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Moral Responsibility and Mental Illness: A Case Study

MATTHEW R. BROOME, LISA BORTOLOTTI, and MATTEO MAMELI

Introduction

Various authors have argued that progress in the neurocognitive and neuropsychiatric sciences might threaten the commonsense understanding of how the mind generates behavior, and, as a consequence, it might also threaten the commonsense ways of attributing moral responsibility, if not the very notion of moral responsibility.[1] In the case of actions that result in undesirable outcomes (e.g., someone being harmed), the commonsense conception—which is reflected in sophisticated ways in the legal conception—tells us that there are circumstances in which the agent is entirely and fully responsible for the bad outcome (and deserves to be punished accordingly) and circumstances in which the agent is not at all responsible for the bad outcome (and thereby the agent does not deserve to be punished). The commonsense conception also tells us that between these two cases (full responsibility and total lack thereof) there is a whole range of in-between cases where the agent is responsible for the bad outcome to some extent but not fully,[2] and where the punishment should be proportionate to the extent to which the agent is responsible and should vary according to the type of responsibility involved. Again, this view is reflected (in complex ways) in legal distinctions.

According to both commonsense and the current legal conception, the responsibility status of the agent is determined by the causal process that led to the outcome and, more precisely, by the specific nature of the psychological process that led to the particular action. Some psychological processes justify an ascription of full responsibility, whereas others justify an ascription of "reduced" responsibility.[3] In the neuroethical literature, it is often argued that an understanding of the deterministic chain of events that take place in the brain and lead to particular actions will make many of the distinctions drawn in the commonsense and legal conception seem ungrounded. As a consequence, there will be a strong temptation to abandon these distinctions and perhaps to give up the notion of moral responsibility altogether.

In our opinion, it is far too early to say what global impact the neurocognitive and neuropsychiatric sciences will have on our intuitions about moral responsibility. And it is far too early to say whether the notion of moral responsibility will survive this impact (and if so, in what form). But it is certainly worth starting to think about the local impact that these sciences can or should have on some of

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our distinctions and criteria. It might be possible to use some of the tools offered by these sciences in order to refine or revise some of the categories currently used, without—for the time being at least—worrying too much about the fate of the notion of moral responsibility. This is an area where a piecemeal approach might be more productive: Only after an evaluation of many distinct cases and situations will it be possible to say something general about the current notion of moral responsibility.

In this article, we will focus on a single clinical case: a young man who has been convicted for assault on a neighbor and whose sentence was affected by a pre-existing diagnosis of mental illness. We will use this case, and an analysis of the similarities and differences between this case and other possible cases, in order to raise some (local but important) issues about the implications that discoveries in neuropsychology and neuropsychiatry can have for the way moral responsibility is attributed to agents and, more specifically, to agents with diagnoses of mental illnesses.

The Case

Bill was a 21-year-old male who was charged by the police with two counts of burglary and of grievous bodily harm with intent.[4] When he was charged, he already had a diagnosis of schizophrenia, dating from 2 months prior to the offences but with a likely duration of illness of 2–3 years prior to the offenses.

Bill was first admitted to a psychiatric inpatient unit for 6 weeks in April and May, with his offenses taking place in July of the same year. At the time of admission, Bill sought help and was admitted voluntarily into the hospital. Bill had previously contacted the police because he was concerned that he was acting "weird." He reported that he was hearing people talking to him whom he could not see, including a former friend called "James." He claimed that this had been happening for the past few years. He also claimed that his neighbor in the apartment above had been banging and shouting and that he felt his own thoughts were being taken out of his head. At the time of admission in April, Bill also reported that he believed the radio had been playing programs about his life and that, over the festive period, when he opened an Easter card he could hear the Easter Bunny talking to him. The immediate reason Bill called the police was that he was having thoughts that he was invulnerable and said he was contemplating testing this by jumping off the balcony of his 17th floor apartment. Bill also felt that there were some people out to harm him and was concerned that the material and stitching of his trousers was becoming "fluid-like."

