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# Stop the insane insanity defense: Levi Aron's mental troubles shouldn't render him innocent

BY SAM VAKNIN

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Louis Lanzano/Pool

Suspect Levi Aron (above) is eligible for federal death penalty because he took 8-year-old Leiby Kletzky across state lines.

Levi Aron, who has confessed to kidnapping, murdering and dismembering 8-year-old Leiby Kletzky in Brooklyn last month in a crime that horrified the entire city, has one last resort: to claim that he was insane when he committed the crime.

Having just been found competent enough to eventually stand trial in Brooklyn Supreme Court, Aron and his lawyers will likely now point to a history of "psychiatric disorders," including hearing voices, in an attempt to plead NGRI ("not guilty by reason of insanity"). Yesterday, the Associated Press obtained the report of an evaluation that showed Aron to have an "apathetic" mood - as well as a schizophrenic sister, now deceased.

The insanity defense in criminal trials is nothing new. The Babylonian Talmud had this to say some 1,500 years ago: "It is an ill thing to

knock against a deaf-mute, an imbecile or a minor. He that wounds them is culpable, but if they wound him they are not culpable."

But even the Talmudic rabbis would have been baffled by the modern version of the insanity defense, which has become less about compassion for the mentally ill than a loophole for criminals to escape through.

To start with, no one seems to be able to define "insanity" unequivocally. Insanity in a courtroom is not the same as the colloquial expression (i.e., "he is nuts"). To add to the confusion, it is equally distinct from the way psychiatrists use the term - which, in fact, they rarely do.

Indeed, when it comes to the antiquated insanity defense, the legal profession is completely at odds with modern psychiatry, which recognizes that "insanity" is an inaccurate term to use in describing an incredibly wide spectrum of mental states, not all of which should automatically get a criminal off the judicial hook.

The legal system applies three tests to determine whether a suspect should be held not responsible for his or her actions:

* Diminished capacity. Can the suspect tell right from wrong? Does he or she lack substantial capacity to "know and appreciate" the criminality or wrongfulness of the alleged conduct?

* Criminal intent. Did the suspect intend to act in the way that he or she did?

* Irresistible impulse. Was the suspect unable to control his or her behavior?

But many mental health scholars today regard these broad "tests" as subjective, biased and even ludicrous. What matters is whether the defendant's perception or understanding of reality is impaired. This so-called "reality test" is the only true measure of "insanity," critics say.

A perpetrator should go unpunished - and be hospitalized instead - only if he is found to be completely divorced from reality by diagnosticians from both sides, a far cry from today's insanity defense.

But the rigorous criterion of a reality test applies only to psychopaths such as Tucson shooter Jared Lee Loughner, whose reality was subverted by apparently intense bouts of psychosis (delusions, hearing voices, etc.). In these extreme instances, a criminal may be so thoroughly unaware of reality that his or her mental state really does deserve courtroom consideration.

All others should be deemed both sane and culpable for all intents and purposes, insist most psychiatrists.

Moreover, a perception and understanding of reality can co-exist even with the severest forms of mental illness. Even when a suspect is deemed mentally ill, as long as he or she passes the reality test, that suspect should be held criminally responsible.

The serial killer Jeffrey Dahmer, accused of killing 17 young men and boys, pleaded NGRI in 1992. Despite obvious mental health troubles, however, the jury rightly found that he was responsible for his actions and sentenced him to more than 900 years in prison.

Consider, also, the cases of the Norway shooter, Anders Behring Breivik or Unabomber Ted Kaczynski: Both have coherent world-views, a consistent internal logic and highly complex ethical codes. Their philosophy may be repellent or outlandish, but that alone does not make them insane.

Breivik, for instance, is not delusional. Yet his lawyer is seriously considering using the insanity defense.

This is not to say that a defendant's mental state at the time of the crime is irrelevant: He or she may have held mistaken (even delusional) beliefs or may have misread the situation, may have been misinformed, may have been under the influence of mind-altering drugs, may have lacked criminal intent, may have been unable to tell right from wrong or to control his or her urges.

