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From *M'Naghten* to *Currens*, and Beyond

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THE DECISION in *United States v. Currens*,¹ setting forth a new rule of the criminal responsibility of the mentally ill, has provided new fuel to the fire of controversy over *M'Naghten*.² When the *Durham*³ rule replaced the ancient *M'Naghten* rule in the District of Columbia, there were high hopes that reform would spread throughout the nation.⁴ But only the Virgin Islands and, with serious restrictions, Maine,⁵ have been willing to adopt *Durham*. All other jurisdictions have remained impervious to the onslaughts of its reform implications.

In this particular paper, I shall not debate the desirability of replacing the *M'Naghten* rule. I shall start with the assumption (which many readers will question) that *M'Naghten* is dead—that the “knowledge of right and wrong” test of criminal responsibility remains only to be buried, and that the real issue is how long must the funeral services go on and how many decades must pass before the law ceases to mourn at its grave. For the truth is that the principle behind *M'Naghten*, namely, that defect of cognition as a consequence of mental disease is the primary exculpatory factor in the determination of legal insanity, has probably never been other than a legal fiction. I assert, without attempting to prove it here, that all psychiatrists of high caliber and experience invariably utilize, as the basis of formulating their own expert opinion about the mental responsibility of a given defendant, some other criteria than defects of cognition. They may or may not give lip-service to *M'Naghten* and may or may not advocate its change. But in their own reasoning about the defendant's mental condition, in their own appraisal of the mentally ill defendant's criminal responsibility, they give

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¹ *United States v. Currens*, 290 F.2d 751 (3d Cir. 1961).

² *M'Naghten's Case*, 10 Clark & F. 200, 8 Eng. Rep. 718 (1843).

³ *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954).

⁴ Sobeloff, *Insanity and the Criminal Law: From McNaghten to Durham, and Beyond*, 41 A.B.A.J. 793 (1955).

⁵ ME. REV. STAT. ANN. ch. 149, § 38-A (Supp. 1961).

cognitive defects small measure compared to other psychopathological manifestations. If it were otherwise, extremely few defendants would ever be found legally insane.⁶

The difficulty is that these "other criteria" of criminal responsibility are, in most instances, unformulated, unexpressed, idiosyncratic to the particular expert, perhaps even to the particular defendant, and most certainly not endorsed by appropriate judicial decision or legislative enactment. That expert testimony in criminal trials appears chaotic, inconsistent, and sometimes absurd is no reflection upon the state of knowledge of psychiatry. Rather it reflects upon the obstinacy of the law, which demands an impossible adherence to a fiction of little relevancy to the issue being decided.⁷

Since *M'Naghten* there have been various modified and substitute rules of criminal responsibility, all of which have been attempts to bring the issue of the criminal responsibility of the mentally abnormal defendant into harmony with the realities of human abnormal psychology. None of these new rules has ever achieved widespread acceptance. They include the irresistible impulse rule,⁸ the New Hampshire rule,⁹ the *Durham* rule,¹⁰ and, in 1961, the *Currens* rule.¹¹ Innumerable rules have been proposed, but never accepted by any jurisdiction. The only one that has received serious consideration is the American Law Institute formula.¹²

Judge John Biggs, Jr., in the *Currens* decision, provides the following new rule: "The jury must be satisfied that at the time of committing the prohibited act the defendant, as a result of mental disease or defect, lacked substantial capacity to conform his conduct to the requirements of the law which he is alleged to have violated."¹³

The decision discusses in a most scholarly manner the beneficial implications of this new rule over *M'Naghten* and *Durham*, as well as its relationship to the American Law Institute formula from which it is derived. It is a temptation here to quote much of Judge Biggs' decision, to compare the implications of *Currens* phrase by phrase with *Durham*, and to assert the superiority of those decisions over both *M'Naghten* and the irresistible impulse test.¹⁴ This would require an extensive treatise beyond the scope of

⁶ Diamond, *Criminal Responsibility of the Mentally Ill*, 14 STAN L. REV. 59 (1961).

⁷ Diamond, *The Fallacy of the Impartial Expert*, 3 ARCHIVES OF CRIMINAL PSYCHODYNAMICS 221 (1959).

⁸ *Parsons v. State*, 81 Ala. 577, 2 So. 854 (1887); see PERKINS, CRIMINAL LAW 762 (1957).

⁹ *State v. Jones*, 50 N.H. 369 (1871); *State v. Pike*, 49 N.H. 399 (1869).

¹⁰ *Durham v. United States*, 214 F.2d 682, 874 (D.C. Cir. 1954).

¹¹ *United States v. Currens*, 290 F.2d 751, 774 (3d Cir. 1961).

¹² MODEL PENAL CODE § 4.01(1) (Tent. Draft No. 4, 1955). The text of this rule is given in full in *United States v. Currens*, *supra* note 11, at 774.

¹³ *Id.* at 774.