Despite these florid symptoms, Bill was managed on the ward with his full consent and he accepted antipsychotic medication. His recovery was good and he was discharged after 6 weeks with no evidence of any psychotic symptoms such as delusions or hallucinations. At the time of discharge, his care was taken over by a community mental health team that specialized in the early stages of psychotic illnesses in young people, with his consultant psychiatrist being one of the authors (M.B.). After discharge, Bill engaged well with the community team and saw his doctor and community nurse at frequent intervals. However, Bill was unwilling to engage in any community rehabilitation activities, and the team became concerned within a few weeks of discharge that he was at risk of relapsing and becoming ill. Bill spent much of his time playing computer console

games and smoking cannabis and was socially isolated. Despite the team's concerns, they were able to continue seeing him. His family reassured the team that he was well, and Bill denied all psychotic symptoms but admitted to being "low." On further questioning, he reported to the team that his neighbor had been making a lot of noise, which was keeping him awake at night. Bill informed the team that he had discussed this with the neighbor and that the problem had been resolved. One week later, Bill was charged with two counts of burglary and of grievous bodily harm with intent.

Bill was interviewed by M.B. 2 months after the alleged offense. Bill admitted to having been noncompliant with medication after the first week or two of discharge, despite at the time informing the team that he was taking medication. Bill reported that approximately 2 weeks after returning to his apartment (around the time he ceased medication) the banging and the shouting from the apartment above had begun again. He also said he could hear someone he could not identify say "you bastard." He denied any of the other experiences he had previously reported during his time in the hospital. Bill informed M.B. that one day he had seen the door to the apartment where he thought the noise came from open: Bill had entered and removed a set of keys and an axe and hammer. He stated that he had removed the latter two items as he did not want them "used against" him and that he had taken the keys "in case I needed to enter the flat again." This initial entry was unplanned and impulsive and occurred several days prior to the alleged offenses. It seems that gradually his anger, frustration, and sleeplessness had increased and he had begun shouting back at the room in the night. Events culminated one evening: He got dressed and went to the apartment above. Bill claimed his intention at this time was simply to "frighten the tenant" but had appreciated that he may get into at least an argument if not a fight. On explicit questioning, Bill admitted he had considered the possibility that his actions may lead to serious harm to himself or the resident of the apartment, but had decided to proceed nevertheless. Bill reentered the apartment above and admitted to quickly losing his temper and becoming more aggressive than he had intended. He injured the resident in the apartment seriously, leading to superficial wounds and a fracture of one of the facial bones. No weapons were used. The tenant required hospital care via the Accident and Emergency department at the local hospital but was discharged and did not require inpatient care or a surgical intervention. Bill was bailed to his grandmother's property and the court ordered him not to attend his own apartment.

At the time of his assessment, it was clear that Bill was fit to plead. He understood the indictment, was capable of following the evidence submitted in his case, could instruct his legal team, could follow court proceedings, and could understand the role of the jurors and witnesses. Further, from what Bill can recall, it seems that, at the time of the offense, he was able to form specific intentions; he was certainly aware that his actions may lead to violence and harm. At the time of assessment, though, he denied any formal plans to harm the tenant of the apartment above and was surprised at how events had escalated and at how he had lost his temper. Bill was able to realize that the actions he had committed were wrong and unlawful. The opinion of his clinical team was that at the time of the offense he was in all likelihood relapsing from his psychotic illness. He had poorly engaged with his clinical team, and had been noncompliant with medication for several weeks prior to the offense. Further, he reported a recurrence

of auditory experiences (banging, shouting) that had previously abated. M.B. believed these experiences to be hallucinatory in nature. However, at the time of the assessment following the offense, Bill denied there being any relation between his offense and his mental illness and denied the possibility of the auditory experiences being hallucinatory.

