Tilburg University

(Un)accountability and the Forensic System

Oei, T.I.

Published in:
Mededelingenblad van de Nederlandse Vereniging voor Psycho-analyse

Publication date:
2000

Link to publication in Tilburg University Research Portal

Citation for published version (APA):
Oei, T. I. (2000). (Un)accountability and the Forensic System. *Mededelingenblad van de Nederlandse Vereniging voor Psycho-analyse*, *15*(7), 213-219.

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 15. Sep. 2024

(UN)ACCOUNTABILITY AND THE FORENSIC SYSTEM

T.I. Oei MD PhD FCCP*

Key words: Forensic Psychiatry, (un)accountability, involvement system

ABSTRACT. - The defendant, the Public Prosecutor, the expert witness and the judge, all use the same discourse, i.e. the forensic involvement system. In this article, this phenomenon will be discussed for the first time on the basis of psychiatric arguments and illustrated by an actual court case.

Introduction

The involvement system is the sum total of relations and connotations which in a particular context has a very clear function, specific to that situation and from which it takes its special significance. W.K. van Dijk in his valedictory lecture at the State University in Groningen on 22 January 1985, for instance, gave an illustration of such an involvement system - an idea launched from the phenomenology field in particular. He places the involvement system within the framework of what we understand as illness, a topic raised earlier by Jaspers (1965).

Minkowski (1967) discerningly describes, as an example of phenomenological characterization, the nuance difference between schizoid/schizophrenic and syntonic. 'The schizoid/schizophrenic and the syntonic are both capable of expressing goodness and sympathy in their behaviour; they will, however, do so in different *ways* (italics T.O.), the one in a warm, intuitive, "sympathetic" manner, with a deep feeling for degree, and the other in a somewhat colder, more distant manner, more out of duty than purely emotional. There is a difference in nuance, and it is that "nuance" that will determine the *essence* for us (italics T.O.). Here it is the frame which makes the picture', he says, 'frame' here meaning the person's own way of seeing and acting. In Minkowski's view, *diagnostics by penetration* is the essence of behaviour (or psychiatric) specialist expertise. This kind of involvement system - unique because of its specific cohesion and personal viewpoint - is important for the individualizing approach in forensic psychiatric reporting work.

The possible connection between diagnosis, offence, the risk of recidivism and the connected and gradual aspects of it, or the resulting consequences for the level of accountability, is an important subject in the field of forensic psychiatry. It is also a very fascinating issue, because it touches on the very core of our human existence! Acting on the basis of (a certain sense of) total freedom is, after all, what is always regarded as the highest value and the primary purpose of life. Knowing what we do, recognizing that what we have to do, constitutes the potential to live our lives to the full, in the realisation that the consequences of our actions lie within our own control, are all important elements in this regard.

Diagnostics is the medical means by which human suffering can be objectively

measured, classified and sorted according to a particular therapeutic model, e.g. the biological psychiatric, the psycho-analytical, or the psycho-social model. An example of each of these is presented here.

In biological psychiatry, the so-called monoaminergic dysfunction plays a significant role. In certain forms of depression, for instance, we know that the serotonergic brain metabolism decreases. Monoamines, such as serotonine, are important chemical agents (neurotransmitters) in the brain which play a role in transferring information via the nerve pathways (Van Praag, 1992). A distinction is usually made between functional and non-functional depressions, and in the case of a functional depression, there is a detectable biochemical dysfunction, i.e. a serotonergic depression. This is not the case, however, in non-functional depressions such as dysthymic (innately, situationally, environmentally-dictated) depression.

Within the psycho-analytical model, a depression can develop from the person's inability to come fully to terms with the loss of a key figure in his or her immediate circle; i.e. the mourning depression which follows when the grief attached to that loss has not been properly processed. The cause of this has to be sought more in the unconscious 'climate' of the emotional experience. Kuiper (1976) gives another insight into this (p.105) : 'A boy is worried about masturbation, his father makes a comment during lunch about weak behaviour, lack of personal discipline and perseverance, and regards such behaviour as unmanly. On his way home the son had had a sexual fantasy, which he was feeling guilty about. He thinks his father is referring to this. He starts to worry, is unable to do his studies, fails his exams, and the vicious circle has begun. Would it have been possible to predict that this boy would have reacted so strongly to his father's remark? Perhaps - if one had known everything about him. Although predictions are not usually possible, our (psycho-analytical T.O.) interpretation, which implies an assumption of causal factors might, in fact, be quite correct. In this way, its purpose together with a multi-causal complex of other factors, are all closely interwoven and often make human life unpredictable, although that unpredictability does not exclude meaning-ful and correct interpretations and explanations. An unexpected event is an intricate complex of factors which, because of the chance element, can have exceptional repercussions.'

