Diagnosing insanity 170 years apart: Pierre Rivière and Anders Breivik

Diagnosi di follia a distanza di 170 anni: Pierre Rivière e Anders Breivik

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Summary

Objectives

In 2011 Anders Behring Breivik, ABB, slaughtered 77 civilians in a twofold attack in Oslo and on the island of Utøya, Norway. During his trial ABB's sanity or lack thereof was fiercely contested. Two psychiatric evaluations arrived at radically different diagnoses of psychosis and personality disorder respectively. Though unrivalled in its bestiality, the case of ABB is not unique. In 1835, a French peasant Pierre Marie Rivière, PMR, in a seemingly incomprehensible act of cruelty killed his immediate family. Some contemporaries, including Esquirol, saw in PMR the traces of radical irrationality (psychosis) while others ascribed his deeds to an evil personality.

Thus a basic disagreement on the nature of rationality and madness appears to have persisted across the centuries. The aim of this paper is to clarify the sources of this diagnostic divergence and to shed some light on pressing epistemological and clinical issues related to the diagnostic process, its conceptual foundation and the question of differential diagnosis.

Methods

A 1975 book by Foucault et al. contains a manuscript by PMR detailing the background for his actions and extracts from the legal and psychiatric documents pertaining to the case. During the trial of ABB the two psychiatric evaluations were leaked to the press and made available online.

Results

In both cases the assessors had access to a very similar body of information from which the elements were selected that seemed to support their diagnostic conclusion. This selectivity led to widely different interpretations of the seemingly identical source psychopathological phenomena. The potential for a diagnostic disagreement in psychiatry has remained unresolved by the neuroscientific advances of the intervening years and, indeed, by the use of the so-called "operational" criteria.

Conclusions

The diagnostic process always involves a selection among the body of the available "objective" data. This selection process is prefigured by the diagnostician's conceptual template that structures her cognitive field and thereby renders some information relevant and excludes other as irrelevant. Moreover, the conceptual template influences the psychopathological significance of the clinical presentation. The operations of the conceptual templates or grids of prototype hierarchy are constituted by the examiner's knowledge and experience, ethical and other personal inclinations, and a host of other factors. Such cognitive constraints on the diagnostic process, already described by Jaspers, cannot be eliminated by the so-called "operational" diagnostic systems.

In the case of PMR, the major source of the diagnostic disagreement could be traced to the different levels of professionalism of the involved examiners. In the case of ABB, a nearly procrustean adherence to the ICD 10 criteria (which were not immune to different interpretations) was at the heart of the diagnostic disagreement and seemed to invite private psychological interpretations. The diagnostic disagreement in the case of ABB seems to disclose some serious because fundamental epistemological weaknesses of the ICD-10, notably an absence of a prototypical grid that is needed to structure the psychiatrist's cognitive field and an impossibility of adequate description and definition of the psychopathological phenomena (symptoms and signs) through the so-called "operational criteria", i.e. brief, simple, lay language statements. Defining the diagnostic classes by a specific number of seemingly mutually independent features, and without any emphasis on the phenomenological typicality or structure of both the diagnostic class and its constituents, is likely to entail diagnostic distortions. Finally, it is suggested that in terms of diagnosis, the notion of the schizophrenia spectrum appears as being highly relevant in both cases.

Key words

Breivik • Rivière • Psychosis • Rationality • Nosology • Diagnosis

Introduction

In 2011 Anders Behring Breivik (ABB) murdered 77 civilians in a twofold attack on downtown Oslo and the island of Utøya, Norway. During his trial there emerged a fierce debate among mental health professionals and the general public on the issue of his potential insanity. Two diagnostic evaluations (according to the ICD-10 criteria), performed by independent psychiatric teams, arrived at radically different conclusions. The first found ABB to suffer from paranoid schizophrenia whereas the second diag-

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nosed him with narcissistic personality disorder with antisocial traits. On the basis of the second evaluation, ABB was sentenced to 21 years in preventive custody with a minimum time of 10 years. The forensic details and the debate surrounding the Breivik case were commented upon in World Psychiatry [1].

A somewhat similar, though much less spectacular incident happened in France in 1835. A young peasant, Pierre Marie Rivière (PMR), murdered his mother, sister and brother. He was examined by a local physician and was first considered sane. However, a second psychiatric evaluation and additional review of all documents pertaining to the case, performed by the renowned Parisian alienists Esquirol and Leuret, diagnosed PMR with psychosis. PMR was therefore not condemned to death. However, some years later he committed suicide in prison.

We intend to present and compare both cases, juxtaposing the psychopathological considerations involved in assigning the respective diagnostic sets. For that purpose, we will use the forensic-psychiatric information concerning PMR and ABB that is publicly available (see below). This presentation is to serve as a basis of a reflection on pressing epistemological and clinical concerns related to the nature of the diagnostic system, the diagnostic process and differential diagnosis [2]. The story of PMR, which took place at the birth of modern psychiatric nosology, will highlight certain recurrent, and therefore general problems confronting the process of psychiatric diagnosis. We will then explicitly articulate the conceptual and clinical issues implicit in the a-theoretical polythetic "operational-criteria" based system, as compared to its predecessor (e.g. ICD-8), namely a prototypical classification whose constituent classes are organized around the narrative descriptions of category-characteristic prototypes and associated phenomenological and theoretical reflections.

Information sources

The 1975 book "I, Pierre Rivère, having slaughtered my mother, my sister, and my brother … A case of parricide in the 19th century" [3] edited by Michel Foucault et al. contains a manuscript by PMR detailing the background for his actions, extracts from the legal documents, and the psychiatric evaluations of PMR.

During the trial of ABB, the two successive psychiatric evaluations were leaked to the press and made available online [4].

