagnosed as manic in this country.

One of the realizations growing from this general reassessment of the manic syndrome is that in addition to the "euphoric-grandiose" presentation commonly associated with this disease, there is also a "paranoid-destructive" subtype,[1] and this pattern may cause an individual so afflicted to come to the attention of the criminal justice system before or instead of the mental health practitioner.

Some support for this view comes from the work of Good,[2] who reviewed the cases of 100 consecutive referrals for psychiatric evaluation at the Massachusetts Correctional Institute at Framingham (MCIF). In contrast to an expected incidence of 2.2%, he found instead a 10.0% incidence of primary affective disorder, of which 7% were clearly bipolar, and 1% possibly bipolar. In only two of these cases (2%) was the diagnosis made prior to admission to the facility.

The author's own experience as Consultant to both pre- and post-trial sections of the Forensic Programs Division, St. Elizabeth's Hospital, Washington, DC supports this notion as well. On numerous occasions, individuals who have been repeatedly diagnosed as suffering from character disorders, schizophrenia of various types, depressive neuroses or a succession of different diagnoses have been felt in retrospect to be suffering from manic-depressive psychosis, manic or circular type, and have responded very favorably to lithium carbonate therapy.

The issue is an important one because the crimes for which these individuals have been convicted are likely, in many cases, to have been committed while the perpetrator is acutely psychotic in a manic phase. When such is the case, these individuals are likely candidates for an insanity defense. Perhaps more importantly, however, such a finding would hold out the hope of curing the illness while satisfying the State's interest in public safety without the need for incarceration.

*Dr. Ratner is Consultant to the Forensic Program Division of St. Elizabeth's Hospital, Wash., DC, and Associate Clinical Professor of Psychiatry and Behavioral Sciences at George Washington University School of Medicine, Wash., DC.

It is the premise of this paper that manic illness is easily and often overlooked or undetected in criminal defendants at the pre-trial and pre-sentence stages for reasons integral to the disease itself. First, the phasic nature of the disease will often result in an individual's reaching a state of partial or complete remission by the time he is seen by an attorney, judge or mental health professional. The delays common to the judicial process in most jurisdictions may tend to increase the importance of this factor. The second reason that mental illness may not be suspected in such cases is that the crimes committed in the manic state often appear to be premeditated and self-enriching, as if performed with malice aforethought and clear criminal intent. To a layman, be he judge or juror, such crimes as writing bad checks, attempting a con game or shoplifting are purposeful, self-enriching and criminal acts. Intuition or "common sense" rejects the notion that such crimes can be manifestations of a serious mental illness in the absence of obviously bizarre or disorganized behavior patterns.

In spite of this "common sense" perception, there are individuals who commit such crimes during acute manic phases and only during such episodes of illness. For such individuals, the cost of failure to detect the illness can include lengthy, unproductive incarcerations, the withholding of potentially curative treatment and the break-up of homes and families in the false belief that incarceration is necessary for punishment, isolation or rehabilitation.

The following case presentation illustrates the concurrence of manic illness and apparently motivated crime, as well as a failure of detection at the pre-trial level.

Case Illustration

A 25-year-old, single white man was referred by his attorney for pre-sentence examination in February, 1976. The man, Mr. S., had been arrested in Wash., DC, while attempting to perpetrate a swindle he had read about in the Jan. 13, 1976 edition of the **New York Times,** known as the "Bank Examiner Game." As detailed in a newspaper report about the patient after his capture,[3] the "game" involves "a man on the telephone, the 'inspector,' convincing a 'pigeon' he's trying to capture a dishonest bank employee.

"The victim, usually a woman who lives in a good neighborhood, is asked to withdraw a sizable sum from her account, presumably in order to catch the mythical embezzler removing even more.

"The 'inspector' arranges for a man to meet her across the street or at home to take the money for protection and evidence. He hands the victim a signed receipt, and that is the last she sees of him or her money.

"Police emphasize that banks never ask customers to help with an internal investigation, but many women, swayed by the pitch to do something helpful, are taken in."

The newspaper report went on to detail Mr. S's failed attempt as follows: "A double con game began Tuesday afternoon when Mrs. J., a real estate agent... who has a separate listing in the telephone directory, was at home... with a headache.

"She said when a young man, identifying himself as 'Lt. Higgins' of the New York Police Department, temporarily detailed to Washington, called to ask her assistance, she immediately smelled a rat. She said she stalled him a moment and got her husband on an extension: 'Joe, I think I have a con man.'

