Denise Russell

Psychiatry: Making Criminals Mad

Psychiatry is increasingly attempting to attribute criminal behaviour to biological rather than social causes. Denise Russell reports on the dubious justification for this move, its implications for "criminals" and the vested interests of drug companies.

In the '80s, psychiatry has attempted to shift itself, take over, if you like, another area of inquiry, that of criminology. At the same time, however, this move has not been accompanied by adequate theoretical justification from the medical profession. A situation, obviously, not without its problems.

One of the signs of psychiatry's attempt to move into criminology is the statement by psychiatrists of their express desire to do so. This sometimes surfaces when psychiatrists comment on court processes. Reviewing the major opinions given by the U.S. Supreme Court on mental health law from 1975 to 1983, the psychiatrist Appelbaum concludes: "The Supreme Court's decisions in both the civil and criminal areas display a profound and initially puzzling ambivalence towards psychiatry and psychiatrists."[1]

The court is arguing that the actions of psychiatrists are in some sense irrelevant — that larger issues are at stake. Appelbaum comments, "Many psychiatrists have felt that if the profession could only 'reach' the Court, if psychiatrists could persuade the justices of their noble intent, their moral probity, and the scientific and medical bases of psychiatric care, the court would find itself compelled to rule favourably on psychiatric claims."[2]

The desire by psychiatrists to entrench and expand their involvement in criminal proceedings is reflected in the amount of concern ands research that goes into the public's perceived attitude towards this. If anything, these attitudes appear to be increasingly negative. They sank very low after the Hinckly verdict of not guilty of murder by reason of insanity, after he had shot President Reagan. A report on attitudes after the Hinckly verdict shows that older people were much more negative towards psychiatry in the courtroom than younger people were. The authors suggest that this could be explained by familiarity with psychiatry — the younger people being more closely linked to an era when psychiatry had become more accepted.[3] It could be argued against this, however, that the older people were more familiar with psychiatry — having had more time to witness its practices.

So, firstly, the desire is there for psychiatry to expand its area of influence within criminology. Perhaps the most significant sign of this expansion is the sift that has taken place in the way certain psychiatric disorders are described by the American Psychiatric Association in a

new system of diagnosis put out in 1980. This system is called the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, DSM III, for short.[4] It has been widely adopted around the Western world.

Criminality as a disorder

Through previous diagnostic schemes, psychiatry has revealed a concern with criminal behaviour when it has been associated with other forms of abnormality. What is new about the DSM-III is the inclusion of criminality as the disorder even when it is not associated with any other abnormalities. This can be illustrated by a comparison of three of the diagnoses from the DSM-III with three of the diagnoses from the Second Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-II).[5]

Diagnostic Changes

In the DSM-III, various "conduct disorders" are listed. The disorders fall under the general category of "disorders usually first evident in infancy, childhood or adolescence". They are characterised by a continual pattern of conduct which either violates the rights of others, or runs counter to major social norms or rules that are appropriate for the child's age. It is clear that all types of long-term criminal behaviour may be covered by this description. One might then ask whether criminality is enough to attract this label "conduct disorder"? The interesting point is that in the new scheme it is, whereas in the old scheme it was not. In the DSM-III, there are two types of conduct disorder involving aggression: the undersocialised aggressive disorder and the socialist aggressive disorder. A person displaying the latter may be one who engages in criminal behaviour while showing evidence of social attachment to others. A recent psychiatric text notes that this criminal behaviour may take a mild form, for example lying, petty theft or vandalism; a moderate form, for example physical aggression, reckless driving, serious stealing, breaking and entering, extortion; or a severe form, for example, serious physical aggression against others.[6] The criminal diagnosed as having the socialised aggressive conduct disorder shows affection and empathy to **some** others, usually not the victims, but more commonly, a peer group. The sole mark of this mental disorder is criminal behaviour.

"unsocialised aggressive reaction" which is similar to the "undersocialised aggressive conduct disorder" of the DSM-III. The descriptions of both of these categories involve more than mere criminal behaviour. But the DSM-II has no diagnostic category corresponding to the "socialised aggressive conduct disroder" of the DSM-III.

A study conducted last year on adolescents admitted to psychiatric hospitals in the U.S. with the diagnosos of "conduct disorder" was compared to adolescents admitted to the same hospitals without this diagnosis. The major factor distinguishing the first group of adolescents from the second was **violence.**[7] This indicates a willingness, on the part of practising psychiatrists to see violence alone, as a form of mental disorder requiring hospital treatment and further suggests that psychiatric practice is indeed guided by the new diagnostic scheme.