The case of Pierre Marie Rivière

Childhood

PMR was born in 1814 in a small village in Normandy, France, as the oldest of five siblings. His peasant parents were widely known to be living in a disharmonious relationship. The court witnesses testified that the mother exposed her husband to abuse and violence. PMR was fond of his father but considered his mother a mean and wicked woman, who would drive her husband "… to such despair that he was sometimes tempted to commit suicide" [3, p. 24]. PMR terminated his schooling at the age of 12. The local priest found him to be intelligent, curious, and interested in religion and science. He was ambitious and strived to rise above his status. However, PMR "lacked the tact" required to interact with other people.

Around the age of 8 PMR changed. He became introverted, increasingly isolated, cruel to other children and animals, and displayed bizarre behavior. He desperately tried to "… live in society, but I did not have tact enough to do that, I could not find the words to say, and I could not appear sociable with the young people of my own age" [3, p. 103]. "Later my ideas changed and I thought I should be as other men. Nevertheless I displayed peculiarities. My schoolmates noticed this and laughed at me (…) Above all I had a horror of incest which caused me to shun approaching the women of my family. When I thought I had come too close to them, I made signs with my hand as if to repair the harm I believed I had done" [3, p. 101-2]. Several witnesses emphasized his cruelty. He tortured and crucified frogs and birds and he even invented a new torturing technique, which he named in his memoirs as "enceepharating" [3, p. 104]; it consisted of transfixing the animal to a tree with three sharp nails through the abdomen.

The crime

PMR grew increasingly preoccupied with his father's situation and the suffering inflicted on him by the mother and he began contemplating how best to protect and save him. One day, at a church ceremony, he witnessed several people begin to weep when his father intoned a psalm. At that very moment he decided to kill his mother, sister and little brother. The sister had to die because PMR considered her to be an accomplice of his mother. His little brother also had to die, but for different reasons: partly because of his love for these two women, partly because the killing of the brother would make his father abhor PMR so much "that he will rejoice in my death" [3, p. 106]. PMR described in his memoirs how thoroughly he contemplated and planned his crime, e.g., with details concerning timing and the clothes he was to wear. He minutely described the murders. The police report quotes the neighbours to have heard PMR say just before fleeing the house: "I have just delivered my father from all his tribulations. I know that they will put me to death, but no matter" [3, p. 39]. PMR fled into the woods where he roamed for days before being apprehended and questioned by the police.

Psychiatric evaluations of PMR

In the prison, PMR spent 11 days completing his manuscript with the famous opening lines: "I, Pierre Rivière, having slaughtered my mother, my sister, and my brother …" [3, p. 54]. Several witnesses from the village and PMR's own family were interviewed during the investigation. Some gave detailed accounts of PMR's bizarre behaviour and described his fear of women, his tendency to talk to himself while alone, and his complete isolation from his peers. Others, however, mainly emphasized his cruelty, his preference for solitude and they expressed doubts about his intelligence.

During the trial, the prosecutor highlighted the precocity of PMR's cruel character, his intelligence, curiosity in school, and his ability to meticulously plan his acts, while the jury suspected that his cognitive abilities might have allowed him to simulate madness. His manuscript was considered proof of both his intellectual abilities and an insight into the immorality of the crime.

Several physicians and psychiatrists examined PMR with different conclusions on his mental state. The doctor who observed PMR during his incarceration had not noticed any signs of insanity or disturbed intelligence. A general practitioner without any special knowledge of psychiatry, Dr. Bouchard, was tasked with drafting a psychiatric evaluation immediately after PMR's arrest. He did not observe any signs of mental illness - idiocy, mania or dementia - and he emphasized PMR's intact cognitive functioning: "Pierre Rivière is not a monomaniac, because he does not harbor delusions on one and only one subject; he is not a maniac, because he is not in a habitual state of agitation; he is not an idiot, because he has written a wholly sane memoir …" [3, p. 141]. Dr. Bouchard omitted in his report any reference to the disposition to mental illness on the maternal side of the family, the unequivocally established history of personality change, change of behavior and its grossly bizarre elements, as well as PMR's fearful ideas concerning incest. Instead, he emphasized that PMR never suffered from illnesses or injuries that might have affected his brain functioning. Dr. Bouchard pointed out the shocking tranquility with which PMR spoke of his crime and concluded that: "Nothing in his answers indicates any derangement of the mental faculties" [3, p. 123]. Rather, he considered PMR to be of a "melancholic character" with a preference for solitude and cruelty. This account resonated with the prosecutor's indictment: "… from his childhood [PMR] gave signs of a savage character which to this day has led him to avoid young persons of his age and seek solitude" [3, p. 49]. In other words, PMR did not display the erratic behavior of the insane but rather proved himself "(…) taciturn and reflective, with an ardent, cruel, and violent imagination" [3, p. 49].

A psychiatrist in charge of the psychiatric asylum in Caen, Dr. Vastel, was also asked to examine PMR and give his own medical opinion. He pointed to a hereditary element of madness on the maternal side of PMR's family. He found PMR to have suffered from insanity since childhood. He drew attention to the fact that PMR explained his fear of incest with a belief that a fluid with some mysterious incestuous properties was being emitted from his own body. Moreover, Dr. Vastel stressed the bizarre quality of PMR's asocial behavior and, finally, he emphasized that PMR's reflections or motivations behind his crime (a belief that the triple-murder would ultimately pave the way for his father's liberation and future happiness) were a mark of insanity in their own right. In his view PMR was a mad and dangerous man.

Finally, a group of Parisian alienists, including the renowned Esquirol and Leuret, was asked to give their expert opinion about PMR's mental state based upon a review of all files pertaining to the case (police records, medical documents, and PMR's manuscript). They firmly concluded that PMR was indeed insane, had exhibited signs of madness since his childhood, and that his deluded mind was the reason behind the crime.