¹⁴ For the directly opposite view see Mueller, *M'Naghten Remains Irreplaceable: Recent Events in the Law of Incapacity*, 50 GEO. L.J. 105 (1961).

this paper. Hence, I must presume that the reader will also familiarize himself with these decisions and the basic issues involved in determining the criminal responsibility of the mentally ill.¹⁵

In short, the present situation can be summed up by stating that despite the esteem psychiatrists have for *Durham* and despite their high hopes for its adoption throughout the nation, the legal opposition to its further adoption is enormous. Moreover, I think it will be only a short time before it is abandoned in the District of Columbia.¹⁶

Currens is superior to *Durham*, if for no other reason, because it omits the troublesome "product" clause of both the *Durham* and the New Hampshire rules. Criminal behavior is not the "product" of mental disease in the strict cause and effect relationship that the law would like to believe. The vast majority of mental illnesses result in no criminal behavior of any kind. But certain psychological abnormalities in certain individuals so affect the motivational, ideational, and volitional psychology of those individuals that, under special environmental circumstances, aggressive, destructive, or immoral antisocial behavior occurs. In most of these instances the psychiatrists can say with probability, but never with certainty, that if it were not for the mental illness, the overt act would not have occurred.

The essential phrase of *Currens*, "lacked substantial capacity to conform," should, I think, be much simpler for both the psychiatric expert and the lay juror to ponder over. Further, it provides opportunity for the expert to describe any aspect of the defendant's psychology that he thinks may have some relevancy to his capacity to conform, whether it is a lack of knowledge of the wrongfulness of his act, or of its nature and quality, as required under *M'Naghten*, or whether it is the defect of volitional control specified by the irresistible impulse test, or the "product" relationship of *Durham*.

Currens is thus more inclusive than any previous rule of responsibility. This will make *Currens* more appealing to those who believe the existence of mental illness of any kind should be given the fullest possible consideration in a criminal trial. But for all those who believe that mental illness and what they regard as the fantasies of psychiatrists and humanist reformers already receive more attention than they deserve in our courts of law, *Currens* will be a threat, and vigorous opposition is to be expected.

As much as I admire Judge Biggs' enlightened understanding of psychiatry, his scholarly historical knowledge, and his impeccable legal reasoning, and as much as the *Currens* rule appeals to me as a psychiatrist who must

¹⁵ See generally DONNELLY, GOLDSTEIN & SCHWARTZ, CRIMINAL LAW 733 (1962). Although it is too old to include the modern decisions, an excellent reference is GLUECK, MENTAL DISORDER AND THE CRIMINAL LAW (1925).

¹⁶ See *Blocher v. United States*, 288 F.2d 853, 860 (D.C. Cir. 1961) (Burger, J., concurring).

examine particular defendants, appraise their mental condition, and communicate my opinions to the trier of fact, I still do not think that *Currens* will achieve significant acceptance. The reasons are simple: The public will not like *Currens* or its consequences; judges will not approve for much the same argument as Judge Burger uses to assault *Durham*; ¹⁷ and what is worse, psychiatrists will not like its consequences as soon as they feel their full impact upon their mental hospitals.

The problems of reforming the rules for determining the criminal responsibility of the mentally ill become greatly intensified with two categories of defendants: (1) those who are suffering from a borderline or latent schizophrenia; and (2) those suffering from a character disorder variously described by nebulous words such as psychopathic personality, sociopathic personality, sexual psychopath, psychopathic deviant, and the like. The vast majority of troublesome, difficult, and debatable verdicts and appeals result from the trials of defendants who suffer from one or the other of these two conditions. No one knows for sure what proportion of our prison population consists of such individuals, but it must be very high.

Are borderline schizophrenia and character disorders mental diseases? Much ridicule has been heaped upon the staff of St. Elizabeth Hospital in Washington, D.C., for committing themselves, in 1957, to the view that sociopathic personality was henceforth to be considered a mental disease. ¹⁸ Between 1954 and 1957, St. Elizabeth Hospital psychiatrists generally had testified that sociopathic personality was not a mental disease, and hence a defendant suffering from such condition was not insane under *Durham*. The immediate consequence of their shift of position in 1957 was a ten-fold increase in acquittals on the ground of insanity in the District of Columbia. ¹⁹ Yet this change of attitude by the Washington psychiatrists was imperative, for their earlier position was untenable and inconsistent with all of the standard diagnostic classifications. ²⁰

It is true that there are many voices in psychiatry who protest that no type of deviant psychological behavior is a mental disease, that there is no analogy between disease of the body and disease of the mind or emotions, and that the terms *disease* and *illness* should not be applied even to the conceptualization of psychological abnormality. ²¹ Although the adherents of

¹⁷ *Ibid.*

¹⁸ See Mueller, *supra* note 14, at 116. See also Blocker v. United States, 288 F.2d 853, 874 (D.C. Cir. 1961) (Miller and Bastian, JJ., dissenting).

¹⁹ Statistics obtained by the staff of the California Special Commissions on Insanity and Criminal Offenders established by executive order of the Governor, May 4, 1960 (to be published).

²⁰ AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL, MENTAL DISORDERS 38 (1952).

²¹ See generally SZASZ, THE MYTH OF MENTAL ILLNESS (1961). See also Blocker v. United States, 288 F.2d 853, 859 (D.C. Cir. 1961) (Burger, J., concurring).

this view have much logic on their side, it is unlikely that any sizable proportion of psychiatrists agree. Most of us still regard psychiatry as a specialty of medicine and we look upon the various categories of mental abnormality as divisible into entities properly called *diseases*. Such abnormalities, be they manifested by disorder of mind, emotion, character, or behavior, are correctly considered to be illnesses in a sense analogous to the use of the term in describing the pathology of the body.