"J. called the police, who asked Mrs. J. to bait a trap for the swindler.

"The plan called for Mrs. J. to go to the bank yesterday morning, withdraw money from her savings account and jewelry from her safe deposit box. Then an agent, wearing gold-rimmed glasses and three bandages on his nose, would call at her house, take the packages and give her a receipt.

"And, when she and the suspect were face to face in her living room, she persuaded him to make lengthy notes on a receipt, thus giving the police even more evidence.

"But when the man stood handcuffed and surrounded by police in her living room, the heroine felt sorry for him.

" 'That guy really had to be stupid', she mused, 'I really conned the poor soul.'

" 'I've never done anything like this before,' Mrs. J. said he told her. She said she believed him. Her husband, Joseph, who retired in 1968 after 26 years as an FBI agent, disagreed."

As was clear from the history given to me, Mrs. J's intuition was correct. Mr. S. had no criminal record and in fact was a graduate of a large Eastern Ivy League college. At the time of my examination, there was no evidence of psychosis, and Mr. S. proved to be an excellent historian. He had grown up in upstate New York, the third of four children in a family that was intact until the father committed suicide six years prior. The father was deeply in debt, drank excessively and had seen himself as a failure in business.

Two years prior to S.'s arrest, his younger brother had developed a frank manic-depressive psychosis, manic type, and had been placed on lithium by a treating psychiatrist. This psychiatrist, while reviewing the family history, had allegedly concluded that, in retrospect, the father was probably also a manic-depressive. The maternal grandfather was said to have been manic-depressive as well. While neither of the other two siblings was known to be ill, the sister, who was the eldest, was known as a moody person.

After graduation from college, the patient, whose future plans were not well-formed, had moved to a suburb of New York City where he worked as a carpenter, lived by himself and devoted most of his attention to a woman. When their relationship cooled, however, he had moved to Washington eight months before his arrest. Possibly clinically depressed, he had felt he had needed to "get away."

After getting a job as a carpenter, he had audited some courses in a local law school, telling his mother that he was a law student. He claimed he had done some lobbying and writing for an "environmental group" and was finishing a book on politics. While it appeared that the move had been precipitated by a major disappointment in his relationship with the woman mentioned above, S. divulged little about his feelings of sadness or anger at first. Nor was it clear until later how his grandiosity and distorted judgment had affected his behavior and caused concern among his acquaintances. Only recently, he admitted that on a visit to him in Washington, two months prior to his arrest, the same girlfriend had found him "a different person," who frightened her with his grandiosity and decreased need for sleep.

A picture thus emerged of an individual with a strong family history of affective disorder, some evidence of recent grandiosity, and a period of behavior (about three months) that was in marked contrast to his lifelong pattern. Further, there were good grounds for speculating that the pattern was precipitated by a rejection at the hands of his girlfriend of several years.

On the other hand, there was very little insight, and information about subjective perceptions and emotions was not provided. There were no gross signs of psychosis one month after the crime. His attorney, an alert and sensitive woman practicing in a jurisdiction where the insanity defense has high visibility, had not even thought of raising it. Since my examination was prior to sentence and after conviction, the issue was in any event moot at that point; however, I considered the evidence very strong and, in a letter to the court, reported him as a manic-depressive who should be followed psychiatrically and not incarcerated. The court concurred and placed him on probation.

It was thenceforth decided that lithium carbonate not be started, based purely on a retrospective evaluation, however suggestive, and instead, S. was followed without medication until July, 1976. At this point, he became depressed and anxious, with symptoms of hopelessness, feeling "overwhelmed" and vegetative signs. Though reluctant to take medication for fear that he would be seen by himself and others as an "invalid . . . like my brother and father," he eventually accepted mellaril, 25 to 50 mg. h.s. By October, he had improved and maintained a satisfactory adjustment until February, 1977.

At this time, just a year after the first offense, he visited his old girlfriend for a weekend. During the visit, the woman managed to divulge that she had recently had an abortion and that the "father" was an old rival of S. for her affections. On his next therapy visit, he was distinctly different, showing an unaccustomed expansiveness, developing grandiosity and a tremendous irritability when challenged in any way. He had been transformed from a carpenter's apprentice to a budding entrepreneur, with sudden plans to buy land and erect luxury homes. He saw several bankers who were said to be interested in his plans.