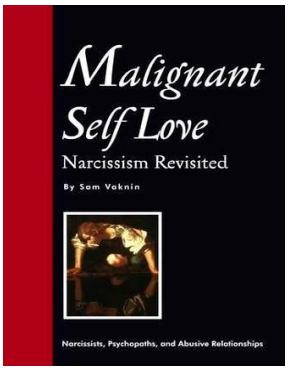
A troubled mental state can be accounted for during the sentencing, but the all-purpose insanity defense is an outdated tactic that poorly serves justice and science alike.

*Vaknin is the author of "Malignant Self Love: Narcissism Revisited" and other books on personality disorders.*

http://samvak.tripod.com/insanitydefense.html

# *The Insanity of the Defense*

***By: Dr. Sam Vaknin***

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***"You can know the name of a bird in all the languages of the world, but when you're finished, you'll know absolutely nothing whatever about the bird… So let's look at the bird and see what it's doing – that's what counts. I learned very early the difference between knowing the name of something and knowing something."***

Richard Feynman, Physicist and 1965 Nobel Prize laureate (1918-1988)

***"You have all I dare say heard of the animal spirits and how they are transfused from father to son etcetera etcetera – well you may take my word that nine parts in ten of a man's sense or his nonsense, his successes and miscarriages in this world depend on their motions and activities, and the different tracks and trains you put them into, so that when they are once set a-going, whether right or wrong, away they go cluttering like hey-go-mad."***

Lawrence Sterne (1713-1758), "The Life and Opinions of Tristram Shandy, Gentleman" (1759)

## *I. The Insanity Defense*

***"It is an ill thing to knock against a deaf-mute, an imbecile, or a minor. He that wounds them is culpable, but if they wound him they are not culpable." (Mishna, Babylonian Talmud)***

If mental illness is culture-dependent and mostly serves as an organizing social principle - what should we make of the insanity defense (NGRI- Not Guilty by Reason of Insanity)?

A person is held not responsible for his criminal actions if s/he cannot tell right from wrong ("lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct" - diminished capacity), did not intend to act the way he did (absent "mens rea") and/or could not control his behavior ("irresistible impulse"). These handicaps are often associated with "mental disease or defect" or "mental retardation".

Mental health professionals prefer to talk about an impairment of a "person's perception or understanding of reality". They hold a "guilty but mentally ill" verdict to be contradiction in terms. All "mentally-ill" people operate within a (usually coherent) worldview, with consistent internal logic, and rules of right and wrong (ethics). Yet, these rarely conform to the way most people perceive the world. The mentally-ill, therefore, cannot be guilty because s/he has a tenuous grasp on reality.

Yet, experience teaches us that a criminal maybe mentally ill even as s/he maintains a perfect reality test and thus is held criminally responsible (Jeffrey Dahmer comes to mind). The "perception and understanding of reality", in other words, can and does co-exist even with the severest forms of mental illness.

This makes it even more difficult to comprehend what is meant by "mental disease". If some mentally ill maintain a grasp on reality, know right from wrong, can anticipate the outcomes of their actions, are not subject to irresistible impulses (the official position of the American Psychiatric Association) - in what way do they differ from us, "normal" folks?

This is why the insanity defense often sits ill with mental health pathologies deemed socially "acceptable" and "normal" - such as religion or love.

Consider the following case:

A mother bashes the skulls of her three sons. Two of them die. She claims to have acted on instructions she had received from God. She is found not guilty by reason of insanity. The jury determined that she "did not know right from wrong during the killings."

But why exactly was she judged insane?

