MENTAL ILLNESS AND MORAL DISCERNMENT: A CLINICAL PSYCHIATRIC PERSPECTIVE

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Abstract. As a contribution to a wider discussion on moral discernment in theological anthropology, this paper seeks to answer the question "What is the impact of mental illness on an individual's ability to make moral decisions?" Written from a clinical psychiatric perspective, it considers recent contributions from psychology, neuropsychology and imaging technology. It notes that the popular conception that mental illness necessarily robs an individual of moral responsibility is largely unfounded. Most people who suffer from mental health problems do not lose the capacity to make moral decisions, and mental illness on its own rarely explains anti-social or criminal behaviour. Moreover, the assumptions of some scientists, that recent developments in neuropsychology and brain imaging suggest biological determinism, must be treated with caution.

I. INTRODUCTION

In everyday life, individuals are required to make moral decisions — what is the right or wrong thing to do in any given situation? The following rather trivial example will serve as an illustration.[1] Suppose a woman's relative has a high temperature and needs some medication in order to lower it. The medication is available at the local shop. However, the woman has no money. Should she steal it so that her relative can get the treatment that he needs? At first sight, it seems obvious that all that is required for solving a problem like this is to think things through. Using her reason, she should consider the two options, the consequences and pros and cons of choosing one way or the other, and come to a decision. However, the more one considers how moral decisions are made, the more obvious it becomes that there is much more involved than simply using our reason. As she ponders her "dilemma", she will also be (consciously or unconsciously) influenced by her family and cultural background, her personality type, emotions and experience. Her gender, educational background and intellectual ability will also influence, for example, how far she is able to see beyond the initial apparent dichotomy and consider other options.[2]

We cannot, therefore, say that making such a choice is a straightforward process — it is, in fact, highly complex. Indeed, so many things seem to call our freedom with regard to decision-making into question that we have to ask if we are free to make our own choices at all, or is everything we think and do predetermined in some way? And if we are not free agents, what can we say about moral responsibility?

Such questions have, of course, preoccupied moral philosophy for centuries, and little consensus has been reached.[3] Theological anthropology must also grapple with them, but with additional considerations. For the Christian theist, in addition to social, psychological, ethical and cultural factors, there are

1 Cf the "Heinz Dilemma" in Lawrence Kohlberg, *Essays on Moral Development Vol 1: The Philosophy of Moral Development* (Harper & Row, 1981),12.

2 Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development*, Harvard Univ. Press, 1982.

3 For an overview see Thomas Pink, *Free Will: A Very Short Introduction* (Oxford Univ. Press, 2004); Meghan Griffith, *Free Will: The Basics* (Routledge, 2013); Gary Watson, "Introduction", in *Free Will*, ed. Gary Watson (Oxford Univ. Press, 2003).

questions with regard to the relationship between a sovereign God and fallen humanity. At the most simplistic level, if God is creator, and sovereign over his creation, how far, if at all, do human beings have freedom to act as they wish? To what extent is the belief in the sovereignty of God compatible with the idea that we can be free agents?[4]

The question of how and why people make the decisions they do is a highly complex one. From a pastoral perspective, that very complexity should compel us to look with compassion on those who have made mistakes in the past or who are facing moral dilemmas in the present. Life is far from straightforward and we should not pretend that it is anything other. However, by the same token, we need to be secure enough in our own convictions not to allow awareness of the complexities to paralyse us with regard to moral decision-making, or to impose hard-line rules and principles in an inflexible manner.

There is, however, another aspect which is very seldom taken into consideration in theoretical discussions of moral discernment in theological anthropology, but which is frequently encountered in pastoral practice. That question is, how far does mental illness affect an individual's capacity to discern between right and wrong? Would the presence of a mental illness affect the person in our hypothetical example's ability to make a decision? The issue at the heart of these questions is, of course, whether people with mental illness should be exempt from moral responsibility — from praise, blame, or punishment. There is, therefore, a need for theological anthropology to take these matters into account. With this in mind, the purpose of this paper is to present some insights from the perspective of general clinical psychiatry and answer the question: how far does the experience of mental illness impact an individual's ability to discern between good and evil?

II. SOME GROUNDWORK

Before proceeding, some groundwork needs to be done. According to the World Health Organisation, mental health is

> a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[5]

On the basis of this statement alone, we might think that mental health has to do with a basic level of functioning in society, and to a certain extent this is true. However, we would also want to say that mental health has much to do with the ability to experience pleasure, make and sustain healthy relationships, and be able to care about others. We might also be tempted to think that people are either mentally healthy or mentally unwell. However, this is untrue. Mental health professionals speak of a mental health continuum. It is quite possible for people who do not have symptoms of a mental disorder to be mentally "unhealthy", to have difficulty coping with everyday life, perhaps because of prolonged stress or changes in circumstances. It is also entirely possible for people who have symptoms of a mental health disorder to be mentally healthy, in so far as they are coping with everyday life, and able to participate in activities which are important to them. We should not therefore, assume a sharp dichotomy between mental health and mental ill health.[6]

The second thing to consider before we proceed is what we mean by mental illness. At its most simplistic, mental illness is characterised by abnormalities in thinking (cognitions), feelings (emotions) and behaviour. Cognitive abnormalities are found, for example, in psychotic illness such as schizophrenia in which an individual may have a false belief (delusion) or be experiencing hallucinations (seeing, hearing or smelling

4 See the collection of readings in Marc Cortez and Michael P. Jensen, eds., *T&T Clark Reader in Theological Anthropology* (Bloomsbury T&T Clark, 2018), 199–260; Kevin Timpe, *Free Will in Philosophical Theology* (Bloomsbury Academic, 2014); Marc Cortez, *Theological Anthropology: A Guide for the Perplexed* (Bloomsbury T&T Clark, 2010), 98–130.