He began to date a large number of women, and discussed them as if they were good for sex and little more. When challenged, he became angry and intimated that he was being "judged unfairly."

He printed a large number of invitations to a "cherry blossom party" in his neighborhood. Soon thereafter, I received calls from his roommate and several friends about increasingly bizarre behavior. He wrote a dishonored check for his therapy and then ceased coming for appointments. Shortly thereafter, I was informed by his attorney that he had fled the jurisdiction in violation of his probation in a new pickup truck that he had paid for with non-existent funds.

I did not see him again until Jan. 10, 1978. He returned this time in anticipation of his probation being revoked and hoped I could help keep him out of prison. He told the following story:

Regarding the truck, he "knew" he did not have the funds but "fooled himself" into thinking he would have them before the check cleared. This was the same reasoning he had displayed regarding the first crime: he "knew" it was wrong to con the woman, but intended to return the money when he was "On my feet."

In any case, he had travelled to another location where he intended to stay the summer, but within a month had begun to "panic" as he realized his probation officer would be "after him." He accordingly drove back to DC and left the truck on the dealer's lot with a note of apology. He did not inform his probation officer for fear that he would be "locked up" and hoped that the return of the truck would end the matter. In late June, he was arrested hitchhiking on the New York State Thruway and was returned here because of an outstanding warrant for his arrest. He was convicted of a felony, but not incarcerated when he and his family agreed to make good all of the expenses incurred by the truck dealership. With that, he returned to work in DC, but did not contact me.

In September, 1977, he reported he had begun to feel "really down" with low energy, low self-esteem, apathy and overeating. He returned to his home town in November and was seen by his family physician there. By then, S. and his family had realized that he was a manic-depressive, and his family doctor started him on lithium carbonate.

He thus returned to me both for court intervention and to be monitored for his lithium levels. Again at this time, there was no evidence of psychosis and his sensorium was intact; however, he manifested more insight into his condition than in the past, as exemplified by his willingness to discuss his perceptions and thought processes as he recalled them from his manic episode.

He subsequently was granted an extension of his probation and continued working as a carpenter at his previous job. Since then, he has remained on lithium carbonate in excellent compliance. Not only has he had no further recurrences of mania, depression or criminality; he has moved forward in his job and become involved in a meaningful relationship with a

woman. At this time, he is a foreman and project manager for a thriving renovation concern and is considering getting engaged. Side-effects of the medication have been few and mild, and he recognizes his responsibility to take it for the foreseeable future.

Discussion

This case is an example of a manic-depressive individual whose crimes are felt to have been committed only during manic episodes. While suspected, the diagnosis and its correlation with criminal acts could not be substantiated during the initial evaluation period, since the two impediments to early diagnosis noted above were both in evidence: first, Mr. S.'s illness was either in partial or complete remission by the time he came to the attention of a mental health professional and, second, the nature of the crime was so "reasonable" that the simultaneous presence of a mental illness was not even considered.

That the diagnosis of mania was suspected at all was due to the availability of accurate and complete histories both of the family and of the individual himself. It has been noted[4] that a family history is often crucial in making a differential diagnosis of manic-depressive psychosis from the schizonphrenias. The same is clearly true with regard to its distinction from various other conditions, especially including character and personality disorders.

No less important was accurate information regarding S. himself. In this case, it was most helpful to know that he possessed no criminal record, nor was his past behavior in any way reflective of anti-social trends. He was not drawn from a social class or subculture where crime might be considered a quasi-acceptable way of redressing the inequalities of opportunity in our society. Thus, it was clear that the commission of this crime was totally inconsistent with everything else about S.'s life.

The suspicion that the criminal act was a manifestation of, or at least occurred in the presence of, a manic state was inspired not only by its inconsistency, but also by information regarding his behavior just prior to the crime. The sudden move to the Wash., DC area right after suffering a kind of an abandonment, i.e., by his woman friend, seemed to fit the pattern of a flight from the threat of a depression brought on by the loss of an object. After reaching Washington, S. described a kind of frantic involvement in a variety of activities including "writing a book about politics," "lobbying" and being the manufacturer's representative for a voting machine company. In retrospect, S. recalled a decreased need for sleep as well as his girlfriend's concern over his health during her visit. The grandiosity of his thinking was in stark contrast to his penniless condition at the time of arrest.