The jury, however, found PMR guilty and sentenced him to death. Yet, because of a persisting uncertainty among the judges, King Louis Philippe was asked to intervene. Following the advice of his minister of justice the king granted PMR a partial pardon because seemingly the crime per se – as one newspaper put it – "bore every sign of insanity" [3, p. 171]. PMR's death sentence was therefore converted to life imprisonment. Some years later, PMR committed suicide.

The case of Anders Behring Breivik

The story

ABB was born in 1979 in Oslo, Norway and following the divorce of his parents he grew up with his mother and half-sister. At the age of 4 he was examined by the Child Psychiatric Service. A recommendation to place him in foster care never materialized, however. His development over the next few years seems to have been fairly inconspicuous. However, as a teenager he was apprehended for petty crimes and he dropped out of high school in his third year. He then started a string of companies, the last of which sold fake academic diplomas. This was shut down in 2006 due to legal concerns and a few months later he moved back in with his mother. Over the next years he grew increasingly isolated and devoted his time to online gaming, preparing his terror act and writing the 1518 pages manifesto "2083 – A European Declaration of Independence", which in three books detailed

his motivation for the coming attacks. Book 1 offered a subjective history of Europe, focusing on the threat allegedly posed by Islam, book 2 addressed the current situation, and book 3 encouraged the reader to partake in the outlined ideological struggle. Whereas large parts of the first two books were directly lifted from a range of far-right websites, ABB seemed to have been the main author of the third.

July 22nd, 2011 ABB detonated a car bomb in the downtown government quarter in Oslo, killing eight people and severely injuring others. Two hours later, he travelled from the bombsite to the small island of Utøya, where a summercamp of the Norwegian social-democratic youth organization took place. He arrived dressed as a police officer and immediately started firing at the hundreds of persons gathered on the island, killing, execution-style, 69 persons, mainly children and adolescents, while injuring many others. Survivors reported that he was laughing and shouting while shooting. After 50 minutes, he called the police saying: "Yes, hello, my name is Commander Anders Behring Breivik from the Norwegian anti-communist resistance movement. I'm on Utøya for the moment. I want to give myself up" [1]. Finally, ABB was apprehended by the police and subjected to a forensic psychiatric assessment.

The first psychiatric assessment

Two court appointed psychiatrists conducted 13 interviews of a total duration of 36 hours with ABB, in addition interviewing his mother and hearing or viewing all police interrogations. They combined unstructured with structured diagnostic interviews. On November 29th 2011 they submitted their report, diagnosing ABB with paranoid schizophrenia. ABB was considered to be psychotic both at the time of the assessment and at the time of his crime. Melle [1] provides an excellent summary of the assessment:

"This conclusion was based on central contents of Breivik's thought system. He told (...) that he had "precedence as the ideological leader for the Knights Templars organization, with the mandate of being both a military order, a martyr organization, a military tribunal, judge, jury and executioner". He thought he was a pioneer in a European civil war, and compared his situation to that of Tsar Nicolas of Russia and Queen Isabella of Spain. He believed that it was likely (with somewhat varying degrees of likelihood) that he could be the new regent in Norway following a coup d'état. He said he decided who should live and who should die in Norway. This responsibility was felt as real, but also a heavy burden. He believed that a considerable proportion of the Norwegian population (several hundred thousands) supported his deeds. If he became the new regent, he would take the name Sigurd the Crusader the Second (Sigurd the Crusader was a Norwegian medieval king who reclaimed parts of Portugal from Muslim rule). (:::) He thought he would be given the responsibility for deporting several hundred thousands of Muslims to North Africa. He believed there was an ongoing ethnic cleansing in Norway and feared for his life. He thought the events he was a part of could start a nuclear third world war. He worked with solutions to improve the Norwegian ethnic genetic pool, make illnesses extinct and reduce the divorce rate. He thought about reservations for indigenous Norwegians, DNA testing and factories for mass deliveries of babies. He believed that the house of Glucksburg (current Norwegian royal house) would be removed through revolution in 2020. As an alternative to recruiting a new regent from the leadership of the Knights Templars, one could make DNA tests of the remains of King Olav the Saint (the Viking King who introduced Christianity to Norway) and then choose the one with best genetic likeness to be the new king.

The psychiatrists saw these as grandiose delusions with bizarre and paranoid qualities that went far beyond conspiracy notions about an Islamist take-over of Europe. They thus did not consider him psychotic by mistaking his extremist, racist, right-wing views as delusional, but because they thought he had grandiose delusions regarding his own role in this extremist universe. While his political opinions unfortunately are shared by others, he stood alone in his claims of an exalted role in the alleged Knights Templars organization, or even in the claims of this organization's existence. In addition, Breivik claimed he had exceptional personal abilities, for instance knowing what other people – including his evaluators – thought, without fully explaining them how.

The two psychiatrists perceived his language as stilted and technical, using common words in new contexts mixed with unusual words, which he said he had made himself and that the psychiatrists perceived as neologisms. There were otherwise no signs of grossly disorganized speech or actions. He usually displayed restricted, but sometimes also inappropriate affect when talking about his killings, which he called "the executions of traitors". He got animated when talking about his shooting rampage and about his Manifesto. The psychiatrists saw this as an example of affective flattening with incidents of incongruent affect. There were no outward signs of depression, mania, auditory hallucinations or ideas of reference, influence phenomena or ideas of thought insertion".