Nevertheless, this poses a serious dilemma for the law. For if conditions of borderline schizophrenia and sociopathic personality are not mental diseases, then neither are conditions of active schizophrenia or any other psychoses that the law regards as producing mental abnormalities exculpating under *M'Naghten*. On the other hand, if active schizophrenia and other psychoses are accepted by psychiatry and the law as *diseases*, then the borderline conditions and most, if not all, of the character disorders must also be acknowledged as *mental diseases*. The reasons for this will be discussed below, but for the moment, assume its correctness. Then what are the consequences for the law and for penology?

Consider the consequences if *Currens* becomes the law of the land. Very large numbers of defendants, accused of crimes both great and small, who are now regarded by the public and by the law as not sick but bad people, will be acquitted on the ground of insanity. Presumably, they will be sent to mental hospitals for indeterminate stays rather than to prisons for defined periods of time. In the non-judgmental view of the psychiatrist, such mentally diseased defendants will almost invariably be considered as lacking "substantial capacity to conform" their conduct to the requirements of the law.²² A considerable proportion of our potential prison population will then be sent to hospitals, staffed and administered by psychiatrists ill-equipped by temperament or training either to treat these borderline and character disorders, or to maintain the necessary security precautions that society demands. Modern trends in public and private mental hospitals are definitely toward the open-door hospital with voluntary admission of patients. It would not be easy, and certainly not at all acceptable to the psychiatric profession and to the public, to reverse this trend and return to the maximum security state hospital of the past in order to accommodate the new patients to be committed under *Currens*.

Then why not do what the American Law Institute recommends, and what the Maine statutory version of *Durham* specifies, and exclude the

²² The opposite view is asserted by a Dr. Cushard, quoted in *Blocker v. United States*, *supra* note 21, at 861 n.12 (Burger, J., concurring). I think Dr. Cushard's view, as quoted, is nonsense and reflects a judgmental and moralistic attitude inappropriate to a psychiatrist. He is quoted as stating: "I think these people are able to control their acts if they make the necessary effort."

sociopath and his ilk from the benefits of the relaxed rule of responsibility?²³ The answer is that such special restrictive clauses aimed at excluding certain specified categories of individuals from exculpation simply do not make any psychiatric sense. They are as arbitrary and capricious as excluding defendants with red hair or blue eyes or Negro blood from the benefits of the law of criminal responsibility. They define by legislative fiat what is and what is not a psychiatric condition. Further, they grossly discriminate against the defendant who is poor. In practically any case where the crime itself, or alcoholism or drug addiction, is supposedly the only evidence of mental disease, a skilled, competent, and interested psychiatrist who spends sufficient time could discover other manifestations of mental abnormality sufficient to exculpate under the ALI or Maine rules. But the routine case, superficially examined by court-appointed psychiatrists devoting a wholly inadequate time to the study of the defendant, would seldom end in acquittal. It costs a good deal of money for a defendant to engage psychiatric experts to make a full study of his case. The defendants who have such money would have no difficulty in demonstrating to the trier of fact that their criminal behavior was not the only thing that troubled them. In all likelihood, defendants without such funds would be routinely passed by as "sane." Thus a type of economic discrimination, which is bad enough under our present rule of *M'Naghten*, would become much worse.²⁴

Until shortly after 1900, psychiatry was generally a sub-specialty of neurology. This intensely medically-oriented psychiatry reached its peak with the diagnostic and classification system devised by Kraepelin.²⁵ Emphasis was placed on the overt, demonstrable evidence of mental disease (such as delusions and hallucinations), and it was hoped that exact descriptions of such overt disease manifestations would eventually result in an ability to catalogue mental disease with the precision customary to the science of neurology. It was already possible by that time for the neurologist to locate exactly the lesion in the brain, spinal cord, or peripheral nerves that caused a particular paralysis or sensory disorder. This was done by obtaining a careful history of the onset and progression of symptoms and then meticulously mapping out the areas of the body demonstrating the paralysis, reflex disturbances, or sensory loss. If one possessed sufficient knowledge of the anatomy and function of the nervous system, deducing

²³ MODEL PENAL CODE § 4.01(1) (Tent. Draft No. 4, 1955) excludes "an abnormality manifested only by repeated criminal or otherwise anti-social conduct." All of the psychiatrists who participated in the drafting of the ALI formula repudiated it because of the inclusion of this restrictive clause. Observe that Judge Biggs does not include it in *Currens*. The Maine statute, although modeled after *Durham*, has a similar exclusion of criminality, and also of drug addiction and alcoholism. ME. REV. STAT. ANN. ch. 149, § 38-A (Supp. 1961).

²⁴ See Diamond, *supra* note 6, at 226.

²⁵ KRAEPELIN, *EINFÜHRUNG IN DIE PSYCHIATRISCHE KLINIK* (1905).

the size and position of the lesion was easily possible. Then, knowing the location of the lesion, one could often deduce the etiological agent, and sometimes prescribe a remedial treatment. The neurologists were able, through these methods, to demonstrate the existence of hundreds of discrete neurological diseases with particular, well defined, and uniformly located lesions, disclosed by reasonably constant subjective and objective symptoms and pathological manifestations of body function. It was anticipated that the same would be accomplished in the area of mental disease.