If such information caused mania to be suspected, it was only the opportunity of follow-up that allowed the diagnosis to be confirmed. When S. sustained a full-blown and classic manic attack a year later, the underlying diagnosis was no longer open to doubt. Furthermore, the failure of symptoms to reappear during more than two years of lithium maintenance

therapy constitutes yet another corroboration of the diagnosis.

Follow-up also provided substantiation for the contention that criminal acts occurred only in the context of a manic attack. While this notion may not be susceptible of proof beyond a shadow of doubt, its likelihood was greatly enhanced by the facts: (1) that a second (pecuniary) crime did occur while the individual was observably acutely manic, and (2) that no crimes have been committed during the subsequent euthymic period. The author concluded that he could state with reasonable medical certainty that the presence of an acute manic state was a prerequisite in this individual for the commission of criminal acts.

Unfortunately, the factors present in this case which led to the suspicion and confirmation both of the disease and of its presence during the crimes are often unavailable to the forensic psychiatrist. Among those seen for pre-trial or pre-sentencing examinations, a very large proportion present with family histories ranging from inadequate and incomplete to virtually non-existent (as in the case of those growing up in orphanages, foster homes or with two stepparents as a result of sequential deaths and divorces). Often, nothing is known about one side or both sides of the family (typically the father's), and what information may exist is subject to modification in the telling. In splintered families, relatives often drift apart and lose touch altogether. In other cases, shame over mental illness or suicide prevents information from reaching the examiner. Ignorance often leads to misinterpretation of illness, so that one is often left only with such vague facts as, "Uncle hospitalized for mental illness years back . . ."

Information regarding the accused himself may be more available, but also misleading. In particular, a prior criminal record or other manifestations of a coexisting character disorder will obscure detection of the manic illness. For example, a case (#1) reported by Good[2] had a record of repeated shoplifting and parole violations when seen by a court psychologist, who considered her hysterical. A manic episode in prison caused her to come to the attention of psychiatrists again.

Most defendants come from the lowest rungs of the social ladder. The fact that self-enriching crime makes more sense for the poor and disadvantaged and is less ego-dystonic for certain milieus and subcultures also contributes to the lowering of the index of suspicion for mental illness. Information that would allow the examiner to reconstruct the development of a hypothesized manic episode is also often unavailable. The accused himself is often unwilling or unable to provide us with much insight into his behavior, and his relationships are often so partial, distant and uninvolved that little insight is available from others.

Finally, the opportunity for follow-up is rather rare. Had I not seen S. in a private capacity, had he not received probation and had he not chosen to remain with me in treatment over the following year, none of the subsequent developments in his case would have become known to me.

Finally, the reader should note that data from the Minnesota Multiphasic Personality Inventory (MMPI), which was administered to S. when first seen by me, was of no value in making the diagnosis. While the **Ma.** scale was elevated by more than one standard deviation (MA = 75), the suggestion of manic-depressive illness was made by only one psychologist of three experienced in forensic psychology consulted by the author. The automated scoring service to which the MMPI was first submitted did not suggest this possibility at all. In fact, the report was judged in retrospect to be misleading insofar as it suggested that characterological problems were primarily involved. While the observations were not necessarily inaccurate, there was not the slightest suggestion that other factors could be involved.

The single psychologist who claimed to see manic-depressive illness in this profile argued that the combination of an elevated manic scale with an exagerated need to see the self as free of pathology (F − K = −13) is a telling sign of manic illness.[5]

Further discussion of the use of psychological testing to detect mania is far beyond the scope of this paper, but since our fundamental notions of what constitutes manic illness are in flux,[4] we must be aware of the limitations of testing based on these notions. It is interesting to note that in Rapaport et al's standard text[6] only a single entry is found in the Index regarding "Manic thought disorder, indicators of." This is a reference to a Sorting test. The equivalent number of references to indicators of schizophrenia exceeds 50.

Insanity Defense

The detection of illness-dependent crime is clearly desirable, both for the individual and the State, if the illness can be easily and effectively treated. For such individuals as S., lithium carbonate holds out the prospect of a cure for their illness with a resulting elimination of recidivist behavior. The State benefits from timely treatment of the individual as well, since protection of the public is achieved without the expense of a lengthy incarceration in overcrowded facilities. Such a happy outcome can be achieved through appropriate sentencing should such an individual have been convicted, but it is the author's contention that these criminals are candidates for the insanity defense both under McNaughton and ALI standards. In an earlier paper,[7] we have attempted to rationalize the extension of the insanity defense to cover certain forms of episodic dyscontrol without confronting the issue of the overall legitimacy of the defense itself. In effect, the argument is that if anyone is eligible for such a defense, the individuals in question must be included in the eligible group.