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***Her belief in the existence of God - a being with inordinate and inhuman attributes - may be irrational.***

But it does not constitute insanity in the strictest sense because it conforms to social and cultural creeds and codes of conduct in her milieu. Billions of people faithfully subscribe to the same ideas, adhere to the same transcendental rules, observe the same mystical rituals, and claim to go through the same experiences. This shared psychosis is so widespread that it can no longer be deemed pathological, statistically speaking.

***She claimed that God has spoken to her.***

As do numerous other people. Behavior that is considered psychotic (paranoid-schizophrenic) in other contexts is lauded and admired in religious circles. Hearing voices and seeing visions - auditory and visual delusions - are considered rank manifestations of righteousness and sanctity.

Perhaps it was the content of her hallucinations that proved her insane?

***She claimed that God had instructed her to kill her boys. Surely, God would not ordain such evil?***

Alas, the Old and New Testaments both contain examples of God's appetite for human sacrifice. Abraham was ordered by God to sacrifice Isaac, his beloved son (though this savage command was rescinded at the last moment). Jesus, the son of God himself, was crucified to atone for the sins of humanity.

A divine injunction to slay one's offspring would sit well with the Holy Scriptures and the Apocrypha as well as with millennia-old Judeo-Christian traditions of martyrdom and sacrifice.

***Her actions were wrong and incommensurate with both human and divine (or natural) laws.***

Yes, but they were perfectly in accord with a literal interpretation of certain divinely-inspired texts, millennial scriptures, apocalyptic thought systems, and fundamentalist religious ideologies (such as the ones espousing the imminence of "rapture"). Unless one declares these doctrines and writings insane, her actions are not.

we are forced to the conclusion that the murderous mother is perfectly sane. Her frame of reference is different to ours. Hence, her definitions of right and wrong are idiosyncratic. To her, killing her babies was the right thing to do and in conformity with valued teachings and her own epiphany. Her grasp of reality - the immediate and later consequences of her actions - was never impaired.

It would seem that sanity and insanity are relative terms, dependent on frames of cultural and social reference, and statistically defined. There isn't - and, in principle, can never emerge - an "objective", medical, scientific test to determine mental health or disease unequivocally.

## II. The Concept of Mental Disease - An Overview

Someone is considered mentally "ill" if:

1. His conduct rigidly and consistently deviates from the typical, average behaviour of all other people in his culture and society that fit his profile (whether this conventional behaviour is moral or rational is immaterial), or
2. His judgment and grasp of objective, physical reality is impaired, and
3. His conduct is not a matter of choice but is innate and irresistible, and
4. His behavior causes him or others discomfort, and is
5. Dysfunctional, self-defeating, and self-destructive even by his own yardsticks.

Descriptive criteria aside, what is the ***essence*** of mental disorders? Are they merely physiological disorders of the brain, or, more precisely of its chemistry? If so, can they be cured by restoring the balance of substances and secretions in that mysterious organ? And, once equilibrium is reinstated – is the illness "gone" or is it still lurking there, "under wraps", waiting to erupt? Are psychiatric problems inherited, rooted in faulty genes (though amplified by environmental factors) – or brought on by abusive or wrong nurturance?

These questions are the domain of the "medical" school of mental health.

Others cling to the spiritual view of the human psyche. They believe that mental ailments amount to the metaphysical discomposure of an unknown medium – the soul. Theirs is a holistic approach, taking in the patient in his or her entirety, as well as his milieu.

The members of the functional school regard mental health disorders as perturbations in the proper, statistically "normal", behaviours and manifestations of "healthy" individuals, or as dysfunctions. The "sick" individual – ill at ease with himself (ego-dystonic) or making others unhappy (deviant) – is "mended" when rendered functional again by the prevailing standards of his social and cultural frame of reference.

In a way, the three schools are akin to the trio of blind men who render disparate descriptions of the very same elephant. Still, they share not only their subject matter – but, to a counter intuitively large degree, a faulty methodology.

As the renowned anti-psychiatrist, Thomas Szasz, of the State University of New York, notes in his article ***"The Lying Truths of Psychiatry"***, mental health scholars, regardless of academic predilection, infer the etiology of mental disorders from the success or failure of treatment modalities.

