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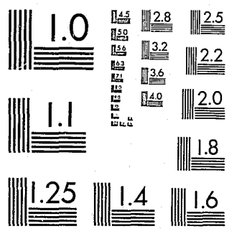

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Criminality and Psychopathology: Treatment for the Guilty

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Irresponsibility and Pathology

The controversy over the guilt or illness of social offenders and the relative merits of punishment and treatment is rooted in moral and philosophical preconceptions which lie deeper in our social consciousness than does our clinical and social understanding of criminality.

On the one hand we tend to think that criminal acts are a natural but primitive expression of self-interest — of a sort to which we would all succumb if we thought we could get away with it, or if we had not been so strictly brought up. By this view criminality is not pathological, but a condition of primitive good health, for which the threat of punishment is an appropriate and effective means of social control. On the other hand there is a strong and competing tendency to view criminal acts as symptoms or consequences of a pathological process rooted in either the social circumstances or the psychological structure of the criminal.

There are, of course, important distinctions to be made between the pathological conditions of different criminals, and numerous partings of the ways among those who are inclined to view criminal acts as signs of an illness.

At one extreme we recognize the psychotic offender whose acts are the result of a medically diagnosed illness. This is the paridigm case of the offender who is not guilty by reason of insanity. At the other extreme is the "pure" criminal who seems to be psychologically intact, and whose only symptom of pathology (if we choose to regard it as such) is a pattern of antisocial behavior. In between these extremes lie the vast majority of our offenders who display various kinds and various degrees of disturbance in their personality, along with their criminal behavior.

In our society at the present time most of us, including most of the clinicians and jurists among us, are willing to regard the antisocial actions of the psychotic offender as not being within the responsible control of the offender. But we become progressively less comfortable with this position as we proceed along the continuum toward the more purely antisocial type of criminal. John Hinckley is clearly emotionally disturbed, but was he responsible for his act? At the furthest extreme very few people are willing to take the unpopular position that patterns of criminal behavior are per se symptoms or consequences of a pathological condition beyond the control of the offender.

The Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM III) will classify such offenders — if their criminality is extensive enough — as "antisocial personality disorders," which, of course, implies that they have an illness of sorts. But many of us in clinical work, and perhaps especially those of us who work closely with social offenders, tend to be somewhat embarrassed by this diagnosis. I think that we're not convinced it's a real illness. When confronted with criminal irresponsibility in a client we are likely either to condemn the behavior and disqualify the client, or we seek to treat an underlying pathology and end up rescuing the client from accountability and implicitly excusing his irresponsible behavior. It is perhaps fortunate that the condition (antisocial personality disorder) is nearly universally regarded as incurable, and hence we turn our backs on it and to the dilemma it poses with a clear conscience and a sense of relief.

The dilemma that pervades the whole issue of mental or emotional illness versus criminal responsibility is simply this: We take the concepts of pathology and responsibility as forming a logically exclusive dichotomy. If a person is ill, then he is not to be held responsible for the symptoms or consequences of that illness. Conversely, if a person is responsible for his behavior, then that behavior cannot be the symptom or the consequence of an illness.

It is this strict dichotomy in our fundamental concepts that makes us uncomfortable with the diagnosis of "antisocial personality disorder," but the dilemma is not restricted to this diagnosis or to the more criminal end of the continuum described above. Even with psychotic offenders a close examination of their behavior often reveals a measure of conscious control over their actions and an irresponsibility and malignancy of purpose which, even if attributable to their psychosis, is difficult to excuse. And yet we are by and large willing to excuse psychotic offenders from responsibility simply because they are so blatantly and obviously ill.

The conclusion I recommend is that the problem lies with the dichotomy itself. I believe we must rethink our basic concepts of pathology and responsibility, and must recognize that there are a great number of cases in which being irresponsible and being ill are not mutually exclusive, but are, in fact, identical. For these people, irresponsibility is their form of pathology.

Criminal Patterns of Experience

I refer to this class of people as "criminal personality disorders." I don't intend this as a new diagnostic category. Rather, it includes some individuals from each of the recognized categories of personality disorder, as well as schizophrenia and other major clinical syndromes. Some people in each of these diagnostic categories adopt a criminally antisocial posture in their internal experience and social relationships, as a solution to fundamental issues of their existence.