The anticipations of the neurologists were thoroughly shattered by the publication of two books: Sigmund Freud's *The Interpretation of Dreams*, published in 1900; and Eugen Bleuler's *Dementia Praecox, or the Group of Schizophrenias*, published in 1911.²⁶ It would take many volumes to adequately describe the revolutionary changes in psychiatry that are directly attributable to the work of Freud and Bleuler. And we are still in the midst of the revolution. Suffice it to say that Freud's discoveries led to the development of psychoanalysis and psychodynamic psychiatry, which is the dominant psychiatry of the present day in every situation *except the courtroom*. Bleuler completely altered the concept of schizophrenia. Although he did not discover the cause and cure of the disease (nor has anyone else yet done so) he did demonstrate that schizophrenia was a completely different type of disease, or group of diseases, than the Kraepelinians had thought. He showed that the overt manifestations of the illness, such as delusions and hallucinations, were only secondary symptoms—the end products of ego disintegration—rather than clues to the illness itself. The basic disorder in schizophrenia was a very serious, though subtle, disturbance in the integration of thought and feeling,²⁷ together with certain difficult to demonstrate, but nevertheless malignant, alterations in the nature of the patient's ability to conceptualize and to experience appropriate emotion.

Modern psychotherapeutic psychiatry as practiced today by well trained physicians conceptualizes mental illness as a complex interplay of forces: instinctual as well as acquired and environmental social forces interacting with the defenses and adaptive functions of the ego. As a result of this interplay of forces, abnormalities of thought, feeling, volition, motivation, and behavior arise, and are manifested by various symptoms. In fact, it is no longer possible to speak of specific abnormalities of single mental func-

²⁶ FREUD, *DIE TRAUMDEUTUNG* (1900); BLEULER, *DEMENTIA PRAECOX ODER DIE GRUPPE DER SCHIZOPHRENEN* (1911).

²⁷ The term schizophrenia, coined by Bleuler, literally means "split mind." However, Bleuler did not mean this in the sense of split or double personality. The split personality is an hysterical phenomenon and is not a type of schizophrenia. The splitting in schizophrenia refers to a fragmentation of the ego, particularly to a dissociation between the intellectual and the emotional functions of the personality.

tions, such as volition. Rather, every disorder of this fluid balance of forces results in disturbances describable only in terms of the total individual and his environment.

Obviously such a dynamic conceptualization of mental illness sacrifices much of the precision and discreteness so eagerly sought by the early neurologists. But what has been gained has been a marvelously useful, psychologically broad concept of all human behavior, not just of gross mental abnormality. Medical psychology has expanded far beyond its old borders and has contributed significant insights into almost every field of human activity—the arts as well as the sciences.

However, during this modern psychodynamic revolution, organically oriented psychiatry, with its heritage from Kraepelin, has not been dormant. Shock therapy, initiated by Manfred Sakel²⁸ in 1934, with the use of insulin coma, later to be supplanted by electro-shock therapy, discovered by Cerletti and Bini²⁹ in 1938, which in turn has been nearly superseded by the tranquilizers and the anti-depressant drugs, have kept very actively alive a system of psychiatric treatment based upon non-psychological approaches.

At times there have been serious schisms—almost ideological conflicts—between the psychodynamic psychiatrist with his psychotherapeutic treatment, and the organically oriented neuro-psychiatrist with his physical and chemical remedies. It is difficult for a psychoanalyst, such as myself, who was professionally born and raised, so to speak, in the psychology of Freud, to admit that there might be something to the organic, physical, and chemical approach toward mental disease. Yet the evidence is accumulating rapidly; the therapeutic efficacy of the recently developed phenothiazine tranquilizers and the anti-depressant drugs such as imipramine and tranylcypromine is very impressive.³⁰

It would be a mistake to assume that the recent resurgence of interest in the physical and chemical causes and treatment of mental disease means that psychiatry will soon return to the precise, specific symptom-lesion concept of the 19th century neurologist. These biochemical approaches toward mental disease have, like the earlier psychological approaches, further blurred the distinctions between what little remains of our psychiatric disease entities. For example, anti-depressant drugs are effective to some degree against emotional depression no matter what the cause of the depres-

²⁸ Sakel, *Schizophreniebehandlung mittels Insulin-Hypoglykämie sowie hypoglykämischer Shocks*, 84 *WIENER MEDIZINISCHER WOCHENSCHRIFT* 1211 (1934).

²⁹ Cerletti & Bini, *L'elettroshock*, 19 *ARCHIVIO DI PSICOLOGIA, NEUROLOGIA E PSICHIATRIA* (Milano) 226 (1938).

³⁰ These drugs are usually referred to by their trade names: *i.e.*, Tofranil (imipramine), Parnate (tranylcypromine), and Thorazine, Compazine, and Stelazine, which are varieties of the phenothiazine tranquilizers. Closely related drugs of similar purpose are manufactured by various companies under a variety of other trade names.

sion. Schizophrenia, manic-depressive psychosis, psychoneurosis, character disorders, and normal grief are all conditions that may result in serious emotional depression. An anti-depressant drug, if it works at all, tends to discriminate little between diagnostic classifications. The same is true of the tranquilizers. The most that can happen is that one can learn empirically that a particular drug possibly may work better or worse in a particular disease entity. But the differences are very crude and uncertain.