In dealing with ABB's manifesto, the experts stated their intention to abstain from passing judgment on his political convictions. However, they were puzzled by his explicit intention with the document, namely to "*save Europe from multiculturalism and an Islamic take-over* (original italics)" [5, p. 57], because this seemed to clash with its "banal

and to some extent downright infantile mode of expression" [5, p. 57]. Since ABB made the impression of an intelligent man, they struggled to understand what might motivate such incongruency. Thus they speculated that it might be due to him having lost "the overall cognitive and intellectual functions [that] one would expect him to employ in order to assess the outside world's experience and understanding of the product" [5, p. 57]. Accordingly they found the manifesto to be "almost pathetically egocentric" [5, p. 58] in its detailed descriptions of meaningless trivialities of ABB's daily life, and argued that this was a function of his grandiose ideas: "(…) I will always know that I am perhaps the biggest champion of cultural conservatism, Europe has ever witnessed since 1950" [5, p.61]. This was also, they argued, what drove ABB to include a section offering the reader farming advice, which to the experts seemed "very weird or bizarre in the context" [5, p. 64].

The second evaluation

However, a chorus of more or less informed opinions exploded when the diagnostic conclusion was leaked to the press and became available online. Laymen, psychiatrists, and other professionals immediately questioned the diagnosis. ABB himself felt offended and explicitly wanted to be viewed as a sane person engaged in a mortal ideological struggle. The public debate was quite vocal, at times even virulent, and spread to the rest of Scandinavia. Some people feared that a psychotic ABB would avoid punishment and soon be walking the streets. Moreover, some, among the politically correct, preferred to see ABB as a sane extreme right-wing terrorist, thus testifying to the fact that terror is not an exclusive attribute of radical islamism.

In response to all that turmoil, the court appointed a second pair of psychiatrists in January 2012 for a re-assessment. This was carried out six months after the first. By that time, ABB had for several months undergone frequent consultations with the psychiatric treatment team in the prison. No longer in isolation, he also had access to the first psychiatric report and to the details of his mental condition as debated in the media.

The main part of the new evaluation was based on the same instruments as the first. However, additionally a 3 week in-patient observation in the prison by trained psychiatric personnel was carried out. The psychiatrists submitted their report in April 2012. It firmly rebutted the previous diagnostic verdict and concluded that ABB was not psychotic but suffered from a narcissistic personality disorder with antisocial traits. On August 24th 2012 the court judged ABB to be compos mentis and sentenced him to 21 years of confinement with a possibility of prolongation.

The second evaluation could essentially be seen as an attempt to systematically deconstruct its predecessor's main conclusive sections. We will therefore look at the most significant chunks of this evaluation.

1. Past information

Approximately 5 years prior to the attack, ABB moved back in with his mother (highly unusual in Scandinavia), and withdrew from social interaction. In the first evaluation ABB's mother is interviewed in an effort to shed light on this move and the behavioral changes that ensued. The second evaluation, on the other hand, relied solely on information from the police interrogations. However, the contents of the family interviews by psychiatrists in the first assessment and the police interrogations used in the re-assessment, differ significantly.

In the first report ABB's mother explained how a rather sinister transformation set in around 2006 and became dramatically accentuated in 2010. She found her son "all weird" [5, p. 79]. Either he would refuse to leave his room or he would sit awkwardly close to her. She found it increasingly difficult to follow his flow of speech as he brought up the names of past Danish kings, warlords, and "all kinds of strange things" [5, p. 81]. She felt unsafe and explicitly feared that he might be going insane.

On the other hand, the description she gave to the police and thus the one used in the second evaluation is very different. Here, she expressed her disbelief that her son might be involved in such a hideous crime and stressed how reasonable, mature, and kind he always was. She admitted that something about him had changed but the bizarre air of this alteration (elicited by the first team of psychiatrists) was absent here, and none of the previous information was taken up in the second assessment. Instead, it was stated in the second evaluation that ABB had changed slightly in the winter of 2011 and started working out a lot. The mother felt as if "he was a different person" [6, p. 87], but the nature of this transformation was not developed. Instead, it was explained with a reference to ABB's use of anabolic steroids: "She thought it had to do with "all the drugs he was taking" [6, p. 87].

2. The question of delusionality

The second evaluation also rebutted their predecessors' claim to have identified a number of delusions. This rebuttal concerns, for instance, an entry in the record of ABB's general practitioner in the spring of 2011: ABB expressed a worry that he might have been infected with his mother's sinusitis even though he had made a habit of wearing a mask indoors. During the first evaluation, ABB's mother explained that he ordered her not to sneeze, refused coming into the kitchen, and took his meals in his own room. He began walking around with his hands covering his face and for some time he

did indeed wear a mask. The first evaluation categorized this behavior as being expressive of delusional ideation. The second psychiatric team refuted that assessment. Not having addressed the issue directly with ABB, they based their appraisal on a brief psychiatric evaluation carried out in prison shortly after the first report was finalized and made public. ABB felt insulted upon learning his diagnosis. He declared that he would take the opportunity to modify some of his earlier statements in order to be judged compos mentis. Thus, with respect to the fear of infection, he now pointed out that he only wore the mask because he was eager to be fit for a shooting competition and denied having been fearful of getting infected in other contexts. On these grounds, the second team of experts decided to: "interpret the story of the mask differently, namely as exaggerated caution/hypochondria but with no failure of reality testing" [6, p. 219]. They concluded that nothing suggested that ABB should have harbored somatic delusions at any point.

Concerning ABB's belief system revolving around the Muslim take-over, left-wing complacency, preservation of a pure Norwegian genetic pool, and Knights Templars (an organization which does not exist), the second evaluation agreed with the first that ABB harbored pathological self-aggrandizement. However, by the time of the second assessment ABB downplayed the importance of the Knights Templars and pictured himself as a "foot-soldier", performing his duties and explained that he earlier had exaggerated his own role. The second evaluation stated that ABB had "ideas of heightened self-worth, power and knowledge that may be reminiscent of what is observed in delusional disorders. Not least the ideas concerning the Knights Templars appear peculiar. He has, however, rationalized this and explained that it is a *willed idea* (our italics)" [6, p. 225].