Another marker of the extension of psychiatry into criminology as indicated in shifts in diagnosis concerns the psychopath, otherwise known as the sociopath, or more genteelly as the "anti-social personality". Something significant is revealed if we contrast the description given in the DSM-II of an "anti-social personality disorder". The former description is reserved for individuals who are basically unsocialised and "whose behaviour pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups or social values .... are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalisations for their behaviour. **A mere history of repeated legal or social offences is not sufficient to justify this diagnosis.**

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In contrast, the DSM-III description of an "anti-social personality disorder" is as follows: "The essential feature is a Personality Disorder in which there is a history of continuous and chronic anti-social behaviour in which the rights of others are violated, persistence into adult life of a pattern of anti-social behaviour that began before the age of 15, and failure to sustain good job performance over a period of several years." This description contrasts with the previous one in that it is now othe outward behaviour which is offensive to others, which is stressed over an inner state which may or may not be particularly problematic to others. Outward behaviour of a criminal nature would fit in well with the description of an "anti-social personality" given in the DSM-III and, in this description, there is no qualification as there is in the DSM-II, that mere criminality is insufficient to warrant the diagnosis. A recent text asserts that the "anti-social personality disorder should not be thought of as synonymous with criminality".[8] Yet what is the basis of the distinction given the description that I have quoted? The authors' answer is so weak that one suspects their seriousness: "Anti-social personality disorder can be distinguished from illegal behaviour, because anti-social personality disorder involves more areas of the person's life".[9] It comes as no surprise that they claim that, in prison populations, the prevalence of anti-social personality may be as high as 75 percent. If the only distinguishing mark of the other 25 percent is that their criminality doesn't involve many areas of the person's life, then the distinction is impossibly vague and arbitrary. At least it involved enough to get them into jail. There is then no clear distinction between the anti-social personality disorder of the DSM-III and criminality.

The third significant change in diagnoses which bears on the expansion of psychiatry into criminology concerns

the adjustment disorders of the DSM-III in comparison with the adjustment reaction classification of the DSM-II. In both schemes these disorders are described as acute reactions to overwhelming environmental stress, but then a difference emerges. In the older scheme, adjustment reactions were further subdivided according to age — whether the person was an adolescent, adult, etc. In the new scheme, adjustment disorders are grouped according to whether they are associated with particular moods or behaviour and it's the latter which allows in a third avenue for bringing criminality within the domain of psychiatry. One of these new classifications is entitled, "Adjustment disorder with disturbance of conduct". This disorder is described as follows: "the predominant manifestation involves conduct in which there is violation of the rights of others or of major age — appropriate societal norms and rules. Examples: truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities". Again, what we have here is criminal behaviour, without any other abnormality and yet the behaviour counts as a mental disorder.

Psychiatry's move over

How has it come about that psychiatry has been able to take over criminality? There appear to be three conditions which have made this possible: 1) the weakness of alternative theories and practices; 2) the push from the drug companies to move into new markets; and 3) the strength of the medical model in general psychiatry, and the attempt to carry that aura of strength over into medical theories of criminology.

The main rival to psychiatric explanations of criminal behaviour is the belief that criminals are evil and need to be punished. The high rates of recidivism and the increase in the crime rate with systems that embody this belief have led many to question it. Yet there remains a popular desire to see crime as a feature of individual criminals (rather than, for example, a phenomenon of a particular social context — a position which I would favour). Isolation of the criminal and attempts to change him or her are also generally regarded as the best course of action; but how do we back that up if we are not seeing the criminal as an evil person any more? Obviously there is room here for a theory which gives a rationale to these popular desires and attitudes; the criminal is not bad, but he is mad, his madness justifies his isolation and calls out for treatment.*

Drug companies cash in

The second condition making it possible for psychiatry to expand into this area is the background support of the drug companies. For the last thirty years, the drug industry has been either the first or the second most profitable industry in the world. Recorded profits are fare in excess of manufacturing industry averages and these profits have attracted new money to the industry at more than three times the average rate.[10] The industry is consequently on the make for new markets. There is a very nice mark-up on psychiatric drugs in particular. Valium, whose wholesale price is twenty-five times the price of gold, sells at twenty times the total production cost.[11] There is, then, a specific desire to expand the consumption of psychiatric drugs. If more behaviour is coming to be seen as a psychiatric problem, then the door is open for drug industries to move in to these new areas, and, indeed, with the recent classification of conduct disorders, personality disorders and adjustment disorders, there are recommendations for drug therapy; phenothiazines - major tranquilisers for conduct disorders, anti-depressants for anti-social persoality disorders, and minor tranquilisers for adjustment disorders. Many of the drug advertisements which appear in psychiatric journals in the last year or so, emphasise the effectiveness of certain drugs in taming aggression and hostility suggesting that criminals are among the targeted population group. Also, there is a lot of emphasis in these ads on slow-release injections which maintain control over the patient for some weeks as a method for getting over non-compliance in treatment — a procedure which has obvious relevance to the handling of criminals who do not accept that they are crazy and in need of psychiatric help.