Furthermore, the neurophysiological postulates upon which the use of these drugs are predicated involve exceedingly complex neuro-hormonal mechanisms little, if at all, related to conventional diagnostic entities. One can only predict that if and when the theory and practice of biochemical psychiatry is well developed, it too will turn out to be dynamic, in the sense of the complex inter-action of metabolites, enzymes, genetic defects, and biophysical electrical activities. It will be far from a static, specific, lesion-oriented neurology.

So the law cannot hopefully look toward either modern psychodynamic psychiatry or biochemical psychiatry for a solution to its needs for categorical, all-or-none, sane-or-insane dichotomies. All we psychiatrists can tell the law is that if you think you have trouble with our inconsistencies now, wait and see what the future holds.

All of this leads us back to the discussion of the borderline or latent schizophrenic, *i.e.*, the schizophrenic individual without obvious, overt signs of psychosis, such as hallucinations and delusions, yet equally as seriously mentally ill, and the character disorders, including the sociopathic personality. These are chiefly the conditions producing mental states that will preclude criminal responsibility under *Currens*, but not under *M'Naghten*, and that may well include a majority of criminal offenders. They must be acknowledged as mental diseases, if one acknowledges anything as a mental disease.

First, let me say that what follows must not be regarded as scientifically demonstrated psychiatric truth. Nor is it even the accepted opinion of a majority of psychiatrists. These are matters about which there is little agreement. Opinions from one extreme to the opposite can easily be found in the current psychiatric literature, and one would have no difficulty in obtaining suitable citations to articles by reputable authorities that would "prove" or "disprove" any given point. Further, much of this is in the nature of a prediction of what will be discovered rather than what has already been demonstrated. Regardless, I believe it is impossible to discuss the inherent difficulties of *any* rule of criminal responsibility of the mentally ill without considering the possible future progress of our psychiatric knowledge about these troublesome cases.

There are two areas of intensive research now going on that are rele-

vant to this issue: (1) There is intensive research, rapidly progressing, whose goal is the demonstration of specific biochemical and/or neurophysiological factors as the cause of schizophrenia.⁸¹ If this goal is fulfilled, it will be a relatively simple matter to conclusively prove the presence or absence of schizophrenia. I believe that then all those borderline and latent cases that now cause so much dispute among the experts⁸² will turn out to be unequivocally as sick or sicker than the cases with hallucinations and delusions now excused by *M'Naghten*. (2) The widespread electroencephalographic testing of habitual criminal offenders, sociopaths, and those with character disorders has revealed what many of us had long suspected: That many of these unfortunate individuals are suffering from an organic, neuro-physiological disease of the brain, which completely dominates their behavior. Their appearance of normalcy, their apparent ability to exercise free will, choice, and decision (and somehow invariably choose the wrong instead of the right) is purely a façade, an artifact that conceals the extent to which they are victims of their own brain pathology.⁸³

So at the risk of future mortification, I make the following predictions:

1. That within ten years biochemical and physiological tests will be developed that will demonstrate beyond a reasonable doubt that a substantial number of our worst and most vicious criminal offenders are actually the sickest of all. And that if the concept of mental disease and exculpation from responsibility applies at all, it will apply most appropriately to them. And further, that it will apply equally to the vast horde of minor, habitual, aggressive offenders who form the great bulk of the recidivists. The law and the public, whether they like it or not, will be forced by the stark proof of scientific demonstration to accept the fact that large numbers of individuals who now receive the full, untempered blow of social indignation, ostracism, vengeance, and ritualized judicial murder are sick and helpless victims of psychological and physical disease of the mind and brain.⁸⁴

⁸¹ See generally TULANE DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, SCHOOL OF MEDICINE, TULANE UNIVERSITY, STUDIES IN SCHIZOPHRENIA, A MULTIDISCIPLINARY APPROACH TO MIND-BRAIN RELATIONSHIPS (1954).

⁸² See *People v. Nash*, 52 Cal. 2d 36, 338 P.2d 416 (1959), as an example of a so-called borderline schizophrenic defendant executed as a horrifying vicious murderer but who was very mentally ill, indeed.

⁸³ Thompson, *Psychopathy*, 4 ARCHIVES OF CRIMINAL PSYCHODYNAMICS 736 (1961), expresses the view that this is already a demonstrated, scientific fact. This is an extreme position.

⁸⁴ The reader must not assume that I believe that all criminal behavior is a consequence of disease of the mind or brain. Sociological and situational causes play the dominant role in large numbers of crimes. Further, the emphasis in this paper on organic and physiological disorders does not reflect an abandonment of interest in the psychological, such as discussed in Diamond, *Identification and the Sociopathic Personality*, 4 ARCHIVES OF CRIMINAL PSYCHODYNAMICS 456 (1961). It is just that the imminent research discoveries in biochemical and neurophysiological psychiatry are best suited to illustrate the thesis of the present paper. The cause of crime is not now, and probably never will be, reducible to a single factor. Each indi-

2. My second prediction is that it will be ten times ten years, or even much longer, before the discovery of any consistently effective, thoroughly reliable method of psychiatric treatment for these sick individuals who now plague society with their behavioral disorders. Long before that day arrives the treatment of non-criminal psychiatric patients will be conducted in hospitals entirely free from the taint of the bars, the locked doors, and the prison atmosphere of the old state hospital. Much of the psychiatric treatment of ordinary civilians will be done in out-patient clinics and in private offices. Few, if any, of the physical facilities that would ensure maximum security will persist in the mental hospital of the future. Even now, with each passing year, psychiatrists and their mental hospitals are becoming less and less suitable for the care of mentally ill patients who are criminal offenders and whose danger to society demands that social protection take priority over the welfare of the individual patient.