5 World Health Organisation, "Mental Health: Strengthening our Response", accessed April 1, 2020. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

6 See Corey L. M. Keyes, "The Mental Health Continuum: From Languishing to Flourishing in Life", *Journal of Health and Social Behavior* 43, no. 2 (2002).

something which is not real). Disorders of emotion are to be found in illnesses such as bipolar disorder or depression. Abnormalities of behaviour may be found in dissocial or psychopathic disorders, for example, or in stress-related illnesses such as obsessive-compulsive disorder.[7]

The term "mental illness" is used to describe a wide-ranging group of conditions and disorders of varying causation, presentations and pathologies. These may have an identifiable physical cause, for example, in organic brain disorders, dementia and delirium. Organic brain disorders may also come about as a result of harm done by alcohol and drug abuse. We are also concerned with illnesses such as schizophrenia, or mood disorders such as bipolar illness or depression, stress-related disorders such as anxiety, phobias or obsessive-compulsive disorder, and personality disorders such as psychopathic (dissocial) disorder.[8]

Thirdly, we need to say something about the purpose of psychiatry. As in any branch of medicine, it is the psychiatrist's job to alleviate suffering. Psychiatrists identify and treat illnesses; they do not make moral judgements and they do not use the language of good and evil in clinical practice. Nor is it their prerogative to assess an individual's culpability (which is the task of the law) or whether a person might be said to have sinned (which might be the job of the theologian). It is true that psychiatrists are often called on to treat people who have done terrible things such as rape or murder. However, these people's behaviour may or may not be related to a mental illness. In fact, as we shall see below, most people who commit serious crimes of this nature do not have a mental illness. True, it is part of the general psychiatrist's remit to ask questions as to the ability of an individual to make decisions with their consequences in mind. Is the person able to look after him or herself? Is he or she able to look after his or her affairs? After due deliberation (see section 5), the psychiatrist may consider that a patient may be likely to make decisions which have "negative" consequences — that is, decisions which may lead to suffering for or harm to themselves or others. When these "negative consequences" include criminality, and the law becomes involved, it is the task of the forensic psychiatrist to offer specialist advice to the police and to the courts. At no point, however, is it the job of a psychiatrist to assess or pronounce on whether or not a person is good or evil, or indeed whether their actions are good or evil.

It must be said at the outset, too, that psychiatrists do not cure mental illness. Their work is usually concerned with decreasing symptoms, minimising the impact of an illness and maximising the patient's ability to have quality of life in spite of the illness. For example, bipolar disorder is characterised by periods of irritability and elation of mood, coupled with disorders of thinking, and periods of increased activity followed by episodes of profound depression. This illness typically begins in early adult life and has a relapsing and remitting course. Medications and psychological interventions can make a difference — they are generally thought to halve the number of severe episodes an individual might experience in their lifetime. But even with optimal treatment, many patients with bipolar disorder are very mildly hypomanic or mildly depressed for half of their lives. The same may be said for the majority of mental illnesses — patients are enabled to live with their symptoms, but are seldom cured of them completely.

III. OBSERVATIONS FROM PSYCHOLOGY ON NORMAL HUMAN BEHAVIOUR AND MORAL DISCERNMENT

Before we go on to discuss the impact of mental illness on moral discernment, it is important to make some observations with regard to decision-making amongst the "normal" population. We have already noted that the act of making moral decisions is remarkably complex, with many and varied factors involved. We also know that human beings — even the most intelligent — do not always get things right.

7 The diseases recognised by psychiatrists are listed in World Health Organisation, *International Classification of Diseases 11th Revision* (World Health Organisation, 2012) (ICD-11) and American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association Publishing, 2013).

8 In this paper we are not concerned with developmental disorders such as autism or with genetic disorders such as Down's Syndrome.

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All human beings, no matter how clever they are, make decisions which cause themselves and others suffering and distress. Here we will note some findings from psychological research.

lll.1. Psychological bias

Psychology has shown that there are certain observable tendencies in human behaviour which suggest that the human mind is prone to certain biases which can lead to flawed thinking. David Robson's article, "The Stupidity Trap", which was published in the *New Scientist*, summarises some of the findings, and we will mention three here.[9]

The first example is the "sunk cost" fallacy. An illustration of this might be a person who starts up a business and puts great investment into it. Nevertheless, the business begins to fail. Despite clear evidence that it is failing, that person continues to insist that the idea is a good one and continues to invest in it. It is clear to everyone else that the idea is not working, but the person will not let it go.

