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MORAL LIMITATIONS IN MENTAL DISEASE

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MENTAL disease is an illness which interferes with one's usual method of thinking, feeding and acting. From the group of mental patients the psychiatrist derives his "clinical material." His purpose, therefore, is to effect a cure for his patient, to relieve his suffering and restore him again to his normal self.

Frequently, in addition to his role as therapist, the psychiatrist is called upon to evaluate the seriousness of his patient's acts and their circumstances in relationship to those of other people. This function, as "the expert," has its greatest application in medico-legal matters and the psychiatrist is called upon to determine whether a certain individual may or may not have been responsible for his actions.

In the case of criminal or legal matters, the ultimate decision usually rests with the court. The court takes into consideration the ascertained facts both from the point of view of the prosecution and the defense, the expressions of witnesses, the individual interpretations by those interested, the interpretations of the facts by rules of evidence, the deliberations of the jury, supposedly in the light of evidence presented, but frequently distorted by individual feelings of some of its members.

In the evaluation of an act, whether in terms of guilt showing it to have been planned, deliberate, with full realization of consequences, or to have been carried out in a fit of mental derangement, the procedure eventually is reduced to relatively simple questions: first, whether or not the individual knew the difference between right and wrong; secondly, whether the person's actual guilt can be proven beyond all question of a doubt; thirdly, whether a reasonable doubt in favor of the delinquent can be presented to warrant his dismissal or acquittal.

Thus, in civil matters the determination of responsibility is chiefly decided on objective evidence and does not always fully take into account the subjective feeling, thought and purpose of the individual himself. This latter determines the moral responsibility for his act. Thus, instances may arise where there could be disharmony between the "legal" and the "moral responsibility" for actions of the patient.

Before going further in our discussion of the moral limitations of certain abnormal mental states, let us consider the criteria by which we define a serious sinful act. Perhaps the clearest statement is in our Catechism which states, "a serious sin is committed if it is concerned with grievous matter against the law of God or the church with sufficient reflection and full consent of the will." One who in act meets these requirements is performing a morally reprehensible act, an act for which God's judgment will be given in condemnation.

These ideas, however, rely on the antecedent definition of man as a rational animal composed of body and soul constituting an inviolable personality with rights and duties. In the case of an individual who is mentally sick, it is quite obvious that many variations in these concepts will arise. The grievousness of the matter may be altered in the mind of the sick individual. His attitude toward some trivial matter may be extreme or he may be unable to recognize or realize something actually serious. The reflection on the matter may be altered, either being severely obsessed and having so much emotional turmoil that he is incapable of rational thinking, or, on the other hand, his thinking processes so disintegrated that reflection of any kind may be impossible. The consent of the will may be modified to such a degree that it could also be invalid either in terms of some terrific driving force arising from within that the patient simply cannot resist, or likewise some tendency within himself which makes him follow the line of least resistance.

In scanning the clinical literature about this topic one is impressed by the dearth of material. Theological material obtained did not readily correlate itself with the recognized clinical types of mental disease. This fact, however, is not difficult to understand, especially since our present-day classifications of mental diseases do not extend much beyond fifty years. The moralist dealt with the problem for a long time before the physician was able to differentiate the various problems for the moralist.

To define our matter in reference to mental abnormality we must, first, consider whether the abnormality as such has always existed and is a form of deficiency, or is something acquired, therefore a form of insanity. The existence of moral insanity must be recognized and has been defined, as "a feeling or perversion of feeling and conduct, leading to vicious and criminal acts in those who have previously lived upright and reputable lives." Moral imbecility is "an original defect of character displayed from an early age and consisting of an inability to be altered by punishment, however severe, certain and prompt, from vicious acts."

One must distinguish between moral and mental (or intellectual) deficiency because the moral defective or imbecile may achieve a high level of intellectual development, yet his activities and accomplishments may

fall so far short of his intelligence as measured by a test as to throw questions on the validity of the intelligence test. "Moral" considerations as applied to the patient are therefore subject to modifications.