In a depression with a psycho-social background, we see a depressed mother, for instance, who cannot cope with her illness (symptoms) because she feels that the members of her family show absolutely no understanding of her situation. The cause of this kind of depression, therefore, lies in, or is sustained by, the dysfunctional system and the obscure relationships at work within the family. The depressed mother, for example, is expected to do too much, and for too long, to keep things going in the family. She becomes increasingly ill, whilst her family blames her more and more for being ill, or accuses her of pretending to be ill (Oei, 1986).

Crime and abnormal behaviour

In forensic psychiatry we frequently meet defendants charged with an offence; a punishable act and, as such, a socially unacceptable one. Peters (1966) made the comment in his Ph.D. thesis some years ago, that every serious crime presumes abnormal conduct ('Those who commit crimes, which a society regards as serious, are by definition abnormal'). In these circumstances, it is the task of the psychiatrists and psychologists to decide what they under-

stand by such an ('abnormal') epithet, and whether they detect in the accused any behavioural abnormality which is reflected in their forensic behaviour-science vocabulary. In other words, can they point, in the context of an actual punishable behaviour type, to a behaviour-science behaviour pattern, that not only fits into their specific psychiatric/psychological vocabulary, but which also supports the probability of a causal connection?

However much insight this process may contain, the behaviour specialist approaches the issue quite differently in practice. As a forensic psychiatrist, i.e. the first behaviour specialist consulted, he usually meets the accused without knowing anything whatsoever about him. And even when as second behaviour specialist he sees the accused, for instance, when he has to prepare a report pro Justitia (for the prosecution), he focuses on what he sees as the defendant's psychiatric and psychological condition at the time of the examination, after which he refers his findings, as far as possible, back to the situation at the time of the offence. Was the behaviour of the accused, at the time of the offence, really disturbed and if so, how serious was the disturbance? And, on the basis of which mechanisms is it possible to demonstrate a causal connection with the offence?

It will be obvious that the existence of a biological psychiatric diagnosis is often not, in itself, sufficient to establish the degree of accountability at the time in question. Beyaert (1990) says about this : 'The psychiatrist can no longer be content with medical diagnoses, but will have to indicate the grading of the development disorder or illness and the degree to which it determined the involuntariness at the time of the offence.' This means that the diagnosis of an epileptic attack, for instance, is not sufficient reason, in itself, for assuming that the defendant's level of accountability was any less. Certainly not when he has had no epileptic seizures for a long time, and even less so when no such seizure could have occurred at the time the offence was committed. Mooij (1987) has illustrated, with a very clear example, that epilepsy, particularly when there is a possibility of a twilight state, does not automatically free someone from unaccountability. To such a person, only a limited degree of accountability can be imputed, as a result of negative influencing of his reflex capacity (the 'pros' and 'cons' being consciously weighed against each other), in the case, for instance, of a consciousness disorder such as the twilight state. Behaviour specialists, therefore, have to employ psycho-analytical and possibly psycho-social insights and explanation models, as well as biological psychiatric diagnoses. In this case, they will need to investigate whether, for instance, the accused, on the basis of his epilepsy, had shown any personality changes in the past, and whether there were problems within his family and/or social relationships outside the home (inter-personal), as a result of which his behaviour had worsened mentally and/or socially to such an extent that it ultimately became criminal.

(Un)accountability of the defendant and the role of actors

The individual problem of accountability necessitates individual testing and evaluation of the accused's personality structure. Only after possible causal mechanisms between disorder and offence have been established or are made plausible, and after the degree of accountability has become clear, can there be any discussion of recidivism risks. This is important when advising the judge in respect of the imposition of a non-punitive order.

There are probably (in my view) at least three 'involvement systems' which can be linked to each other. The time lapse and the sequence, both differ in accordance with the line

of approach. The link relates to the following factors : the mental disorder, the offence, recidivism risks, (un)accountability, and the need for care and treatment, together with a possible non-punitive order.

1. The **judicial involvement system** : in sequence, firstly the (possible) offence, and then the possible risk of recidivism, followed by a (possible) disorder, the (un)accountability, and finally the meting out of punishment (care and treatment within the framework of a non-punitive order).
2. The **behaviour specialist involvement system** : in sequence, firstly a (possible) disorder, then its relation to the (possible) offence, (un)accountability, the possible risk of recidivism (important for care and treatment options), and the need for a non-punitive order.
3. The **justiciable/defendant involvement system** : firstly the offence, then the (possible) disorder, the possible risk of recidivism, and finally the need for treatment. The accused is usually strongly opposed to a (criminal) non-punitive order. If he is not acquitted, he usually prefers imprisonment (i.e. he chooses punishment!).