A second example is "Solomon's paradox". This is when individuals are seen to be able to advise on other peoples' dilemmas, but are unable to make wise decisions for themselves. It is called the Solomon paradox because King Solomon was renowned for accruing wisdom and for giving advice and good judgements to other people, but seemed to make terrible decisions in his own private life — having numerous pagan wives and concubines, and failing to impart his wisdom to his son.

A third example is "earned dogmatism" in which an expert in a particular subject, for example, an area of scientific research, overestimates his or her own expertise and becomes closed-minded, believing their opinion is right and incontestable, and failing to take all aspects of the issue into account.

These examples describe phenomena in which intelligent people seem to have blindspots which cause them to fail to take certain things into account when they are making decisions. In doing so they are probably exercising some self-protection against losing something which they find too costly to give up, for example, their sense of self-esteem or self-confidence.

The point of mentioning these biases is to show that "normal" people can have impaired judgement which can affect their decision-making ability. As well as extraneous factors such as family circumstances, stress or physical illness, we can be subject to unconscious desires which affect our ability to make decisions, moral or otherwise — even when we know a great deal about the subject.

lll.2 Obedience to Authority

If we have a tendency as individuals to make poor decisions, even when it is obvious to others what we should do, psychology has also shown that pressure from other people is likely to impair our ability to discern things moral. Here, we will describe a very famous study now considered seminal, which was carried out by the American social psychologist Stanley Milgram in 1963. This study lays open just how easily normal individuals may be persuaded to harm others.[10] In this experiment, 40 males were recruited and advised that they would be taking part in research which was studying the impact of punishment on learning.

The learning task was to memorise pairs of words, and the participants were told that they were to administer punishment to the learners when they got the words wrong. Instructed by an authority figure, they were to administer electric shocks to the learner, who was in an adjacent room strapped to a chair with electrodes attached to his wrists, increasing from 15 volts (slight) to 450 volts (danger: severe). Unbeknownst to the participants, however, the "learner" was a stooge, and there was no electric current. The "learner" was able to see what electric voltage had been "delivered". As the voltage increased, he increased his protests, demanding to be let out, saying he could not stand the pain, and at 300 volts, no longer verbally responding when "shocked".

The results of the experiment were alarming. None of the research participants stopped administering shocks when the learners first asked them to. Only one in eight of the research participants stopped

9 David Robson, "How to Upgrade Your Thinking and Avoid Traps that Make you look Stupid", *New Scientist*, accessed December 24, 2020, https://www.newscientist.com/article/mg24132180-100-how-to-upgrade-your-thinking-and-avoid-traps-that-make-you-look-stupid/.

10 Stanley Milgram, "Behavioral Study of Obedience", *The Journal of Abnormal and Social Psychology* 67, no. 4 (1963).

at 300 volts — which was after the learner had been pounding on the wall and asking to be let out, and when they no longer verbally responded. 65% (26 out of 40) of the participants continued right to the end of the experiment, administering 450 volts.

The purpose of the experiment was to see how far a person will proceed before refusing to comply with an authority figure's instructions. Milgram did a number of these experiments, each with slightly different variables. His broad finding was that there is a tendency in most people to obey authority without question.[11] Why? In this case, the distance between the participant and the victim may have reduced the empathic response in the participants. Gradually, as the experiment progressed, the research participants seemed to see the learners as unworthy and deserving of punishment. The research participants seemed to hand over their moral judgement to the authority figure, and they appeared also to be particularly concerned to do the work well, becoming engrossed in the task. The fact that the experiment was carried out at a prestigious university (Yale) may also have had an influence on the participants' reluctance to question authority.

Milgram's work has been subject to considerable critique, not least with regard to the ethics of his research.[12] However, his ideas remain very influential. From a clinical perspective, certain psychological therapeutic interventions have been developed which can help increase an individual's identification with the feelings of others (empathy) and help improve a person's judgements about his or her behaviour. This is one of the tools used in restorative justice — a process in which offenders get to meet the victims of their crimes and see how their actions have affected them. This can help engender and maximise empathy and influence future judgements and choices.[13]

lll.3 Social discernment between Good and Evil

Just as human nature is complex so is our "social" nature. In other words, human beings are profoundly influenced by culture, family background and societal norms. We have noted that individuals are all prone to be hampered in their moral discernment by certain tendencies, certain psychological blindspots,b43 which can affect their judgement. In this section we will note that human beings are also profoundly influenced by the group that they live in. In his article, "Good and Evil — A Psychiatrist's Perspective", Andrew Powell points out that large groups of people have been responsible for more evil acts than individuals.[14] He notes just how much evil has been perpetrated by ordinary citizens collectively during the last century — the Nazi holocaust, Stalin's great purge, the bombing of Hiroshima and Nagasaki, the murderous regimes of the Khmer Rouge and Idi Amin — to name only a few examples. The need to self-preserve, Powell suggests, means that we human beings can and do develop a tendency to become indifferent in the face of evil, convincing ourselves that those whom we deem to be a threat — whether to self, family, clan, community or nation — are somehow inferior to us, even to the extent of considering them to be subhuman or not human at all. As Powell notes, these are defence mechanisms designed to protect the self from threat. The point seems to be that we all, individually and collectively, are capable of perpetrating or ignoring evil for self-serving purposes, protecting ourselves from self-doubt and "undermining our self-idealisation". When whole nations develop this mindset, the results are catastrophic.