Keeping these standards in mind one may look upon the individual reaction types and try to evaluate the moral implications of each. Prior to fifty years ago the classifications of mental diseases were very indefinite. This was due largely to the fact that classification was an individual matter and there was no unanimity of thought. Our present classification is derived from that set out by Kraepelin in which he tended to arrange mental disorders in categories common one with the other. Diseases having known causative factors in common were grouped together, thus eliminating many illnesses which were merely names. Modifications of this classification have been made from time to time, but these have tended to simplify it for better understanding. We may consider them in the following order:

1. *The Organic Reaction Types.*

Here we include all mental disturbances due to temporary or permanent effect upon the organic structure of the central nervous system. They include reactions due to infections of the brain, the effects of drugs, alcohol and gases, disturbances in circulation resulting in brain damage, senile deterioration, metabolic disorders, brain tumor, degenerative brain disease, and somatic diseases of any kind which either directly or indirectly affect the brain. The chief personality disturbances noted are those resulting from physiological change in the central nervous system itself. There are varying degrees of confusion, hallucinatory experiences and delirious episodes. Naturally, the efficiency and judgment of the individual is reduced and his thought processes are definitely interfered with. His inhibitions are lessened due to lack of cohesion in the nervous system itself.

Such persons would at times be unable to satisfactorily control emotional or instinctive drives and during the duration of their disease would be only partially responsible, or would not be morally responsible for their actions or the effects thereof.

2. *The Affective Reaction Types.*

These disturbances embrace all the so-called cases of mania and melancholia. This condition has for a long time been known as manic-depressive insanity. The term, affective reaction type, is used to designate the fact that the primary psychopathology is due to a disturbance of affect, mood or feeling, which in turn modifies behavior. The chief phases of the disorder, as described, are the manic or depressive, both of which may occur in the same

individual, but this is not usually the case. We usually find that an individual is either of the manic or the depressed variety. In each phase there are variable degrees which in the case of the manic may be anything from a mere feeling of enthusiasm to that of wild excitement. On the other hand, the depressive stage may vary all the way from simple depression, consisting of nothing more than a feeling of discomfort, to that of a very severe depression in which the individual is unable to think or reason.

The primary disorder, as I have pointed out, is a matter of feeling, variations of which modify the ability to judge things properly and render the patient irresponsible. In the case of the severe manic or the severe depressive phase there may not be much question of an individual's moral invalidity, but in the simple depression, or the so called hypomanic states some question may arise as to where normality ceases and abnormality begins. In the hypomanic state we find a person who becomes overly enthusiastic and overly active about the usual things in his existence, but as the clinical state reaches maturity he is carried away with his own enthusiasm, and his judgment is distinctly impaired and there is a distinct loss of inhibitions which may carry him into any number of moral transgressions of one kind or the other. In the case of the depressive individual somatic symptoms may persist for a long time. He may seek medical help, but since no physical cause for his complaints can be found, the general depressive features of the situation may be overlooked. As an after-thought, he may develop many fantastic ideas as to why he is ill, including that of fixed conviction of unforgivable sin, eternal damnation, etc., which justifies him in his contemplated suicide.

3. *Schizophrenia (Dementia Praecox), Paranoia and Paranoid Conditions.*

These reaction types are primarily delusional in character and are built up of certain rationalizations of the individual in reference to the inadequacies of life. There is a need for vindication and over a period of time, certain unreal ideas, thoughts and actions are accepted as being actual, real and are acted upon as such. In simpler types of schizophrenia there is no question of the disarranged thought processes and the patient, himself, cannot be held responsible. However, in the more severe and systematized types of reaction such as we see in the paranoid states where the contact with reality has been fairly well maintained, it is difficult to see the dividing line. Such an individual becomes

more of a law unto himself and does not therefore feel himself morally obligated by the usual restrictions. He is motivated toward some violent or homicidal act contrary to the law of the land and the rule of God.

4. *Epilepsy*

Epilepsy is of importance for a number of reasons. Primarily, there is a loss of consciousness, which may be associated with convulsive manifestations. There are some instances, in which the epileptic may lack insight into the nature of his condition, not realizing its nature, refusing to accept it. Over a period of time, he may get such a distorted picture of himself, that his mind may take on abnormal attitudes and he may react violently to them. Most epileptics, however, do not take this attitude, because with therapy for better control of convulsive seizures available, many individuals so afflicted look upon their illness in the same way as they would look upon any other illness.

Perhaps the chief concern with the epileptic stems from the periods of confusion which usually follow seizures. Especially the so-called epileptic equivalents or variants, where the epileptic patient instead of having a convulsive seizure goes into a violent rage for which he has complete amnesia or loss of memory and is unable to recall anything which transpired during the interval, are important to a student of the patient's responsibility. Occasionally these seizures reach homicidal proportions and for this the individual is not responsible. Fortunately again, these incidents are extremely rare and should cast no reflection upon the average epileptic patient who is under treatment to keep his illness under control and who leads a normal life.