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This form of "reverse engineering" of scientific models is not unknown in other fields of science, nor is it unacceptable if the experiments meet the criteria of the scientific method. The theory must be all-inclusive (anamnetic), consistent, falsifiable, logically compatible, monovalent, and parsimonious. Psychological "theories" – even the "medical" ones (the role of serotonin and dopamine in mood disorders, for instance) – are usually none of these things.

The outcome is a bewildering array of ever-shifting mental health "diagnoses" expressly centred around Western civilisation and its standards (example: the ethical objection to suicide). Neurosis, a historically fundamental "condition" vanished after 1980. Homosexuality, according to the American Psychiatric Association, was a pathology prior to 1973. Seven years later, narcissism was declared a "personality disorder", almost seven decades after it was first described by Freud.

***III. Personality Disorders***

Indeed, personality disorders are an excellent example of the kaleidoscopic landscape of "objective" psychiatry.

The classification of Axis II personality disorders – deeply ingrained, maladaptive, lifelong behavior patterns – in the Diagnostic and Statistical Manual, fourth edition, text revision [American Psychiatric Association. DSM-IV-TR, Washington, 2000] – or the DSM-IV-TR for short – has come under sustained and serious criticism from its inception in 1952, in the first edition of the DSM.

The DSM IV-TR adopts a categorical approach, postulating that personality disorders are ***"qualitatively distinct clinical syndromes"*** (p. 689). This is widely doubted. Even the distinction made between "normal" and "disordered" personalities is increasingly being rejected. The "diagnostic thresholds" between normal and abnormal are either absent or weakly supported.

The polythetic form of the DSM's Diagnostic Criteria – only a subset of the criteria is adequate grounds for a diagnosis – generates unacceptable diagnostic heterogeneity. In other words, people diagnosed with the same personality disorder may share only one criterion or none.

The DSM fails to clarify the exact relationship between Axis II and Axis I disorders and the way chronic childhood and developmental problems interact with personality disorders.

The differential diagnoses are vague and the personality disorders are insufficiently demarcated. The result is excessive co-morbidity (multiple Axis II diagnoses).

The DSM contains little discussion of what distinguishes normal character (personality), personality traits, or personality style (Millon) – from personality disorders.

A dearth of documented clinical experience regarding both the disorders themselves and the utility of various treatment modalities.

Numerous personality disorders are "not otherwise specified" – a catchall, basket "category".

Cultural bias is evident in certain disorders (such as the Antisocial and the Schizotypal).

The emergence of dimensional alternatives to the categorical approach is acknowledged in the DSM-IV-TR itself:

***"An alternative to the categorical approach is the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another"*** (p.689)

The following issues – long neglected in the DSM – are likely to be tackled in future editions as well as in current research. But their omission from official discourse hitherto is both startling and telling:

- The longitudinal course of the disorder(s) and their temporal stability from early childhood onwards;
- The genetic and biological underpinnings of personality disorder(s);
- The development of personality psychopathology during childhood and its emergence in adolescence;
- The interactions between physical health and disease and personality disorders;
- The effectiveness of various treatments – talk therapies as well as psychopharmacology.

## *IV. The Biochemistry and Genetics of Mental Health*

Certain mental health afflictions are either correlated with a statistically abnormal biochemical activity in the brain – or are ameliorated with medication. Yet the two ***facts*** are not ineludibly facets of ***the same*** underlying phenomenon. In other words, that a given medicine reduces or abolishes certain symptoms does not necessarily mean they were ***caused*** by the processes or substances affected by the drug administered. Causation is only one of many possible connections and chains of events.

To designate a pattern of behaviour as a mental health disorder is a value judgment, or at best a statistical observation. Such designation is effected regardless of the facts of brain science. Moreover, correlation is not causation. Deviant brain or body biochemistry (once called "polluted animal spirits") do exist – but are they truly the roots of mental perversion? Nor is it clear which triggers what: do the aberrant neurochemistry or biochemistry cause mental illness – or the other way around?