I follow Yochelson and Samenow in adopting a phenomenological point of view in describing the characteristics and pathology of this class of person, as well as in the conduct of treatment (Yochelson and Samenow, 1977).[1] Phenomenology is a perspective or frame of reference that can be applied to many areas of personality and behavior. With regard to criminal behavior it requires that we examine the experience of criminality from the subjective point of view of the criminal himself.[2]

While there are many different patterns of criminal experience, these patterns tend to center around common themes. The following is a simplified description of one such pattern of criminal experience.

A striking characteristic of many personality disorders, both criminal and noncriminal, is a pervasive subjectivity in their overall experience of life. Developmentally these people have failed to fully differentiate themselves as discreet and autonomous individuals. Phenomenologically, their experience of life is self-oriented and subjective. They tend to relate to and evaluate external circumstances solely in

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[1]. My debt to these authors is considerable. Although I diverge from them in many details I regard their contribution as a true "giant step forward" in the understanding and treatment of the criminal personality.

[2]. The basic concept of phenomenology can be described as follows. Each behavior or action performed by a person is experienced in a quite different manner by the person who performs it than by another person who observes it. The external observer perceives an "objective" physical movement. The performer of the action experiences this same movement "subjectively" as a cluster of feelings, sensations, thoughts, and intentions. It is this domain of subjective experience to which the concept of phenomenology refers. Thus the phenomenology of a given action is that action as subjectively experienced by the person who performs it. Similarly, the phenomenology of a type of personality is a set of enduring patterns of subjective experience, including thoughts, feelings, sensations, and, in general, ways of experiencing the world. The same personality which can be described objectively in terms of enduring patterns of behavior can be described phenomenologically in terms of enduring patterns of thinking, feeling, and sensation. We can thus conceive of personality as a certain phenomenological configuration that endures through time. This configuration can be either healthy or pathological. In general, personalities revealed as pathological from a phenomenological frame of reference will also meet the criteria for one or another personality disorder as defined by the DSM-III.

terms of their impact upon their own private states of feeling. Such people might reveal in therapy, for instance, that they understand that telling the truth about something means nothing more nor less than sharing their feelings about it. There is no clear distinction within their cognitive and experiential processes between subjective experience and objective fact. Such people may be especially vulnerable to emotional injury, as any and all perceived events have immediate repercussions in their emotional feeling state.

Many such people — and, again, not just the criminals among them — attempt to force reality into a manageable and congenial form by the magical expedient of controlling their subjective experience of reality. In this form of pathology, the cognitive and experiential processes not only remain relatively undeveloped, they become diverted to the task of creating and maintaining an illusory and wishful experience of reality.

This wishful or magical construction of reality is a familiar pattern with many of the people I refer to as criminal personality disorders. Their criminality appears to develop from this foundation in the following way. Experiencing frustration and injury (from a quite early age), they become invested in experiencing the world as a more congenial and less threatening place. Their efforts at magical control take concrete forms. They will picture their circumstances and their prospects in unrealistically optimistic terms. They become ego-invested in the reality of the picture. They will select just those perceptions that support the picture, and will discount, ignore, or deny those that don't. Statements of other people are interpreted as guarantees and promises that this state of affairs will hold true. In short, they devise an optimistic picture of the world and try with all their might to build the world into the picture.

Inevitably, reality disappoints them. Because of their intense emotional investment in the created image, this disappointment is experienced as intense and bitter frustration. They feel that the world has dealt them a deep and personal emotional blow. It is unfair. The people in their life have lied to them. The world in general is a horrible and malicious place, most especially towards themselves. They are angry about it, and are unshakeable in the righteousness of their anger. They come to interpret social barriers to the immediate gratification of their desires as a personal injustice. Even the slightest criticism is experienced as a severe attack on their identity. They learn to react with anger to whatever is frustrating or uncomfortable in their life.

In this state of anger, which may become a practically permanent feature of their experience, antisocial behavior is a natural outcome. The ground is set for a life of hostility and crime. At the same time, the inevitable pattern of disappointment and frustration when reality fails to fulfill their wishful expectations leads in a vicious circle to even greater efforts at control. The pathological "solution" to their life circumstances perpetuates these same circumstances.

Magical control will be supplemented by more overt methods as they learn to use all the resources at their disposal, including physical force, intimidation, manipulation, and guile in their effort to exercise power and control over the world of their experience. In their single-minded effort such people can experience moments of success. With many such people, the ultimate success is a successful crime. It is common for criminals to report that the elation and excitement of a successful crime is a more important motive for their crimes than any prospect of financial gain.

A permanent albeit tumultuous pattern is established, and the individual becomes attached to each element of the pattern. The transition from experienced injury to righteous anger becomes automatic and practically instantaneous. From this frame of reference the world is both clearly defined and justly open for the taking. In the world of their experience, they have secured a license for crime.