5. *Mental Deficiency*

By mental deficiency we mean the individual who lacks enough intelligence to readily adjust to changes in his life situation. There are three main clinical varieties of mental deficiency—idiocy, imbecility, and moronic conditions. The idiot is an individual, who no matter how old he becomes chronologically, never gets beyond the mental age of 3 years. In terms of IQ the percentage of intelligence does not rise beyond 20%.

There is usually no question of his inability to get along in life and his inability to assume any moral obligations of any kind. There are usually additional defects in the central nervous system to contend with, chiefly in the coordinating faculties, so that such a person usually spends his life as a nursing problem.

The imbecile is one whose mental age does not go beyond 7 years, on a percentage basis it does not go beyond 50% of the normal for his age.

With the imbecile there is again no question of his inability for mature or moral obligations. He is a little more efficient than the idiot and can be taught a few tasks which do not require skill, but except when evidence to the contrary is available, he is not ordinarily responsible for his acts.

The moron's intelligence varies between a mental age of 7 and 12 years, or 50 to 70% for his age. A moron can be taught many things, especially those of the higher level and may be a useful citizen. He may constitute a goodly percentage of factory or other type of unskilled labor. However, he is not capable of assuming a great degree, if any, of executive responsibility. He can be taught certain types of skill of a routine nature and will carry out his task successfully, but if he is displaced, he will have difficulty in readjusting himself to a new skill or occupation.

His ability to understand obligations is almost in direct proportion to his level of intelligence. He is therefore capable of understanding his obligations in a proportionate degree. However, in view of the fact that his intellectual ability is at a defective level, allowances must be made for him in accordance with the normal standard.

6. *The Psychoneuroses*

The psychoneurotic reaction types occupy a special place in the field of mental illness. There are no clearly defined boundaries in nature.

There is, moreover, many a case of mental illness difficult to assign either to the psychoneurotic or to the psychotic group. From the well developed psychosis on the one hand, to the well developed psychoneurosis on the other, there is a world of difference, both descriptively and therapeutically. Transitions may occur; a patient who reacts psychoneurotically at one time may be psychotic at another. The chief difference between the psychoneurosis and the psychosis is the fact that the psychosis involves a change in the entire personality of the subject in whom it appears, while in the psychoneurosis only a part of the personality is affected. With the development of a psychoneurosis there is often no outward personality change of any kind. In the psychosis reality is changed qualitatively, is regarded differently from the normal and the patient reacts accordingly. In the psycho-

neurosis reality remains unchanged qualitatively, but its value may be quantitatively diminished.

Clinically, a psychoneurosis implies either a bodily disturbance without structural lesion and dependent, in a way unknown to the patient, on mental causes, or it may be a mental disturbance not the result of bodily disease in the form usually of morbid fear, persistent ideas or motor acts, all of which the patient realizes to be abnormal. The meaning of these, though, he is at a loss to understand.

The bodily disturbances may be sensory and entirely subjective or motor and directly observable or visceral. The sensory disturbances may occur in any or all systems of the body in a given patient, accounting for the numerous dysesthesias or peculiar sensations including pain of which the patient complains, also the palpitations, anorexia, weakness and fatigue as well. These disturbances are emphatically real and not "imaginary" and are probably the result of variable imbalances which have been induced in the functions of the autonomic nervous system. The motor seizures are paralysis, paresis, tics, tremors, anomalies of gait and speech disorders, such as ophonia. The visceral disturbances include tachycardia, vomiting, diarrhea, constipation and vasomotor disturbances. These are definitely indicative of autonomic imbalance. The chief types are neurasthenia, the anxiety states, hysteria, and the obsessive-compulsive neuroses. We will consider them in order.

Neurasthenia has often been used in a wide sense. However, to be accurate it should be confined to those cases in which fatigue, mental or physical, is the prominent symptom. Frequently we obtain the history that such individuals are involved in situations which are beyond them and in trying to cope with the demands made of them, grew tired and irritable. Many times, domestic upheavals may result, for which they may be unwittingly made the objects of severe recrimination. Perhaps, in the earlier phases of such a disorder some careful consideration on the part of the patient would have prevented such an occurrence, but once established, the matter must receive careful guidance.

The anxiety states comprise another group of the psychoneurotics who live a very disturbed existence due to abnormal uncontrollable fear. Sometimes the fear is indefinite and "free floating" in which case it does not constitute a particular problem other than to make the patient feel tense and nervous. This tendency does, however, at times become attached to certain things, experiences or acts, and these in turn take on inordinate

proportions. The fears are terrific; the individual, himself, may lose all sense of proportion and his moral values are inaccurate. In the moral sense corrections have to be made, step by step with treatment.