In the end, Bill was found guilty and was sentenced to 2 years' probation and a suspended custodial sentence. Because of his diagnosis of mental illness, the sentence was less than otherwise would be expected.

Moral Responsibility and the Generation of Behavior

A clear sign of mental illness in Bill was that he had certain kinds of hallucinatory auditory experiences (i.e., loud noises coming from the neighboring apartment). But suppose these experiences had not been hallucinatory, that is, suppose Bill had actually had a very noisy neighbor. What kind of ascription of responsibility would we have made in relation to the harm inflicted on his neighbor in those circumstances? What kind of punishment would Bill have deserved for his attacking his truly noisy neighbor? Should the fact that the experiences were hallucinatory (and thereby that the neighbor was not in fact noisy) make a difference in relation to how we conceive of Bill's responsibility for what he did and of the punishment he deserves? It is true that Bill was hallucinating: He was hallucinating that his neighbor was making loud noises, and the content of the hallucination explains in part why he attacked his neighbor. Had he not hallucinated that his neighbor was making loud noises, Bill would have probably not attacked and harmed his neighbor. But it is also true that having noisy neighbors does not morally justify assaulting them. That is, had Bill's neighbor been truly noisy, Bill would have still been doing something blameable in assaulting his neighbor. If one has a noisy neighbor, then one should try to convince his neighbor to be less noisy, and, failing that, one should perhaps call the police.[5]

It may be useful to compare Bill's case with other cases. Suppose a man has a delusion that consists of a belief that his wife has been cheating on him. As a result, he kills his wife (in a premeditated way, let us assume). Would he be less responsible for what he did than a person who correctly believes that his wife is cheating on him and, as a result, kills his wife (in a premeditated way)? Prima facie, he would not. It is true that, had the delusional husband not believed (falsely) that his wife was cheating on him, he would have not killed his wife. But it is also true that having an adulterous wife does not morally justify murdering her.

Unless relevant differences are found, it seems that someone who thinks that there is no reduced responsibility in the delusional husband (relative to the nondelusional husband who kills his wife) should also be committed to thinking that there is no reduced responsibility in Bill's case (relative to someone who assaults a noisy neighbor on the basis of veridical experiences). One might want to argue, though, that actually there are differences between the two cases. One could try to claim, for example, that the reaction of the nonhallucinating neighbor attacker is not morally justified in relation to the triggering stimulus (a noisy neighbor), but it is at least understandable (in some sense to be specified) given such stimulus, and perhaps also proportionate to such stimulus. In contrast, one might argue, the reaction of the nondelusional jealous husband is neither

understandable nor proportionate to the triggering stimulus. This (alleged) difference might then be used to justify granting reduced responsibility to Bill but not to the delusional husband. On this line of thought the ground for ascribing reduced responsibility is not to be found in the fact that, had the person not had the delusional/hallucinatory state, he would not have committed the bad action. Rather it is to be found in the fact (if it is a fact) that the content of the hallucination/delusion made the action understandable, even though not morally justified.

A similar line of argument is that it may be possible to ascribe reduced responsibility to people with delusions or hallucinations in cases where the action (which led to the undesirable outcome) was the only rational thing for them to do, given the content of the delusional or hallucinatory states. In a recent paper, John Campbell discusses the case of a man who believed from the scaly appearance of his skin that a lizard was inside his body and tried to remove the lizard with a knife, harming himself as a result.[6] Campbell suggests that, despite the fact that there is no background of rationality that helps us make sense of this man's beliefs and behavior, arguably it is not unreasonable to try and remove a source of danger from oneself if one believes that there is real danger.[7] If the man believed that the doctor would not help him and that there were no professional lizard killers around, then the prospect of removing it himself with a knife may have seemed to him the only rational thing to do; by comparison, one can think about the case of a person trapped on Mount Everest who rationally decides to remove a gangrenous or frostbitten arm to save his or her life. The rational person balances perceived risks in order to survive: In this case, the relevant risks are the risk incurred in cutting oneself with a knife and the risk of being eaten from the inside by a poisonous lizard (compare the latter with the risk of the gangrene leading to certain death).

