

The Insanity Defense: Bad or Mad or Both?

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The “insanity defense” is one of the most misunderstood aspects of forensic psychiatry. Not only is it an opportunity for laypersons (and not a few clinicians) to envision “hired guns” and “whores of the court,” but it brings to mind dangerous people being allowed to run amok in society after some token period of hospitalization.

Here’s what we’re talking about, broadly summarized, as codified in various state and federal statutes: A person generally has not committed a crime unless he or she has both committed an illegal act and *intended* to commit an illegal act. Thus there are lots of kinds of “killing,” but only some of them are “murder,” and lots of kinds of “taking,” only some of which are “stealing.” You can think of examples yourself, such as accidents, misunderstandings, self defense, acts by small children, and *some* acts by *some* people with a mental illness or “defect” (“defect” is usually a legal reference to mental retardation or a structural brain problem).

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That “some” is critical. As I’ve discussed in earlier columns, the point is not what diagnosis the defendant has, but how it affected his or her ability to do certain things at the time of the allegedly criminal act. The law says (using its own language, not our clinical definitions) that the relevant factor is the person’s *ability* to do certain specific things, not his or her diagnosis (or even symptoms *per se*).

The main differences among the various states’ insanity defense statutes have to do with how the insanity defense process can get started in a case, who has the burden of proving the presence or absence of legal “insanity,”

and whether or not the statute allows for a defendant who is otherwise sane but, because of a mental disease or defect, could not *resist* committing a particular act (referred to as the “volitional” part of some insanity defense laws). Some states refer to knowing (or “appreciating”) what one is doing; others refer to being able to know. Most insanity defense statutes read something like the following (assuming they lack the “volitional” part just mentioned).

A defendant must be found not guilty by reason of insanity if, at the time of the alleged offense, and as a result of a severe mental disease or defect, he did not know what he was doing, or that what he was doing was wrong.

For the purposes of this statute, “mental disease or defect” does not include a condition for which the only, or primary, manifestation is chronic antisocial or illegal behavior.

Lots of Smoke, Not Much Fire

In spite of all the media hype and cocktail party conversation, the insanity defense is quite uncommon. Lawyers consider it from time to time, but several things prevent its being raised very often.

First, it’s hard to win. In a typical case, the defendant must virtually admit he or she committed the act of which he is accused. Then the lawyer must a) struggle to convince the jury or judge that the defendant shouldn’t be held responsible for it (even in today’s climate of personal responsibility), b) allay jurors’ near-primal fears of people who are mentally ill and dangerous, and c) try to get them to consider the defendant’s mental state objectively while the prosecution is presenting them with gruesome descriptions of the victim(s) (often accompanied by large, color photos).

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What do each of the following killers have in common: Ted Bundy (who killed young women on two coasts), John Wayne Gacy (who buried the remains of over 30 young men in the walls and floor of his house), Albert DeSalvo (the "Hillside Strangler"), David Berkowitz (whose nickname "Son of Sam" came from the instructions he said came from his neighbor's dog), and Jeffrey Dahmer (who ate parts of his victims).

That's one of my favorite questions to audiences when I give talks about the insanity defense. Invariably, some hapless listener yells out "They were all found not guilty by reason of insanity" or "Some shrink got them off with the insanity defense." In fact, although all of them attempted an insanity defense, none was successful and all but one are dead, executed by the State or their fellow inmates.

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In addition to the probability of losing, even psychiatrically deserving defendants may not agree to an insanity plea because they don't want to be viewed as mentally ill. Sometimes this has to do with a wish to be just "bad" rather than "bad and mad." In other cases, a person with genuine mental illness may deny his illness by eschewing that avenue of defense.

Ted Kaczynski, the so-called "unabomber," instructed his attorneys not to raise the issue of his competence or sanity. Although one reason may have been to preserve his right to make political statements from the stand (not uncommon in terrorism trials), he also appeared very reluctant to have people view him, and his opinions, as being out of touch with reality.