In this situation, the contention is based on our opinion that the judgment of the affected individual during the manic phase is so seriously impaired as to make him, in terms of the American Law Institute Model Penal Code criteria for a defense of insanity, unable to appreciate the wrongfulness of his acts. While Mr. S. described a factual grasp of the illegality of his

actions, it is proposed that he clearly lacked a rational grasp. For example, after the first incident, he stated that he had "convinced myself" that it wasn't "really wrong," since he "needed the money" and "intended to pay it back." After the second offense, it was only as his illness remitted that it began to dawn on him that he was in trouble for breaking the law while on probation. Even then he thought by returning the slightly used truck with a note, he could cancel out the charges lodged against him.

It is ironic that the very common sense approach responsible for convincing the public that an insanity defense is valid in some cases is also likely to deprive individuals such as S. from benefiting from one. Forensic psychiatrists are well aware that such things as the degree of bizarreness of a crime, the apparent lack of reasonable motive and even the personal appearance of the defendant at trial are major predictors of the likelihood that an insanity defense will be sustained. Individuals who look well at trial and whose crimes can be seen as premeditated and self-enriching have a far smaller chance of succeeding with a defense of NGBRI than does the hallucinating schizophrenic whose crimes are minor, apparently pointless, unpremeditated and devoid of personal financial gain.

In the latter situation, expert psychiatric testimony may do no more than confirm and corroborate what judge, jury and even prosecutor feel to be the case. Such cases are often uncontested by the government. In the former situation, however, one can expect to be contested, often by other experts, in a climate of hostility to the allegation of insanity. While it is true that NGBRI is a social judgment properly made by laymen who represent the community, it would be nihilistic to infer that one should reify "intuition" and "common sense" by declining to present one's case. The psychotic distortions of judgment characteristic of the manic thought disorder can certainly be severe enough to render one's ordinary capacity to appreciate wrongfulness ineffective. This observation is well-illustrated by S., whose behavior in the euthymic state served as a control for his behavior while manic.

So long as the appreciation of wrongfulness remains a prerequisite for the assumption of criminal responsibility, there are excellent grounds for maintaining that in cases like this, responsibility for the criminal acts must be removed from the defendant.

In states using the McNaughton test, the same argument applies. With this standard, the issue becomes the understanding of the term, "Distinguishing right from wrong." In the author's opinion, the distorted judgment referred to above would be sufficient to prevent the acute manic from being able meaningfully to distinguish right from wrong.

Summary

A case has been presented of a young manic depressive man whose first contact with a mental health professional was in connection with a criminal act performed during a manic episode. Information that is often not avail-

able or inadequate, especially a comprehensive family history, enabled the author to infer the presence of the illness at the time of the crime. An extended follow-up allowed the diagnosis to be confirmed, treatment to be instituted and reasonable certainty to be attained that the crimes occurred only as a manifestation of or in conjunction with the active phase of the illness. The obstacles to accurate diagnosis in such cases and their appropriate management are discussed in hopes of heightening the awareness of readers to the possibilities of such unsuspected cases in their midst.

References

1. Beigel, A. and Murphy, D.: Assessing Clinical Characteristics of the Manic State. American Journal of Psychiatry 128:6, 1971.
2. Good, M.I.: Primary Affective Disorder, Aggression and Criminality. Archives of General Psychiatry 35:954-960, 1978.
3. Washington Star, Section B: Thursday, Jan. 15, 1976.
4. Pope, H.G., Jr. and Lipinski, J.F., Jr.: Diagnosis in Schizophrenia and Manic-Depressive Illness. Archives of General Psychiatry 35:811-828, 1978.
5. Madsen, Robert, PhD: Personal communication.
6. Rapaport, D.; Gill, M. and Schafer, R.: Diagnostic Psychological Testing. (Rev. Ed) New York: International Universities Press, 1968.
7. Ratner, R. and Shapiro, D.: The Episodic Dyscontrol Syndrome and Criminal Responsibility. Bulletin of the American Academy of Psychiatry and the Law. Vol. VII, No. 4 (1979). □