Hysteria is a condition which has been much maligned, despite the fact that the true dissociated hysteric is a very sick person. The uninformed and the unappreciative will frequently seem to take a very uncompromising and severe attitude toward the person suffering from hysteria, and their denouncements will almost invariably fix the complex and at times make the patient intractable.

There is a distinct difference between hysteria and malingering. In the latter there is a definite attempt to deceive others—family, friends, doctors—that a state of illness is present which does not actually exist. Even in the malingerer, the mere fact that he does feign disease is psychopathological and our experiences as an examining neuropsychiatrist, on various induction boards in World War II, (with the possible exception of those cases where malingering was resorted to because of the monetary loss involved in accepting service in the armed forces,) indicated that the malingerer was a bad psychic risk, and was invariably rejected.

The patient who converts mental conflicts into physical terms, however, probably does so originally in an effort to escape a situation which has become more or less intolerable, and therefore indicates in so doing a certain lack or weakening of moral fiber.

Perhaps, at this stage a brief explanation of the matter would suffice to clear it up, both from the point of view of moral as well as mental health. Circumstances, though, sometimes prevent this from being carried out, so that when the syndrome has been completely established, full moral imputability must be withheld.

The obsessive-compulsive states really deserve and require our wholehearted, sympathetic understanding. In the simplest sense of the word, the obsessional neurotic has scruples which may run the gamut of all his ethical responses, affecting his domestic, religious, occupational, and marital attitudes and obligations, all of which may at one time or another be distorted in his mind. He may follow equally unreasonable and ridiculous methods (compulsions) for their correction, not only without success, but frequently making the problem more acute. Here again there is a distorted moral value which has to be corrected in the mind of the patient with step by step change in the clinical picture.

7. *The Constitutional Psychopathic States.*

In any attempt to present a panorama of the varieties of patients we will find that most of them will fall into groups which are fairly well recognized. There are some, however, which while having characteristics in common, nevertheless are not sufficiently distinct to belong anywhere. The same is true among mental phenomena, and a certain variety of cases do not readily lend themselves to proper classification, although many of the characteristics of the recognized clinical types may be present.

Such a "waste basket" is our concept of the psychopathic personality. Here we include persons who have been from childhood or early youth habitually abnormal in their emotional reactions and general behavior. They do not react, except perhaps episodically to a degree of abnormality which could be classified as insane, nor do they show intellectual defect, although their behavior and action is not what we could call intelligent behavior.

There is evidently some interference or arrest in the maturation process which prevents them from ever approaching the responsibilities of life on an adult level, despite the fact that intellectually they may be good or superior. Their practical accomplishments in life seldom, if ever, come up to early predictions, and their general behavior remains on an infantile, puerile or adolescent level. They can tolerate or assume responsibility to a certain point, which being reached, is generally followed by an abrupt disintegration, an attempt to resynthesize their lives, only to be followed by another upheaval at a later date. They never seem able to profit by their own experiences, and get themselves into repeated trouble.

In this category belong many people who do not regularly come under the attention of a psychiatrist unless specifically directed to determine why they cannot keep themselves out of trouble. The things which deter most of us seem to have relatively little influence on correcting their lives. The priest sees them; the courts see them; they are petty criminals, delinquents, repeated sex offenders, recurrent alcoholics, pathological liars, prostitutes and sexual perverts. When they are confronted with the effects of their own misdeeds, they are usually quite remorseful, but I believe this to be usually due to the inconveniences of the moment, rather than a true appreciation of their plight. Their moral sense is usually quite dull, they are actual moral imbeciles in the strict sense of the word, and morality as we know it for them simply does not exist.

SUMMARY

In this paper we have attempted to present some of the obvious limitations of individuals whose state of life happened to be temporarily or permanently affected by some unusual mental condition. For purposes of comparison, we felt the moral evaluation of such matters would be of interest, relying as it does on the presentation of objective evidence in the matter. We also attempted to state, as briefly and concisely as possible, the basic factors in the recognized clinical types of mental disorders and the obvious moral limitations of each.

These consisted of mental disorders—organic injury or disease, intellectual defect, disturbances in affect, mood or feeling, abnormal delusional states, temporary interference in consciousness, as in epilepsy, partial personality derangements, as in the psychoneuroses, and lastly, defects in the development of a mature emotional or moral outlook.