3. Finally, my third prediction: For many, many years to come, and certainly long after the ten years specified by my first prediction, all criminal offenders—sick or well, schizophrenic or sociopathic, or just plain normal, if such there be—will require various combinations of institutional control, probation, and parole supervision providing a range of facilities from the strongest possible maximum security to nearly total social freedom. Although psychiatric and psychological treatment techniques will be in evidence throughout the system, the main burden of rehabilitation of individual offenders will still rest upon essentially non-medical methods. These will still include the old standbys (as inadequate as they may be) of restriction of freedom, humanely tempered discipline, educational and vocational training, together with some kind of moral indoctrination, which will probably continue to be administered, as it is now, through a system of rewards and punishments. Certainly there will be increased use of psychiatric diagnostic techniques, together with a wide use of easily applied treatment methods such as group psychotherapy, psychopharmacological remedies, and whatever new methods come forth from our clinics and laboratories. But it is to be hoped that there will also be a substantial increase in the use of social and economic methods of behavioral control, such as job placement after release, preservation of family relationships, realistic acceptance back into the social community, and so forth.

The interesting thing is that these non-medical, social rehabilitation techniques are just as desirable for the mentally ill offender as they are for

vidual offender must be analyzed in terms of his social environment, his unique life situation, the psychodynamic forces within his personality, as well as the effects of functional or organic mental and brain disease. Each of these factors must be allotted its due significance. In addition, the law chooses to place its emphasis upon the moral element of the crime, a factor about which the psychiatrist, being no expert on that subject, has little to say.

the offender who shows no evidence of mental disease. And paradoxically, specific psychiatric techniques, such as group therapy, are just as useful for the normal offender as they are for the mentally ill offender. By and large, it has already been demonstrated by prison hospitals, such as the California Medical Facility at Vacaville, California, that just about any type of psychiatric treatment that could be given at a mental hospital can also be given in a prison, providing properly trained psychiatric personnel are available.

There are encouraging signs that many of the detrimental, destructive, inhumane, and just plain wasteful aspects of the prison system are slowly diminishing, at least in California. Over-crowding is still an urgent liability everywhere, but at least in some areas of the California prison system (such as Vacaville and the various minimum security camps) the old-time atmosphere of fear, distrust, suspicion, and explosive aggressivity upon the part of both inmates and personnel is giving way to a more hopeful climate of enthusiastic rehabilitation.

In the days of Daniel M'Naghten and before, the defense of not guilty by reason of insanity had much more intrinsic logic than it has now. In the 18th and early 19th centuries, in England, there were only three alternative verdicts for most major felony cases: acquittal, conviction and execution by hanging (with chance of reprieve by the King), and acquittal on the ground of insanity. Those defendants who escaped capital punishment by reprieve or legal technicality were usually punished by transportation to the colonies; benefit of clergy had largely disappeared. A successful defense of insanity meant lifetime incarceration in a hospital that was not greatly different from a prison. The typical English prison and work-house was filled with prisoners of a variety that corresponds more to our present county jail population. Thus, with any crime of serious proportion, be the offender sane or insane, there was no thought of rehabilitation and eventual restoration to society. The verdict of insanity meant only that the defendant would not be executed; it did not mean that he would be set free. This dichotomous disposition by means of the death penalty for the sane or the equivalent of true life imprisonment for the insane lent itself well to the development of an all-or-none, sane or insane, rule of criminal responsibility. There was no thought of any concept of responsibility that would provide diminished or intermediate grades of responsibility, because there were few, if any, possibilities for any type of intermediate form of punishment. This English pattern was carried over to the United States by our general adoption of the English common law. But it was not long after the Revolutionary War that both England and the United States began to alter the harshness of their penal laws. Fewer and fewer felonies were subject to capital punishment, and prison confinement for a specified number

of years became the fate of the average felon. Much later, and more gradually, the eventual release of some of the criminal insane from their prison-like hospitals became possible.

Only in comparatively recent times have we reached the state of affairs where only a tiny minority of felons are actually executed, where a very small number actually serve out life sentences, and where very few of the criminal insane spend the rest of their lives in hospitals. It is now anticipated at the time of sentencing or commitment that rehabilitation and restoration to society will occur with both the sane and the insane. The only question is now how long it will take.

California, being a state with a phenomenal population boom, requires a continual expansion of both its prison and its mental health facilities. The expansion cannot keep up with the population increase, so that hospitals and prisons are always badly over-crowded. But this very pressure of population growth forces the development of a much wider variety of prison and hospital institutions than one sees in other areas of the country. Most of all, it makes it imperative that there be no "warehousing of human beings,"³⁵ no locking up either prisoners or patients and throwing the keys away.