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The dominance of the medical view within psychiatry generally has also played a part in making the psychiatric expansion into criminology possible. In the past, psychiatry has had many competing explanations of madness and although several are still around today, the idea that madness is a medical illness or disorder is slowly squeezing out conflicting ideas. As the editor of the *American Journal of Psychiatry* said in 1984: "psychiatry has turned back toward the rest of medicine - has finally been equipped to turn back .... So, except in certain enclaves such as analytic practice, the clinician whose touch has the daintiness of a safecracker's fingers is out of date. Sensitivity to proper drug levels — no small act — has pushed aside sensitivity to emotional nuances".[12] A field with many competing explanations is in a much weaker position to take over new areas than afield with an established paradigm. If there is, however, one dominant mode of explanation in a particular field, some rationale for expansion might be given as folows — explanations of a certain sort seem to be working in field x, so why not try them out in the field? This is precisely what we have here with the development of new medical theories of criminology in the last few years.

The attempts to give a medical account of criminology reduce to attempts to explain criminal behaviour in terms of biology and most of these theories rely on a supposed relationship between aggression and crime. So it is argued that, if aggression has a

* The male gender is used here because most criminals are male.

biological base, then criminal behaviour has also. Cruel experiments on cats, monkeys and humans have revealed that, if their brain is electrically stimulated in certain places, aggressive attacks will be made. The cats and monkeys made it clear that they intended to do the experimenter harm; one human subject said, "If you're going to hold me you'd better get five more men". Whereupon she stood up and started to strike the experimenter" — who then turned the current down.[13]

The Biological answer?

It is claimed that a creature's level of aggression is, in part, determined by heredity. Extremely aggressive strains of mice, rabbits and guinea pigs have been bred. Human experiments haven't been reported in this area but, on the basis of the animal findings, Kenneth Moyer, an American psychology professor, claims that "neurological differences (relating to aggression) must be inherited in the same way that differences in the shape of noses are".[14]

Another arm of this proposal that biology affects aggression and hence criminality is the claim that blood chemistry affects the level of aggression, in particular the amount of testosterone, the male hormone. The basis for this claim is that castration seems to have a calming effect. Some authors suggest that it is also of relevance that males are more aggressive than females and, compared with females, males commit more crimes — worldwide, except for sex specific offences such as abortion.[15]

Certain allergies which affect blood chemistry are also claimed to increase aggression.

After discussing all these theories, Moyer claims "Just as there are wild cats and wild monkeys, there are wild people, individuals who have so much spontaneous activity in the neural systems which underlie aggressive behaviour that they are a constant theat to themselves and to those around them".[16]

Ginsburg claims that biology is "presumably involved in aggression" in the ways suggested above. He also clings on to a watered-down version of the old chromosome theory. This is the idea that individuals containing an extra Y-chromosome (the male chromosome) are more aggressive than others. Acknowledging that research has shown that there is no invariable association between the extra Y and aggression, he still claims that we can make the assumption that **at least some** XYY males have an unusual tendency to aggression.[17]

A furthery theory has been put forward recently: that psychopaths have some sort of brain malfunction — a disturbance in the frontal lobe of the brain which is supposed to be linked to certain cognitive functions.

Several points of criticism can be brought to bear on the over-all orientation which attempts to define the criminal as a medical pychiatric problem. Firstly, it is claimed that aggression has a biological base. It is then assumed that there is a link between aggression and criminal behaviour and then it is concluded that criminality has a biological base. This link is highly contentious. Even if one assumes that the criminal population is adequately represented in prisons, not every prisoner is aggressive and what of white collar criminals who don't end up in jail? The link between aggression and criminality gains its crecibility only when we narrow down the relevant crimes to violent ones against people and property. Yet the medical model of criminality purports to cover the whole field.

That aggression can be sparked by electrical stimulation of the brain is not surprising, yet it does not establish that aggression is generally **caused** by our biology rather than, for example, social conflicts. It's possible to electricallystimulate the brain to make us have a sensation of an orange, even when there isn't one there, but we can hardly infer that all perceptions of oranges, or perceptions in general, are simply a matter of biology.

There are gross methodological problems with the research on the inherited nature of aggression. Recent studies have shown that differences between aggressive and peaceful mice, which were thought to be due to genetic differences were, in fact, due to handling differences. The so-called aggressive strains were handled more roughly than the others.[18] This has thrown a question mark over the animal research in this area.