The following paragraphs are presented in order to throw light on the lines taken by the different parties and the individual during an actual court case, in other words, the discourse they employ - it is a random selection from a court session report which recently, and quite by chance, came to hand.

The defendant in an actual court case

It concerns a 21 year old physically handicapped man who, following a number of thefts, has been held in custody. It is decided, however, not to press the charge further, on the grounds that he is not only chronically psychotic, but that he also shows signs of an impulse-control disorder. He is ordered instead to be admitted to a psychiatric institution for a maximum of one year.

During the court hearing, the defendant says : 'I did not hit the woman in the clothes shop (offence T.O.). I was being held by my arms, and I couldn't get loose. She was hurting me. I did not run away. I always feel pain when I try to make something clear and people don't understand me (disorder T.O.). I have written a letter for you. I am against people who sell heroin, because it's forbidden (recidivism T.O.). When I was thirteen my parents separated and I used to walk the streets alone (care/treatment, possible non-punitive order T.O.).'

The Public Prosecutor : 'The defendant's problems lie somewhere on the borderline between two circuits. He has committed several punishable offences (offences T.O.). It is difficult to say whether or not a serious offence has been committed. The Public Prosecutions Department is of the opinion that a twelve year offence has been committed and that the defendant is also guilty of having disturbed the peace. The risk of recidivism (recidive T.O.) is certainly present. If nothing is done (care/treatment T.O.) to treat the defendant's psychotic condition (disorder T.O.), it will almost certainly happen again. I am happy that he is now prepared to cooperate in a psychiatric or psychological examination (possible non-punitive order T.O.).'

In the defendant's statement to the police, he says : 'It is true that I have committed a

theft (offence T.O.). I was grabbed by a woman and detained, and later also by two men. I think they were wrong. They should have telephoned the police. I help to track down thieves (disorder? T.O.). I hit the security officer. I was hit much more. I am a tramp and I committed the offence so that I would be put in prison again (recidivism T.O.). I only use "hash" (care/treatment, self medication? T.O.).'

The behaviour specialist's report states : 'He is confused. He refuses medication; he suffers from chronic psychosis (disorder T.O.). His development has been limited and he has a pathological mental disorder. It is possible that with medication he would have been less confused at the time of the offence (offence T.O.). It was apparent earlier, however, that he had often had impulsive explosions. Although he had tried on a jacket just before the offence, thus giving the impression that his actions were reasoned and deliberate, it must be assumed that his illness has limited his capacities to such an extent that he would have been totally unaccountable for his actions at the time of the offence (unaccountability/diminished responsibility T.O.). The fact that he was undergoing treatment at the time of the offence, is no reason to assume that he was less seriously ill, on the contrary; he regularly had impulse explosions when taking medication. The nature of the offence in question (running away with a clothed shop-window dummy) is evidence of a limited sense of reality. The recidivism risk should be regarded as very high (recidivism T.O.). Continuation of the psychiatric treatment is advisable (care/treatment T.O.), therefore, and should be given intramurally. Bearing in mind the defendant's lack of motivation, this treatment should be given within a compulsory order framework. The nature of the offence in question would not normally justify a non-punitive hospital treatment order; a realistic option in this case would be admittance to a psychiatric hospital, for no longer than one year (non-punitive order T.O).'

Complementary to this, Remmelink (1995) wrote about 'accountability' as follows : 'The perpetrator found to have acted whilst the balance of his mind was disturbed (diminished responsibility), is exempt from punishment and all charges against him will be dropped. Whether or not someone is accountable for his deeds, is partly dependent on the social circumstances, the nature and the context of the punishable act, as it actually took place. The presence of accountability is the foundation of the charge, and its absence is seen as a variant of psychic force majeure, arising from a mental sickness. People who are mentally ill/declared insane are accountable in principle.'

Conclusive remarks

What is clear from the above, is that the three actors in the court case referred to, i.e. the defendant, the Public Prosecutor, and the behaviour specialist, all use the **forensic involvement system** in their own ways. As has already been said, the following factors : the disorder, the offence, recidivism, (un)accountability, care and treatment, and any possible non-punitive order, are all part of this system.

It is obvious that the lawyer is going to link the recidivism risks to the actual execution of the punitive/court order, on the basis that this should decrease the danger to society as a whole. The behaviour specialist usually relates the disorder prognosis to the result of the treatment, whilst the defendant requests care and treatment in the hope of preventing another offence. When the defendant's disorder is so serious that he cannot see the need for treatment, his defending counsel will want to convince him that it *is* necessary.