Suppose, for example, that, in addition to the hallucinations and delusions described in the case report, Bill had genuinely believed that his neighbor was a robot or an alien, intrinsically evil and not amenable to reason. Some peaceful solutions to the problem of the noise would then have ceased to make sense to Bill. In such circumstances perhaps, assaulting the neighbor would have seemed to Bill the only rational thing to do. In this scenario, Bill has a whole set of delusional beliefs that make his action seem to him the rational thing to do. This may perhaps justify granting the ascription of reduced responsibility (relative to the non-hallucinating neighbor attacker).

Alternatively, suppose that Bill had tried talking to his neighbor in order to convince him to stop producing loud noises, but with no effect, because his neighbor was not actually producing any loud noises and could not thereby make sense of Bill's request. Suppose also that Bill had actually called the police, but again with no effect, because the police would not take Bill seriously because of his clinical history. Finally, suppose that Bill had come to believe (delusionally) that the noise made by the neighbor signified an imminent threat to himself and his life. In this other scenario, again, assaulting his neighbor would perhaps have seemed to Bill the rational thing to do. And, again, this may perhaps justify an ascription of reduced responsibility. But, as in the previous scenario, this depends on the presence of additional delusional beliefs.

If one wants to use this line of thought in order to ascribe reduced responsibility to Bill, one needs to provide evidence for the claim that the additional

delusional beliefs—those that, in conjunction with the hallucinatory experiences, make the assault seem the only rational thing for the subject to do—were in fact present in Bill. Obviously, one cannot simply assume that because Bill had the hallucinatory experiences he also had other delusional states.

An alternative strategy for arguing that it would be wrong to compare Bill to his nonhallucinating counterpart would be the following: Bill's hallucinatory experiences are just the tip of an iceberg, they are just the symptom of a more serious problem that affects Bill's decisionmaking competence and thereby his ability to act in morally and legally acceptable ways. Kennett and Matthews argue, for example, that one cannot exercise self-control unless one is able to establish some continuity between present experienced events and both memories of one's past and projections of oneself into the future.[8] Disorders that manifest themselves as impairments of memory or imagination might then *in some cases* be accompanied by an impairment of the ability to behave in morally and legally acceptable ways: People with dissociative disorders, manias, dementia, or amnesia may have their autonomous agency compromised, with implications for *mens rea*, as they may not be able to frame intentions over time. On this view, it may be possible to ascribe reduced responsibility to Bill not because he had hallucinatory experiences but because he was affected by a serious malfunctioning of the machinery designed to make people behave in morally and legally acceptable ways.

Bill's hallucinations and delusions may signal other neuropsychological dysfunctions that are relevant to acting rationally or morally. For instance, Bill might not be able to form intentions in the standard way, or he might not be able to resist certain strong desires (desires that he does not necessarily identify with or approves of) in the standard way when forming intentions. These dysfunctions would not be the result of having the hallucination or having the delusion, but rather they would be something that is correlated with the hallucinations and delusions. For instance, there could be a neuropsychological deficit that is the common cause both of the hallucinations and delusions and of the dysfunction of the intention-forming or desire-consuming machinery. Alternatively, there could be a case of comorbidity, where Bill's hallucinations and delusions are combined with other (causally independent) problems.

If one wanted to use these considerations in order to argue that Bill needs to be "excused" for his action, one would have to provide evidence for the existence of a malfunctioning in Bill's decisionmaking machinery. Not all mental disorders affect the ability to make decisions in ways that conform to moral and legal norms, and hallucinatory experiences are not necessarily associated with such malfunctioning. Assuming the opposite without any evidence could in fact be seen as a form of stigmatization, especially in the context of establishing whether the patient meets the criteria for being able to make decisions for himself or herself or to give consent. Perhaps, though, in the case of Bill there was some evidence of such malfunctioning, as suggested by the fact that at some point he was considering jumping from the 17th floor. But in order to establish whether this intention of his was actually good evidence for some malfunctioning in his decisionmaking machinery, a more detailed analysis would be needed.