They perceive themselves as victims. When they are arrested and incarcerated, they typically perceive this as one more instance of others' injustice towards themselves. As their criminal "solution" fails, they experience this failure not as evidence that a new solution must be found, but as further validation and proof of their criminal point of view.

And the cycle goes on.

Treatment: Responsibility as Cure

The pathology in these patterns of experience is apparent. The criminal's awareness of reality is systematically distorted. His attempted solutions to the discomfort that lies at the center of his existence perpetuates the conditions of that discomfort. And finally, the criminal lives in a closed circle of behavior and experience that effectively puts a stop to the process of emotional growth, and eliminates the possibility of achieving those forms of feeling, consciousness, and action that lie at the highest levels of human development.

At the same time, the irresponsibility that criminals adopt as their basic life position is not an "illness" in a narrowly medical sense that implies nonresponsibility. The criminal's irresponsibility is a moral condition, as well as a clinical one. Consequently the treatment process must also be a process of moral change. For the criminal personality disorder becoming responsible is one and the same with getting well.

Criminals may very well have personality disorders other than (and deeper than) their criminal "life solution." Still, *irresponsibility* remains a valid description of their pathology, and *becoming responsible* remains the appropriate goal in treatment. With most noncriminal personality disorders — including the noncriminal aspect of criminal personality disorders — there is a lack of adult autonomy which precludes fully responsible, adult functioning. Such people adopt a life posture in which avoidance of responsibility is a central feature. In my opinion this remains true even in socially functional, high achieving personality disorders. With these individuals the pathological aspect of their personality is displayed as a lack of responsible functioning and self-definition in limited areas of their total life experience. In the treatment process with such clients it is essential that change be initiated by the client. Treatment which is imposed externally (whether or not this treatment is verbal or nonverbal makes little difference) will almost certainly leave the internal structure of their personality untouched, as these clients will tend to respond to the therapeutic stimuli with the same habitual patterns which constitute their pathology. If, on the other hand, the client consciously initiates the effort to change, this action itself embodies elements of adult autonomy and responsibility which is the goal of treatment. Clients can thus redefine themselves through their efforts to change.

In short, such clients must "grow themselves up," or they won't grow up at all.

This process requires that clients come to accept responsibility for their present condition, without excuses and without resorting to causal explanations for their condition that are (or were) beyond their personal control.[3] It also requires that they accept *becoming a responsible adult*, in an old-fashioned moral sense, as a personal life goal.

Confrontation has traditionally been one of the most widely used tools in dealing with criminal clients. While confrontation does recognize the criminals' irresponsibility, it triggers the very patterns of hostility and defiance that need to be targeted for change. A more detached and clinical approach to the client's irresponsibility can avoid this difficulty. The therapist can display the client's irresponsibility as an objective fact, and utilize moral judgment as a clinical tool. The incentive for change then comes not from an external demand for conformity but from the client's own recognition of what and how he is. The application of self-directed behavioral change techniques to the distortions and irresponsible patterns in the client's own experience then becomes a powerful therapeutic strategy.

At the first step the clients learn to identify their pathological (= irresponsible) patterns of experience, at the times they occur. This act of identification requires an objective and detached observation of their experience which itself effectively interrupts their habit of indulging their emotional experiences and criminal thoughts — running wild, for instance, with a sense of injury or rage. When they deliberately apply techniques of intervention (which is step 2), they are already experiencing responsible adult motivation and ways of thinking. Thus the goals of treatment are foreshadowed in the very beginnings of treatment. The goals are insinuated into the process. The ultimate goal is, of course, to establish firm habits of responsible thinking and experience.

This phenomenological approach has additional advantages in quickly establishing credibility with the clients, as they recognize the therapist's accurate description of how they experience the world. Sociopathic maneuvers and ploys intended to antagonize the therapist or otherwise disrupt treatment can be immediately identified and displayed by the therapist as pathological patterns within the client. By thus focusing attention on the client's own patterns of experience, they can be led to recognize that their condition of irresponsibility and the process of becoming a responsible person are within their direct control, and their control alone.

Once the concept of responsibility and the phenomenological focus of attention are established at the central core of the treatment process, a great variety of therapeutic methods and techniques become relevant tools in the process of change. Most clients will require a supportive and nurturing environment, but one which also provides continuous objective feedback as to their present condition and their efforts to change. Some may benefit from analytic therapy and a "working through" of internal issues as they strive to overcome their own barriers to maturation and growth. In principle, any therapeutic technique which is compatible with acceptance of responsibility by the client (and this includes most popular, modern therapies) can be effectively applied within the basic strategy described here.