The manner and the degree to which factors relative to the forensic involvement system interact with each other, are dependent on the individual facts and situations of the various people (actors) involved in the criminal proceedings. They are not, however, always clearly defined at the start of the trial, and because these factors are at play in differing sequences, it is difficult to predict what the judge's verdict is likely to be. The judge will also make use of the forensic involvement system, although his function demands that he also takes many more factors into consideration, including what is reasonable and just. It is up to the judge, therefore, to bring all these factors together and translate them into a judgement.

The defendant, thus, has very little say in what happens, once the (damage/suffering arising from the) offence has occurred. In this situation, he has few choices but to trust in the bench reaching a wise and just decision. Oei (1995) makes a plea for unravelling the defendant's fiction for the benefit of reality ('factuality') for the judge, with the help of a behaviour-specialist witness. In the 'ball-point affair' in Leiden (1995), the defendant's psychotherapist was called to testify as an expert-witness, while at the same time there was no (independent) behaviour specialist report available. Apparently, the public prosecutor, the examining magistrate, lawyer, (family of the) defendant, as well as the probation officer, all came to the conclusion that there was no need for such an examination, - and this is very surprising. The official verdict must satisfy society's sense of justice, as well as achieving a difficult but necessary acceptance on the part of the defendant. It is obvious that the decision of the bench, must also say something about the defendant's accountability, and the assisting role played by the forensic involvement system should be equally obvious.

What the above illustrates, is that (actors as) the defendant, the Public Prosecutor, the expert witness and the judge all use the same discourse : i.e. the forensic involvement system. The fact that this involvement system can have heuristic value in the behaviour sciences, in formulating hypotheses which can be scientifically tested, is something which the pro Justitia reporter experiences daily. On the one hand, the automatic aspect of the empathic 'Verstehen' has to be put into perspective, and, on the other hand, this intuition (essential for a clear-cut, evident, finding) serves as a 'shield' or protection (in connection with the causal hypotheses it formulates) against a possible scientific rejection (Ebmeier, 1987). It is, in other words, a system of key words, essential to the criminal proceedings. A cohesive whole of specific items that together, and in its typical order, characterizes the manner in which the individuals concerned actually operate. That independent and, at the same time, subjective action, suggests that these leading actors in the case, to a certain extent, are inter-dependent. One element is the stage on which they all meet and where truth must prevail in the eyes of the judge. That truth is judicial - and not psychological.

* Forensic Psychiatrist in Rotterdam and Dordrecht, and Professor of Forensic Psychiatry at the Tilburg University of Brabant, Department of Criminal Law, P.O. Box 90153, 5000 LE Tilburg, The Netherlands.

References

Beyaert, F.H.L., Terugkijken en vooruitzien in de forensische psychiatrie (Looking back and looking forward in forensic psychiatry), *Tijdschrift voor Psychiatrie* 32, 1990, Editio Amicorum, p. 42.

Ebmeier, K.P. Explaining and Understanding in Psychopathology, *British Journal of Psychiatry* 151, 1987, p. 800-804.

Jaspers, K. *Allgemeine Psychopathologie* (General Psychopathology), Berlin, 8th edition, p. 651 onwards.

Kuiper, P.C., *Psychoanalyse als hermeneutiek* (Psychoanalysis as hermeneutics), Te elfder ure (The eleventh hour), Psychoanalyse (Psychoanalysis) 1, 23, 1976, p. 92-123.

Minkowski, E. *Het menselijk aspect van de kosmos* (The human aspect of the cosmos), Utrecht, 1967, p. 127.

Mooij, A.W.M., Handeling en Inzicht (Action and Insight), *DD*, 17, 1987, p. 354-355.

Oei, T.I., Depressie : gezin uit, ziekenhuis in (Depression : leave the family, into the hospital). *Nederlands Tijdschrift voor Geneeskunde*, 130, 1986, p. 241-243.

Oei, T.I., *Feit en Fictie* (Fact and Fiction), Arnhem 1995.

Peters, A.A.G., *Opzet en schuld in het strafrecht* (Intention and guilt in criminal law), Deventer, 1966, p. 191.

Remmelink, J., *D. Hazewinkel-Suringa's (barrister) Inleiding tot de studie van het Nederlandse Strafrecht* (Introduction into the study of Dutch Criminal Justice), Arnhem, 14th ed. 1995, p. 249-250.

Van Praag, H.M., About the centrality of mood lowering in mood disorders. *European Neuropsychopharmacology*, 2, 1992, p. 393-404.