3) The negative symptomatology

ABB's practical involvement in the world was very limited from 2006 onwards. In the first evaluation his mother described how he inverted his circadian rhythm and spent most of his time in his own room. This was viewed in the first evaluation as being emblematic of developing negative symptomatology. The second evaluation, however, emphasized the rationality behind the withdrawal, namely ABB's wish to dedicate himself exclusively to his ideological project, pointing to "a willed and calculated action" [6, p. 223]. Furthermore attention is called to the apparent unlikelihood of a schizophrenia patient paying rent while living with his mother: "In a clinical setting it is not seldom seen that schizophrenic patients move in with their parents in the early stages of their illness *but usually they do not pay for it*" [6, p. 223] (our italics).

Both evaluations found that ABB exhibited blunted affect (also visible during the TV coverage of his trial) but differed entirely in evaluating its significance. The first report considered blunted (and occasionally incongruous) affect as clearly reflective of the negative domain of the clinical picture of schizophrenia, whereas the second assessment saw it "a token of failure of empathy"[6,p.222] and concluded that his "emotional flattening is not judged to be of the type that is seen in severe mental disorders but is understood to be expressive of pathological personality features" [6, p. 263].

4) The formal thought disorder (disorder of speech)

The first evaluation emphasized the presence of formal thought disorder severe enough to count as a diagnostic criterion for schizophrenia. They described loosening of associations, perseveration, and a tendency to employ mathematical terms where they were utterly out of place. Finally, they pointed out a significant number of self-created expressions such as "suicidal-humanist" and "knight-justiciar-grandmaster", which they qualified as neologisms. The second evaluation conceded that ABB's language usage was somewhat peculiar. Thus, the suicide risk assessments carried out in the first period of his incarceration mention, for instance, that ABB described his joie de vivre as alternating between 10-30% with apathy occurring at 0%. But rather than seeing those statements as indicative of psychopathology, the second assessment concluded that they were a rational and creative measure. Explicitly invoking ABB's own reference to an "effective means of communication" [6, p. 237], they stressed that it should not be viewed as "a sign of aberration" [6, p. 237]. Similarly the second evaluation acknowledged that ABB used a significant number of homemade words but rejected that this should be tantamount to formal thought disorder. Instead it is argued that since a word like "anarcho-jihadist" was made up of two existing words, it could not qualify for a neologism at all. The experts reasoned that the emergence of such words is an integral part of any dynamic language while neologisms should be understood as word-formations "wholly unknown and unintelligible to others" [6, p. 262]. This, then, allowed them to conclude that no schizophrenic formal thought disorder was detectable in the case of ABB.

5) The manifesto

The second evaluation offered a reasonably lengthy resume of the manifesto thus mapping out much of the thought system described by Melle. It also mentioned a reading by the Norwegian Police Security Service, pointing out that the document remained difficult to access in spite of its many chapters, because it was characterized by many repetitions. The experts conceded that they had no special authority on political or ideological matters but maintained that in order for them to fulfill their terms of reference they needed to address these issues nonethe-

less. They then concluded that aberrant and unacceptable as ABB's ideological aims may be, they were shared by a number of political subcultures and thusly not indicative of psychotic thought processes. Furthermore they stipulated that the sheer amount of research and work put into writing the manifesto by ABB was incompatible with (schizophrenic) withdrawal and psychotically conditioned loss of functioning.

Discussion

Similarities

The stories of PMR and ABB bear a significant resemblance, corresponding pointwise to each other with respect to the overall nature of psychopathology, the type of crime, and the motivations of those crimes by specific sets of beliefs. Both perpetrators found it worthwhile to produce a manifesto. In both cases, the ability to write a manifesto, and other indications of intact intelligence, were considered by some as being incompatible with the notion of psychosis. In both situations, a descriptive psychodiagnostic approach was employed, resulting in a diagnostic disagreement, vacillating between personality disorder and psychosis. Thus, despite the spectacular scientific, and especially neuroscientific, advances of the 170 years separating these events, on both occasions the diagnostic decisions were unanchored in any extra-clinical/neurobiological findings but relied exclusively on the interpretations of clinical descriptive data.
In both cases, the sets of assessors had access to a very similar, if not identical, body of information, from which they selected the elements that seemed to point to and support their diagnostic verdicts.

The reading template

A co-worker of Foucault, Philippe Riot [7], analyzed how, in the case of PMR, information was being sorted in the process of addressing the question of PMR's potential (in)-sanity. Foucault and Riot introduce here a notion of a "grille de lecture" or "reading template" (or, more broadly, "comprehension template"), a template, "which operates by a selection among the whole body of facts reported by Rivière and the witnesses and [which] sets up a coding system for their interpretation" [7, p. 235]. The reading template, so to say, *prefigures* the selection process, i.e. what, in fact, is being "read" at all, and what is seen as relevant. The examiner's conceptual sophistication, his professional knowledge, ethical inclinations, his cultural-social context, and a host of other, often tacit or hidden motivations and assumptions constitute a given template. The notion of a template is an instance of a larger question, namely the very nature of the epistemic or cognitive subject-world relation. What is relevant and what counts as a "fact" or "information" among the chaotic myriads of seemingly unconnected data, initially confronting us in any epistemic situation? Cognitive science talks here of the so-called "frame problem", i.e. "the issue of how to decide what is relevant, indeed what is even the relevant overall context within which to approach a given problem" [8, p. 356]. Phenomenology and cognitive science operate with the notions of prototype-gestalt and typification. Perceiving something is to perceive it *as a something*, i.e., as a token or instance of a certain type. This is intrinsic to all cognition and hence to the psychiatric diagnostic process as well. We always apprehend a clinical situation through a conceptual grid or template that imposes a provisional hierarchical matrix of relevance and signification on the single elements of the cognitive field. In other words, the epistemic act always activates a guiding prototype. Recent authoritative reviews of cognitive and theoretical research on mechanisms of concept formation, use, and understanding, suggest that concepts (thus including diagnostic and other psychopathological concepts) are not constituted by a list of criteria (which is called "the classical view") but are rather organized around prototypes [9]: a "(…) theory of concepts must be primarily prototype-based (…), within a broader knowledge representation scheme in which the concept is positioned both within a hierarchy and within a theoretical framework(s) appropriate to that domain" [10].
The creation of contemporary diagnostic systems such as DSM-III-5 and ICD-10 was, in fact, an epistemological regression. It was essentially motivated by a wish (theoretically and empirically uninformed and already outdated during the creation of DSM-III [for details see Parnas and Bovet 2014]) [11] to eliminate the influence of prototypical templates and to replace them with "objective" criteria ("objective" templates), i.e. basing the psychiatric diagnosis primarily on *a specific number of certain symptoms and signs* (see Nordgaard et al., 2013; Parnas et al., 2013) [8 12]. Those symptoms and signs were erroneously believed to be unproblematically definable through brief, lay language descriptions, independently of other symptoms and independently of any contextual relations (see Parnas and Bovet, 2014) [11].