IV. MENTAL ILLNESS AND MORAL DECISION-MAKING

We have noted that mentally "healthy" people can and do make decisions which have negative consequences, and that their thinking is influenced by unconscious mental processes. This is a feature of

11 Stanley Milgram, "Some Conditions of Obedience and Disobedience to Authority", *Human Relations* 18, no. 1 (1965).

12 Gina Perry, *Behind the Shock Machine: The Untold Story of the Notorious Milgram Psychology Experiments* (The New Press, 2013).

13 Steve Taylor, "The Real Meaning of 'Good' and 'Evil'", *Psychology Today*, August 26, 2013.

14 Andrew Powell, "God and Evil — A Psychiatrist's Perspective" Paper given to 3rd Mental Anguish and Religion Conference on 1st July 2002 at the Institute for Arts, London", accessed April 21, 2020, https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.564.6642&rep=rep1&type=pdf.

normal human experience, even if we might prefer not to admit it to ourselves. But what about mental illness? How far might mental illness affect our capacity for judgement? According to the World Health Organisation, one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide.[15]

Given this statistic, this is clearly a very important question to ask. At the outset we have to say that patients with mental illness do tend to make poor general (of which the moral may or may not be a subset) decisions in everyday life. They are less likely to take care of their physical health or to adhere to recommended treatments, or to be able to sustain employment. For example, patients with schizophrenia (which is characterised by changes in perception, thinking, behaviour and mood) are more likely to make poor choices (that is, choices with negative consequences for themselves and others) because of the way their brains function, in particular with regard to their perception of themselves in relation to others and in the processing of emotion. They are less able to look after themselves or maintain stable relationships. Studies have shown that patients with bipolar disorder, whilst in a phase of normal mood, have significant deficits in their understanding of themselves in relation to others, and in emotional processing. For example, only 20% of patients with bipolar disorder get married compared with 60% of the general population, and they are ten times more likely to be unemployed. Deficits in self-perception and emotional processing make it difficult for bipolar patients to identify other people's emotional states and intentions. They are more likely to make poor choices. This impacts on their decision-making and so their ability to sustain relationships and employment. A knowledge that this is the case can be useful in the clinical setting as it can help patients understand the frequent difficulties they have with forming and sustaining social relationships and employment or other commitments.

A clinical understanding of this neuropsychological reality can sometimes help to inform therapeutic interventions. For example, a psychological intervention known as cognitive remediation has been successfully used to modify the course of a diverse range of conditions including schizophrenia, bipolar disorder, ADHD, traumatic brain injury and stroke. Another example of a therapeutic intervention is dialectic behavioural therapy which targets emotional dysregulation and helps reduce impulsive behaviour. This treatment has been used to help individuals with borderline personality disorders and eating disorders.

V. MENTAL CAPACITY

It is part of the psychiatrist's role to make clinical assessments of a patient's capacity with regard to specific decisions (whether moral or not). This is usually broken down into four distinct questions:

1. Is the patient able to understand the relevant information?
2. Is the patient able to retain the relevant information?
3. Is the patient able to consider and weigh the relevant information in order to make a decision?
4. Is the patient able to communicate their decision?

With regard to question 1, numerous mental disorders can impact on a patient's ability to understand information relevant to making a decision. For example, delusions, delirium, acute intoxication, eating disorders, dementia, and Post Traumatic Stress Disorder may mean that patients lack capacity due to impairments in their ability to understand relevant information. With regard to question 2, likewise, numerous mental disorders can impact on a patient's ability to retain relevant information in order to make a specific decision. Examples of this are severe anxiety states, psychotic illnesses associated with thought disorder (such as schizophrenia), dementia, brain infections and severe depression. With regard to question 3, various states

15 World Health Organisation, "Mental Disorders Affect One in Four People", accessed March 31, 2020, https://www.who.int/news/item/28-09-2001-the-world-health-report-2001-mental-disorders-affect-one-in-four-people.

can affect a patient's ability to consider and weigh up information — for example, dementia, severe depression, having delusions or hallucinations, or being in a heightened state of anxiety. Lastly, certain conditions can impact patients' ability to communicate their decisions — for example, dementia, schizophrenia, and depressive stupor.

We might think that individuals with mental illnesses which make them more at risk of poor decision-making with regard to self-care and maintaining interpersonal relationships are bound to be very poor at moral decision-making. But this is not the case. In fact, when it comes to discerning between right and wrong, and making good and sound decisions with regard to moral matters, the vast majority of people with a mental illness are able to do so most of the time. In other words, they retain the capacity to make moral decisions in spite of their illness. Of course, sometimes patients do lose their capacity to make judgements (whether moral or not). But this is surprisingly rare. In populations of around 100,000 people, at any given point there are likely to be just 30 or so working age adults who are so ill that they lose the capacity to make decisions about their care or treatment.[16] Moreover, individuals who do lose capacity generally regain it as their illness improves. In clinical practice, it is quite usual for patients who are severely unwell, and who are tormented by severe psychotic experiences, to be treated and looked after safely in an open ward surrounded by other highly disturbed patients. Although many of these patients have illnesses of a nature and degree that necessitate their detention and treatment in hospital against their wishes, the vast majority of these patients, almost regardless of their pathology, retain a remarkably high degree of social decorum and social judgement.