Inevitably, this will mean that future expansion of both mental health and correctional services will be forced to place emphasis on decentralized, community facilities. The California Department of Mental Hygiene is making impressive plans for the establishment of local clinics and day-care centers, and for many other significant experiments in the utilization of treatment methods in the patients' home communities. They do not contemplate any increase in the old-style, isolated, large state hospital type of installation. Economic, if not humanitarian, reasons hopefully will force a similar development upon the State Department of Corrections. It can be anticipated that the day of the large, centralized, isolated prison will soon be over. Large numbers of criminal offenders who are not immediately dangerous to society must be dealt with in some way on the local level and by means other than physical confinement.

There is an urgent need for the development of some sort of correctional system analogous to the medical model of hospitals, clinics, and home care. In medicine, a patient is not irrevocably committed to receive his treatment in just a hospital or just a clinic. When he is sick enough to require it, he is put in a hospital. The minute he recovers to the point at which he can be effectively treated as an out-patient, he is discharged from the hospital. If he relapses, he goes back into the institution. This switch from in-patient to out-patient takes place often during the course of any single, chronic ailment.

³⁵ I attribute this descriptive phrase to Richard A. McGee, Administrator of the Youth and Adult Corrections Agency, State of California.

A correctional system could be organized around the same philosophy. Prisons of the conventional type would be used mainly for short term diagnostic and treatment programs. Release on parole with close supervision on the community level would occur as quickly as it could be determined that it was reasonably safe. If there was a relapse of deviant behavior, the offender could then be immediately returned to an institution, to be released again as soon as it appeared that there was a reasonable chance of adjustment. Only a few highly dangerous prisoners would be kept inside a prison for the long periods of time that are now customary. A realistic view of human nature would accept the fact that many offenders would have to shuttle back and forth between institutional and parole facilities many times before their ultimate rehabilitation was accomplished.

Such a system would, of course, do offense to the traditional view of imprisonment as part of a system of punishment and retribution. There will be much objection to the calculated risks inherent in early release from confinement. Nevertheless, the population explosion will soon teach the public the stern lesson that locking up criminal offenders for five, ten, and twenty years is an economic luxury they cannot afford.

California, today, is progressing rapidly in the direction of this type of penal reform. If further reform is accompanied by appropriate public and legislative education, I think that the full development of this infinitely more flexible, more effective, and more humane correctional system is certain to occur. It is to be hoped that other states may soon follow the lead of California.

There is a danger that liberalization of the rules of criminal responsibility, as is achieved by *Durham* and *Currens*, may inadvertently subvert the basic principles of humanitarian penal reform. Large numbers of offenders can, under these laws, be labeled as insane, then confined for indeterminate periods up to life in institutions called mental hospitals, which are really prisons in disguise, with only a pretense of treatment and with gross disregard of civil liberties and due process.

This is particularly likely to happen under the circumstances of my predictions, where the majority of criminals are recognized as sick, yet no definitive medical treatment is available. The institutions in which these insane offenders are kept may be worse than a prison. The social stigma of the label "criminal insane" may be more degrading than the label "convict" alone. The custodial officers, although called "doctors," may be more punitive and anti-therapeutic in their attitudes than true correctional officials. Such a state of affairs would permit an elaborate hoax to be perpetrated whereby society creates a smug illusion of reform, yet basically changes nothing. In the name of psychiatric enlightenment, penal reform can be obstructed. One can surround the criminal law with all sorts of admirable protections of due process and civil liberties, then cancel it all out by using

so-called welfare laws, purportedly of a non-criminal type, to inflict punishment and social sanctions upon the very class of persons who least deserve them. It is no idle threat, for precisely this has already happened in the usual hospital for the criminal insane, the psychopathic delinquent, and the sexual psychopath. The tragedy is that this can be done in the name of mental health, with the expedient rationalization that it is necessary for the protection of society.

Hence, I am very concerned that efforts to obtain reform of our archaic methods of administering criminal justice through liberalization of the rules of criminal responsibility of the mentally ill, while still retaining the irrational all-or-none principle of sane or insane, may backfire in ways that the authors of these reforms did not intend. The new classes of the mentally ill offenders established by these decisions will still be punished and degraded, but now they will lack many of the traditional safeguards of the criminal law. At the same time, the sane offender, the supposedly normal individual who violates the law, can be relegated (with the implied approval of the psychiatrist who has certified to his normalcy) to a prison system without even the pretense of a rehabilitative atmosphere. This would be directly contrary to the promising picture of future penal evolution that I described above.

It is for these reasons that I believe it is more desirable to place the emphasis on general reform of the whole body of criminal law and the entire correctional system rather than attempt to solve this problem by dividing the population of criminal offenders into two categories of responsible and not responsible. The *M'Naghten* rule draws the line between the two categories far off to one extreme. *Currens* rectifies this by drawing the line close to the middle or even beyond. But it is just possible that the line should not be drawn at all. Rather, efforts should be directed toward the elimination of capital punishment, toward the reduction of public and governmental attitudes of punishment and vengeance, and toward the evolution of a correctional system that will truly rehabilitate the offender and restore him to a normal life in his community as quickly as possible. If psychiatric and medical techniques can be used in this process of rehabilitation, so much the better. If other, non-medical means are effective, let them be used. But let all useful means be applied to all offenders, be they mentally ill or not.