The claim that the level of the male hormone, testosterone, is somehow linked to aggression at least can't be as clear cut as selective appeal to animal studies make it appear: "All normal **male animals** in the reproductive age group produce much greater quantities of testosterone than females; yet many of these males (are not aggressive e.g. rabbits) .... And there exist primate species where the female is clearly more aggressive .... than the male, e.g. Tamarins".[19] Hence the level of testosterone can't be a sure indicator of the level of aggression.

The claims about allergies affecting aggression are vague and unsubstantiated. Fatigue, nervousness, irritability, fears, rage and distorted thinking are taken as symptoms of the underlying allergy — a brain allergy — but research into the brain has not revealed its presence. It is mere conjecture.

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It seems ridiculous to keep maintaining even a modified version of the idea that those with an extra Y chromosome are more aggressive than others when research continually refutes that claims. To say, as Ginsburg does, that at least some XYY males have an unusual tendency to aggression, reflects nostalgia for the old theory but little else — as some XYY males aren't aggressive and some males or femals without chromosome anomalies are aggressive.

Burning out parts of the brain has proved effective in taming the cat, Lynx rufus rufus, and the wild Norway rat, both of which attack unprovoked, without the operation.[23] Surgeons vary in their reports of the success of these operations on humans 41.5 percent to 92 percent,[24] but the success in taming aggression has to be weighed against the irreversible side effects of these operations — personality changes, intellectual and physiological impairment and decreases in spontaneity and creativity.[25] Certain sorts of electrical brain stimulation have also been used under the medical orientation. An electrode is placed in the brain and connected to a radio which is bolted to the person's head. This radio receiver can be activated by a transmitter some distance away and through the resulting stimulation of the brain, aggressive impulses can be blocked. The problem with this procedure has been that people tend to feel conspicuous with radios on their heads but miniaturisation in electronics has provided a solution. It's possible to build a unit about the size of a ten cent coin which takes the radio, the power to operate it, and a radio transmitter which will send out brainwaves The problem that this procedure gives some individuals horrendous control over others is not, of course, overcome, and there is also what is known as the "kindling effect", an irreversible change in the brain resulting from the stimulation which means that the person becomes more prone to convulsion.

An analysis done last year of the study that was supposed to reveal that psychopaths have a brain malfunction has uncovered several weaknesses, for example psychopaths certainly didn't do so well as the "control" group on certain cognitive tasks, but the "control" group consisted of university students who differed from the psychopaths in age, education, general ability and drug or alcohol abuse, and any of these factors could have been relevant to the different test scores.[20] In fact, in a study controlling for these factors, psychopaths did not come out as particularly weak on cognitive tasks as the author of this study asserts: "it would seem prudent to rule out non-organic explanations of task performance before involving an organic one."[21] This comment could be generalised to apply to the whole biological orientation in the field of criminology — rule out the non-organic, non-biological, non-medical explanations of criminology first before moving into the biological domain. Why? The answer lies in an assessment of the consequences of holding different positions. If, for example, you believe, as I do, that criminology is to be understood in terms of social conflict and that no resolution can be found by focusing on the individual criminal, then the focus should be on social change — measures to decrease injustice and inequality. This sort of action stands in sharp contrast to the practices which follow from the medical model of criminology. They involve, as one author puts it, "influencing the internal milieu, by producing changes in the individual's physiology".[22] The use of psychiatric drugs in only one such practice, and in the present day, is the most common. All of these drugs have irritating and/or debilitating effects and if they do succeed in controlling aggression, they produce a certain dullness. Some cause irreversible brain damage.

Another procedure to control aggression which emerges from the medical approach is castration. This may achieve the end, but it is irreversible and some well known side-effects. Some medical writers look for what they call "less drastic measures", e.g. taking adolescents who have displayed aggression or who might, because they have the chromosome anomaly, and using behaviour modification techniques or drugs which block the effects of the male hormone. The side-effects of these drugs are not well researched, but there is an overriding problem here — the fact that these adolescents are selected for special treatment would have a stigmatising effect and it could, in fact, increase the hostility which now, at least, has a rational foundation.

A New Era?

Psychiatry visibly enters the criminal domain when psychiatrists assist the courts in determining the individual offender's competency to stand trial or guilt or lack of guilt by reason of insanity. Their role here is not new, but it is expanding. Psychiatry has entered less visibly into developing and passing on theories of criminal behaviour to those concerned with the crime problem, and into the domain of treatment. It's in these last two areas that the medical-biological view is having an impact — an impact which, according to one writer, will change history: "The increase in our knowledge of atomic forces moved us into a new era. The increase in our understanding of the physiology of behaviour will move us into another and the effects will be even more profound",[26] or, as another author put it: much crime and deviant behaviour may actually be caused biochemically .... (and) it may be that as the biochemical causes are found and treated most citizens would see the goals and means and rewards and punishments provided by advanced capitalist societieis to be sufficient for them to conform[27] — a new era maybe, but do you want to go there?

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