Case Examples

The following examples illustrate the difficulty juries have finding psychiatric mitigation of brutal behavior.

Although he had no formal psychiatric history, a middle-aged senior Navy noncommissioned officer developed increasing paranoia about the way his wife

treated their daughter and his children by a previous wife. Many witnesses agreed that he believed she was using voodoo on him, sapping his strength, and trying to cheat his children out of their military service benefits. The witnesses also testified that his wife was, in reality, manipulating and humiliating him, which caused him great anguish. Eventually, he sent long, rambling letters to several relatives telling them that he would have to kill her if she did not stop. The letters, which I believe were genuine, had considerable psychotic content, bizarre justifications of the need to kill her, and instructions about caring for his children after he died. Very soon after mailing them, he went to his home and killed her; her infant grandson, and his infant daughter with his service pistol. He then called police and waited for them to arrive, emerging from the house weeping and tenderly carrying his dead baby.

No insanity defense was entered, but the sentencing phase of the trial focused on "mitigating circumstances" to try to avoid the death penalty. After the defendant was found guilty, the jury heard testimony about his psychiatric symptoms, his excellent work record, the lack of violence in his background (he had never been involved in combat), his love for all of his children, and the absence of any indication that he would be a violent threat to prison staff or other inmates if he were to be sentenced to life in prison instead of death. The jury sentenced him to death.

A young man had been raised by a lesbian mother, who had allowed herself to be impregnated by a man whom she then immediately left. She expected her child to be a female, and when he turned out to be male she gave him a feminine name (which she legally changed to an androgynous one after a few years). Before he was six, she occasionally dressed him in girls' clothing, encouraged him to be effeminate for her friends, and took pictures of him wearing frilly dresses. When he was 4 or 5 years old, she spent several months in a "separatist" colony (a group of women who avoided all contact with males), where he was the only male. When he was approaching puberty, she exposed herself to him during her menses, in the presence of another woman, and laughed about his needing "to know about these things." This happened again during adolescence. She derided him when he wanted to date girls in high school and during his senior year sent him to live with an openly homosexual male artist so that he could "learn about gay men."

Late in adolescence, he began to exhibit psychotic symptoms and antisocial behavior. He was hospitalized several times for schizophrenia, sometimes as part of deferred adjudication for inappropriate

behavior toward women (e.g., breaking into a house and standing over a sleeping woman, believing she was a friend in another person's body; breaking in and leaving branches of nettles on a teenage girl's bed). Some of these events may have been associated with substance abuse, but there was ample evidence of functional psychosis as well. He was receiving Social Security disability payments because of his illness.

A few days before the alleged crime, several weeks after discontinuing his antipsychotic medication, he left his house and stayed alone in a wooded area. There is no indication that he used any illegal drugs, but he may have been actively hallucinating. He then went to his mother's home, hit her on the head with a heavy object, and continued beating her until she lost consciousness and died. The police described a very unusual crime scene. The mother's body was found near the front door, nude from the waist down, and had been smeared with Campho Phenique™, an oily camphor substance. There was a bathtub full of water and a single swipe mark from a bloody mop, but no other evidence that someone had tried to conceal a crime. The police next went to the defendant's house and found him cowering nude in a closet. His house was extremely disheveled, with many unusual characteristics (e.g., bizarre marks and words on the walls, windows painted over, and ritualistic-appearing piles of objects on the floor).

An insanity plea was entered. Well-corroborated history, interviews, and comprehensive testing (including instruments designed to elicit signs of malingering) all suggested chronic psychosis with an acute exacerbation in which he believed his mother had been replaced by a demon. The psychosis remitted somewhat with antipsychotic medication while he was in jail awaiting trial, but the delusion that he had killed a demon and not his "real" mother persisted. He would sometimes say that his real mother was somewhere in the stars, watching over him, since being driven from her body by the demon he eventually killed.

The defendant declined a plea bargain, expressing the expectation that he would be sent to a hospital for "about a year, or maybe get probation." At trial, the prosecutor focused on his outward (if rather inept) manipulateness and on the brutality of the killing. In spite of testimony in his defense by his mother's friends, all of whom believed he was very ill and that his mother would not have wanted him to go to prison, he was found guilty and received a very long sentence.