This concept of treatment obviously presupposes the client's willing participation and cooperation in therapy. In fact, I am frankly unable to imagine a form of therapy that can be imposed on unwilling criminal clients with the desired result of producing a responsible human being.

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[3]. This point raises interesting philosophical questions of freedom and causality. It is not that there are no external causes for their pathology. It is rather that accepting responsibility for one's condition is offered as a conscious achievement available to them; one which marks a first major step in the process of becoming a fully autonomous and responsible person.

This, of course, is the catch. Criminals generally do not experience the kind of self-dissatisfaction that leads more responsible people to seek treatment. Such dissatisfaction as they do experience is likely to be brief and quickly forgotten, or attributed to the evil doings of other people. Thus, with the majority of criminals, this condition of dissatisfaction has to be created. Put most simply, criminal personality disorders *must not be permitted* to be comfortable and satisfied with their forms of life.

Practically, in our present society, the most effective means of creating this state of affairs with adult criminals is by arrest and incarceration.[4] Repeated incarceration does, in fact, create a sense of self-dissatisfaction with a significant percentage of criminals (though by no means all of them). This dissatisfaction is experienced only during periods of incarceration or after arrest when incarceration is imminent. For this reason, effective treatment must be offered as an integral part of, and not as an alternative or substitute for, our systems of law enforcement and corrections. When these systems are functioning well, a significant number of criminals will eventually see their way to volunteer for treatment.

Incarceration also provides for two other conditions which I believe are essential for effective treatment. These are time, and the creation of a total therapeutic environment. The first of these is, of course, automatic, as incarceration traditionally provides nothing but time. The second takes some deliberate effort, but it is not an impractical project.[5] A total therapeutic environment, or "therapeutic community" can be a powerful force for change, even with the most antisocial of individuals. Responsible social values and serious dedication to change can be instilled as the norm and expectation in the therapeutic community. Social cooperation, mutual respect, and a rational approach to problem solving can be learned by being practiced.[6] When the force of such a "treatment culture" is combined with professional clinical techniques and supervision of the individual change process, effective treatment of criminal personality disorders becomes a practical possibility.

Psychosis and the Insanity Defense

For many years the insanity defense has provided a less than fully satisfactory option in criminal proceedings involving psychotic or emotionally disturbed offenders. The number of cases in which, due to mental illness, an offender is fully and certainly free of responsibility for their actions is very small. In the majority of cases in which the plea is upheld there is a measure of doubt and a lingering suspicion that the mentally ill offender should not be fully excused from accountability. Still, when the offender is clearly mentally ill, we have felt bound to uphold the insanity plea, and have placed these people in mental institutions with the hope that traditional medical treatment would cure their disease and their antisocial behavior together.

Such has not generally been the case, in spite of the dramatic efficacy of psychotropic medications. These medications can substantially reduce the most disabling symptoms of schizophrenia and affective disorders. Successfully treated patients can lead a happy and productive life, provided that their underlying personality is sufficiently intact and functional. Unfortunately, this condition is not met in a large proportion of severely disturbed patients. Our mental hospitals continue to house and treat chronic psychotic patients who are disabled not by psychotic symptoms but by underlying inadequacies of personality (Swartz and Swartz, 1976). With patients who have been found not guilty of felony offenses due to insanity, their personality is likely to be to some degree criminal, with irresponsibility as a dominant feature. As with many noncriminal psychotic patients, there is often no precise delineation between their personality disorder and their psychosis. Their symptoms tend to be continuous, with episodes of acute psychosis arising out of the more or less permanent background of their personality disorder.

If these patients do not learn to exercise effective control over their destructive personality patterns, medical treatment of their psychosis is likely to be subverted by their unwillingness to responsibly pursue treatment. Not only will they refuse to take medication (once given the freedom to do so), they will continue to indulge those subjective patterns of thought and feeling which most readily develop into full-blown psychotic episodes.

This, of course, is an old and familiar story in our mental hospitals. These institutions tend to embrace a medical conception of psychopathology which excludes moral responsibility. The irresponsibility of these patients is thus defined as beyond the domain of therapeutic intervention. Paradoxically, the patterns of antisocial behavior which were judged in the courts

[4]. This is also true of juvenile criminals who are at an advanced stage of criminality. At earlier stages premature incarceration can accelerate the development of criminal attitudes.