The templates involved in the case of Rivière

In the PMR case, the role of different "reading templates" is easy to detect in the professional backgrounds of the involved parties. The "sanity"-party (the police, lawyers and Dr. Bouchard, all non-psychiatrists) did not ascribe any significant value to the historical information and failed to detect delusions as well as a flagrant irrationality of the motivation behind the triple murder. PMR's apparently high intelligence was interpreted as counting against

the possibility of psychosis. Their assessment pictured a malicious and cruel personality. The "insanity" party, on the other hand, was composed of psychiatrists. Among them was Esquirol, the ultimate authority on the issue of madness and the author of the first modern psychiatric textbook [13], and the man who developed the concept of "monomania", a precursor term for "delusion". Moreover, the French alienists were able to express their opinion without any distracting worries about political correctness, pressure from the public or the media. They took an inclusive or global view, thus also emphasizing the general sense of irrationality, not exhausted by isolated "monomaniac" statements. They concluded: "1) That Pierre Rivière consistently showed signs of madness since the age of four; 2) That his mental disorder persisted, though to a less intense degree, after the homicides he committed; 3) That the homicides are due solely and exclusively to delusion" [3, p. 165]. Furthermore they pointed out how some "mental defectives" [3, p. 165] experienced a temporary amelioration of their symptoms after their crime. What is remarkable here is the grasping of a gestalt of the entire story in its evolutive detail and the arrival at a portrait of an irrational, increasingly isolated person.

Templates in the case of ABB

The case of ABB is much more convoluted to assess. Independently of any further clinical or conceptual concern, it seems almost beyond belief that the two sets of psychiatrists could arrive at so different diagnoses. There were no known professional differences between the assessors. Both teams framed their diagnostic considerations in the terms of the ICD 10 (officially in use in Norway), serving as a part of their "reading template". Both teams had access to similar information. One potential and plausible source of difference is the time lag of approximately 6 months separating the two assessments. Yet the possibility of an amelioration of ABB's mental condition during his confinement (with regular psychiatric consultations during that time) was rejected in the second assessment. Another likely possibility, that ABB went to great lengths in order to dissimulate his condition (retracting, modifying or explaining away his initial statements) was dismissed by the second assessment with references to the lengthy interviews and the around the clock observation of his prison *behavior* during a period of 3 weeks, an observation that failed to detect hallucinatory attitudes, catatonic behavior or other bizarre features. A third factor, on which we only can speculate in the absence of any explicit information, is a potential effect of the court's unprecedented decision to order a second evaluation, even though the first one was duly approved by the Norwegian Psychiatric Forensic Council. The court's decision came in response to a *vox populi*, demanding, what was believed to be proper justice, i.e. an ordinary punishment rather than a psychiatric sanction. Norway's Prime Minister channeled that popular atmosphere by publicly stating shortly before the beginning of the trial that the country would be best served with a verdict of ordinary punishment. In other words, the very fact of ordering a second assessment might have carried with it an implicit message to find ABB non-psychotic and accountable for his horrific crimes.

The structure and content of both assessments correspond to the single ICD-10 criteria, even approaching a procrustrean level. As an example, the first evaluation saw ABB's delusions as being "bizarre". We agree with the presence of the element of "bizzareness" as this term is understood in phenomenological psychiatry [14]. However, the definition of "bizzareness" in ICD-10 and DSM-IV seems to include a feature of (physical) impossibility, which does not appear to be fulfilled by any of ABB's statements. The structure of the second psychiatric report resembles a point-by-point debunking of the first report, rather than providing an independent, de novo argument for the diagnosis of personality disorder. For example, one may wonder how compatible the notion of a narcissistic personality is with the absence of interpersonal relations (social isolation)? Would anonymous online gaming be a satisfactory substitute for personal relations in meeting the criterion of "desire for admiration", *constitutive* of the non-psychotic narcissism [15 16]? Is ABB's apparent solipsistic grandiosity of the narcissistic kind?

The "diagnostic criteria" of the ICD-10 (i.e., the symptoms and signs) are contrary to popular belief not "operational" in any epistemological or scientific sense. They are just brief common sense descriptions phrased in an ordinary non-technical lay language at "the lowest order of inference" [11]. This is, of course, a very serious deficiency of the polythetic system, whose categories are based on "symptom counting" [17]. This is amply illustrated by the disagreement on ABB's mental state. The ICD-10 "criteria", simplified into a-contextual primitives, fail to disambiguate the diagnostic questions. Even the relatively unambiguous definitions of behavioral "signs" (e.g. blunted affect) did not prevent the psychiatrists from engaging in psychological interpretations (see above: the negative symptoms and formal thought disorder).