One successful insanity plea from the 1970s might turn out differently today.

A young mother killed her four children, aged 3 months to 6 years. She had no prior psychiatric history, and there was no indication that she had tried to kill herself as well. She sat quietly until her husband came home, then allowed herself to be taken to jail and a psychiatric hospital.

At her trial, the psychiatrist for the prosecution acknowledged the probability of postpartum depression or psychosis, but noted that there was no indication that she didn't know the nature and consequences of her acts, nor that they were wrong. The defense's psychiatrist testified for only a few minutes, largely to say to the jury that no "sane" mother would kill her children. She was found NGRI and hospitalized for several years.

A Controversial Strategy

From time to time, defense attorneys rediscover the idea that if a defendant with severe mental illness is allowed to remain psychotic, he or she will have a better chance to convince a jury that the illness is real and could have kept him from knowing what he was doing (in legal terms, from forming the "intent" required in order to be convicted of a crime).

A man with a clear history of chronic psychotic illness was accused of pushing a young woman into the path of a speeding New York subway train. He was subsequently evaluated and found to be so psychotic that he was not competent to stand trial. He was placed on antipsychotic medication, which alleviated the psychosis and restored his competence, but left him sleepy and reserved during his eventual trial. The jury deadlocked. As a new trial approaches, his attorney wants to have the defendant's medication stopped so that he will appear psychotic before the jury, presenting in what the lawyer describes as his former violent and extremely delusional state.

Some mental health professionals and advocates view this as a logical effort to help the jury understand the true condition of the defendant. Most legal and forensic scholars and practitioners, however, recognize many flaws in such a plan.

First, avoiding treatment would often deprive the defendant of his right to be competent during his trial (i.e., his right to be present in both mind and body to confront his accusers and participate in his defense). Whatever the imagined benefit to an individual defense, a broad judicial policy of preserving the right to be competent during trial is arguably a higher priority. Many states simply will not allow a defendant to voluntarily remain incompetent to stand trial (unless the treatment is unusually dangerous). To do so would force the conundrum of letting the defendant himself control whether or

not he is ever tried, while anticipating that he will eventually petition for release on grounds of never having been convicted.

There is a substantial ethical issue associated with any physician's being a party to stopping clinically needed care, or deciding not to treat a condition such as psychosis or depression, for some social purpose.

Second, defense lawyers may be somewhat naive about the state in which their clients will appear if left unmedicated. Many people with psychotic illness have symptoms that change from week to week, day to day, or even hour to hour. Some get worse after events such as killing someone, being arrested (and perhaps pursued and traumatized in the process), being incarcerated, and facing trial. Some develop psychosis only after the incident of which they are accused, or may be profoundly depressed about what they have done. On the other hand, some defendants improve after an event such as a murder,

which may have some temporary internal "resolving" influence, or in the often structured environment of incarceration. These post-incident states may be irrelevant to the person's condition at the time of the act for which he or she was arrested (the only time that really matters). In any event, any psychosis that is produced by stopping or withholding antipsychotic medication is unlikely to be exactly the same as that allegedly present during the "crime."

Third, there is a substantial ethical issue associated with any physician's being a party to stopping clinically needed care, or deciding not to treat a condition such as psychosis or depression, for some social purpose. While a case might be made for such a strategy being in the patient's interest (and any person about whom you are making treatment decisions *is* your "patient"), these symptoms are not usually benign. They are painful and can be dangerous.

Finally, presenting a delusional defendant to a jury can backfire. Laypersons are often afraid of people who appear dangerous and psychotic. The jurors may, and often do, decide that although the defendant is "sick," the safest place to treat him is in prison rather than a psychiatric hospital (where, they probably believe, he could be quickly released).

The Final Word

The insanity defense is neither overused nor an easy way for accused criminals to "beat the rap." It's not a strategy for the faint of heart.