We need also to note that mental capacity is decision specific. An individual may retain the capacity to make a decision with regard to whether or not they would like tea or coffee, but be unable to manage their financial affairs. Likewise, a patient's capacity to discern between right and wrong is also dependent on specifics. For example, a patient might be able to reach a judgement that it is wrong to steal money from a person, but be unable to see that it is wrong to evade taxation.

When a psychiatrist seeks to determine whether or not a patient has mental capacity, he or she is making a clinical judgement. Such assessments are often not dichotomous; they are not straightforward. Assessing a patient's capacity is not like taking their temperature. Regardless of the specific nature and degree of a patient's mental illness, their mental states will usually be fluid and chaotic, with periods of increased self-awareness and insight interspersed with periods of fluctuating emotions and ability to concentrate and attend.

VI. POPULAR BELIEFS ABOUT MENTAL ILLNESS AND VIOLENT ACTS

Although it might seem counter-intuitive, mental illness, on its own, rarely provides an explanation for extremes of antisocial behaviours. Contrary to popular belief, patients gripped by severe mental disturbance rarely harm others or act on their disturbed beliefs or experiences. Surprisingly few mass killers suffer from a serious and enduring mental illness such as schizophrenia or bipolar disorder. An American study from 2004 of 60 mass murders, showed that only 6% of the perpetrators were psychotic at the time of the killings.[17] For mass shootings the percentage is even less. In the United States, less than 5% of all violent crime is perpetrated by individuals suffering from a mental disorder at the time of the incident.[18] This is considerably lower than the prevalence of mental disorder in the general population, which is around 15%. Moreover, where violent crime *is* committed by individuals with mental illness,

16 This excludes people with dementia, people in acute delirium in general hospitals, and people with moderate to severe learning disability. For fuller UK statistics see National Health Service, "Mental Health Act Statistics, Annual Figures 2018-19", accessed September 24 2020, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures.

17 J. R. Meloy et al., "A Comparative Analysis of North American Adolescent and Adult Mass Murderers", *Behavioral Sciences & the Law* 22, no. 3 (2004).

18 Jeffrey W. Swanson et al., "Mental Illness and the Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy", *Annals of Epidemiology* 25, no. 5 (2015).

the aggressive acts tend to be more minor (such as verbal or physical assault), and are less likely to be homicide. Their violent acts are more likely to be directed at those they live with rather than strangers or members of the public.[19] When those who have a mental disorder do perpetrate a seriously violent act, they very commonly do so under the influence of drugs or alcohol or have a compounding history of childhood abuse.[20]

VII. fMRI SCANNING

In recent years, many scientific publications have reported on the use of functional magnetic resonance imaging (fMRI) in the study of the brain.[21] Numerous neuropsychological and neuroanatomical studies using fMRI have shown that those suffering from certain mental illnesses have specific deficits which make it more difficult for them to make considered and rational decisions. These abnormalities impact on their ability to make decisions. For example, one aspect of our thinking processes is cognitive control. This refers to the ability flexibly to direct behaviour in accordance with goals which have been set.[22] Cognitive control functions include detecting and correcting errors, task switching and regulating emotion. Functional MRI scans have shown that the neuroanatomical structures and networks engaged in cognitive control are widespread throughout the brain. They have also identified neuroanatomical deficits in those with mental disorders which are associated with impairments in cognitive control systems. For instance, individuals with emotionally unstable disorder (also known as borderline personality disorder) and mood disorders have control deficits with regard to the regulation of emotion. Individuals with anxiety disorders have deficits associated with a bias to attending to negative stimuli. In other words, they are more likely to focus on negative outcomes rather than positive ones, or to interpret what they see in negative terms. fMRI scanning has been able to image the areas of the brain which are functioning when this deficit is in operation.

Another example of our thinking processes is dealing with risk. In decisions which involve weighing up risk, the individual is typically balancing the thought of a large reward with an unlikely outcome against that of a smaller reward which is associated with a more likely outcome. A "healthy" person will be able to take into account the consequences of each option and make a decision accordingly (regardless of whether the decision is a moral one or not). Functional MRI has identified those areas and pathways which are activated when making such decisions. It has also identified functional deficits in the brains of people who suffer from panic attacks. Such patients have abnormalities in the cognitive processing and prediction of future-oriented fear. For example, a patient might have a panic attack due to an irrational fear of being sick in public, despite being fully aware that this is unlikely to happen. Similar imaging has been recorded in patients who engage in unhealthy gambling habits.

By means of imaging, therefore, we are now able to identify the neuroanatomical structures and pathways which are used during specific cognitive tasks in relation to certain types of cognitive processes and how these relate to specific mental disorders. Functional MRI scanning has also helped identify functional deficits in certain neuroanatomical areas and networks of the brain and associated deficits in cognitive processing. This is a remarkable development and it is an expanding field of scientific knowledge. Science is now able to link specific mental disorders which are associated with particular cognitive deficits to specific underlying functional neuroanatomical changes in the brain. This helps to give us a unique understanding of the challenges which patients with particular mental disorders have in relation to making judgements.