There seems to be a potential tension between lay and expert conceptions of the relationship between moral and legal responsibility and mental illness. In the lay account, agents such as Bill are often taken to have reduced responsibility just

because they are—generically—mentally ill, even though their illness does not impact on their intention-formation machinery. It is sufficient to read the reconstruction of crimes committed by people with mental illness in daily newspapers to see that the presence of some psychiatric disorder (actually diagnosed or suspected on the basis of the agent's observed behavior and speech) is taken to play a determining role in the explanation of how and why the crime took place. Psychiatrists, though, are often able to assess the agents' general intention-formation skills and often find that they are not impaired to an extent that compromises their capacity for decisionmaking.

Let us make an apparent digression to illustrate the importance of comorbidity in the prevention of criminal activities and the assessment of responsibility for criminal actions. We consider briefly the case of people suffering from Capgras delusion, that is, people who believe that a close relative or partner has been replaced by a replica, someone who looks like their relative or partner in all physical respects but is not in fact their relative or partner. These patients in many cases also have delusions of persecution and develop paranoid thoughts about the presumed impostor. Bourget and Whitehurst describe four cases of Capgras characterized by violent acts (including homicide):[9] In each case the patient had a long history of paranoia and persecutory delusions. Capgras delusion and delusions of persecution are independent phenomena: One can have one without the other. But one hypothesis is that people who have both Capgras and delusions of persecution have a better reason than people with just Capgras to be hostile to the "replicas."[10] Not only are the "replicas" believed to be impostors by the person with delusions, as they are not believed to be who they say they are, but they are also believed to be evil and dangerous, and thus they can be expected to cause harm. In cases of probable comorbidity such as these, it seems important for the purposes of crime prevention and fair sentencing to know which factor or combination of factors would make it more likely and more "understandable" for a person with mental illness to act violently. It is reasonable to be alert when a diagnosis of Capgras is made and ask whether it is accompanied by (i.e., it "signals") the presence of delusions of persecution. This is just an example. Other suggestions made to explain why some people with Capgras commit crimes and some do not make reference to impulsive behavior, social withdrawal, or substance abuse.

Conclusion

Are the courts taking into account the distinctions we have discussed (e.g., whether there is a direct causal link between the diagnosed mental illness and criminal behavior) when they decide what punishment (if any) to deliver? Ascribing reduced responsibility (in the context of illegal actions) to certain people because they are "mentally ill" is problematic and could, in fact, make such people more prone to commit illegal actions. In Bill's case, his mental illness interfaced with the legal process at the last stage, namely, at sentencing, when the regular or guideline sentence for the offense was "individualized" in the light of his diagnosis. But the problem we have just mentioned does not affect only the stage of sentencing. In the United Kingdom, the 1983 Mental Health Act provides a mechanism for the detention of mentally disordered offenders. Further, at every stage through the criminal justice system, the Act provides a means whereby the individual can be "diverted"

into mental health services. For example, after an arrest an individual can be admitted to a psychiatric hospital or the courts may remand an individual to a psychiatric hospital for a medical report. Indeed, many magistrates' courts have "diversion teams," staffed by mental health professionals, to facilitate assessments and provide advice. Individuals on remand in custody (i.e., awaiting trial or sentencing) can also be transferred to a hospital under the Mental Health Act. Finally, the courts may make a psychiatric disposal rather than recommend a custodial sentence and order an offender to be transferred to a hospital. We are not saying that the Mental Act should necessarily be modified, but we are saying that current practice, in the context of the widespread misconceptions of the relation between mental illness and proper functioning of the decisionmaking machinery, may lead to problems and needs to be reassessed.