[5]. My own experience is with the Correctional Treatment Program at Oregon State Hospital. However, in practically every state we find state hospital populations languishing at a small percentage of their physical capacity, while state prisons are full to overflowing. The cost of furnishing and staffing state hospital buildings as correctional treatment facilities, expensive as this is, is less than the cost of building and staffing new prisons.

[6]. The concept of a therapeutic community derives from two independent sources: Maxwell Jones, who applied principles of self-government to groups of mental hospital patients, and Synanon, which applied a mutual self-help strategy to groups of heroin addicts living together. The Synanon strategy was highly confrontive, and became the foundation for most residential drug abuse treatment programs in this country. A contemporary therapeutic community need not be bound by the doctrines or dogmas of either of these historical sources. The single essential criterion is that the ends and the means of therapy be reinforced by all elements of the resident client's social environment.

to be consequences of mental illness, tend to be viewed as purely moral concerns by the mental hospital staff responsible for their treatment.

The inadequacy of our present system has recently become the focus of widespread public concern. The Hinckley verdict has triggered a reaction which threatens to disrupt the present system, but without necessarily providing for the clear thinking and careful planning required if we are to achieve a better one. A well-publicized alternative under consideration in a number of states is the substitution of a new verdict, *guilty but mentally ill*, for the present *not guilty by reason of insanity* (*Newsweek*, April 24, 1982).

The concept of "guilty but mentally ill" would appear to be compatible with the claim made here that irresponsibility is a form of pathology in many social offenders. Upon a closer look, however, it is apparent that the proposed legislation is based on the same radical separation of illness from moral responsibility as is the present legislation. Under the new legislation as proposed in several states we would see consecutive responses to the antisocial acts of disturbed offenders. They would be first treated for their mental illness in mental hospitals, and then transferred to prison to serve the remainder of their criminal sentence. They will thus be consecutively treated and punished for the same set of behaviors. Such a system seems certain to foster a narrowly medical concept of treatment, and an equally narrow concept of punishment. If this occurs, emotionally disturbed offenders will continue to slip through the cracks as both mental health and correctional institutions limit their attention to aspects of the offenders' situation which have little relevance to, or effect upon, the pathology inherent in their personalities.

Conclusions

I have argued that the rigid distinction between pathology and irresponsibility (or illness versus evil, if you will), which is deeply rooted in both our popular and scientific consciousness, has prevented us from achieving a practical and realistic understanding of the psychopathology of criminal offenders. In desperation we have developed dogmatic postures which have led us to behave toward our social offenders very much like some bad parents behave toward their children. We tend, inconsistently, both to overpunish and to overexcuse. If we judge their behavior to be a sign of illness, we impose some form of treatment which doesn't begin to touch upon the underlying pathology of their personality, and which implicitly or explicitly excuses their irresponsible behavior. We create institutions that attempt treatment but which founder in their inability to rationalize the concepts of pathology and treatment in the face of criminal irresponsibility. In most cases, once a criminal sentence is passed, no further attention is paid to the offender — except, of course, by the overburdened staff of our prisons. We either ignore them or we impose a punishment and then ignore them, and the resentment continues to build on both sides.

We have recognized for a long time that incarceration, in itself, will change very few criminals. We are just beginning to recognize that the problem is not with the prisons.

What prisons and the threat of incarceration can do is define a limit and provide an incentive to change. This is an essential first step, but it will lead nowhere unless we look beyond it and recognize that criminal behavior will not change as long as the criminals' habits of personality — their ways of perceiving, feeling, and thinking — do not change. And, finally, we need to recognize that these habits will not change and cannot be made to change by traditional means alone, whether "correctional" or "therapeutic." Even with the best of intentions to stop being criminal, our criminals will not be able to accomplish this change if left to their personal efforts and willpower alone. Neither would most of us succeed on our own if for any reason we chose to attempt to reshape our personalities. Psychotherapy can provide the necessary tools, but only if we are willing to recognize irresponsibility as a pathological condition and accept the intrinsically moral nature of the required change.

Finally, we must recognize that no single element in our system of institutions, from law enforcement to incarceration and treatment, can have significant impact on the problem of crime if each of these elements functions in practical isolation from the others. It is useful to remind ourselves to consider how this system is experienced by our social offenders. We can, if we choose, present a more consistent and more meaningful message to these offenders than we are doing now. The techniques and resources are available to utilize our present system of institutions to provide an unyielding definition of limits, and both a clear direction and realistic opportunity for change.

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