19 Olav Nielssen et al., "Homicide of Strangers by People with a Psychotic Illness", *Schizophrenia Bulletin* 37, no. 3 (2011).
20 Paul S. Appelbaum, "Violent Acts and Being the Target of Violence Among People With Mental Illness-The Data and Their Limits", *JAMA psychiatry* 77, no. 4 (2020); H. J. Steadman et al., "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods", *Archives of General Psychiatry* 55, no. 5 (1998).
21 A Functional MRI scan allows both the activity and the structure of the brain to be seen in real time as the brain undertakes particular tasks.
22 See Ricardo Cáceda, Charles B. Nemeroff, and Philip D. Harvey, "Toward an Understanding of Decision Making in Severe Mental Illness", *The Journal of Neuropsychiatry and Clinical Neuroscienes* 26, no. 3 (2014).

However, while we can identify certain pathways which are employed in certain thought processes, we are not yet in a position to say anything about the causation of these thought processes. That is, we can only say that some patients have these neuroanatomical differences, but we cannot at present say what precisely their relationship to the behaviour is or why people with these mental illnesses are more likely to make decisions with negative consequences.

VIII. PSYCHOPATHY

Psychopaths are popularly thought to be heartless individuals who inflict suffering on others because they lack the ability to empathise. It is certainly true that psychopaths lack capacity for empathy. However, this is not the main concern in clinical or legal practice. In UK law a psychopath is defined as an individual who persistently engages in seriously irresponsible behaviours. A fundamental characteristic of a "typical" psychopath is that they are poor decision makers. fMRI scanning has shown that the brains of psychopaths seem to be so wired that they are poor at considering how they will feel in the future about what makes them feel good in the present.[23] There is a particular part of the brain which is very important for this kind of "mental time-travel". The ventromedial prefrontal cortex is necessary for looking at how we or others are going to feel about something in the future and making decisions based on that. The brains of psychopaths are poor at generating such simulations. This makes them have difficulty in making decisions; it also means that they are more impulsive, and less able to learn from previous mistakes. It is interesting to note that the functional deficits in these specific neuroanatomical circuits are not unique to psychopaths, but are also present in individuals with severe substance abuse problems, people who are addicted to gambling, and compulsive overeaters.

Once again, knowledge of this sort can sometimes be helpful in the clinical setting. Simply informing (educating) psychopaths about their condition and why it impacts them in the way that it does, why they are prone to repeat harmful actions, and struggle to learn from experience, is often seen as helpful. Further, psychological treatment to improve problem solving and increase their potential awareness of others' feelings can make a difference. Nevertheless, the fact that some features have been found in the brains of psychopaths does not allow us to take a deterministic view of their behaviour. Psychiatry is still divided as to whether or not psychopaths can be held morally responsible or not.[24]

IX. CLINICAL PERSPECTIVES: THE LIMITS OF SCIENCE

Clearly, in recent years, great advances have been made with regard to our scientific knowledge of neurological pathways and how different areas of the brain relate to each other. But to what extent does this knowledge really shed light on the impact of mental illness on an individual's ability to make sound judgements between right and wrong? Here we must exercise some caution and note that despite these advances, our understanding of why people behave as they do remains very limited indeed. Psychiatry is a very young discipline in comparison to other branches of medicine. For example, much research is undertaken to develop and produce psychotropic medications to treat mental illness. But the fact is that we know very little about how or why psychotropic medications work. We do not know why or how antidepressants, mood stabilisers, antipsychotics and anti-anxiolytics really work. The same is true of these recent advances in neuropsychology and brain imaging.

The capacity to conduct increasingly sophisticated psychological research on the processes of and influences on thinking, emotions and behaviour, does not necessarily add to our proficiency in helping individu-

23 Jay G. Hosking et al., "Disrupted Prefrontal Regulation of Striatal Subjective Value Signals in Psychopathy", *Neuron* 95, no. 1 (2017). For a layman's presentation of their findings, see Carey Goldberg, "Psychopaths: Cold Blood or Broken Circuit? Inmate Brain Scans Find New Flaws", accessed March 26, 2020, https://www.wbur.org/commonhealth/2017/07/07/psychopaths-brain-scans-neuron.

24 Steve Ramplin and Gloria Ayob, "Moral Responsibility in Psychopathy: A Clinicophilosphical Case Discussion", *BJPsych Advances* 23, no. 3 (2017).

als. So too, the ability to conduct increasingly sophisticated research which informs us of which parts and networks of the brain are active in real time, while very valuable for research purposes, has limited clinical or personal relevance. The fact that we can see the brain functioning does not mean that we can explain why the brain is functioning in the way that it is. The brain is by far the most complex organ in the body, and we know virtually nothing about how it truly works. We do not know the mechanism of a thought or what a memory is, or how it is stored, or what is going on when we remember things. We do not understand consciousness.