The kind of deflection from the criminal justice system that we have just mentioned was documented in the "National Confidential Inquiry into Homicides and Suicides by Mentally Ill People in the UK."[11] Many clinicians now advocate that all alleged offenses committed by those with mental disorder should be referred to the criminal justice system in the first instance, both to allow an adequate assessment of the relationship between offending and illness to be made, but also to make sure that an objective record exists of events that can be utilized by mental health services in the future for risk assessment. The goal of facilitating record keeping and communication between professionals was an important recommendation of the Ritchie inquiry into the care and treatment of Christopher Clunis.[12] There are still, however, circumstances in which police are not called or choose not to charge.

These are complex and important issues that deserve much more attention than has been given to them so far. We hope to have shown that general labels like "mentally ill" are unlikely to be helpful in a context in which moral responsibility (or lack thereof) needs to be ascribed and punishment (or lack thereof) needs to be established. In contrast, proper reflection on the various ways (normal and pathological) in which behavior is caused can tell us a great deal about common criteria for ascription of moral responsibility and about how to refine and revise such criteria in sensible ways.

Notes

1. See Gazzaniga M. *The Ethical Brain*. Chicago: University of Chicago Press; 2005; Greene J, Cohen J. For the law, neuroscience changes nothing and everything. *Philosophical Transactions of the Royal Society, London* 2004;B359:1775–85; Levy N. The responsibility of the psychopath revisited. *Philosophy, Psychiatry and Psychology* 2007;14(2):129–38; Kennett K. *Agency and Responsibility*. Oxford: Oxford University Press; 2001:chaps. 6 and 7.
2. Mitchell EW. Madness and meta-responsibility: The culpable causation of mental disorder and the insanity defence. *Journal of Forensic Psychiatry & Psychology* 1999;10(3):597–622.
3. The term *diminished responsibility* in its technical sense is defined by appropriate legal codes (such as The Homicide Act 1957 in the United Kingdom) and it is generally used when defending someone against a charge of murder. In this paper we use the term *reduced* responsibility to mean that a person is less than fully responsible for a particular action, where the action does not need to be murder.
4. "Bill" is not the young man's real name, and other details of the case (when not relevant to the philosophical discussion that will follow) have been modified to protect confidentiality.
5. Another important question is this: Should we consider Bill responsible for the relapse of his illness because of his smoking of cannabis and to his noncompliance with medication? We do not have room to address this important issue here.

6. The case is first described in Browning SM, Jones S. Ichthyosis and delusions of lizard invasion. *Acta Psychiatrica Scandanavica* 1988;78:766–7.
7. Campbell J. What does rationality have to do with psychological causation? Propositional attitudes as mechanisms and as control variables. In: Broome M, Bortolotti L, eds. *Psychiatry as Cognitive Neuroscience: Philosophical Perspectives*. Oxford: Oxford University Press; 2009:chap. 7.
8. Kennett J, Matthews S. Mental time travel, agency and responsibility. In: Broome MR, Bortolotti L, eds. *Psychiatry as Cognitive Neuroscience: Philosophical Perspectives*. Oxford: Oxford University Press; 2009:chap. 16.
9. Bourget C, Whitehurst L. Capgras Syndrome: A review of the neurophysiological correlates and presenting clinical features in cases involving physical violence. *Canadian Journal of Psychiatry* 2004;49:719–25.
10. See also the discussion in Bortolotti L, Broome MR. If you didn't care, you wouldn't notice: Recognition and estrangement in psychopathology. *Philosophy Psychiatry and Psychology* 2007;14(1):39–42.
11. Appleby L, Shaw J, Amos T. National confidential inquiry into homicides and suicides by mentally ill people in the UK. *British Journal of Psychiatry* 1997;170(2):101–2.
12. Ritchie J, Dick D, Lingham R. *Report of the Inquiry into the Care and Treatment of Christopher Clunis*. North East Thames and South East Thames Regional Health Authorities. London: Her Majesty's Stationery Office, 1994.