That psychoactive medication alters behaviour and mood is indisputable. So do illicit and legal drugs, certain foods, and all interpersonal interactions. That the changes brought about by prescription are desirable – is debatable and involves tautological thinking. If a certain pattern of behaviour is described as (socially) "dysfunctional" or (psychologically) "sick" – clearly, every change would be welcomed as "healing" and every agent of transformation would be called a "cure".

The same applies to the alleged heredity of mental illness. Single genes or gene complexes are frequently "associated" with mental health diagnoses, personality traits, or behaviour patterns. But too little is known to establish irrefutable sequences of causes-and-effects. Even less is proven about the interaction of nature

and nurture, genotype and phenotype, the plasticity of the brain and the psychological impact of trauma, abuse, upbringing, role models, peers, and other environmental elements.

Nor is the distinction between psychotropic substances and talk therapy that clear-cut. Words and the interaction with the therapist also affect the brain, its processes and chemistry - albeit more slowly and, perhaps, more profoundly and irreversibly. Medicines – as David Kaiser reminds us in ***"Against Biologic Psychiatry"*** (Psychiatric Times, Volume XIII, Issue 12, December 1996) – treat symptoms, not the underlying processes that yield them.

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### *V. The Variance of Mental Disease*

If mental illnesses are bodily and empirical, they should be invariant both temporally and spatially, across cultures and societies. This, to some degree, is, indeed, the case. Psychological diseases are not context dependent – but the pathologizing of certain behaviours is. Suicide, substance abuse, narcissism, eating disorders, antisocial ways, schizotypal symptoms, depression, even psychosis are considered sick by some cultures – and utterly normative or advantageous in others.

This was to be expected. The human mind and its dysfunctions are alike around the world. But values differ from time to time and from one place to another. Hence, disagreements about the propriety and desirability of human actions and inaction are bound to arise in a symptom-based diagnostic system.

As long as the ***pseudo-medical*** definitions of mental health disorders continue to rely exclusively on signs and symptoms – i.e., mostly on observed or reported behaviours – they remain vulnerable to such discord and devoid of much-sought universality and rigor.

### *VI. Mental Disorders and the Social Order*

The mentally sick receive the same treatment as carriers of AIDS or SARS or the Ebola virus or smallpox. They are sometimes quarantined against their will and coerced into involuntary treatment by medication, psychosurgery, or electroconvulsive therapy. This is done in the name of the greater good, largely as a preventive policy.

Conspiracy theories notwithstanding, it is impossible to ignore the enormous interests vested in psychiatry and psychopharmacology. The multibillion dollar industries involving drug companies, hospitals, managed healthcare, private clinics, academic departments, and law enforcement agencies rely, for their continued and exponential growth, on the propagation of the concept of "mental illness" and its corollaries: treatment and research.

### *VII. Mental Ailment as a Useful Metaphor*

Abstract concepts form the core of all branches of human knowledge. No one has ever seen a quark, or untangled a chemical bond, or surfed an electromagnetic wave, or visited the unconscious. These are useful metaphors, theoretical entities with explanatory or descriptive power.

"Mental health disorders" are no different. They are shorthand for capturing the unsettling quiddity of "the Other". Useful as taxonomies, they are also tools of social coercion and conformity, as Michel Foucault and Louis Althusser observed. Relegating both the dangerous and the idiosyncratic to the collective fringes is a vital technique of social engineering.

The aim is progress through social cohesion and the regulation of innovation and creative destruction. Psychiatry, therefore, is reifies society's preference of evolution to revolution, or, worse still, to mayhem. As is often the case with human endeavor, it is a noble cause, unscrupulously and dogmatically pursued.

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***The Myth of Mental Illness***

***In Defense of Psychoanalysis***

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