Even in light of these advances, we are still only able to say that human beings are highly complex creatures with multiple interacting factors at play that influence our ability to make sound judgements about right and wrong. In every human being, whether mentally unwell or not, there are social, historical, political, religious and familial influences at play, as well as psychodynamic factors. Frequently too, other factors such as alcohol, tiredness, boredom, loneliness or a desire to impress affect our ability to make good judgements. Equally, certain symptoms of mental illness, such as profound low mood, a flashback of a traumatic event or experiencing a hallucination commanding that you do something, or having a delusion that a particular individual is going to do something to harm you, or heightened fear may also have an effect on decision-making.

X. CONCLUSION

In this paper we have been considering the question of how far mental illness might affect an individual's ability to make moral decisions. We have presented a general clinical psychiatric perspective, which we hope will be of use to theologians as they discuss issues of free will, determinism and moral responsibility. We have observed that psychology has corroborated what philosophers have known all along — that the process of decision-making in general is highly complex, and not just a matter of using one's reason. Conscious and unconscious forces are at play when we make any kind of decision (moral or not), both individually and collectively. As the woman in our hypothetical example decides whether or not to steal the medicine for her relative, her decision will not simply be a matter of consciously weighing up the rights and wrongs of stealing, or considering the possible consequences of her actions. She will also be influenced by her upbringing, her personal circumstances and emotional state amongst other things. No matter how intelligent she is, unconscious forces will influence her thinking.

But what if she is mentally ill? How far will that affect her judgement? While this question is important with regard to the assessment of culpability (assuming she decides to steal, that is), whether or not she has a mental illness is far less likely to be a factor in her decision-making process than we might think. Certainly, there are some conditions, such as acute anxiety, psychosis or brain injury, which could affect her judgement. But for the vast majority of psychiatric patients, even those who might be prone to making unwise decisions with regard to their own self-care, mental illness will not hinder their ability to make moral decisions. Moreover, mental illness on its own rarely explains anti-social or criminal behaviour, and the common perception that mentally unwell people are more likely to commit violent crime is ill-founded.

The issue of mental illness should not be ignored in discussions of moral discernment and responsibility, but neither should it be allowed to override other considerations.[25] Most importantly, it should never be assumed that the presence of a mental illness necessarily robs an individual of the capacity to make moral decisions. In addition, it is right that theologians take advances in neuropsychology and brain imaging into account as they think about questions of moral discernment.[26] However, it is important also to realise how much we do not know about the workings of the brain. The assumptions of

25 See also Gerben Meynen, "How Mental Disorders Can Compromise the Will", in *Free Will and The Brain*: *Neuroscientific, Philosophical and Legal Perspectives*, ed. Walter Glannon (Cambridge Univ. Press, 2015).

26 For examples of such discussions see Nancey C. Murphy and Warren S. Brown, *Did My Neurons Make Me Do It? Philosophical and Neurobiological Perspectives on Moral Responsibility and Free Will* (Oxford Univ. Press, 2007); Neil Messer, "Determinism, Freedom and Sin: Reformed Theological Resources for a Conversation with Neuroscience and Philosophy", *Studies in Christian Ethics* 28, no. 2 (2015); Alan Torrance, "Developments in Neuroscience and Human Freedom: Some Theological and Philosophical Questions", *Science and Christian Belief* 16, no. 2 (2004).

some scientists, for example, that a knowledge of how the brain works shows us that human thinking and behaviour is solely biologically determined, must be treated with great caution.[27] When it comes to our understanding of the brain, human behaviour and mental illness, there is still a great deal to learn.

BIBLIOGRAPHY

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*. Washington, D.C.: American Psychiatric Association Publishing.

Appelbaum, Paul S. 2020. "Violent Acts and Being the Target of Violence Among People With Mental Illness-The Data and Their Limits". *JAMA psychiatry* 77, no. 4: 345–46. doi:10.1001/jamapsychiatry.2019.4266.

Cáceda, Ricardo, Charles B. Nemeroff, and Philip D. Harvey. 2014. "Toward an Understanding of Decision Making in Severe Mental Illness". *The Journal of Neuropsychiatry and Clinical Neuroscienes*". 26, no. 3: 196–213. doi:10.1176/appi.neuropsych.12110268.

Cortez, Marc. 2010. *Theological Anthropology: A Guide for the Perplexed*. London: Bloomsbury T&T Clark.

Cortez, Marc, and Michael P. Jensen, eds. 2018. *T&T Clark Reader in Theological Anthropology*. London: Bloomsbury T&T Clark.

Gazzinga, Michael. 2011. *Who's in Charge? Free Will and the Science of the Brain*. New York, NY: Harper Collins.

Gilligan, Carol. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard Univ. Press.

Goldberg, Carey. "Psychopaths: Cold Blood or Broken Circuit? Inmate Brain Scans Find New Flaws". Accessed March 26, 2020. https://www.wbur.org/commonhealth/2017/07/07/psychopaths-brain-scans-neuron.

Griffith, Meghan. 2013. *Free Will: The Basics*. London: Routledge.

Hosking, Jay G., Erik K. Kastman, Hayley M. Dorfman, Gregory R. Samanez-Larkin, Arielle Baskin-Sommers, Kent A. Kiehl, Joseph P. Newman, and Joshua W. Buckholtz. 2017. "Disrupted Prefrontal Regulation of Striatal Subjective Value Signals in Psychopathy". *Neuron* 95, no. 1: 221-231.e4. doi:10.1016/j.neuron.2017.06.030.