The most significant problem confronting the ICD 10 approach is that psychiatric symptoms and signs are, in fact, *not* atomic, mutually independent entities, devoid of meaning, and ready to enter a diagnostic algorithm through their sheer sufficient number [8 18 19]. Rather, major psychiatric disorders and their component features (symptoms and signs) manifest (and were originally constituted by) their gestaltic salience [11]. The discussion of ABB's potential psychosis serves as an excellent illustration of the issue of gestalt. Thus, the second psychiatric evaluation, splitting up the psychopathological picture

into seemingly atomic, self-sufficient components, and addressing these one at a time and independently of each other, arrived at a gradual normalization of what at the first reading appeared as a sheer case of madness. However, ABB's isolation, fear of infection, bizarre home behavior, plans for genetic purification of Norway, membership of Knight Templars, and, most importantly, his logic behind murdering scores of social-democratic youngsters in order to prevent them from growing into potential future pro-islamic politicians, hardly appear, in our eyes, as mutually independent ideas, propositions, or contingent episodes of unrelated behaviors. Rather, they seem to operate as *interdependent aspects* of a *radical irrationality* or deficient "we"-perspective, characteristic of the psychotic disorders [20]. In fact, ABB's plan behind the crime closely resembles that of PMR: both plans can perhaps withstand a critical examination from the perspective of formal logic. At the same time, however, those plans violate "the logic of the world" [21], i.e., our pre-reflective, ante-predicative, and very basic attunement to the shared world, a "vital contact with reality" [22] or "common sense" [23]. In both crimes, we may therefore talk about "autistic activity" [22] or of "crazy action" ("Unsinnige Handlung") [24], a characteristic phenomenological feature of the schizophrenia spectrum disorders. As a matter of fact King Louis Philippe's minister of justice, a layman, recommended commuting PMR's sentence precisely because the parricide, in its motivation and execution, appeared to him as insane.

Conclusions

Prototypical considerations

Recently, we have witnessed a broad disappointment with the contemporary polythetic operational diagnostic systems, which have not only failed to translate into advances of etiological knowledge but also resulted in severe restrictions of clinical utility of psychiatric diagnosis [25 26 27 28 29 30]. These problems comprise a marked ignorance of descriptive psychopathology [26], high levels of co-morbidity (defying conceptual understanding), arbitrary diagnostic thresholds, "epidemics" of fashion diagnoses (e.g., the autistic spectrum, ADHD, "Borderline" etc.), and nearly insurmountable problems of differential diagnosis[2]. This latter issue is closely linked to the clinicians' lack of a prototypically organized grid that needs to be deployed in any diagnostic situation. This problem cannot be alleviated by a manual of differential diagnosis that consists exclusively of a multitude of computer-ready binary decision trees, each one starting from a different complaint [31]. These negative consequences and the stagnation of clinical psychiatry do not only follow from the complexity of the brain and human behavior or from fallible human implementation of the polythetic-operational ideas. Rather, the problems stem directly from the erroneous epistemological foundations of the entire operational project [11]. Defining diagnostic classes without any conceptual considerations of their phenomenological typicality and organizing structures is bound to create serious diagnostic confusions [2 20 32]. As an example, the DSM-IV diagnostic algorithm for "major depression" (where the composite criteria, e.g., psychomotor retardation/agitation, are split into the single symptoms) results in 1497 possible symptomatic combinations [33]. If the diagnosis "depression" is solely based on "symptom counting" and unaccompanied by a theoretical grasp of what we mean by the concept of depression and its corresponding prototypical-clinical instantiation (i.e. conceptual/construct validity), then the diagnostic category becomes a purely nominalistic label, devoid of meaning and applicable to a variety of disparate mental disorders.

Rivière and Breivik: the same prototype?

From our external point of view, nothing in the publicly accessible material regarding either PMR or ABB seems to be in contradiction with the diagnostic notion of a schizophrenia spectrum disorder. Schizophrenia is not only a mixture of positive and negative symptoms (defined at a very high severity level) with clear borders, as the DSM-5 and ICD-10 would have us believe. In empirical reality, schizophrenia is a certain prototypical gestalt that extends to milder, less symptomatic conditions, jointly designated as the schizophrenia spectrum disorders (SSD). It is not uncommon that an individual patient may occupy different of the SSD sub-categories over time [34]. The SSD is perhaps the most heavily research-validated psychiatric category [35] and it comprises in the ICD-10: schizophrenia, other non-affective psychosis, schizotypal disorder and perhaps paranoid personality disorder. The generative core of this gestalt comprises a dislocation from the shared, social world, inadequate grasp of shared meanings, fundamental disorders of self-experience and rationality, with an emergence of variously articulated, private ontological frameworks. These central features were subsumed by Bleuler, Minkowski, and Blankenburg, under the term of "autism" [36 37].

Both perpetrators seemed to manifest a psychopathological gestalt marked by interpersonal isolation and solitude, inadequate or bizarre interpersonal behaviors, indices of formal thought disorder, or more broadly, forms of radical irrationality, psychosis-near symptoms and frank delusions. The concepts of prototype and spectrum allow here for an intrinsic dimensionality of the clinical manifestation, with a possibility of clinically familiar oscillations between frankly psychotic and subpsychotic mental states.

Conflict of interests
None.

References

1 Melle I. *The Breivik case and what psychiatrists can learn from it*. World Psychiatry 2013;12:16-21.

2 Parnas J. *Differential diagnosis and current polythetic classification*. World Psychiatry in press.

3 Foucault M, editor. *I, Pierre Rivière, having slaughtered my mother, my sister, and my brother … A case of parricide in the 19th century*. Lincoln and London: University of Nebreaska Press 1975.