It seems to me that, at least in the present state of development in California, the legal doctrine of limited or diminished responsibility may accomplish more than would the adoption of *Durham* or *Currens*, or any other rule that reinforces the sane-insane dichotomy.³⁶

³⁶ See generally Diamond, *With Malice Aforethought*, 2 ARCHIVES OF CRIMINAL PSYCHODYNAMICS 1 (1957); Diamond, *supra* note 6; Weihofen & Overholser, *Mental Disorder Affecting the Degree of a Crime*, 56 YALE L.J. 959 (1947).

All of this adds up to the bare thesis that the arbitrary division of the criminal offender into the two classes of the sane and the insane no longer makes any sense. Shifting the line of demarcation between the sane and the insane, as is accomplished by *Durham* and *Currens*, is at best only a transitional remedy that may be expedient for an incompletely developed correctional system.

The ever growing body of scientific, psychiatric, and sociologic knowledge about deviant behavior no longer permits a division of the responsible from the not responsible. This is so because modern science has accumulated a vast amount of information indicating that a very large proportion of criminal offenders are very sick people. Much of the evidence for this, at the present time, is not convincing to those preoccupied with moral judgment and vengeful retribution. But very soon the evidence may become so convincing that even the most conservative thinker will have to accept its validity. Yet it does not follow that just because the criminal is recognized as mentally sick that medicine will be able, by itself, to successfully cure or control this sickness.³⁷ Nor will hospitals of the conventional type, or of the type projected in future developments, be of a sort where mentally sick criminals can be adequately cared for with due regard to the protection of society.

Responsibility as a concept is losing its usefulness as a moral judgment and is acquiring a new, and much more valuable, therapeutic meaning. Thus, with many mentally ill persons, one may speak of their "extended responsibility."³⁸ Extended responsibility means that mentally ill persons are to be treated as if they were more responsible for their actions than they really may be, simply because it is therapeutically and socially desirable to do so.³⁹ At the same time, it may be therapeutically and socially useful to diminish the responsibility of those whom society and the law have previously held to be fully accountable.

Such far-reaching changes in ancient concepts of absolute morality and supposed natural law are not going to be eagerly received by many in our

³⁷ The considerable lag between the recognition of a condition as an illness and the discovery of an effective treatment is not a problem special to mental diseases. Remember that physical disease, like cancer, tuberculosis, etc., were recognized as specific diseases for thousands of years before cures were discovered that would be effective in even a few cases. There is apt to be a much shorter time lag between the discovery of the essential etiological agent of a disease and the discovery of an effective cure.

³⁸ This phrase comes from the Menninger Foundation, Topeka, Kansas, where I first heard it used in this sense by Dr. Joseph Satten. Freud did not use the phrase, but he certainly originated the idea of extending personal responsibility to the patient for the patient's own psychopathology and the consequences of his unconscious mind. See Freud, *Moral Responsibility for the Content of Dreams*, 5 COLLECTED PAPERS 154 (1959, original article published 1925).

³⁹ This idea is more fully developed by Szasz in *LEGAL AND CRIMINAL PSYCHOLOGY* (Toch ed. 1961).

society. There will be wailing and outcries by those who habitually long for the real or imagined virtues of the past. Yet even the most cursory historical analysis of the behavioral sciences,⁴⁰ and of the trend of philosophy, theology, economics, social welfare, and politics makes it inescapably clear that these changes are already occurring.

It is evident that there are constitutional, traditional, moral, and religious reasons why the total defense of insanity will not soon be completely abandoned. Actually, there is no need for psychiatry to urge its full abandonment. If constitutional due process requires that the defense of insanity retain a token place in our system of criminal justice and if this results in a limited number of mentally ill offenders receiving total exculpation by the law, no harm is done. Harm is done, however, if psychiatry and the law divert their attention and limited energies from the urgent problem of the great mass of criminal offenders toward the peripheral issue of insanity.

It makes more sense to focus reform efforts directly upon the total system of administration of criminal justice and thus attempt to cope with the bulk of anti-social deviation in constructive, humane, and effective ways. From such a viewpoint the solution is not to make new laws that will displace large portions of the prison population into mental hospitals, which then become prisons in disguise. Rather, it would be better to transform correctional systems and prison institutions into fit places to which mentally ill persons may be sent for treatment, rehabilitation, and eventual restoration to a normal life in their families and communities.

It will not be just a coincidence if, in the final analysis, the same humane psychological, medical, and sociological methods that are conducive to the rehabilitation of the mentally ill and emotionally disordered criminal turn out to be identical with those required for the supposedly normal and fully responsible offender.

⁴⁰ See Dain & Carlson, *Moral Insanity in the United States 1835-1866*, 118 AMERICAN J. PSYCHIATRY 795 (1962), for a description of how a change in the opposite direction took place in the attitudes of psychiatrists within a very brief span of time. It is astonishing to me that Professor Gerhard O. W. Mueller, a distinguished authority on criminal jurisprudence, can in this day and age make the statement that: "since the definition of what constitutes a crime has not changed and cannot possibly change as long as humanity exists, how can the concept of what does not constitute a crime change? Crime remains crime and no crime remains no crime. This remains constant." Mueller, *M'Naghten Remains Irreplaceable: Recent Events in the Law of Incapacity*, 50 GEO. L.J. 105, 111 (1961).