Keyes, Corey L. M. 2002. "The Mental Health Continuum: From Languishing to Flourishing in Life". *Journal of Health and Social Behavior* 43, no. 2: 207–22. doi:10.2307/3090197.

Kohlberg, Lawrence. 1981. *Essays on Moral Development Vol 1: The Philosophy of Moral Development*. San Francisco, CA: Harper & Row.

Meloy, J. R., Anthony G. Hempel, B. T. Gray, Kris Mohandie, Andrew Shiva, and Thomas C. Richards. 2004. "A Comparative Analysis of North American Adolescent and Adult Mass Murderers". *Behavioral Sciences & the Law* 22, no. 3: 291–309. doi:10.1002/bsl.586.

Messer, Neil. 2015. "Determinism, Freedom and Sin: Reformed Theological Resources for a Conversation with Neuroscience and Philosophy". *Studies in Christian Ethics* 28, no. 2: 163–74. doi:10.1177/0953946815570591.

Meynen, Gerben. 2015. "How Mental Disorders Can Compromise the Will". In *Free Will and The Brain: Neuroscientific, Philosophical and Legal Perspectives*, edited by Walter Glannon, 125–45. Cambridge: Cambridge Univ. Press.

Milgram, Stanley. 1963. "Behavioral Study of Obedience". *The Journal of Abnormal and Social Psychology* 67, no. 4: 371–78. doi:10.1037/h0040525.

—. 1965. "Some Conditions of Obedience and Disobedience to Authority". *Human Relations* 18, no. 1: 57–76. doi:10.1177/001872676501800105.

Murphy, Nancey C., and Warren S. Brown. 2007. *Did My Neurons Make Me Do It? Philosophical and Neurobiological Perspectives on Moral Responsibility and Free Will*. Oxford: Oxford Univ. Press.

27 See Michael Gazzinga, *Who's in Charge? Free Will and the Science of the Brain* (Harper Collins, 2011).

National Health Service. 2019. "Mental Health Act Statistics, Annual Figures 2018-19". Accessed 24th September 2020. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures.

Nielssen, Olav, Dominique Bourget, Taina Laajasalo, Marieke Liem, Alain Labelle, Helina Häkkänen-Nyholm, Frans Koenraadt, and Matthew M. Large. 2011. "Homicide of Strangers by People with a Psychotic Illness". *Schizophrenia Bulletin* 37, no. 3: 572–79. doi:10.1093/schbul/sbp112.

Perry, Gina. 2013. *Behind the Shock Machine: The Untold Story of the Notorious Milgram Psychology Experiments*. New York, NY: The New Press.

Pink, Thomas. 2004. *Free Will: A Very Short Introduction*. Oxford: Oxford Univ. Press.

Powell, Andrew. 2002. "Good and Evil — a psychiatrist's perspective" Paper given to 3rd Mental Anguish and Religion Conference on 1st July 2002 at the Institute for Arts, London. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.564.6642&rep=rep1&type=pdf.

Ramplin, Steve, and Gloria Ayob. 2017. "Moral Responsibility in Psychopathy: A Clinicophilosphical Case Discussion". *BJPsych Advances* 23, no. 3: 187–95. doi:10.1192/apt.bp.115.015321.

Robson, David. 2019. "How to Upgrade Your Thinking and Avoid Traps that Make you look Stupid". *New Scientist*, February 20, 2019. https://www.newscientist.com/article/mg24132180-100-how-to-upgrade-your-thinking-and-avoid-traps-that-make-you-look-stupid/

Steadman, H. J., E. P. Mulvey, J. Monahan, P. C. Robbins, P. S. Appelbaum, T. Grisso, L. H. Roth, and E. Silver. 1998. "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods". *Archives of General Psychiatry* 55, no. 5: 393–401. doi:10.1001/archpsyc.55.5.393.

Swanson, Jeffrey W., E. E. McGinty, Seena Fazel, and Vickie M. Mays. 2015. "Mental Illness and the Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy". *Annals of Epidemiology* 25, no. 5: 366–76. doi:10.1016/j.annepidem.2014.03.004.

Taylor, Steve. 2013. "The Real Meaning of 'Good' and 'Evil'". *Psychology Today*. 26th August 2013. https://www.psychologytoday.com/gb/blog/out-the-darkness/201308/the-real-meaning-good-and-evil.

Timpe, Kevin. 2014. *Free Will in Philosophical Theology*. London: Bloomsbury Academic.

Torrance, Alan. 2004. "Developments in Neuroscience and Human Freedom: Some Theological and Philosophical Questions". *Science and Christian Belief* 16, no. 2: 123–37.

Watson, Gary. 2003. "Introduction". In *Free Will*, edited by Gary Watson, 1–25. Oxford: Oxford Univ. Press.

World Health Organisation. 2001. "Mental Disorders Affect One in Four People". Accessed March 31, 2020. https://www.who.int/news/item/28-09-2001-the-world-health-report-2001-mental-disorders-affect-one-in-four-people.

—. 2012. *International Classification of Diseases 11th Revision*. Geneva: World Health Organisation.

—. 2018. "Mental Health: Strengthening our Response". Accessed April 1, 2020. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.