4 http://www.vg.no/nyheter/innenriks/22-juli/psykiatrisk_vurdering/.

5 Husby T. *Rettspsykiatrisk erklæring avgitt den 29.11.11 til Oslo Tingrett i henhold til oppnevnelse av 28.07.2011 [Forensic report]*.

6 Tørrissen T, Aspaas A. *Rettspsykiatrisk erklæring til Oslo tingrett. Avgitt 10.04.12*.

7 Riot P. *The parallel lives of Pierre Rivière*. In: Foucault F, editor. *I, Pierre Rivière, having slaughtered my mother, my sister, and my brother … A case of parricide in the 19th century*. Lincoln and London: University of Nebreaska Press 1975, pp. 229-50.

8 Nordgaard J, Sass LA, Parnas J. *The psychiatric interview: validity, structure, and subjectivity*. Eur Arch Psychiatry Clin Neurosci 2013;263:353-64.

9 Machery E. *Doing without Concepts*. New York: Oxford University Press 2009.

10 Murphy GL. *The big book of concepts*. Cambridge MA: The MIT Press 2002.

11 Parnas J, Bovet P. *Psychiatry made easy: operation(al)ism and some of its consequences*. In Kendler KS, Parnas J, editors. *philosophical issues in psychiatry III: the nature and sources of historical change*. Oxford: Oxford University Press 2014, pp. 190-213.

12 Parnas J, Sass LA, Zahavi D. *Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object*. Schizophr Bull 2013;39:270-7.

13 Esquirol JED. *Des maladies mentales considérées sous le rapport medical, hygiénique, et medico-légal*. Paris: Libraire de l'Académie Royale de Médicine 1838.

14 Cermolacce M, Sass L, Parnas J. *What is bizarre in bizarre delusions? A critical review*. Schizophr Bull 2010;36:667-79.

15 Kohut H. *The restoration of the self*. New York: International Universities Press 1977.

16 Kernberg OF. *Borderline conditions and pathological narcissism*. New York: Aronson 1975.

17 McHugh PR. *Rendering mental disorders intelligible: adressing psychiatry's urgent challenge*. In Kendler KS, Parnas, J, editors. *Philosophical issues in psychiatry II: noslogy*. Oxford: Oxford University Press 2012, pp. 269-80.

18 Parnas J, Sass LA, Zahavi D. *Recent developments in the philosophy of psychopathology*. Curr Opin Psychiatry 2008;21:578-84.

19 Parnas J, Sass LA, Zahavi D. *Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object*. Schizophr Bull 2013;39:270-7.

20 Parnas J. *Philosophical and phenomenological perspectives on psychosis*. In Waters F, Stephane M, editors. *The assessment of psychosis: a reference book and rating scales for research and practice*. New York: Routledge 2014, pp. 17-43.

21 Tatossian A. *Phénoménologie des psychoses*. Paris: Masson 1979.

22 Minkowski E. *La schizophrénie. Psychopathologie des schizoïdes et des schizophrénes*. Paris: Pavot 1927.

23 Blankenburg W. *Der Verlust der natürlichen Selbstverständlichkeit*. Stuttgart: Enke 1971.

24 Conrad K. *Die beginnende Schizophrenie – Versuch einer Gestaltanalyse des Wahns*. Stuttgart: Thieme 1958.

25 Andreasen NC. *DSM and the death of phenomenology in America: an example of unintended consequences*. Schizophr Bull 2007;33:102-12.

26 Frances AJ, Widiger T. *Psychiatric diagnoses: lessons from the DSM-IV past and cautions for the DSM-5 future*. Annu Rev Clin Psychol 2012;8:109-30.

27 Hyman SE. *The diagnosis of mental disorders: the problem of reification*. Annu Rev Clin Psychol 2010;6:155-79.

28 Hyman SE. *Diagnosing the DSM: diagnostic classification needs fundamental reform*. Cerebrum 2011Mar-Apr;2011:6.

29 Kendler KS, Parnas, J, editors. *Philosophical issues in psychiatry II: noslogy*. Oxford: Oxford University Press 2012.

30 Kendler KS, Parnas J, editors. *Philosophical issues in psychiatry III: the nature and sources of historical change*. Oxford: Oxford University Press 2014.

31 First M. *DSM 5 Handbook of differential diagnosis*. Arlington: American Psychiatric Publishing 2014.

32 Parnas J, Jansson L. *Self-disorders: clinical and conceptual implications for the diagnostic concept of schizophrenia*. Psychopathology, in press.

33 Østergaard SD, Jensen SO, Bech P. *The heterogeneity of the depressive syndrome: when numbers get serious*. Acta Psychiatr Scand 2011;124:495-6.

34 Parnas J, Raballo A, Handest P et al. *Self-experience in the early phases of schizophrenia: 5-year follow-up of the Copenhagen Prodromal Study*. World Psychiatry 2011;10:200-4.

35 Parnas J, Licht D, Bovet P. *Cluster A personality disorders: a review*. In Maj M, Akiskal HS, Mezzich JE, et al, editors. *Personality disorders. World Psychiatric Association's series in evidence and experience in psychiatry*. Chichester: John Wiley & Sons Ltd. 2005, pp. 1-74.

36 Parnas J. *DSM IV and the founding prototype of schizophrenia: Are we regressing to a pre-Kraepelinian nosology?* In Kendler KS, Parnas J, editors. *Philosophical issues in psychiatry II: Noslogy*. Oxford: Oxford University Press 2012, pp. 237-59.

37 Parnas J. *The core Gestalt of schizophrenia*. World Psychiatry 2012;11:67-9.